

# Union Calendar No. 168

111<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 3200

**[Report No. 111–299, Parts I, II, and III]**

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

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## IN THE HOUSE OF REPRESENTATIVES

JULY 14, 2009

Mr. DINGELL (for himself, Mr. RANGEL, Mr. WAXMAN, Mr. GEORGE MILLER of California, Mr. STARK, Mr. PALLONE, and Mr. ANDREWS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

OCTOBER 14, 2009

Additional sponsors: Mr. KILDEE, Mrs. MALONEY, and Mr. BACA

OCTOBER 14, 2009

Reported from the Committee on Energy and Commerce with an amendment  
[Strike out all after the enacting clause (other than sections 321 and 322, title IV of division A, subtitle A of title I of division B, and title VIII of division B) and insert the part printed in *italic*]

[For text of sections 321 and 322, title IV of division A, subtitle A of title I of division B, and title VIII of division B, see copy of bill as introduced on July 14, 2009]

OCTOBER 14, 2009

Reported from the Committee on Ways and Means with an amendment

[Strike out all after the enacting clause (other than title VII of division B and division C) and insert the part printed in boldface roman]

[For text of title VII of division B and for division C (and the original sections of the bill that fall within the jurisdiction of the Committee on Ways and Means), see copy of bill as introduced on July 14, 2009]

OCTOBER 14, 2009

Reported from the Committee on Education and Labor with an amendment

[Strike out all after the enacting clause (other than sections 161 through 163, 322, and 323 and title IV of division A, division B, section 2002 and titles I through IV of division C, and subtitles A, B, C, and E of title V of division C) and insert the part printed in boldface italic]

[For text of sections 161 through 163, 322, and 323 and title IV of division A, division B, section 2002 and titles I through IV of division C, and subtitles A, B, C, and E of title V of division C, see copy of bill as introduced on July 14, 2009]

OCTOBER 14, 2009

Committees on Oversight and Government Reform and the Budget discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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## **A BILL**

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

1 *Be it enacted by the Senate and House of Representa-*  
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES,**  
 4 **AND SUBTITLES.**

5 (a) *SHORT TITLE.*—*This Act may be cited as the*  
 6 *“America’s Affordable Health Choices Act of 2009”.*

7 (b) *TABLE OF DIVISIONS, TITLES, AND SUBTITLES.*—  
 8 *This Act is divided into divisions, titles, and subtitles as*  
 9 *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*

*Subtitle G—Early Investments*

*TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVI-  
 SIONS*

*Subtitle A—Health Insurance Exchange*

*Subtitle B—Public Health Insurance Option*

*Subtitle C—Individual Affordability Credits*

*Subtitle D—Health Insurance Cooperatives*

*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 Carry Out Health Insurance Exchange Subsidies*

*Subtitle D—Other Revenue Provisions*

*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 Medicare 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 Provision*

*Subtitle E—Public Reporting on Health Care-Associated Infections*

**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, Waste, and Abuse*

**TITLE VII—MEDICAID AND CHIP**

*Subtitle A—Medicaid and Health Reform*

*Subtitle B—Prevention*

*Subtitle C—Access*

*Subtitle D—Coverage*

*Subtitle E—Financing*

*Subtitle F—Waste, Fraud, and Abuse*

*Subtitle G—Payments to the Territories*

*Subtitle H—Miscellaneous*

**TITLE VIII—REVENUE-RELATED PROVISIONS**

**TITLE IX—MISCELLANEOUS PROVISIONS**

**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**

*Subtitle A—Drug Discount for Rural and Other Hospitals*

*Subtitle B—Programs*

*Subtitle C—Food and Drug Administration*

*Subtitle D—Community Living Assistance Services and Supports*

*Subtitle E—Miscellaneous*

1           ***DIVISION A—AFFORDABLE***  
2           ***HEALTH CARE CHOICES***

3 ***SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION;***  
4           ***GENERAL DEFINITIONS.***

5           *(a) PURPOSE.—*

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

10                *(2) BUILDING ON CURRENT SYSTEM.—This divi-*  
11                *sion achieves this purpose by building on what works*  
12                *in today’s health care system, while repairing the as-*  
13                *pects that are broken.*

14                *(3) INSURANCE REFORMS.—This division—*

15                     *(A) enacts strong insurance market reforms;*

16                     *(B) creates a new Health Insurance Ex-*  
17                     *change, with a public health insurance option*  
18                     *alongside private plans and cooperatives under*  
19                     *subtitle D of title II;*

20                     *(C) includes sliding scale affordability cred-*  
21                     *its; and*

22                     *(D) initiates shared responsibility among*  
23                     *workers, employers, and the government;*  
24                 *so that all Americans have coverage of essential health*  
25                 *benefits.*

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

6           (b) *TABLE OF CONTENTS OF DIVISION.*—*The table of*  
 7           *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 preexisting condition exclusions.*

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

*Sec. 113. Insurance rating rules.*

*Sec. 114. Nondiscrimination in benefits; parity in mental health and substance  
 abuse disorder benefits.*

*Sec. 115. Ensuring adequacy of provider networks.*

*Sec. 116. Ensuring value and lower premiums.*

*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 standards.*

*Sec. 125. Prohibition of discrimination in health care services based on religious  
 or spiritual content.*

*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.*

*Sec. 137. Application of administrative simplification.*

*Sec. 138. Information on end-of-life planning.*

*Sec. 139. Utilization review activities.*

*Sec. 139A. Internal appeals procedures.*

*Sec. 139B. External appeals procedures.*

*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.*

*Sec. 153. Whistleblower protection.*

*Sec. 154. Construction regarding collective bargaining.*

*Sec. 155. Severability.*

*Sec. 156. Application of State and Federal laws regarding abortion.*

*Sec. 157. Non-discrimination on abortion and respect for rights of conscience.*

*Subtitle G—Early Investments*

*Sec. 161. Ensuring value and lower premiums.*

*Sec. 162. Ending health insurance rescission abuse.*

*Sec. 163. Ending health insurance denials and delays of necessary treatment for children with deformities.*

*Sec. 164. Administrative simplification.*

*Sec. 165. Expansion of electronic transactions in medicare.*

*Sec. 166. Reinsurance program for retirees.*

*Sec. 167. Limitations on preexisting condition exclusions in group health plans and health insurance coverage in the group and individual markets in advance of applicability of new prohibition of preexisting condition exclusions.*

**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 plans.*

*Sec. 206. Other functions.*

*Sec. 207. Health Insurance Exchange Trust Fund.*

*Sec. 208. Optional operation of State-based health insurance exchanges.*

*Sec. 209. Limitation on premium increases under Exchange-participating health benefits plans.*

*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. Negotiated 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.*  
*Sec. 227. Application of HIPAA insurance requirements.*  
*Sec. 228. Application of health information privacy, security, and electronic transaction requirements.*  
*Sec. 229. Enrollment in public health insurance option is voluntary.*

*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.*

*Subtitle D—Health Insurance Cooperatives*

- Sec. 251. Establishment.*  
*Sec. 252. Start-up and solvency grants and loans.*  
*Sec. 253. Definitions.*

*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 Carry Out Health Insurance Exchange Subsidies*

*Sec. 431. Disclosures to carry out health insurance exchange subsidies.*

*Subtitle D—Other Revenue Provisions*

## PART 1—GENERAL PROVISIONS

*Sec. 441. Surcharge on high income individuals.*

*Sec. 442. Delay in application of worldwide allocation of interest.*

## PART 2—PREVENTION OF TAX AVOIDANCE

*Sec. 451. Limitation on treaty benefits for certain deductible payments.*

*Sec. 452. Codification of economic substance doctrine.*

*Sec. 453. Penalties for underpayments.*

1           (c) *GENERAL DEFINITIONS.—Except as otherwise pro-*  
2 *vided, in this division:*

3                   (1) *ACCEPTABLE COVERAGE.—The term “accept-*  
4 *able coverage” has the meaning given such term in*  
5 *section 202(d)(2).*

6                   (2) *BASIC PLAN.—The term “basic plan” has the*  
7 *meaning given such term in section 203(c).*

8                   (3) *COMMISSIONER.—The term “Commissioner”*  
9 *means the Health Choices Commissioner established*  
10 *under section 141.*

11                   (4) *COST-SHARING.—The term “cost-sharing” in-*  
12 *cludes deductibles, coinsurance, copayments, and*  
13 *similar charges but does not include premiums or any*  
14 *network payment differential for covered services or*  
15 *spending for non-covered services.*

1           (5) *DEPENDENT*.—The term “dependent” has the  
2           meaning given such term by the Commissioner and  
3           includes a spouse.

4           (6) *EMPLOYMENT-BASED HEALTH PLAN*.—The  
5           term “employment-based health plan”—

6                   (A) means a group health plan (as defined  
7                   in section 733(a)(1) of the *Employee Retirement*  
8                   *Income Security Act of 1974*); and

9                   (B) includes such a plan that is the fol-  
10                  lowing:

11                           (i) *FEDERAL, STATE, AND TRIBAL GOV-*  
12                           *ERNMENTAL PLANS*.—A governmental plan  
13                           (as defined in section 3(32) of the *Employee*  
14                           *Retirement Income Security Act of 1974*),  
15                           including a health benefits plan offered  
16                           under chapter 89 of title 5, *United States*  
17                           *Code*.

18                           (ii) *CHURCH PLANS*.—A church plan  
19                           (as defined in section 3(33) of the *Employee*  
20                           *Retirement Income Security Act of 1974*).

21           (7) *ENHANCED PLAN*.—The term “enhanced  
22           plan” has the meaning given such term in section  
23           203(c).

1           (8) *ESSENTIAL BENEFITS PACKAGE.*—*The term*  
2           *“essential benefits package” is defined in section*  
3           *122(a).*

4           (9) *FAMILY.*—*The term “family” means an indi-*  
5           *vidual and includes the individual’s dependents.*

6           (10) *FEDERAL POVERTY LEVEL; FPL.*—*The terms*  
7           *“Federal poverty level” and “FPL” have the meaning*  
8           *given the term “poverty line” in section 673(2) of the*  
9           *Community Services Block Grant Act (42 U.S.C.*  
10           *9902(2)), including any revision required by such sec-*  
11           *tion.*

12           (11) *HEALTH BENEFITS PLAN.*—*The terms*  
13           *“health benefits plan” means health insurance cov-*  
14           *erage and an employment-based health plan and in-*  
15           *cludes the public health insurance option and co-*  
16           *operatives under subtitle D of title II.*

17           (12) *HEALTH INSURANCE COVERAGE; HEALTH*  
18           *INSURANCE ISSUER.*—*The terms “health insurance*  
19           *coverage” and “health insurance issuer” have the*  
20           *meanings given such terms in section 2791 of the*  
21           *Public Health Service Act.*

22           (13) *HEALTH INSURANCE EXCHANGE.*—*The term*  
23           *“Health Insurance Exchange” means the Health In-*  
24           *surance Exchange established under section 201.*

1           (14) *MEDICAID*.—*The term “Medicaid” means a*  
2           *State plan under title XIX of the Social Security Act*  
3           *(whether or not the plan is operating under a waiver*  
4           *under section 1115 of such Act).*

5           (15) *MEDICARE*.—*The term “Medicare” means*  
6           *the health insurance programs under title XVIII of*  
7           *the Social Security Act.*

8           (16) *PLAN SPONSOR*.—*The term “plan sponsor”*  
9           *has the meaning given such term in section 3(16)(B)*  
10          *of the Employee Retirement Income Security Act of*  
11          *1974.*

12          (17) *PLAN YEAR*.—*The term “plan year”*  
13          *means—*

14                (A) *with respect to an employment-based*  
15                *health plan, a plan year as specified under such*  
16                *plan; or*

17                (B) *with respect to a health benefits plan*  
18                *other than an employment-based health plan, a*  
19                *12-month period as specified by the Commis-*  
20                *sioner.*

21          (18) *PREMIUM PLAN; PREMIUM-PLUS PLAN*.—*The*  
22          *terms “premium plan” and “premium-plus plan”*  
23          *have the meanings given such terms in section 203(c).*

1           (19) *QHBP OFFERING ENTITY*.—*The terms*  
2           “*QHBP offering entity*” *means, with respect to a*  
3           *health benefits plan that is—*

4                     (A) *a group health plan (as defined, subject*  
5                     *to subsection (d), in section 733(a)(1) of the Em-*  
6                     *ployee Retirement Income Security Act of 1974),*  
7                     *the plan sponsor in relation to such group health*  
8                     *plan, except that, in the case of a plan main-*  
9                     *tained jointly by 1 or more employers and 1 or*  
10                    *more employee organizations and with respect to*  
11                    *which an employer is the primary source of fi-*  
12                    *nancing, such term means such employer;*

13                    (B) *health insurance coverage, the health in-*  
14                    *surance issuer offering the coverage, including a*  
15                    *cooperative under subtitle D of title II;*

16                    (C) *the public health insurance option, the*  
17                    *Secretary of Health and Human Services;*

18                    (D) *a non-Federal governmental plan (as*  
19                    *defined in section 2791(d) of the Public Health*  
20                    *Service Act), the State or political subdivision of*  
21                    *a State (or agency or instrumentality of such*  
22                    *State or subdivision) which establishes or main-*  
23                    *tains such plan; or*

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

4           (20) QUALIFIED HEALTH BENEFITS PLAN.—The  
5           term “qualified health benefits plan” means a health  
6           benefits plan that meets the requirements for such a  
7           plan under title I and includes the public health in-  
8           surance option and cooperatives under subtitle D of  
9           title II.

10          (21) PUBLIC HEALTH INSURANCE OPTION.—The  
11          term “public health insurance option” means the pub-  
12          lic health insurance option as provided under subtitle  
13          B of title II.

14          (22) SERVICE AREA; PREMIUM RATING AREA.—  
15          The terms “service area” and “premium rating area”  
16          mean with respect to health insurance coverage—

17               (A) offered other than through the Health  
18               Insurance Exchange, such an area as established  
19               by the QHBP offering entity of such coverage in  
20               accordance with applicable State law; and

21               (B) offered through the Health Insurance  
22               Exchange, such an area as established by such  
23               entity in accordance with applicable State law  
24               and applicable rules of the Commissioner for Ex-  
25               change-participating health benefits plans.

1           (23) *STATE*.—The term “State” means the 50  
2           States and the District of Columbia.

3           (24) *STATE MEDICAID AGENCY*.—The term  
4           “State Medicaid agency” means, with respect to a  
5           Medicaid plan, the single State agency responsible for  
6           administering such plan under title XIX of the Social  
7           Security Act.

8           (25) *Y1, Y2, ETC.*.—The terms “Y1” , “Y2”,  
9           “Y3”, “Y4”, “Y5”, and similar subsequently num-  
10          bered terms, mean 2013 and subsequent years, respec-  
11          tively.

12       **TITLE I—PROTECTIONS AND**  
13       **STANDARDS FOR QUALIFIED**  
14       **HEALTH BENEFITS PLANS**  
15       **Subtitle A—General Standards**

16       **SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE**  
17       **MARKETPLACE.**

18       (a) *PURPOSE*.—The purpose of this title is to establish  
19       standards to ensure that new health insurance coverage and  
20       employment-based health plans that are offered meet stand-  
21       ards guaranteeing access to affordable coverage, essential  
22       benefits, and other consumer protections.

23       (b) *REQUIREMENTS FOR QUALIFIED HEALTH BENE-*  
24       *FITS PLANS*.—On or after the first day of Y1, a health bene-  
25       fits plan shall not be a qualified health benefits plan under

1 *this division unless the plan meets the applicable require-*  
 2 *ments of the following subtitles for the type of plan and*  
 3 *plan year involved:*

4 (1) *Subtitle B (relating to affordable coverage).*

5 (2) *Subtitle C (relating to essential benefits).*

6 (3) *Subtitle D (relating to consumer protection).*

7 (c) *TERMINOLOGY.—In this division:*

8 (1) *ENROLLMENT IN EMPLOYMENT-BASED*  
 9 *HEALTH PLANS.—An individual shall be treated as*  
 10 *being “enrolled” in an employment-based health plan*  
 11 *if the individual is a participant or beneficiary (as*  
 12 *such terms are defined in section 3(7) and 3(8), re-*  
 13 *spectively, of the Employee Retirement Income Secu-*  
 14 *rity Act of 1974) in such plan.*

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

22 **SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT**  
 23 **COVERAGE.**

24 (a) *GRANDFATHERED HEALTH INSURANCE COVERAGE*  
 25 *DEFINED.—Subject to the succeeding provisions of this sec-*



1 *tion, for purposes of establishing acceptable coverage under*  
2 *this division, the term “grandfathered health insurance cov-*  
3 *erage” means individual health insurance coverage that is*  
4 *offered and in force and effect before the first day of Y1*  
5 *if the following conditions are met:*

6 (1) *LIMITATION ON NEW ENROLLMENT.—*

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

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

16 (2) *LIMITATION ON CHANGES IN TERMS OR CON-*  
17 *DITIONS.—Subject to paragraph (3) and except as re-*  
18 *quired by law, the issuer does not change any of its*  
19 *terms or conditions, including benefits and cost-shar-*  
20 *ing, from those in effect as of the day before the first*  
21 *day of Y1.*

22 (3) *RESTRICTIONS ON PREMIUM INCREASES.—*  
23 *The issuer cannot vary the percentage increase in the*  
24 *premium for a risk group of enrollees in specific*  
25 *grandfathered health insurance coverage without*

1        *changing the premium for all enrollees in the same*  
2        *risk group at the same rate, as specified by the Com-*  
3        *missioner.*

4        *(b) GRACE PERIOD FOR CURRENT EMPLOYMENT-*  
5        *BASED HEALTH PLANS.—*

6                *(1) GRACE PERIOD.—*

7                        *(A) IN GENERAL.—The Commissioner shall*  
8                        *establish a grace period whereby, for plan years*  
9                        *beginning after the end of the 5-year period be-*  
10                        *ginning with Y1, an employment-based health*  
11                        *plan in operation as of the day before the first*  
12                        *day of Y1 must meet the same requirements as*  
13                        *apply to a qualified health benefits plan under*  
14                        *section 101, including the essential benefit pack-*  
15                        *age requirement under section 121.*

16                        *(B) EXCEPTION FOR LIMITED BENEFITS*  
17                        *PLANS.—Subparagraph (A) shall not apply to*  
18                        *an employment-based health plan in which the*  
19                        *coverage consists only of one or more of the fol-*  
20                        *lowing:*

21                                *(i) Any coverage described in section*  
22                                *3001(a)(1)(B)(ii)(IV) of division B of the*  
23                                *American Recovery and Reinvestment Act*  
24                                *of 2009 (PL 111–5).*

1                   (ii) *Excepted benefits (as defined in*  
 2                   *section 733(c) of the Employee Retirement*  
 3                   *Income Security Act of 1974), including*  
 4                   *coverage under a specified disease or illness*  
 5                   *policy described in paragraph (3)(A) of*  
 6                   *such section.*

7                   (iii) *Such other limited benefits as the*  
 8                   *Commissioner may specify.*

9                   *In no case shall an employment-based health*  
 10                  *plan in which the coverage consists only of one*  
 11                  *or more of the coverage or benefits described in*  
 12                  *clauses (i) through (iii) be treated as acceptable*  
 13                  *coverage under this division*

14                  (2) *TRANSITIONAL TREATMENT AS ACCEPTABLE*  
 15                  *COVERAGE.—During the grace period specified in*  
 16                  *paragraph (1)(A), an employment-based health plan*  
 17                  *that is described in such paragraph shall be treated*  
 18                  *as acceptable coverage under this division.*

19                  (c) *LIMITATION ON INDIVIDUAL HEALTH INSURANCE*  
 20                  *COVERAGE.—*

21                  (1) *IN GENERAL.—Individual health insurance*  
 22                  *coverage that is not grandfathered health insurance*  
 23                  *coverage under subsection (a) may only be offered on*  
 24                  *or after the first day of Y1 as an Exchange-participating*  
 25                  *health benefits plan.*

1           (2) *SEPARATE, EXCEPTED COVERAGE PER-*  
2 *MITTED.—Excepted benefits (as defined in section*  
3 *2791(c) of the Public Health Service Act) are not in-*  
4 *cluded within the definition of health insurance cov-*  
5 *erage. Nothing in paragraph (1) shall prevent the of-*  
6 *fering, other than through the Health Insurance Ex-*  
7 *change, of excepted benefits so long as it is offered and*  
8 *priced separately from health insurance coverage.*

9           (3) *STAND-ALONE DENTAL AND VISION COVERAGE*  
10 *PERMITTED.—Nothing in this division shall be con-*  
11 *strued—*

12                   (A) *to prevent the offering of a stand-alone*  
13 *plans that offer coverage of excepted benefits de-*  
14 *scribed in section 2791(c)(2)(A) of the Public*  
15 *Health Service Act (relating to limited scope*  
16 *dental or vision benefits)for individuals and*  
17 *families from a State licensed dental and vision*  
18 *carrier; or*

19                   (B) *as applying requirements for a quali-*  
20 *fied health benefits plan to such stand-alone*  
21 *plans that is offered and priced separately from*  
22 *a qualified health benefits plan.*

1 **Subtitle B—Standards Guaranteing Access to Affordable Cov-**  
2 **erage**  
3

4 **SEC. 111. PROHIBITING PREEXISTING CONDITION EXCLU-**  
5 **SIONS.**

6 *A qualified health benefits plan may not impose any*  
7 *preexisting condition exclusion (as defined in section*  
8 *2701(b)(1)(A) of the Public Health Service Act) or otherwise*  
9 *impose any limit or condition on the coverage under the*  
10 *plan with respect to an individual or dependent based on*  
11 *any health status-related factors (as defined in section*  
12 *2791(d)(9) of the Public Health Service Act) in relation to*  
13 *the individual or dependent.*

14 **SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR INSURED**  
15 **PLANS.**

16 *The requirements of sections 2711 (other than sub-*  
17 *sections (c) and (e)) and 2712 (other than paragraphs (3),*  
18 *and (6) of subsection (b) and subsection (e)) of the Public*  
19 *Health Service Act, relating to guaranteed availability and*  
20 *renewability of health insurance coverage, shall apply to in-*  
21 *dividuals and employers in all individual and group health*  
22 *insurance coverage, whether offered to individuals or em-*  
23 *ployers through the Health Insurance Exchange, through*  
24 *any employment-based health plan, or otherwise, and shall*  
25 *apply to the public health insurance option, in the same*

1 manner as such sections apply to employers and health in-  
2 surance coverage offered in the small group market, except  
3 that such section 2712(b)(1) shall apply only if, before non-  
4 renewal or discontinuation of coverage, the issuer has pro-  
5 vided the enrollee with notice of non-payment of premiums  
6 and there is a grace period during which the enrollee has  
7 an opportunity to correct such nonpayment. Rescissions of  
8 such coverage shall be prohibited except in cases of fraud  
9 as defined in sections 2712(b)(2) of such Act.

10 **SEC. 113. INSURANCE RATING RULES.**

11 (a) *IN GENERAL.*—The premium rate charged for an  
12 insured qualified health benefits plan and for coverage  
13 under the public health insurance option may not vary ex-  
14 cept as follows:

15 (1) *LIMITED AGE VARIATION PERMITTED.*—By  
16 age (within such age categories as the Commissioner  
17 shall specify) so long as the ratio of the highest such  
18 premium to the lowest such premium does not exceed  
19 the ratio of 2 to 1.

20 (2) *BY AREA.*—By premium rating area (as per-  
21 mitted by State insurance regulators or, in the case  
22 of Exchange-participating health benefits plans, as  
23 specified by the Commissioner in consultation with  
24 such regulators).

1           (3) *BY FAMILY ENROLLMENT.*—By family enroll-  
2           ment (such as variations within categories and com-  
3           positions of families) so long as the ratio of the pre-  
4           mium for family enrollment (or enrollments) to the  
5           premium for individual enrollment is uniform, as  
6           specified under State law and consistent with rules of  
7           the Commissioner.

8           (b) *ACTUARIAL VALUE OF OPTIONAL SERVICE COV-*  
9           *ERAGE.*—

10           (1) *IN GENERAL.*—The Commissioner shall esti-  
11           mate the basic per enrollee, per month cost, deter-  
12           mined on an average actuarial basis, for including  
13           coverage under a basic plan of the services described  
14           in section 122(d)(4)(A).

15           (2) *CONSIDERATIONS.*—In making such estimate  
16           the Commissioner—

17                   (A) may take into account the impact on  
18                   overall costs of the inclusion of such coverage, but  
19                   may not take into account any cost reduction es-  
20                   timated to result from such services, including  
21                   prenatal care, delivery, or postnatal care;

22                   (B) shall estimate such costs as if such cov-  
23                   erage were included for the entire population  
24                   covered; and

1           (C) may not estimate such a cost at less  
2           than \$1 per enrollee, per month.

3           (c) *STUDY AND REPORTS.*—

4           (1) *STUDY.*—*The Commissioner, in coordination*  
5           *with the Secretary of Health and Human Services*  
6           *and the Secretary of Labor, shall conduct a study of*  
7           *the large group insured and self-insured employer*  
8           *health care markets. Such study shall examine the fol-*  
9           *lowing:*

10           (A) *The types of employers by key charac-*  
11           *teristics, including size, that purchase insured*  
12           *products versus those that self-insure.*

13           (B) *The similarities and differences between*  
14           *typical insured and self-insured health plans.*

15           (C) *The financial solvency and capital re-*  
16           *serve levels of employers that self-insure by em-*  
17           *ployer size.*

18           (D) *The risk of self-insured employers not*  
19           *being able to pay obligations or otherwise becom-*  
20           *ing financially insolvent.*

21           (E) *The extent to which rating rules are*  
22           *likely to cause adverse selection in the large*  
23           *group market or to encourage small and mid size*  
24           *employers to self-insure*



1           (2) *REPORTS.*—Not later than 18 months after  
2           the date of the enactment of this Act, the Commis-  
3           sioner shall submit to Congress and the applicable  
4           agencies a report on the study conducted under para-  
5           graph (1). Such report shall include any rec-  
6           ommendations the Commissioner deems appropriate  
7           to ensure that the law does not provide incentives for  
8           small and mid-size employers to self-insure or create  
9           adverse selection in the risk pools of large group in-  
10          surers and self-insured employers. Not later than 18  
11          months after the first day of Y1, the Commissioner  
12          shall submit to Congress and the applicable agencies  
13          an updated report on such study, including updates  
14          on such recommendations.

15 **SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN**  
16                           **MENTAL HEALTH AND SUBSTANCE ABUSE**  
17                           **DISORDER BENEFITS.**

18          (a) *NONDISCRIMINATION IN BENEFITS.*—A qualified  
19          health benefits plan (including the public health insurance  
20          option) shall comply with standards established by the  
21          Commissioner to prohibit discrimination in health benefits  
22          or benefit structures for qualifying health benefits plans,  
23          building from sections 702 of Employee Retirement Income  
24          Security Act of 1974, 2702 of the Public Health Service Act,  
25          and section 9802 of the Internal Revenue Code of 1986.

1           (b) *PARITY IN MENTAL HEALTH AND SUBSTANCE*  
2 *ABUSE DISORDER BENEFITS.*—*To the extent such provi-*  
3 *sions are not superceded by or inconsistent with subtitle C,*  
4 *the provisions of section 2705 (other than subsections (a)(1),*  
5 *(a)(2), and (c)) of section 2705 of the Public Health Service*  
6 *Act shall apply to a qualified health benefits plan, regard-*  
7 *less of whether it is offered in the individual or group mar-*  
8 *ket, in the same manner as such provisions apply to health*  
9 *insurance coverage offered in the large group market.*

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

11           (a) *IN GENERAL.*—*A qualified health benefits plan*  
12 *(including the public health insurance option) that uses a*  
13 *provider network for items and services shall meet such*  
14 *standards respecting provider networks as the Commis-*  
15 *sioner may establish to assure the adequacy of such net-*  
16 *works in ensuring enrollee access to such items and services*  
17 *and transparency in the cost-sharing differentials between*  
18 *in-network coverage and out-of-network coverage.*

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

23 **SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.**

24           (a) *IN GENERAL.*—*A qualified health benefits plan*  
25 *shall meet a medical loss ratio as defined by the Commis-*

1 sioner. For any plan year in which the qualified health ben-  
 2 efits plan does not meet such medical loss ratio, QHBP of-  
 3 fering entity shall provide in a manner specified by the  
 4 Commissioner for rebates to enrollees of payment sufficient  
 5 to meet such loss ratio.

6 (b) *BUILDING ON INTERIM RULES.*—In implementing  
 7 subsection (a), the Commissioner shall build on the defini-  
 8 tion and methodology developed by the Secretary of Health  
 9 and Human Services under the amendments made by sec-  
 10 tion 161 for determining how to calculate the medical loss  
 11 ratio. Such methodology shall be set at the highest level med-  
 12 ical loss ratio possible that is designed to ensure adequate  
 13 participation by QHBP offering entities, competition in the  
 14 health insurance market in and out of the Health Insurance  
 15 Exchange, and value for consumers so that their premiums  
 16 are used for services.

17 **Subtitle C—Standards Guaranteing Access to Essential Bene-**  
 18 **fits**

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

21 (a) *IN GENERAL.*—A qualified health benefits plan  
 22 shall provide coverage that at least meets the benefit stand-  
 23 ards adopted under section 124 for the essential benefits  
 24 package described in section 122 for the plan year involved.

25 (b) *CHOICE OF COVERAGE.*—

1           (1) *NON-EXCHANGE-PARTICIPATING HEALTH*  
2 *BENEFITS PLANS.*—*In the case of a qualified health*  
3 *benefits plan that is not an Exchange-participating*  
4 *health benefits plan, such plan may offer such cov-*  
5 *erage in addition to the essential benefits package as*  
6 *the QHBP offering entity may specify.*

7           (2) *EXCHANGE-PARTICIPATING HEALTH BENE-*  
8 *FITS PLANS.*—*In the case of an Exchange-partici-*  
9 *pating health benefits plan, such plan is required*  
10 *under section 203 to provide specified levels of benefits*  
11 *and, in the case of a plan offering a premium-plus*  
12 *level of benefits, provide additional benefits.*

13           (3) *CONTINUATION OF OFFERING OF SEPARATE*  
14 *EXCEPTED BENEFITS COVERAGE.*—*Nothing in this di-*  
15 *vision shall be construed as affecting the offering of*  
16 *health benefits in the form of excepted benefits (de-*  
17 *scribed in section 102(b)(1)(B)(ii)) if such benefits*  
18 *are offered under a separate policy, contract, or cer-*  
19 *tificate of insurance.*

20           (c) *NO RESTRICTIONS ON COVERAGE UNRELATED TO*  
21 *CLINICAL APPROPRIATENESS.*—*A qualified health benefits*  
22 *plan may not impose any restriction (other than cost-shar-*  
23 *ing) unrelated to clinical appropriateness on the coverage*  
24 *of the health care items and services.*

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

2 (a) *IN GENERAL.*—*In this division, the term “essential*  
3 *benefits package” means health benefits coverage, consistent*  
4 *with standards adopted under section 124 to ensure the pro-*  
5 *vision of quality health care and financial security, that—*

6 (1) *provides payment for the items and services*  
7 *described in subsection (b) in accordance with gen-*  
8 *erally accepted standards of medical or other appro-*  
9 *priate clinical or professional practice;*

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

13 (3) *does not impose any annual or lifetime limit*  
14 *on the coverage of covered health care items and serv-*  
15 *ices;*

16 (4) *complies with section 115(a) (relating to net-*  
17 *work adequacy); and*

18 (5) *is equivalent, as certified by Office of the Ac-*  
19 *tuary of the Centers for Medicare & Medicaid Serv-*  
20 *ices, to the average prevailing employer-sponsored*  
21 *coverage.*

22 (b) *MINIMUM SERVICES TO BE COVERED.*—*Subject to*  
23 *subsection (d), the items and services described in this sub-*  
24 *section are the following:*

25 (1) *Hospitalization.*

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

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

5           (4) *Such services, equipment, and supplies inci-*  
6           *dent to the services of a physician's or a health profes-*  
7           *sional's delivery of care in institutional settings, phy-*  
8           *sician offices, patients' homes or place of residence, or*  
9           *other settings, as appropriate.*

10          (5) *Prescription drugs.*

11          (6) *Rehabilitative and habilitative services.*

12          (7) *Mental health and substance use disorder*  
13          *services, including behavioral health treatments.*

14          (8) *Preventive services, including those services*  
15          *recommended with a grade of A or B by the Task*  
16          *Force on Clinical Preventive Services and those vac-*  
17          *cines recommended for use by the Director of the Cen-*  
18          *ters for Disease Control and Prevention.*

19          (9) *Maternity care.*

20          (10) *Well baby and well child care; treatment of*  
21          *a congenital or developmental deformity, disease, or*  
22          *injury; and oral health, vision, and hearing services,*  
23          *equipment, and supplies at least for children under*  
24          *21 years of age.*

1           (c) *REQUIREMENTS RELATING TO COST-SHARING AND*  
2 *MINIMUM ACTUARIAL VALUE.*—

3           (1) *NO COST-SHARING FOR PREVENTIVE SERV-*  
4 *ICES.*—*There shall be no cost-sharing under the essen-*  
5 *tial benefits package for preventive items and services*  
6 *(as specified under the benefit standards), including*  
7 *well baby and well child care.*

8           (2) *ANNUAL LIMITATION.*—

9           (A) *ANNUAL LIMITATION.*—*The cost-sharing*  
10 *incurred under the essential benefits package*  
11 *with respect to an individual (or family) for a*  
12 *year does not exceed the applicable level specified*  
13 *in subparagraph (B).*

14           (B) *APPLICABLE LEVEL.*—*The applicable*  
15 *level specified in this subparagraph for Y1 is*  
16 *\$5,000 for an individual and \$10,000 for a fam-*  
17 *ily. Such levels shall be increased (rounded to the*  
18 *nearest \$100) for each subsequent year by the*  
19 *annual percentage increase in the Consumer*  
20 *Price Index (United States city average) appli-*  
21 *cable to such year.*

22           (C) *USE OF COPAYMENTS.*—*In establishing*  
23 *cost-sharing levels for basic, enhanced, and pre-*  
24 *mium plans under this subsection, the Secretary*

1           *shall, to the maximum extent possible, use only*  
2           *copayments and not coinsurance.*

3           (3) *MINIMUM ACTUARIAL VALUE.—*

4                   (A) *IN GENERAL.—The cost-sharing under*  
5           *the essential benefits package shall be designed to*  
6           *provide a level of coverage that is designed to*  
7           *provide benefits that are actuarially equivalent*  
8           *to approximately 70 percent of the full actuarial*  
9           *value of the benefits provided under the reference*  
10          *benefits package described in subparagraph (B).*

11                   (B) *REFERENCE BENEFITS PACKAGE DE-*  
12          *SCRIBED.—The reference benefits package de-*  
13          *scribed in this subparagraph is the essential ben-*  
14          *efits package if there were no cost-sharing im-*  
15          *posed.*

16          (d) *ABORTION COVERAGE PROHIBITED AS PART OF*  
17          *MINIMUM BENEFITS PACKAGE.—*

18                   (1) *PROHIBITION OF REQUIRED COVERAGE.—The*  
19          *Health Benefits Advisory Committee may not rec-*  
20          *ommend under section 123(b) and the Secretary may*  
21          *not adopt in standards under section 124(b), the serv-*  
22          *ices described in paragraph (4)(A) or (4)(B) as part*  
23          *of the essential benefits package and the Commis-*  
24          *sioner may not require such services for qualified*



1 *health benefits plans to participate in the Health In-*  
2 *surance Exchange.*

3 (2) *VOLUNTARY CHOICE OF COVERAGE BY*  
4 *PLAN.—In the case of a qualified health benefits plan,*  
5 *the plan is not required (or prohibited) under this Act*  
6 *from providing coverage of services described in para-*  
7 *graph (4)(A) or (4)(B) and the QHBP offering entity*  
8 *shall determine whether such coverage is provided.*

9 (3) *COVERAGE UNDER PUBLIC HEALTH INSUR-*  
10 *ANCE OPTION.—The public health insurance option*  
11 *shall provide coverage for services described in para-*  
12 *graph (4)(B). Nothing in this Act shall be construed*  
13 *as preventing the public health insurance option from*  
14 *providing for or prohibiting coverage of services de-*  
15 *scribed in paragraph (4)(A).*

16 (4) *ABORTION SERVICES.—*

17 (A) *ABORTIONS FOR WHICH PUBLIC FUND-*  
18 *ING IS PROHIBITED.—The services described in*  
19 *this subparagraph are abortions for which the*  
20 *expenditure of Federal funds appropriated for*  
21 *the Department of Health and Human Services*  
22 *is not permitted, based on the law as in effect as*  
23 *of the date that is 6 months before the beginning*  
24 *of the plan year involved.*

1                   (B) *ABORTIONS FOR WHICH PUBLIC FUND-*  
2                   *ING IS ALLOWED.*—*The services described in this*  
3                   *subparagraph are abortions for which the ex-*  
4                   *penditure of Federal funds appropriated for the*  
5                   *Department of Health and Human Services is*  
6                   *permitted, based on the law as in effect as of the*  
7                   *date that is 6 months before the beginning of the*  
8                   *plan year involved.*

9                   (e) *STAND-ALONE COVERAGE.*—

10                   (1) *NO APPLICATION TO ADULT COVERAGE.*—  
11                   *Nothing in this subtitle shall be construed as requir-*  
12                   *ing an individual who is 21 years of age or older to*  
13                   *be provided stand-alone dental-only or vision-only*  
14                   *coverage.*

15                   (2) *TREATMENT OF COMBINED COVERAGE.*—*The*  
16                   *combination of stand-alone coverage described in*  
17                   *paragraph (1) and a qualified health benefits plan*  
18                   *without coverage of such oral and vision services shall*  
19                   *be treated as satisfying the essential benefits package*  
20                   *under this division.*

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

22                   (a) *ESTABLISHMENT.*—

23                   (1) *IN GENERAL.*—*There is established a private-*  
24                   *public advisory committee which shall be a panel of*  
25                   *medical and other experts to be known as the Health*

1 *Benefits Advisory Committee to recommend covered*  
2 *benefits and essential, enhanced, and premium plans.*

3 (2) *CHAIR.*—*The Surgeon General shall be a*  
4 *member and the chair of the Health Benefits Advisory*  
5 *Committee.*

6 (3) *MEMBERSHIP.*—*The Health Benefits Advi-*  
7 *sory Committee shall be composed of the following*  
8 *members, in addition to the Surgeon General:*

9 (A) *9 members who are not Federal employ-*  
10 *ees or officers and who are appointed by the*  
11 *President.*

12 (B) *9 members who are not Federal employ-*  
13 *ees or officers and who are appointed by the*  
14 *Comptroller General of the United States in a*  
15 *manner similar to the manner in which the*  
16 *Comptroller General appoints members to the*  
17 *Medicare Payment Advisory Commission under*  
18 *section 1805(c) of the Social Security Act.*

19 (C) *Such even number of members (not to*  
20 *exceed 8) who are Federal employees and officers,*  
21 *as the President may appoint.*

22 *Such initial appointments shall be made not later*  
23 *than 60 days after the date of the enactment of this*  
24 *Act.*

1           (4) *TERMS.*—*Each member of the Health Bene-*  
2 *fits Advisory Committee shall serve a 3-year term on*  
3 *the Committee, except that the terms of the initial*  
4 *members shall be adjusted in order to provide for a*  
5 *staggered term of appointment for all such members.*

6           (5) *PARTICIPATION.*—*The membership of the*  
7 *Health Benefits Advisory Committee shall at least re-*  
8 *flect providers, consumer representatives, employers,*  
9 *labor, health insurance issuers, experts in health care*  
10 *financing and delivery, experts in racial and ethnic*  
11 *disparities, experts in care for those with disabilities,*  
12 *representatives of relevant governmental agencies. and*  
13 *at least one practicing physician or other health pro-*  
14 *fessional and an expert on children’s health and shall*  
15 *represent a balance among various sectors of the*  
16 *health care system so that no single sector unduly in-*  
17 *fluences the recommendations of such Committee. Not*  
18 *less than 25 percent of the members of the Committee*  
19 *shall be practicing health care practitioners who, as*  
20 *of the date of their appointment, practice in a rural*  
21 *area and who have practiced in a rural area for at*  
22 *least the 5-year period preceding such date.*

23           (b) *DUTIES.*—

24           (1) *RECOMMENDATIONS ON BENEFIT STAND-*  
25 *ARDS.*—*The Health Benefits Advisory Committee*

1       *shall recommend to the Secretary of Health and*  
2       *Human Services (in this subtitle referred to as the*  
3       *“Secretary”) benefit standards (as defined in para-*  
4       *graph (4)), and periodic updates to such standards.*  
5       *In developing such recommendations, the Committee*  
6       *shall take into account innovation in health care and*  
7       *consider how such standards could reduce health dis-*  
8       *parities.*

9               (2) *DEADLINE.—The Health Benefits Advisory*  
10       *Committee shall recommend initial benefit standards*  
11       *to the Secretary not later than 1 year after the date*  
12       *of the enactment of this Act.*

13              (3) *PUBLIC INPUT.—The Health Benefits Advi-*  
14       *sory Committee shall allow for public input as a part*  
15       *of developing recommendations under this subsection.*

16              (4) *BENEFIT STANDARDS DEFINED.—In this sub-*  
17       *title, the term “benefit standards” means standards*  
18       *respecting—*

19                    (A) *the essential benefits package described*  
20       *in section 122, including categories of covered*  
21       *treatments, items and services within benefit*  
22       *classes, and cost-sharing consistent with sub-*  
23       *section (d) of such section; and*

1           (B) *the cost-sharing levels for enhanced*  
2           *plans and premium plans (as provided under*  
3           *section 203(c)) consistent with paragraph (5).*

4           (5) *LEVELS OF COST-SHARING FOR ENHANCED*  
5           *AND PREMIUM PLANS.—*

6           (A) *ENHANCED PLAN.—The level of cost-*  
7           *sharing for enhanced plans shall be designed so*  
8           *that such plans have benefits that are actuarially*  
9           *equivalent to approximately 85 percent of the ac-*  
10           *tuarial value of the benefits provided under the*  
11           *reference benefits package described in section*  
12           *122(c)(3)(B).*

13           (B) *PREMIUM PLAN.—The level of cost-shar-*  
14           *ing for premium plans shall be designed so that*  
15           *such plans have benefits that are actuarially*  
16           *equivalent to approximately 95 percent of the ac-*  
17           *tuarial value of the benefits provided under the*  
18           *reference benefits package described in section*  
19           *122(c)(3)(B).*

20           (c) *OPERATIONS.—*

21           (1) *PER DIEM PAY.—Each member of the Health*  
22           *Benefits Advisory Committee shall receive travel ex-*  
23           *penses, including per diem in accordance with appli-*  
24           *cable provisions under subchapter I of chapter 57 of*

1 *title 5, United States Code, and shall otherwise serve*  
2 *without additional pay.*

3 (2) *MEMBERS NOT TREATED AS FEDERAL EM-*  
4 *PLOYEES.—Members of the Health Benefits Advisory*  
5 *Committee shall not be considered employees of the*  
6 *Federal government solely by reason of any service on*  
7 *the Committee.*

8 (3) *APPLICATION OF FACA.—The Federal Advi-*  
9 *sory Committee Act (5 U.S.C. App.), other than sec-*  
10 *tion 14, shall apply to the Health Benefits Advisory*  
11 *Committee.*

12 (d) *PUBLICATION.—The Secretary shall provide for*  
13 *publication in the Federal Register and the posting on the*  
14 *Internet website of the Department of Health and Human*  
15 *Services of all recommendations made by the Health Bene-*  
16 *fits Advisory Committee under this section.*

17 **SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDATIONS;**

18 **ADOPTION OF BENEFIT STANDARDS.**

19 (a) *PROCESS FOR ADOPTION OF RECOMMENDA-*  
20 *TIONS.—*

21 (1) *REVIEW OF RECOMMENDED STANDARDS.—*  
22 *Not later than 45 days after the date of receipt of ben-*  
23 *efit standards recommended under section 123 (in-*  
24 *cluding such standards as modified under paragraph*  
25 *(2)(B)), the Secretary shall review such standards*

1       *and shall determine whether to propose adoption of*  
2       *such standards as a package.*

3               (2) *DETERMINATION TO ADOPT STANDARDS.—If*  
4       *the Secretary determines—*

5                       (A) *to propose adoption of benefit standards*  
6               *so recommended as a package, the Secretary*  
7               *shall, by regulation under section 553 of title 5,*  
8               *United States Code, propose adoption such*  
9               *standards; or*

10                      (B) *not to propose adoption of such stand-*  
11               *ards as a package, the Secretary shall notify the*  
12               *Health Benefits Advisory Committee in writing*  
13               *of such determination and the reasons for not*  
14               *proposing the adoption of such recommendation*  
15               *and provide the Committee with a further oppor-*  
16               *tunity to modify its previous recommendations*  
17               *and submit new recommendations to the Sec-*  
18               *retary on a timely basis.*

19               (3) *CONTINGENCY.—If, because of the application*  
20               *of paragraph (2)(B), the Secretary would otherwise be*  
21               *unable to propose initial adoption of such rec-*  
22               *ommended standards by the deadline specified in sub-*  
23               *section (b)(1), the Secretary shall, by regulation*  
24               *under section 553 of title 5, United States Code, pro-*



1        *pose adoption of initial benefit standards by such*  
2        *deadline.*

3            (4) *PUBLICATION.*—*The Secretary shall provide*  
4        *for publication in the Federal Register of all deter-*  
5        *minations made by the Secretary under this sub-*  
6        *section.*

7        (b) *ADOPTION OF STANDARDS.*—

8            (1) *INITIAL STANDARDS.*—*Not later than 18*  
9        *months after the date of the enactment of this Act, the*  
10       *Secretary shall, through the rulemaking process con-*  
11       *sistent with subsection (a), adopt an initial set of*  
12       *benefit standards.*

13           (2) *PERIODIC UPDATING STANDARDS.*—*Under*  
14       *subsection (a), the Secretary shall provide for the*  
15       *periodic updating of the benefit standards previously*  
16       *adopted under this section.*

17           (3) *REQUIREMENT.*—*The Secretary may not*  
18       *adopt any benefit standards for an essential benefits*  
19       *package or for level of cost-sharing that are incon-*  
20       *sistent with the requirements for such a package or*  
21       *level under sections 122 (including subsection (d))*  
22       *and 123(b)(5).*

1 **SEC. 125. PROHIBITION OF DISCRIMINATION IN HEALTH**  
 2 **CARE SERVICES BASED ON RELIGIOUS OR**  
 3 **SPIRITUAL CONTENT.**

4 *Neither the Commissioner nor any health insurance*  
 5 *issuer offering health insurance coverage through the Health*  
 6 *Insurance Exchange shall discriminate in approving or*  
 7 *covering a health care service on the basis of its religious*  
 8 *or spiritual content if expenditures for such a health care*  
 9 *service are allowable as a deduction under section 213(d)*  
 10 *of the Internal Revenue Code of 1986, as in effect on Janu-*  
 11 *ary 1, 2009.*

12 ***Subtitle D—Additional Consumer***  
 13 ***Protections***

14 **SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY**  
 15 **HEALTH INSURERS.**

16 *The Commissioner shall establish uniform marketing*  
 17 *standards that all insured QHBP offering entities shall*  
 18 *meet.*

19 **SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS**  
 20 **MECHANISMS.**

21 *A QHBP offering entity shall provide for timely griev-*  
 22 *ance and appeals mechanisms as the Commissioner shall*  
 23 *establish consistent with sections 139 through 139B.*

24 **SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND**  
 25 **PLAN DISCLOSURE.**

26 *(a) ACCURATE AND TIMELY DISCLOSURE.—*

1           (1) *IN GENERAL.*—A qualified health benefits  
2           plan (including the public health insurance option)  
3           shall comply with standards established by the Com-  
4           missioner for the accurate and timely disclosure of  
5           plan documents, plan terms and conditions, claims  
6           payment policies and practices, periodic financial  
7           disclosure, data on enrollment, data on disenrollment,  
8           data on the number of claims denials, data on rating  
9           practices, information on cost-sharing and payments  
10          with respect to any out-of-network coverage, and other  
11          information as determined appropriate by the Com-  
12          missioner. The Commissioner shall require that such  
13          disclosure be provided in plain language.

14          (2) *PLAIN LANGUAGE.*—In this subsection, the  
15          term “plain language” means language that the in-  
16          tended audience, including individuals with limited  
17          English proficiency, can readily understand and use  
18          because that language is clean, concise, well-orga-  
19          nized, and follows other best practices of plain lan-  
20          guage writing.

21          (3) *GUIDANCE.*—The Commissioner shall develop  
22          and issue guidance on best practices of plain lan-  
23          guage writing.

24          (b) *CONTRACTING REIMBURSEMENT.*—A qualified  
25          health benefits plan (including the public health insurance

1 option) shall comply with standards established by the  
2 Commissioner to ensure transparency to each health care  
3 provider relating to reimbursement arrangements between  
4 such plan and such provider.

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

10 (d) *PHARMACY BENEFIT MANAGERS TRANSPARENCY*  
11 *REQUIREMENTS.*—

12 (1) *IN GENERAL.*—Notwithstanding any other  
13 provision of law, a qualified health benefits plan shall  
14 enter into a contract with a pharmacy benefit man-  
15 agers (in this subsection referred to as a “PBM”) to  
16 manage the prescription drug coverage provided  
17 under such plan, or to control the costs of such pre-  
18 scription drug coverage, only if as a condition of such  
19 contract the PBM is required to provide at least an-  
20 nually to the Commissioner and to the QHBP offer-  
21 ing entity offering such plan the following informa-  
22 tion:

23 (A) *Information on the volume of prescrip-*  
24 *tions under the contract that are filled via mail*  
25 *order and at retail pharmacies.*

1           (B) *An estimate of aggregate average pay-*  
2           *ments under the contract, per prescription*  
3           *(weighted by prescription volume), made to mail*  
4           *order and retail pharmacists, and the average*  
5           *amount, per prescription, that the PBM was*  
6           *paid by the plan for prescriptions filled at mail*  
7           *order and retail pharmacists.*

8           (C) *An estimate of the aggregate average*  
9           *payment per prescription (weighted by prescrip-*  
10           *tion volume) under the contract received from*  
11           *pharmaceutical manufacturers, including all re-*  
12           *bates, discounts, prices concessions, or adminis-*  
13           *trative, and other payments from pharma-*  
14           *ceutical manufacturers, and a description of the*  
15           *types of payments, and the amount of these pay-*  
16           *ments that were shared with the plan, and a de-*  
17           *scription of the percentage of prescriptions for*  
18           *which the PBM received such payments.*

19           (D) *Information on the overall percentage of*  
20           *generic drugs dispensed under the contract at re-*  
21           *tail and mail order pharmacies, and the percent-*  
22           *age of cases in which a generic drug is dispensed*  
23           *when available.*

24           (E) *Information on the percentage and*  
25           *number of cases under the contract in which in-*

1            *dividuals were switched from a prescribed drug*  
2            *that was less expensive to a drug that was more*  
3            *expensive, the rationale for these switches, and a*  
4            *description of the PBM policies governing such*  
5            *switches.*

6            (2) *CONFIDENTIALITY OF INFORMATION.—Not-*  
7            *withstanding any other provision of law, information*  
8            *disclosed by a PBM to the Commissioner or a QHBP*  
9            *offering entity under this subsection is confidential*  
10           *and shall not be disclosed by the Commissioner or the*  
11           *QHBP offering entity in a form which discloses the*  
12           *identity of a specific PBM or prices charged by such*  
13           *PBM or a specific retailer, manufacturer, or whole-*  
14           *saler, except—*

15                    (A) *as the Commissioner determines to be*  
16                    *necessary to carry out this subsection;*

17                    (B) *to permit the Comptroller General to re-*  
18                    *view the information provided;*

19                    (C) *to permit the Director of the Congres-*  
20                    *sional Budget Office to review the information*  
21                    *provided; and*

22                    (D) *to permit the Commissioner to disclose*  
23                    *industry-wide aggregate or average information*  
24                    *to be used in assessing the overall impact of*  
25                    *PBMs on prescription drug prices and spending.*

1 **SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS**  
2 **PLANS NOT OFFERED THROUGH THE HEALTH**  
3 **INSURANCE EXCHANGE.**

4 *The requirements of the previous provisions of this sub-*  
5 *title shall apply to qualified health benefits plans that are*  
6 *not being offered through the Health Insurance Exchange*  
7 *only to the extent specified by the Commissioner.*

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

9 *A QHBP offering entity shall comply with the require-*  
10 *ments of section 1857(f) of the Social Security Act with re-*  
11 *spect to a qualified health benefits plan it offers in the same*  
12 *manner an Medicare Advantage organization is required*  
13 *to comply with such requirements with respect to a Medi-*  
14 *care Advantage plan it offers under part C of Medicare.*

15 **SEC. 136. STANDARDIZED RULES FOR COORDINATION AND**  
16 **SUBROGATION OF BENEFITS.**

17 *The Commissioner shall establish standards for the co-*  
18 *ordination and subrogation of benefits and reimbursement*  
19 *of payments in cases involving individuals and multiple*  
20 *plan coverage.*

21 **SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICA-**  
22 **TION.**

23 *A QHBP offering entity is required to comply with*  
24 *standards for electronic financial and administrative trans-*  
25 *actions under section 1173A of the Social Security Act and*

1 *the operating rules under section 1173B of such Act, as*  
2 *added by section 163(a).*

3 **SEC. 138. INFORMATION ON END-OF-LIFE PLANNING.**

4 *(a) IN GENERAL.—The QHBP offering entity —*

5 *(1) shall provide for the dissemination of infor-*  
6 *mation related to end-of-life planning to individuals*  
7 *seeking enrollment in Exchange-participating health*  
8 *benefits plans offered through the Exchange;*

9 *(2) shall present such individuals with—*

10 *(A) the option to establish advanced direc-*  
11 *tives and physician’s orders for life sustaining*  
12 *treatment according to the laws of the State in*  
13 *which the individual resides; and*

14 *(B) information related to other planning*  
15 *tools; and*

16 *(3) shall not promote suicide, assisted suicide, or*  
17 *the active hastening of death.*

18 *The information presented under paragraph (2) shall not*  
19 *presume the withdrawal of treatment and shall include end-*  
20 *of-life planning information that includes options to main-*  
21 *tain all or most medical interventions.*

22 *(b) CONSTRUCTION.—Nothing in this section shall be*  
23 *construed—*

24 *(1) to require an individual to complete an ad-*  
25 *vanced directive or a physician’s order for life sus-*



1        *taining treatment or other end-of-life planning docu-*  
2        *ment;*

3            (2) *to require an individual to consent to restric-*  
4        *tions on the amount, duration, or scope of medical*  
5        *benefits otherwise covered under a qualified health*  
6        *benefits plan; or*

7            (3) *to encourage the hastening of death or the*  
8        *promotion of assisted suicide.*

9        (c) *ADVANCED DIRECTIVE DEFINED.*—*In this section,*  
10       *the term “advanced directive” includes a living will, a com-*  
11       *fort care order, or a durable power of attorney for health*  
12       *care*

13       (d) *PROHIBITION ON THE PROMOTION OF ASSISTED*  
14       *SUICIDE.*—

15            (1) *IN GENERAL.*—*Subject to paragraph (3), in-*  
16       *formation provided to meet the requirements of sub-*  
17       *section (a)(2) shall not include advanced directives or*  
18       *other planning tools that list or describe as an option*  
19       *suicide, assisted suicide or the intentional hastening*  
20       *of death regardless of legality.*

21            (2) *CONSTRUCTION.*—*Nothing in paragraph (1)*  
22       *shall be construed to apply to or affect any option*  
23       *to—*

24            (A) *the withhold or withdraw of medical*  
25       *treatment or medical care;*

1           (B) withhold or withdraw of nutrition or  
2           hydration; and

3           (C) provide palliative or hospice care or use  
4           an item, good, benefit, or service furnished for  
5           the purpose of alleviating pain or discomfort,  
6           even if such use may increase the risk of death,  
7           so long as such item, good, benefit, or service is  
8           not also furnished for the purpose of causing, or  
9           the purpose of assisting in causing, death, for  
10          any reason.

11          (3) *EXEMPTION.*—The requirements of subsection  
12          (a) shall not apply to any State that as of August 1,  
13          2009, requires the inclusion of information prohibited  
14          in such paragraph in advanced directives or other  
15          planning tools.

16 **SEC. 139. UTILIZATION REVIEW ACTIVITIES.**

17          (a) *COMPLIANCE WITH REQUIREMENTS.*—

18               (1) *IN GENERAL.*—A qualified health benefits  
19               plan, and a QHBP offering entity that offers such  
20               plan, shall conduct utilization review activities in  
21               connection with the provision of benefits under such  
22               plan only in accordance with a utilization review  
23               program that meets the requirements of this section.

24               (2) *USE OF OUTSIDE AGENTS.*—Nothing in this  
25               section shall be construed as preventing a qualified

1 *health benefits plan or QHBP offering entity from ar-*  
2 *ranging through a contract or otherwise for persons*  
3 *or entities to conduct utilization review activities on*  
4 *behalf of the plan entity, so long as such activities are*  
5 *conducted in accordance with a utilization review*  
6 *program that meets the requirements of this section.*

7 (3) *UTILIZATION REVIEW DEFINED.—For pur-*  
8 *poses of this section, the terms “utilization review”*  
9 *and “utilization review activities” mean procedures*  
10 *used to monitor or evaluate the use or coverage, clin-*  
11 *ical necessity, appropriateness, efficacy, or efficiency*  
12 *of health care services, procedures or settings, and in-*  
13 *cludes prospective review, concurrent review, second*  
14 *opinions, case management, discharge planning, or*  
15 *retrospective review.*

16 (b) *WRITTEN POLICIES AND CRITERIA.—*

17 (1) *WRITTEN POLICIES.—A utilization review*  
18 *program shall be conducted consistent with written*  
19 *policies and procedures that govern all aspects of the*  
20 *program.*

21 (2) *USE OF WRITTEN CRITERIA.—*

22 (A) *IN GENERAL.—Such a program shall*  
23 *utilize written clinical review criteria developed*  
24 *with input from a range of appropriate actively*  
25 *practicing health care professionals, as deter-*

1            *mined by the plan, pursuant to the program.*  
2            *Such criteria shall include written clinical re-*  
3            *view criteria that are based on valid clinical evi-*  
4            *dence where available and that are directed spe-*  
5            *cifically at meeting the needs of at-risk popu-*  
6            *lations and covered individuals with chronic*  
7            *conditions or severe illnesses, including gender-*  
8            *specific criteria and pediatric-specific criteria*  
9            *where available and appropriate.*

10            *(B) CONTINUING USE OF STANDARDS IN*  
11            *RETROSPECTIVE REVIEW.—If a health care serv-*  
12            *ice has been specifically pre-authorized or ap-*  
13            *proved for an enrollee under such a program, the*  
14            *program shall not, pursuant to retrospective re-*  
15            *view, revise or modify the specific standards, cri-*  
16            *teria, or procedures used for the utilization re-*  
17            *view for procedures, treatment, and services de-*  
18            *livered to the enrollee during the same course of*  
19            *treatment.*

20            *(C) REVIEW OF SAMPLE OF CLAIMS DENI-*  
21            *ALS.—Such a program shall provide for an eval-*  
22            *uation of the clinical appropriateness of at least*  
23            *a sample of denials of claims for benefits.*

24            *(c) CONDUCT OF PROGRAM ACTIVITIES.—*

1           (1) *ADMINISTRATION BY HEALTH CARE PROFES-*  
2           *SIONALS.—A utilization review program shall be ad-*  
3           *ministered by qualified health care professionals who*  
4           *shall oversee review decisions.*

5           (2) *USE OF QUALIFIED, INDEPENDENT PER-*  
6           *SONNEL.—*

7           (A) *IN GENERAL.—A utilization review pro-*  
8           *gram shall provide for the conduct of utilization*  
9           *review activities only through personnel who are*  
10           *qualified and have received appropriate training*  
11           *in the conduct of such activities under the pro-*  
12           *gram.*

13           (B) *PROHIBITION OF CONTINGENT COM-*  
14           *PENSATION ARRANGEMENTS.—Such a program*  
15           *shall not, with respect to utilization review ac-*  
16           *tivities, permit or provide compensation or any-*  
17           *thing of value to its employees, agents, or con-*  
18           *tractors in a manner that encourages denials of*  
19           *claims for benefits.*

20           (C) *PROHIBITION OF CONFLICTS.—Such a*  
21           *program shall not permit a health care profes-*  
22           *sional who is providing health care services to*  
23           *an individual to perform utilization review ac-*  
24           *tivities in connection with the health care serv-*  
25           *ices being provided to the individual.*

1           (3) *ACCESSIBILITY OF REVIEW.*—Such a pro-  
2           gram shall provide that appropriate personnel per-  
3           forming utilization review activities under the pro-  
4           gram, including the utilization review administrator,  
5           are reasonably accessible by toll-free telephone during  
6           normal business hours to discuss patient care and  
7           allow response to telephone requests, and that appro-  
8           priate provision is made to receive and respond  
9           promptly to calls received during other hours.

10           (4) *LIMITS ON FREQUENCY.*—Such a program  
11           shall not provide for the performance of utilization re-  
12           view activities with respect to a class of services fur-  
13           nished to an individual more frequently than is rea-  
14           sonably required to assess whether the services under  
15           review are medically necessary or appropriate.

16           (d) *DEADLINE FOR DETERMINATIONS.*—

17           (1) *PRIOR AUTHORIZATION SERVICES.*—

18           (A) *IN GENERAL.*—Except as provided in  
19           paragraph (2), in the case of a utilization review  
20           activity involving the prior authorization of  
21           health care items and services for an individual,  
22           the utilization review program shall make a de-  
23           termination concerning such authorization, and  
24           provide notice of the determination to the indi-  
25           vidual or the individual's designee and the indi-

1            *vidual's health care provider by telephone and in*  
2            *printed form, as soon as possible in accordance*  
3            *with the medical exigencies of the case, and in*  
4            *no event later than the deadline specified in sub-*  
5            *paragraph (B).*

6            *(B) DEADLINE.—*

7                    *(i) IN GENERAL.—Subject to clauses*  
8                    *(ii), (iii), and (iv), the deadline specified in*  
9                    *this subparagraph is 14 days after the date*  
10                   *of receipt of the request for prior authoriza-*  
11                   *tion, but in no event later than 3 business*  
12                   *days after the date of receipt of information*  
13                   *that is reasonably necessary to make such*  
14                   *determination.*

15                   *(ii) EXTENSION PERMITTED WHERE*  
16                   *NOTICE OF ADDITIONAL INFORMATION RE-*  
17                   *QUIRED.—If a utilization review pro-*  
18                   *gram—*

19                            *(I) receives a request for a prior*  
20                            *authorization;*

21                            *(II) determines that additional*  
22                            *information is necessary to complete*  
23                            *the review and make the determination*  
24                            *on the request; and*

1                   (III) notifies the requester, not  
2                   later than 5 business days after the  
3                   date of receiving the request, of the  
4                   need for such specified additional in-  
5                   formation;

6                   the deadline specified in this subparagraph  
7                   is 14 days after the date the program re-  
8                   ceives the specified additional information,  
9                   but in no case later than 28 days after the  
10                  date of receipt of the request for the prior  
11                  authorization. This clause shall not apply if  
12                  the deadline is specified in clause (iii).

13                  (iii) *EXPEDITED CASES.*—In the case  
14                  of a situation described in section  
15                  139A(c)(1)(A), the deadline specified in this  
16                  subparagraph is 72 hours after the time of  
17                  the request for prior authorization.

18                  (iv) *EXCEPTION FOR EMERGENCY*  
19                  *SERVICES.*—No prior approval shall be re-  
20                  quired in the case of emergency services pro-  
21                  vided by a hospital.

22                  (2) *ONGOING CARE.*—

23                  (A) *CONCURRENT REVIEW.*—

24                  (i) *IN GENERAL.*—Subject to subpara-  
25                  graph (B), in the case of a concurrent re-



1 *view of ongoing care (including hospitaliza-*  
2 *tion), which results in a termination or re-*  
3 *duction of such care, the plan must provide*  
4 *by telephone and in printed form notice of*  
5 *the concurrent review determination to the*  
6 *individual or the individual's designee and*  
7 *the individual's health care provider as soon*  
8 *as possible in accordance with the medical*  
9 *exigencies of the case, and in no event later*  
10 *than 1 business day after the date of receipt*  
11 *of information that is reasonably necessary*  
12 *to make such determination, with sufficient*  
13 *time prior to the termination or reduction*  
14 *to allow for an appeal under section*  
15 *139A(c)(1)(A) to be completed before the ter-*  
16 *mination or reduction takes effect.*

17 *(ii) CONTENTS OF NOTICE.—Such no-*  
18 *tice shall include, with respect to ongoing*  
19 *health care items and services, the number*  
20 *of ongoing services approved, the new total*  
21 *of approved services, the date of onset of*  
22 *services, and the next review date, if any, as*  
23 *well as a statement of the individual's*  
24 *rights to further appeal.*

1           (B) *EXCEPTION.*—Subparagraph (A) shall  
2           not be interpreted as requiring plans or issuers  
3           to provide coverage of care that would exceed the  
4           coverage limitations for such care.

5           (3) *PREVIOUSLY PROVIDED SERVICES.*—In the  
6           case of a utilization review activity involving retro-  
7           spective review of health care services previously pro-  
8           vided for an individual, the utilization review pro-  
9           gram shall make a determination concerning such  
10          services, and provide notice of the determination to  
11          the individual or the individual’s designee and the in-  
12          dividual’s health care provider by telephone and in  
13          printed form, within 30 days of the date of receipt of  
14          information that is reasonably necessary to make such  
15          determination, but in no case later than 60 days after  
16          the date of receipt of the claim for benefits.

17          (4) *FAILURE TO MEET DEADLINE.*—In a case in  
18          which a qualified health benefits plan or QHBP offer-  
19          ing entity fails to make a determination on a claim  
20          for benefit under paragraph (1), (2)(A), or (3) by the  
21          applicable deadline established under the respective  
22          paragraph, the failure shall be treated under this sub-  
23          title as a denial of the claim as of the date of the  
24          deadline.

25          (e) *NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.*—

1           (1) *IN GENERAL.*—Notice of a denial of claims  
2           for benefits under a utilization review program shall  
3           be provided in printed form and written in a manner  
4           calculated to be understood by the participant, bene-  
5           ficiary, or enrollee and shall include—

6                     (A) the reasons for the denial (including the  
7                     clinical rationale);

8                     (B) instructions on how to initiate an ap-  
9                     peal under section 139A; and

10                    (C) notice of the availability, upon request  
11                    of the individual (or the individual’s designee)  
12                    of the clinical review criteria relied upon to  
13                    make such denial.

14           (2) *SPECIFICATION OF ANY ADDITIONAL INFOR-*  
15           *MATION.*—Such a notice shall also specify what (if  
16           any) additional necessary information must be pro-  
17           vided to, or obtained by, the person making the denial  
18           in order to make a decision on such an appeal.

19           (f) *CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR*  
20           *BENEFITS DEFINED.*—For purposes of this subtitle:

21                    (1) *CLAIM FOR BENEFITS.*—The term “claim for  
22                    benefits” means any request for coverage (including  
23                    authorization of coverage), for eligibility, or for pay-  
24                    ment in whole or in part, for an item or service  
25                    under a qualified health benefits plan.

1           (2) *DENIAL OF CLAIM FOR BENEFITS.*—*The term*  
2           *“denial” means, with respect to a claim for benefits,*  
3           *means a denial, or a failure to act on a timely basis*  
4           *upon, in whole or in part, the claim for benefits and*  
5           *includes a failure to provide benefits (including items*  
6           *and services) required to be provided under this title.*

7 **SEC. 139A. INTERNAL APPEALS PROCEDURES.**

8           (a) *RIGHT OF REVIEW.*—

9           (1) *IN GENERAL.*—*Each qualified health benefits*  
10          *plan, and each QHBP offering entity offering such*  
11          *plan—*

12                 (A) *shall provide adequate notice in writing*  
13                 *to any participant or beneficiary under such*  
14                 *plan, or enrollee under such coverage, whose*  
15                 *claim for benefits under the plan has been denied*  
16                 *(within the meaning of section 139(f)(2)), setting*  
17                 *forth the specific reasons for such denial of claim*  
18                 *for benefits and rights to any further review or*  
19                 *appeal, written in a manner calculated to be un-*  
20                 *derstood by the participant, beneficiary, or en-*  
21                 *rollee; and*

22                 (B) *shall afford such a participant, bene-*  
23                 *ficiary, or enrollee (and any provider or other*  
24                 *person acting on behalf of such an individual*  
25                 *with the individual’s consent or without such*

1           *consent if the individual is medically unable to*  
2           *provide such consent) who is dissatisfied with*  
3           *such a denial of claim for benefits a reasonable*  
4           *opportunity (of not less than 180 days) to re-*  
5           *quest and obtain a full and fair review by a*  
6           *named fiduciary (with respect to such plan) or*  
7           *named appropriate individual (with respect to*  
8           *such coverage) of the decision denying the claim.*

9           (2) *TREATMENT OF ORAL REQUESTS.—The re-*  
10          *quest for review under paragraph (1)(B) may be*  
11          *made orally, but, in the case of an oral request, shall*  
12          *be followed by a request in writing.*

13          (b) *INTERNAL REVIEW PROCESS.—*

14               (1) *CONDUCT OF REVIEW.—*

15                       (A) *IN GENERAL.—A review of a denial of*  
16                       *claim under this section shall be made by an in-*  
17                       *dividual who—*

18                               (i) *in a case involving medical judg-*  
19                               *ment, shall be a physician or, in the case of*  
20                               *limited scope coverage (as defined in sub-*  
21                               *paragraph (B), shall be an appropriate spe-*  
22                               *cialist;*

23                               (ii) *has been selected by the plan or en-*  
24                               *tity; and*

1                   (iii) did not make the initial denial in  
2                   the internally appealable decision.

3                   (B) LIMITED SCOPE COVERAGE DEFINED.—

4                   For purposes of subparagraph (A), the term  
5                   “limited scope coverage” means a qualified  
6                   health benefits plan the only benefits under  
7                   which are for benefits described in section  
8                   2791(c)(2)(A) of the Public Health Service Act  
9                   (42 U.S.C. 300gg-91(c)(2)).

10                  (2) TIME LIMITS FOR INTERNAL REVIEWS.—

11                  (A) IN GENERAL.—Having received such a  
12                  request for review of a denial of claim, the  
13                  QHBP offering entity offering a qualified health  
14                  benefits plan, in accordance with the medical ex-  
15                  igencies of the case but not later than the dead-  
16                  line specified in subparagraph (B), complete the  
17                  review on the denial and transmit to the partici-  
18                  pant, beneficiary, enrollee, or other person in-  
19                  volved a decision that affirms, reverses, or modi-  
20                  fies the denial. If the decision does not reverse the  
21                  denial, the plan or issuer shall transmit, in  
22                  printed form, a notice that sets forth the grounds  
23                  for such decision and that includes a description  
24                  of rights to any further appeal. Such decision  
25                  shall be treated as the final decision of the plan.

1           *Failure to issue such a decision by such deadline*  
2           *shall be treated as a final decision affirming the*  
3           *denial of claim.*

4           *(B) DEADLINE.—*

5                   *(i) IN GENERAL.—Subject to clauses*  
6                   *(ii) and (iii), the deadline specified in this*  
7                   *subparagraph is 14 days after the date of*  
8                   *receipt of the request for internal review.*

9                   *(ii) EXTENSION PERMITTED WHERE*  
10                   *NOTICE OF ADDITIONAL INFORMATION RE-*  
11                   *QUIRED.—If a qualified health benefits plan*  
12                   *of QHBP offering entity—*

13                           *(I) receives a request for internal*  
14                           *review,*

15                           *(II) determines that additional*  
16                           *information is necessary to complete*  
17                           *the review and make the determination*  
18                           *on the request, and*

19                           *(III) notifies the requester, not*  
20                           *later than 5 business days after the*  
21                           *date of receiving the request, of the*  
22                           *need for such specified additional in-*  
23                           *formation,*

24                   *the deadline specified in this subparagraph*  
25                   *is 14 days after the date the plan or entity*

1 receives the specified additional informa-  
2 tion, but in no case later than 28 days after  
3 the date of receipt of the request for the in-  
4 ternal review. This clause shall not apply if  
5 the deadline is specified in clause (iii).

6 (iii) *EXPEDITED CASES.*—In the case  
7 of a situation described in subsection  
8 (c)(1)(A), the deadline specified in this sub-  
9 paragraph is 72 hours after the time of the  
10 request for review.

11 (c) *EXPEDITED REVIEW PROCESS.*—

12 (1) *IN GENERAL.*—A qualified health benefits  
13 plan, and a QHBP offering entity, shall establish  
14 procedures in writing for the expedited consideration  
15 of requests for review under subsection (b) in situa-  
16 tions—

17 (A) in which, as determined by the plan or  
18 issuer or as certified in writing by a treating  
19 health care professional, the application of the  
20 normal timeframe for making a determination  
21 could seriously jeopardize the life or health of the  
22 participant, beneficiary, or enrollee or such an  
23 individual's ability to regain maximum func-  
24 tion; or



1           (B) described in section 139(d)(2) (relating  
2 to requests for continuation of ongoing care  
3 which would otherwise be reduced or termi-  
4 nated).

5           (2) *PROCESS.*—Under such procedures—

6           (A) the request for expedited review may be  
7 submitted orally or in writing by an individual  
8 or provider who is otherwise entitled to request  
9 the review;

10           (B) all necessary information, including the  
11 plan’s or entity’s decision, shall be transmitted  
12 between the plan or issuer and the requester by  
13 telephone, facsimile, or other similarly expedi-  
14 tious available method; and

15           (C) the plan or issuer shall expedite the re-  
16 view in the case of any of the situations de-  
17 scribed in subparagraph (A) or (B) of paragraph  
18 (1).

19           (3) *DEADLINE FOR DECISION.*—The decision on  
20 the expedited review must be made and communicated  
21 to the parties as soon as possible in accordance with  
22 the medical exigencies of the case, and in no event  
23 later than 72 hours after the time of receipt of the re-  
24 quest for expedited review, except that in a case de-

1       scribed in paragraph (1)(B), the decision must be  
2       made before the end of the approved period of care.

3       (d) *WAIVER OF PROCESS.*—A plan or entity may  
4       waive its rights for an internal review under subsection (b).  
5       In such case the participant, beneficiary, or enrollee in-  
6       volved (and any designee or provider involved) shall be re-  
7       lieved of any obligation to complete the review involved and  
8       may, at the option of such participant, beneficiary, enrollee,  
9       designee, or provider, proceed directly to seek further appeal  
10      through any applicable external appeals process.

11      **SEC. 139B. EXTERNAL APPEALS PROCEDURES.**

12      (a) *RIGHT TO EXTERNAL APPEAL.*—

13              (1) *IN GENERAL.*—A qualified health benefits  
14      plan, and a QHBP offering entity, shall provide for  
15      an external appeals process that meets the require-  
16      ments of this section in the case of an externally ap-  
17      pealable decision described in paragraph (2), for  
18      which a timely appeal is made either by the plan or  
19      entity or by the participant, beneficiary, or enrollee  
20      (and any provider or other person acting on behalf of  
21      such an individual with the individual's consent or  
22      without such consent if such an individual is medi-  
23      cally unable to provide such consent). The appro-  
24      priate Secretary shall establish standards to carry out  
25      such requirements.

1           (2) *EXTERNALLY APPEALABLE DECISION DE-*  
2 *FINED.—*

3           (A) *IN GENERAL.—For purposes of this sec-*  
4 *tion, the term “externally appealable decision”*  
5 *means a denial of claim for benefits (as defined*  
6 *in section 139(f)(2))—*

7           (i) *that is based in whole or in part on*  
8 *a decision that the item or service is not*  
9 *medically necessary or appropriate or is in-*  
10 *vestigational or experimental; or*

11           (ii) *in which the decision as to whether*  
12 *a benefit is covered involves a medical judg-*  
13 *ment.*

14           (B) *INCLUSION.—Such term also includes a*  
15 *failure to meet an applicable deadline for inter-*  
16 *nal review under section 139A.*

17           (C) *EXCLUSIONS.—Such term does not in-*  
18 *clude—*

19           (i) *specific exclusions or express limi-*  
20 *tations on the amount, duration, or scope of*  
21 *coverage that do not involve medical judg-*  
22 *ment; or*

23           (ii) *a decision regarding whether an*  
24 *individual is a participant, beneficiary, or*  
25 *enrollee under the plan.*

1           (3) *EXHAUSTION OF INTERNAL REVIEW PROC-*  
2           *ESS.—Except as provided under section 139A(d), a*  
3           *plan or entity may condition the use of an external*  
4           *appeal process in the case of an externally appealable*  
5           *decision upon a final decision in an internal review*  
6           *under section 140, but only if the decision is made in*  
7           *a timely basis consistent with the deadlines provided*  
8           *under this subtitle.*

9           (4) *FILING FEE REQUIREMENT.—*

10           (A) *IN GENERAL.—Subject to subparagraph*  
11           *(B), a plan or entity may condition the use of*  
12           *an external appeal process upon payment to the*  
13           *plan or entity of a filing fee that does not exceed*  
14           *\$25.*

15           (B) *EXCEPTION FOR INDIGENCY.—The plan*  
16           *or issuer may not require payment of the filing*  
17           *fee in the case of an individual participant, ben-*  
18           *eficiary, or enrollee who certifies (in a form and*  
19           *manner specified in guidelines established by the*  
20           *Secretary of Health and Human Services) that*  
21           *the individual is indigent (as defined in such*  
22           *guidelines).*

23           (C) *REFUNDING FEE IN CASE OF SUCCESS-*  
24           *FUL APPEALS.—The plan or entity shall refund*  
25           *payment of the filing fee under this paragraph*

1           *if the recommendation of the external appeal en-*  
2           *tity is to reverse or modify the denial of a claim*  
3           *for benefits which is the subject of the appeal.*

4           **(b) GENERAL ELEMENTS OF EXTERNAL APPEALS**  
5 **PROCESS.—**

6           **(1) CONTRACT WITH QUALIFIED EXTERNAL AP-**  
7 **PEAL ENTITY.—**

8                   **(A) CONTRACT REQUIREMENT.—***Except as*  
9                   *provided in subparagraph (D), the external ap-*  
10                   *peal process under this section of a plan or enti-*  
11                   *ty shall be conducted under a contract between*  
12                   *the plan or issuer and one or more qualified ex-*  
13                   *ternal appeal entities (as defined in subsection*  
14                   *(c)).*

15                   **(B) LIMITATION ON PLAN OR ISSUER SE-**  
16                   **LECTION.—***The applicable authority shall imple-*  
17                   *ment procedures—*

18                           *(i) to assure that the selection process*  
19                           *among qualified external appeal entities*  
20                           *will not create any incentives for external*  
21                           *appeal entities to make a decision in a bi-*  
22                           *ased manner, and*

23                           *(ii) for auditing a sample of decisions*  
24                           *by such entities to assure that no such deci-*  
25                           *sions are made in a biased manner.*

1           (C) *OTHER TERMS AND CONDITIONS.*—*The*  
2 *terms and conditions of a contract under this*  
3 *paragraph shall be consistent with the standards*  
4 *the appropriate Secretary shall establish to as-*  
5 *sure there is no real or apparent conflict of in-*  
6 *terest in the conduct of external appeal activities.*  
7 *Such contract shall provide that all costs of the*  
8 *process (except those incurred by the participant,*  
9 *beneficiary, enrollee, or treating professional in*  
10 *support of the appeal) shall be paid by the plan*  
11 *or entity, and not by the participant, bene-*  
12 *ficiary, or enrollee. The previous sentence shall*  
13 *not be construed as applying to the imposition*  
14 *of a filing fee under subsection (a)(4).*

15           (D) *STATE AUTHORITY WITH RESPECT TO*  
16 *QUALIFIED EXTERNAL APPEAL ENTITY FOR*  
17 *HEALTH INSURANCE ISSUERS.*—*With respect to*  
18 *QHBP offering entities offering qualified health*  
19 *benefits plans in a State, the State may provide*  
20 *for external review activities to be conducted by*  
21 *a qualified external appeal entity that is des-*  
22 *ignated by the State or that is selected by the*  
23 *State in a manner determined by the State to*  
24 *assure an unbiased determination.*

1           (2) *ELEMENTS OF PROCESS.*—*An external ap-*  
2 *peal process shall be conducted consistent with stand-*  
3 *ards established by the appropriate Secretary that in-*  
4 *clude at least the following:*

5                   (A) *FAIR AND DE NOVO DETERMINATION.*—

6           *The process shall provide for a fair, de novo de-*  
7 *termination. However, nothing in this para-*  
8 *graph shall be construed as providing for cov-*  
9 *erage of items and services for which benefits are*  
10 *specifically excluded under the plan.*

11                   (B) *STANDARD OF REVIEW.*—*An external*

12 *appeal entity shall determine whether the plan's*  
13 *or issuer's decision is in accordance with the*  
14 *medical needs of the patient involved (as deter-*  
15 *mined by the entity) taking into account, as of*  
16 *the time of the entity's determination, the pa-*  
17 *tient's medical condition and any relevant and*  
18 *reliable evidence the entity obtains under sub-*  
19 *paragraph (D). If the entity determines the deci-*  
20 *sion is in accordance with such needs, the entity*  
21 *shall affirm the decision and to the extent that*  
22 *the entity determines the decision is not in ac-*  
23 *cordance with such needs, the entity shall reverse*  
24 *or modify the decision.*

1                   (C) *CONSIDERATION OF PLAN OR COVERAGE*

2                   *DEFINITIONS.—In making such determination,*  
3                   *the external appeal entity shall consider (but not*  
4                   *be bound by) any language in the plan or cov-*  
5                   *erage document relating to the definitions of the*  
6                   *terms medical necessity, medically necessary or*  
7                   *appropriate, or experimental, investigational, or*  
8                   *related terms.*

9                   (D) *EVIDENCE.—*

10                   (i) *IN GENERAL.—An external appeal*  
11                   *entity shall include, among the evidence*  
12                   *taken into consideration—*

13                   (I) *the decision made by the plan*  
14                   *or QHBP offering entity upon internal*  
15                   *review under section 140 and any*  
16                   *guidelines or standards used by the*  
17                   *plan or QHBP offering entity in*  
18                   *reaching such decision;*

19                   (II) *any personal health and med-*  
20                   *ical information supplied with respect*  
21                   *to the individual whose denial of claim*  
22                   *for benefits has been appealed; and*

23                   (III) *the opinion of the individ-*  
24                   *ual's treating physician or health care*  
25                   *professional.*



1                   (ii) *ADDITIONAL EVIDENCE.*—*Such external appeal entity may also take into consideration but not be limited to the following evidence (to the extent available):*

2  
3  
4  
5                   (I) *The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.*

6  
7  
8  
9  
10                  (II) *The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.*

11  
12  
13  
14                  (III) *Practice and treatment guidelines prepared or financed in whole or in part by government agencies.*

15  
16  
17  
18                  (IV) *Government-issued coverage and treatment policies.*

19  
20                  (V) *Community standard of care and generally accepted principles of professional medical practice.*

21  
22  
23                  (VI) *To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals*

1                    *who are qualified as experts in one or*  
2                    *more fields of health care which are di-*  
3                    *rectly related to the matters under ap-*  
4                    *peal.*

5                    *(VII) To the extent that the entity*  
6                    *determines it to be free of any conflict*  
7                    *of interest, the results of peer reviews*  
8                    *conducted by the plan involved.*

9                    *(E) DETERMINATION CONCERNING EXTER-*  
10                    *NALLY APPEALABLE DECISIONS.—A qualified ex-*  
11                    *ternal appeal entity shall determine—*

12                    *(i) whether a denial of claim for bene-*  
13                    *fits is an externally appealable decision*  
14                    *(within the meaning of subsection (a)(2));*

15                    *(ii) whether an externally appealable*  
16                    *decision involves an expedited appeal; and*

17                    *(iii) for purposes of initiating an ex-*  
18                    *ternal review, whether the internal review*  
19                    *process has been completed.*

20                    *(F) OPPORTUNITY TO SUBMIT EVIDENCE.—*  
21                    *Each party to an externally appealable decision*  
22                    *may submit evidence related to the issues in dis-*  
23                    *pute.*

24                    *(G) PROVISION OF INFORMATION.—The*  
25                    *plan or issuer involved shall provide timely ac-*

1           *cess to the external appeal entity to information*  
2           *and to provisions of the plan relating to the mat-*  
3           *ter of the externally appealable decision, as de-*  
4           *termined by the entity.*

5           *(H) TIMELY DECISIONS.—A determination*  
6           *by the external appeal entity on the decision*  
7           *shall—*

8                     *(i) be made orally or in writing and,*  
9                     *if it is made orally, shall be supplied to the*  
10                    *parties in writing as soon as possible;*

11                    *(ii) be made in accordance with the*  
12                    *medical exigencies of the case involved, but*  
13                    *in no event later than 21 days after the*  
14                    *date (or, in the case of an expedited appeal,*  
15                    *72 hours after the time) of requesting an ex-*  
16                    *ternal appeal of the decision;*

17                    *(iii) state, in layperson’s language, the*  
18                    *basis for the determination, including, if*  
19                    *relevant, any basis in the terms or condi-*  
20                    *tions of the plan; and*

21                    *(iv) inform the participant, bene-*  
22                    *ficiary, or enrollee of the individual’s rights*  
23                    *(including any limitation on such rights) to*  
24                    *seek further review by the courts (or other*

1           *process) of the external appeal determina-*  
2           *tion.*

3           *(I) COMPLIANCE WITH DETERMINATION.—If*  
4           *the external appeal entity reverses or modifies*  
5           *the denial of a claim for benefits, the plan*  
6           *shall—*

7                     *(i) upon the receipt of the determina-*  
8                     *tion, authorize benefits in accordance with*  
9                     *such determination;*

10                    *(ii) take such actions as may be nec-*  
11                    *essary to provide benefits (including items*  
12                    *or services) in a timely manner consistent*  
13                    *with such determination; and*

14                    *(iii) submit information to the entity*  
15                    *documenting compliance with the entity’s*  
16                    *determination and this subparagraph.*

17           *(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-*  
18           *TIES.—*

19                    *(1) IN GENERAL.—For purposes of this section,*  
20                    *the term “qualified external appeal entity” means, in*  
21                    *relation to a plan or issuer, an entity that is certified*  
22                    *under paragraph (2) as meeting the following require-*  
23                    *ments:*

24                             *(A) The entity meets the independence re-*  
25                             *quirements of paragraph (3).*

1           (B) *The entity conducts external appeal ac-*  
2 *tivities through a panel of not fewer than 3 clin-*  
3 *ical peers.*

4           (C) *The entity has sufficient medical, legal,*  
5 *and other expertise and sufficient staffing to con-*  
6 *duct external appeal activities for the plan on a*  
7 *timely basis consistent with subsection (b)(2)(G).*

8           (D) *The entity meets such other require-*  
9 *ments as the appropriate Secretary may impose.*

10         (2) *INITIAL CERTIFICATION OF EXTERNAL AP-*  
11 *PEAL ENTITIES.—*

12           (A) *IN GENERAL.—In order to be treated as*  
13 *a qualified external appeal entity with respect*  
14 *to—*

15                 (i) *a qualified health benefits plan that*  
16 *is a group health plan, the entity must be*  
17 *certified (and, in accordance with subpara-*  
18 *graph (B), periodically recertified) as meet-*  
19 *ing the requirements of paragraph (1)—*

20                         (I) *by the Secretary of Labor;*

21                         (II) *under a process recognized or*  
22 *approved by the Secretary of Labor; or*

23                         (III) *to the extent provided in*  
24 *subparagraph (C)(i), by a qualified*

1                    *private standard-setting organization*  
2                    *(certified under such subparagraph); or*  
3                    *(ii) a QHBP offering entity that is a*  
4                    *health insurance issuer operating in a*  
5                    *State, the qualified external appeal entity*  
6                    *must be certified (and, in accordance with*  
7                    *subparagraph (B), periodically recertified)*  
8                    *as meeting such requirements—*

9                    *(I) by the applicable State author-*  
10                    *ity (or under a process recognized or*  
11                    *approved by such authority); or*

12                    *(II) if the State has not estab-*  
13                    *lished a certification and recertifi-*  
14                    *cation process for such entities, by the*  
15                    *Secretary of Health and Human Serv-*  
16                    *ices, under a process recognized or ap-*  
17                    *proved by such Secretary, or to the ex-*  
18                    *tent provided in subparagraph (C)(ii),*  
19                    *by a qualified private standard-setting*  
20                    *organization (certified under such sub-*  
21                    *paragraph).*

22                    *(B) RECERTIFICATION PROCESS.—The ap-*  
23                    *propriate Secretary shall develop standards for*  
24                    *the recertification of external appeal entities.*  
25                    *Such standards shall include a review of—*

- 1                   (i) *the number of cases reviewed;*  
2                   (ii) *a summary of the disposition of*  
3 *those cases;*  
4                   (iii) *the length of time in making de-*  
5 *terminations on those cases;*  
6                   (iv) *updated information of what was*  
7 *required to be submitted as a condition of*  
8 *certification for the entity's performance of*  
9 *external appeal activities; and*  
10                  (v) *such information as may be nec-*  
11 *essary to assure the independence of the en-*  
12 *tity from the plans or issuers for which ex-*  
13 *ternal appeal activities are being conducted.*

14                  (C) *CERTIFICATION OF QUALIFIED PRIVATE*  
15 *STANDARD-SETTING ORGANIZATIONS.—*

16                  (i) *FOR EXTERNAL REVIEWS OF GROUP*  
17 *HEALTH PLANS.—For purposes of subpara-*  
18 *graph (A)(i)(III), the Secretary of Labor*  
19 *may provide for a process for certification*  
20 *(and periodic recertification) of qualified*  
21 *private standard-setting organizations*  
22 *which provide for certification of external*  
23 *review entities. Such an organization shall*  
24 *only be certified if the organization does not*  
25 *certify an external review entity unless it*

1            *meets standards required for certification of*  
2            *such an entity by such Secretary under sub-*  
3            *paragraph (A)(i)(I).*

4            *(ii) FOR EXTERNAL REVIEWS OF*  
5            *HEALTH INSURANCE ISSUERS.—For pur-*  
6            *poses of subparagraph (A)(ii)(II), the Sec-*  
7            *retary of Health and Human Services may*  
8            *provide for a process for certification (and*  
9            *periodic recertification) of qualified private*  
10           *standard-setting organizations which pro-*  
11           *vide for certification of external review enti-*  
12           *ties. Such an organization shall only be cer-*  
13           *tified if the organization does not certify an*  
14           *external review entity unless it meets stand-*  
15           *ards required for certification of such an*  
16           *entity by such Secretary under subpara-*  
17           *graph (A)(ii)(II).*

18           *(3) INDEPENDENCE REQUIREMENTS.—*

19           *(A) IN GENERAL.—A clinical peer or other*  
20           *entity meets the independence requirements of*  
21           *this paragraph if—*

22           *(i) the peer or entity does not have a*  
23           *familial, financial, or professional relation-*  
24           *ship with any related party;*



1           (ii) any compensation received by such  
2 peer or entity in connection with the exter-  
3 nal review is reasonable and not contingent  
4 on any decision rendered by the peer or en-  
5 tity;

6           (iii) except as provided in paragraph  
7 (4), the plan and the issuer have no re-  
8 course against the peer or entity in connec-  
9 tion with the external review; and

10          (iv) the peer or entity does not other-  
11 wise have a conflict of interest with a re-  
12 lated party as determined under any regu-  
13 lations which the Secretary may prescribe.

14          (B) *RELATED PARTY*.—For purposes of this  
15 paragraph, the term “related party” means—

16           (i) with respect to—

17               (I) a qualified health benefits plan  
18 that is a group health plan, the plan  
19 or QHBP offering entity of such plan;  
20 or

21               (II) a qualified health benefits  
22 plan that is individual health insur-  
23 ance coverage, the health insurance  
24 issuer offering such coverage, or any  
25 plan sponsor, fiduciary, officer, direc-

1                    *tor, or management employee of such*  
2                    *plan or issuer;*

3                    *(ii) the health care professional that*  
4                    *provided the health care involved in the cov-*  
5                    *erage decision;*

6                    *(iii) the institution at which the health*  
7                    *care involved in the coverage decision is*  
8                    *provided;*

9                    *(iv) the manufacturer of any drug or*  
10                   *other item that was included in the health*  
11                   *care involved in the coverage decision; or*

12                   *(v) any other party determined under*  
13                   *any regulations which the Secretary may*  
14                   *prescribe to have a substantial interest in*  
15                   *the coverage decision.*

16                   *(4) LIMITATION ON LIABILITY OF REVIEWERS.—*  
17                   *No qualified external appeal entity having a contract*  
18                   *with a qualified health benefits plan under this part*  
19                   *and no person who is employed by any such entity*  
20                   *or who furnishes professional services to such entity,*  
21                   *shall be held by reason of the performance of any*  
22                   *duty, function, or activity required or authorized pur-*  
23                   *suant to this section, to have violated any criminal*  
24                   *law, or to be civilly liable under any law of the*  
25                   *United States or of any State (or political subdivi-*

1        *sion thereof) if due care was exercised in the perform-*  
2        *ance of such duty, function, or activity and there was*  
3        *no actual malice or gross misconduct in the perform-*  
4        *ance of such duty, function, or activity.*

5        *(d) EXTERNAL APPEAL DETERMINATION BINDING ON*  
6        *PLAN.—The determination by an external appeal entity*  
7        *under this section is binding on the plan involved in the*  
8        *determination.*

9        *(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR*  
10       *REFUSING TO AUTHORIZE THE DETERMINATION OF AN EX-*  
11       *TERNAL REVIEW ENTITY.—*

12            *(1) MONETARY PENALTIES.—In any case in*  
13        *which the determination of an external review entity*  
14        *is not followed by a qualified health benefits plan,*  
15        *any person who, acting in the capacity of authorizing*  
16        *the benefit, causes such refusal may, in the discretion*  
17        *in a court of competent jurisdiction, be liable to an*  
18        *aggrieved participant, beneficiary, or enrollee for a*  
19        *civil penalty in an amount of up to \$1,000 a day*  
20        *from the date on which the determination was trans-*  
21        *mitted to the plan by the external review entity until*  
22        *the date the refusal to provide the benefit is corrected.*

23            *(2) CEASE AND DESIST ORDER AND ORDER OF*  
24        *ATTORNEY'S FEES.—In any action described in para-*  
25        *graph (1) brought by a participant, beneficiary, or*

1        *enrollee with respect to a qualified health benefits*  
2        *plan, in which a plaintiff alleges that a person re-*  
3        *ferred to in such paragraph has taken an action re-*  
4        *sulting in a refusal of a benefit determined by an ex-*  
5        *ternal appeal entity in violation of such terms of the*  
6        *plan, coverage, or this subtitle, or has failed to take*  
7        *an action for which such person is responsible under*  
8        *the plan or this title and which is necessary under the*  
9        *plan or coverage for authorizing a benefit, the court*  
10       *shall cause to be served on the defendant an order re-*  
11       *quiring the defendant—*

12                    *(A) to cease and desist from the alleged ac-*  
13                    *tion or failure to act; and*

14                    *(B) to pay to the plaintiff a reasonable at-*  
15                    *torney's fee and other reasonable costs relating to*  
16                    *the prosecution of the action on the charges on*  
17                    *which the plaintiff prevails.*

18                    *(3) ADDITIONAL CIVIL PENALTIES.—*

19                    *(A) IN GENERAL.—In addition to any pen-*  
20                    *alty imposed under paragraph (1) or (2), the ap-*  
21                    *propriate Secretary may assess a civil penalty*  
22                    *against a person acting in the capacity of au-*  
23                    *thorizing a benefit determined by an external re-*  
24                    *view entity for one or more qualified health bene-*  
25                    *fits plans, for—*

1           (i) any pattern or practice of repeated  
2 refusal to authorize a benefit determined by  
3 an external appeal entity in violation of the  
4 terms of such a plan, or this title; or

5           (ii) any pattern or practice of repeated  
6 violations of the requirements of this section  
7 with respect to such plan or plans.

8           (B) *STANDARD OF PROOF AND AMOUNT OF*  
9 *PENALTY.*—Such penalty shall be payable only  
10 upon proof by clear and convincing evidence of  
11 such pattern or practice and shall be in an  
12 amount not to exceed the lesser of—

13           (i) 25 percent of the aggregate value of  
14 benefits shown by the appropriate Secretary  
15 to have not been provided, or unlawfully de-  
16 layed, in violation of this section under  
17 such pattern or practice, or

18           (ii) \$500,000.

19           (4) *REMOVAL AND DISQUALIFICATION.*—Any per-  
20 son acting in the capacity of authorizing benefits who  
21 has engaged in any such pattern or practice described  
22 in paragraph (3)(A) with respect to a plan or cov-  
23 erage, upon the petition of the appropriate Secretary,  
24 may be removed by the court from such position, and  
25 from any other involvement, with respect to such a

1        *plan or coverage, and may be precluded from return-*  
2        *ing to any such position or involvement for a period*  
3        *determined by the court.*

4        *(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this*  
5        *subtitle shall be construed as altering or eliminating any*  
6        *cause of action or legal rights or remedies of participants,*  
7        *beneficiaries, enrollees, and others under State or Federal*  
8        *law (including sections 502 and 503 of the Employee Re-*  
9        *tirement Income Security Act of 1974), including the right*  
10       *to file judicial actions to enforce actions.*

11       *(g) APPLICATION TO ALL ACCEPTABLE COVERAGE.—*  
12       *The provisions of this section shall apply with respect to*  
13       *all acceptable coverage in the same manner as such provi-*  
14       *sions apply with respect to qualified health benefits plans*  
15       *under this section.*

## 16                                    **Subtitle E—Governance**

### 17       **SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH** 18                                    **CHOICES COMMISSIONER.**

19       *(a) IN GENERAL.—There is hereby established, as an*  
20       *independent agency in the executive branch of the Govern-*  
21       *ment, a Health Choices Administration (in this division*  
22       *referred to as the “Administration”).*

23       *(b) COMMISSIONER.—*

24                                    *(1) IN GENERAL.—The Administration shall be*  
25       *headed by a Health Choices Commissioner (in this di-*

1 *vision referred to as the “Commissioner”)* who shall  
2 *be appointed by the President, by and with the advice*  
3 *and consent of the Senate.*

4 (2) *COMPENSATION; ETC.—The provisions of*  
5 *paragraphs (2), (5), and (7) of subsection (a) (relat-*  
6 *ing to compensation, terms, general powers, rule-*  
7 *making, and delegation) of section 702 of the Social*  
8 *Security Act (42 U.S.C. 902) shall apply to the Com-*  
9 *missioner and the Administration in the same man-*  
10 *ner as such provisions apply to the Commissioner of*  
11 *Social Security and the Social Security Administra-*  
12 *tion.*

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

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

16 (1) *QUALIFIED PLAN STANDARDS.—The estab-*  
17 *lishment of qualified health benefits plan standards*  
18 *under this title, including the enforcement of such*  
19 *standards in coordination with State insurance regu-*  
20 *lators and the Secretaries of Labor and the Treasury.*

21 (2) *HEALTH INSURANCE EXCHANGE.—The estab-*  
22 *lishment and operation of a Health Insurance Ex-*  
23 *change under subtitle A of title II.*

24 (3) *INDIVIDUAL AFFORDABILITY CREDITS.—The*  
25 *administration of individual affordability credits*

1        *under subtitle C of title II, including determination*  
2        *of eligibility for such credits.*

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

5            (b) *PROMOTING ACCOUNTABILITY.—*

6            (1) *IN GENERAL.—The Commissioner shall un-*  
7        *dertake activities in accordance with this subtitle to*  
8        *promote accountability of QHBP offering entities in*  
9        *meeting Federal health insurance requirements, re-*  
10       *gardless of whether such accountability is with respect*  
11       *to qualified health benefits plans offered through the*  
12       *Health Insurance Exchange or outside of such Ex-*  
13       *change.*

14           (2) *COMPLIANCE EXAMINATION AND AUDITS.—*

15           (A) *IN GENERAL.—The commissioner shall,*  
16        *in coordination with States, conduct audits of*  
17        *qualified health benefits plan compliance with*  
18        *Federal requirements. Such audits may include*  
19        *random compliance audits and targeted audits*  
20        *in response to complaints or other suspected non-*  
21        *compliance.*

22           (B) *RECOUPMENT OF COSTS IN CONNECTION*  
23        *WITH EXAMINATION AND AUDITS.—The Commis-*  
24        *sioner is authorized to recoup from qualified*  
25        *health benefits plans reimbursement for the costs*



1           *of such examinations and audit of such QHBP*  
2           *offering entities.*

3           (c) *DATA COLLECTION.*—*The Commissioner shall col-*  
4 *lect data for purposes of carrying out the Commissioner’s*  
5 *duties, including for purposes of promoting quality and*  
6 *value, protecting consumers, and addressing disparities in*  
7 *health and health care and may share such data with the*  
8 *Secretary of Health and Human Services.*

9           (d) *SANCTIONS AUTHORITY.*—

10           (1) *IN GENERAL.*—*In the case that the Commis-*  
11 *sioner determines that a QHBP offering entity vio-*  
12 *lates a requirement of this title, the Commissioner*  
13 *may, in coordination with State insurance regulators*  
14 *and the Secretary of Labor, provide, in addition to*  
15 *any other remedies authorized by law, for any of the*  
16 *remedies described in paragraph (2).*

17           (2) *REMEDIES.*—*The remedies described in this*  
18 *paragraph, with respect to a qualified health benefits*  
19 *plan offered by a QHBP offering entity, are—*

20                   (A) *civil money penalties of not more than*  
21 *the amount that would be applicable under simi-*  
22 *lar circumstances for similar violations under*  
23 *section 1857(g) of the Social Security Act;*

24                   (B) *suspension of enrollment of individuals*  
25 *under such plan after the date the Commissioner*

1           *notifies the entity of a determination under*  
2           *paragraph (1) and until the Commissioner is*  
3           *satisfied that the basis for such determination*  
4           *has been corrected and is not likely to recur;*

5           *(C) in the case of an Exchange-partici-*  
6           *peating health benefits plan, suspension of pay-*  
7           *ment to the entity under the Health Insurance*  
8           *Exchange for individuals enrolled in such plan*  
9           *after the date the Commissioner notifies the enti-*  
10          *ty of a determination under paragraph (1) and*  
11          *until the Secretary is satisfied that the basis for*  
12          *such determination has been corrected and is not*  
13          *likely to recur; or*

14          *(D) working with State insurance regu-*  
15          *lators to terminate plans for repeated failure by*  
16          *the offering entity to meet the requirements of*  
17          *this title.*

18          *(e) STANDARD DEFINITIONS OF INSURANCE AND MED-*  
19          *ICAL TERMS.—The Commissioner shall provide for the de-*  
20          *velopment of standards for the definitions of terms used in*  
21          *health insurance coverage, including insurance-related*  
22          *terms.*

23          *(f) EFFICIENCY IN ADMINISTRATION.—The Commis-*  
24          *sioner shall issue regulations for the effective and efficient*  
25          *administration of the Health Insurance Exchange and af-*

1 *fordability credits under subtitle C, including, with respect*  
2 *to the determination of eligibility for affordability credits,*  
3 *the use of personnel who are employed in accordance with*  
4 *the requirements of title 5, United States Code, to carry*  
5 *out the duties of the Commissioner or, in the case of sections*  
6 *208 and 241(b)(2), the use of State personnel who are em-*  
7 *ployed in accordance with standards prescribed by the Of-*  
8 *fice of Personnel Management pursuant to section 208 of*  
9 *the Intergovernmental Personnel Act of 1970 (42 U.S.C.*  
10 *4728).*

11 **SEC. 143. CONSULTATION AND COORDINATION.**

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

15 *(1) The National Association of Insurance Com-*  
16 *missioners, State attorneys general, and State insur-*  
17 *ance regulators, including concerning the standards*  
18 *for insured qualified health benefits plans under this*  
19 *title and enforcement of such standards.*

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

1           (3) *Other appropriate Federal agencies.*

2           (4) *Indian tribes and tribal organizations.*

3           (5) *The National Association of Insurance Com-*  
4 *missioners for purposes of using model guidelines es-*  
5 *tablished by such association for purposes of subtitles*  
6 *B and D.*

7           (b) *COORDINATION.—*

8           (1) *IN GENERAL.—In carrying out the functions*  
9 *of the Commissioner, including with respect to the en-*  
10 *forcement of the provisions of this division, the Com-*  
11 *missioner shall work in coordination with existing*  
12 *Federal and State entities to the maximum extent*  
13 *feasible consistent with this division and in a manner*  
14 *that prevents conflicts of interest in duties and en-*  
15 *sures effective enforcement.*

16           (2) *UNIFORM STANDARDS.—The Commissioner,*  
17 *in coordination with such entities, shall seek to*  
18 *achieve uniform standards that adequately protect*  
19 *consumers in a manner that does not unreasonably*  
20 *affect employers and insurers.*

21 **SEC. 144. HEALTH INSURANCE OMBUDSMAN.**

22           (a) *IN GENERAL.—The Commissioner shall appoint*  
23 *within the Health Choices Administration a Qualified*  
24 *Health Benefits Plan Ombudsman who shall have expertise*

1 *and experience in the fields of health care and education*  
2 *of (and assistance to) individuals.*

3 (b) *DUTIES.—The Qualified Health Benefits Plan Om-*  
4 *budsman shall, in a linguistically appropriate manner—*

5 (1) *receive complaints, grievances, and requests*  
6 *for information submitted by individuals;*

7 (2) *provide assistance with respect to complaints,*  
8 *grievances, and requests referred to in paragraph (1),*  
9 *including—*

10 (A) *helping individuals determine the rel-*  
11 *evant information needed to seek an appeal of a*  
12 *decision or determination;*

13 (B) *assistance to such individuals with any*  
14 *problems arising from disenrollment from such a*  
15 *plan;*

16 (C) *assistance to such individuals in choos-*  
17 *ing a qualified health benefits plan in which to*  
18 *enroll; and*

19 (D) *assistance to such individuals in pre-*  
20 *senting information under subtitle C (relating to*  
21 *affordability credits); and*

22 (3) *submit annual reports to Congress and the*  
23 *Commissioner that describe the activities of the Om-*  
24 *budsman and that include such recommendations for*  
25 *improvement in the administration of this division as*

1 *the Ombudsman determines appropriate. The Om-*  
2 *budsman shall not serve as an advocate for any in-*  
3 *creases in payments or new coverage of services, but*  
4 *may identify issues and problems in payment or cov-*  
5 *erage policies.*

6 ***Subtitle F—Relation to Other***  
7 ***Requirements; Miscellaneous***

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

9 *(a) COVERAGE NOT OFFERED THROUGH EX-*  
10 *CHANGE.—*

11 *(1) IN GENERAL.—In the case of health insur-*  
12 *ance coverage not offered through the Health Insur-*  
13 *ance Exchange (whether or not offered in connection*  
14 *with an employment-based health plan), and in the*  
15 *case of employment-based health plans, the require-*  
16 *ments of this title do not supercede any requirements*  
17 *applicable under titles XXII and XXVII of the Public*  
18 *Health Service Act, parts 6 and 7 of subtitle B of title*  
19 *I of the Employee Retirement Income Security Act of*  
20 *1974, or State law, except insofar as such require-*  
21 *ments prevent the application of a requirement of this*  
22 *division, as determined by the Commissioner.*

23 *(2) CONSTRUCTION.—Nothing in paragraph (1)*  
24 *shall be construed as affecting the application of sec-*

1        *tion 514 of the Employee Retirement Income Security*  
2        *Act of 1974.*

3        *(b) COVERAGE OFFERED THROUGH EXCHANGE.—*

4            *(1) IN GENERAL.—In the case of health insur-*  
5        *ance coverage offered through the Health Insurance*  
6        *Exchange—*

7            *(A) the requirements of this title do not*  
8        *supercede any requirements (including require-*  
9        *ments relating to genetic information non-*  
10       *discrimination and mental health) applicable*  
11       *under title XXVII of the Public Health Service*  
12       *Act or under State law, except insofar as such*  
13       *requirements prevent the application of a re-*  
14       *quirement of this division, as determined by the*  
15       *Commissioner; and*

16           *(B) individual rights and remedies under*  
17        *State laws shall apply.*

18           *(2) CONSTRUCTION.—In the case of coverage de-*  
19        *scribed in paragraph (1), nothing in such paragraph*  
20        *shall be construed as preventing the application of*  
21        *rights and remedies under State laws with respect to*  
22        *any requirement referred to in paragraph (1)(A).*

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

24           *(a) IN GENERAL.—Except as otherwise explicitly per-*  
25        *mitted by this Act and by subsequent regulations consistent*

1 *with this Act, all health care and related services (including*  
2 *insurance coverage and public health activities) covered by*  
3 *this Act shall be provided without regard to personal char-*  
4 *acteristics extraneous to the provision of high quality health*  
5 *care or related services.*

6       **(b) IMPLEMENTATION.**—*To implement the requirement*  
7 *set forth in subsection (a), the Secretary of Health and*  
8 *Human Services shall, not later than 18 months after the*  
9 *date of the enactment of this Act, promulgate such regula-*  
10 *tions as are necessary or appropriate to insure that all*  
11 *health care and related services (including insurance cov-*  
12 *erage and public health activities) covered by this Act are*  
13 *provided (whether directly or through contractual, licens-*  
14 *ing, or other arrangements) without regard to personal*  
15 *characteristics extraneous to the provision of high quality*  
16 *health care or related services.*

17 **SEC. 153. WHISTLEBLOWER PROTECTION.**

18       **(a) RETALIATION PROHIBITED.**—*No employer may*  
19 *discharge any employee or otherwise discriminate against*  
20 *any employee with respect to his compensation, terms, con-*  
21 *ditions, or other privileges of employment because the em-*  
22 *ployee (or any person acting pursuant to a request of the*  
23 *employee)—*

24               **(1)** *provided, caused to be provided, or is about*  
25 *to provide or cause to be provided to the employer, the*



1       *Federal Government, or the attorney general of a*  
2       *State information relating to any violation of, or any*  
3       *act or omission the employee reasonably believes to be*  
4       *a violation of any provision of this Act or any order,*  
5       *rule, or regulation promulgated under this Act;*

6             (2) *testified or is about to testify in a proceeding*  
7       *concerning such violation;*

8             (3) *assisted or participated or is about to assist*  
9       *or participate in such a proceeding; or*

10            (4) *objected to, or refused to participate in, any*  
11       *activity, policy, practice, or assigned task that the*  
12       *employee (or other such person) reasonably believed to*  
13       *be in violation of any provision of this Act or any*  
14       *order, rule, or regulation promulgated under this Act.*

15        (b) *ENFORCEMENT ACTION.*—*An employee covered by*  
16       *this section who alleges discrimination by an employer in*  
17       *violation of subsection (a) may bring an action governed*  
18       *by the rules, procedures, legal burdens of proof, and rem-*  
19       *edies set forth in section 40(b) of the Consumer Product*  
20       *Safety Act (15 U.S.C. 2087(b)).*

21        (c) *EMPLOYER DEFINED.*—*As used in this section, the*  
22       *term “employer” means any person (including one or more*  
23       *individuals, partnerships, associations, corporations, trusts,*  
24       *professional membership organization including a certifi-*  
25       *cation, disciplinary, or other professional body, unincor-*

1 *porated organizations, nongovernmental organizations, or*  
2 *trustees) engaged in profit or nonprofit business or industry*  
3 *whose activities are governed by this Act, and any agent,*  
4 *contractor, subcontractor, grantee, or consultant of such*  
5 *person.*

6 *(d) RULE OF CONSTRUCTION.—The rule of construc-*  
7 *tion set forth in section 20109(h) of title 49, United States*  
8 *Code, shall also apply to this section.*

9 **SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BAR-**  
10 **GAINING.**

11 *Nothing in this division shall be construed to alter or*  
12 *supersede any statutory or other obligation to engage in col-*  
13 *lective bargaining over the terms and conditions of employ-*  
14 *ment related to health care.*

15 **SEC. 155. SEVERABILITY.**

16 *If any provision of this Act, or any application of such*  
17 *provision to any person or circumstance, is held to be un-*  
18 *constitutional, the remainder of the provisions of this Act*  
19 *and the application of the provision to any other person*  
20 *or circumstance shall not be affected.*

21 **SEC. 156. APPLICATION OF STATE AND FEDERAL LAWS RE-**  
22 **GARDING ABORTION.**

23 *(a) NO PREEMPTION OF STATE LAWS REGARDING*  
24 *ABORTION.—Nothing in this Act shall be construed to pre-*  
25 *empt or otherwise have any effect on State laws regarding*

1 *the prohibition of (or requirement of) coverage, funding, or*  
 2 *procedural requirements on abortions, including parental*  
 3 *notification or consent for the performance of an abortion*  
 4 *on a minor.*

5 *(b) NO EFFECT ON FEDERAL LAWS REGARDING ABOR-*  
 6 *TION.—*

7 *(1) IN GENERAL.—Nothing in this Act shall be*  
 8 *construed to have any effect on Federal laws regard-*  
 9 *ing—*

10 *(A) conscience protection;*

11 *(B) willingness or refusal to provide abor-*  
 12 *tion; and*

13 *(C) discrimination on the basis of the will-*  
 14 *ingness or refusal to provide, pay for, cover, or*  
 15 *refer for abortion or to provide or participate in*  
 16 *training to provide abortion.*

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

21 **SEC. 157. NON-DISCRIMINATION ON ABORTION AND RE-**  
 22 **SPECT FOR RIGHTS OF CONSCIENCE.**

23 *(a) NON-DISCRIMINATION.—A Federal agency or pro-*  
 24 *gram, and any State or local government that receives Fed-*

1 *eral financial assistance under this Act (or an amendment*  
2 *made by this Act), may not—*

3 *(1) subject any individual or institutional health*  
4 *care entity to discrimination, or*

5 *(2) require any health plan created or regulated*  
6 *under this Act (or an amendment made by this Act)*  
7 *to subject any individual or institutional health care*  
8 *entity to discrimination,*

9 *on the basis that the health care entity does not provide,*  
10 *pay for, provide coverage of, or refer for abortions.*

11 *(b) DEFINITION.—In this section, the term “health care*  
12 *entity” includes an individual physician or other health*  
13 *care professional, a hospital, a provider-sponsored organi-*  
14 *zation, a health maintenance organization, a health insur-*  
15 *ance plan, or any other kind of health care facility, organi-*  
16 *zation, or plan.*

17 *(c) ADMINISTRATION.—The Office for Civil Rights of*  
18 *the Department of Health and Human Services is des-*  
19 *ignated to receive complaints of discrimination based on*  
20 *this section, and coordinate the investigation of such com-*  
21 *plaints.*

1       ***Subtitle G—Early Investments***

2       ***SEC. 161. ENSURING VALUE AND LOWER PREMIUMS.***

3           *(a) GROUP HEALTH INSURANCE COVERAGE.—Title*  
4 *XXVII of the Public Health Service Act is amended by in-*  
5 *serting after section 2713 the following new section:*

6       ***“SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.***

7           *“(a) IN GENERAL.—Each health insurance issuer that*  
8 *offers health insurance coverage in the small or large group*  
9 *market shall provide that for any plan year in which the*  
10 *coverage has a medical loss ratio below a level specified by*  
11 *the Secretary, the issuer shall provide in a manner specified*  
12 *by the Secretary for rebates to enrollees of payment suffi-*  
13 *cient to meet such loss ratio. Such methodology shall be set*  
14 *at the highest level medical loss ratio possible that is de-*  
15 *signed to ensure adequate participation by issuers, competi-*  
16 *tion in the health insurance market, and value for con-*  
17 *sumers so that their premiums are used for services.*

18           *“(b) UNIFORM DEFINITIONS.—The Secretary shall es-*  
19 *tablish a uniform definition of medical loss ratio and meth-*  
20 *odology for determining how to calculate the medical loss*  
21 *ratio. Such methodology shall be designed to take into ac-*  
22 *count the special circumstances of smaller plans, different*  
23 *types of plans, and newer plans.”.*

1       (b) *INDIVIDUAL HEALTH INSURANCE COVERAGE.*—  
 2 *Such title is further amended by inserting after section*  
 3 *2753 the following new section:*

4       “**SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.**

5       *“The provisions of section 2714 shall apply to health*  
 6 *insurance coverage offered in the individual market in the*  
 7 *same manner as such provisions apply to health insurance*  
 8 *coverage offered in the small or large group market.”.*

9       (c) *IMMEDIATE IMPLEMENTATION.*—*The amendments*  
 10 *made by this section shall apply in the group and indi-*  
 11 *vidual market for plan years beginning on or after January*  
 12 *1, 2011.*

13       **SEC. 162. ENDING HEALTH INSURANCE RESCISSION ABUSE.**

14       (a) *CLARIFICATION REGARDING APPLICATION OF*  
 15 *GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH IN-*  
 16 *SURANCE COVERAGE.*—*Section 2742 of the Public Health*  
 17 *Service Act (42 U.S.C. 300gg–42) is amended—*

18               (1) *in its heading, by inserting “**AND CON-***  
 19 ***TINUATION IN FORCE, INCLUDING PROHIBI-***  
 20 ***TION OF RESCISSION,”** after “**GUARANTEED RE-***  
 21 ***NEWABILITY”;** and*

22               (2) *in subsection (a), by inserting “, including*  
 23 *without rescission,”* after “*continue in force*”.

1           (b) *SECRETARIAL GUIDANCE REGARDING RESCIS-*  
 2 *SIONS.—Section 2742 of such Act (42 U.S.C. 300gg–42) is*  
 3 *amended by adding at the end the following:*

4           “(f) *RESCISSION.—A health insurance issuer may re-*  
 5 *scind health insurance coverage only upon clear and con-*  
 6 *vincing evidence of fraud described in subsection (b)(2). The*  
 7 *Secretary, no later than July 1, 2010, shall issue guidance*  
 8 *implementing this requirement, including procedures for*  
 9 *independent, external third party review.”.*

10          (c) *OPPORTUNITY FOR INDEPENDENT, EXTERNAL*  
 11 *THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1 of*  
 12 *part B of title XXVII of such Act (42 U.S.C. 300gg–41 et*  
 13 *seq.) is amended by adding at the end the following:*

14          “**SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
 15                                 **THIRD PARTY REVIEW IN CASES OF RESCIS-**  
 16                                 **SION.**”

17          “(a) *NOTICE AND REVIEW RIGHT.—If a health insur-*  
 18 *ance issuer determines to rescind health insurance coverage*  
 19 *for an individual in the individual market, before such re-*  
 20 *scission may take effect the issuer shall provide the indi-*  
 21 *vidual with notice of such proposed rescission and an op-*  
 22 *portunity for a review of such determination by an inde-*  
 23 *pendent, external third party under procedures specified by*  
 24 *the Secretary under section 2742(f).*”

1       “(b) *INDEPENDENT DETERMINATION.*—If the indi-  
 2       vidual requests such review by an independent, external  
 3       third party of a rescission of health insurance coverage, the  
 4       coverage shall remain in effect until such third party deter-  
 5       mines that the coverage may be rescinded under the guid-  
 6       ance issued by the Secretary under section 2742(f).”.

7       (d) *EFFECTIVE DATE.*—The amendments made by this  
 8       section shall apply on and after October 1, 2010, with re-  
 9       spect to health insurance coverage issued before, on, or after  
 10      such date.

11      **SEC. 163. ENDING HEALTH INSURANCE DENIALS AND**  
 12                                      **DELAYS OF NECESSARY TREATMENT FOR**  
 13                                      **CHILDREN WITH DEFORMITIES.**

14      (a) *IN GENERAL.*—Subpart 2 of part A of title XXVII  
 15      of the Public Health Service Act is amended by adding at  
 16      the end the following new section:

17      **“SEC. 2708. STANDARDS RELATING TO BENEFITS FOR**  
 18                                      **MINOR CHILD’S CONGENITAL OR DEVELOP-**  
 19                                      **MENTAL DEFORMITY OR DISORDER.**

20      “(a) *REQUIREMENTS FOR TREATMENT FOR CHILDREN*  
 21      *WITH DEFORMITIES.*—

22                      “(1) *IN GENERAL.*—A group health plan, and a  
 23      health insurance issuer offering group health insur-  
 24      ance coverage, that provides coverage for surgical ben-  
 25      efits shall provide coverage for outpatient and inpa-



1        *tient diagnosis and treatment of a minor child's con-*  
2        *genital or developmental deformity, disease, or injury.*  
3        *A minor child shall include any individual who 21*  
4        *years of age or younger.*

5            *“(2) REQUIREMENTS.—Any coverage provided*  
6        *under paragraph (1) shall be subject to pre-authorized*  
7        *tion or pre-certification as required by the plan or*  
8        *issuer, and such coverage shall include any surgical*  
9        *treatment which, in the opinion of the treating physi-*  
10       *cian, is medically necessary to approximate a normal*  
11       *appearance.*

12           *“(3) TREATMENT DEFINED.—*

13            *“(A) IN GENERAL.—In this section, the*  
14        *term ‘treatment’ includes reconstructive surgical*  
15        *procedures (procedures that are generally per-*  
16        *formed to improve function, but may also be per-*  
17        *formed to approximate a normal appearance)*  
18        *that are performed on abnormal structures of the*  
19        *body caused by congenital defects, developmental*  
20        *abnormalities, trauma, infection, tumors, or dis-*  
21        *ease, including—*

22            *“(i) procedures that do not materially*  
23        *affect the function of the body part being*  
24        *treated; and*

1                   “(ii) procedures for secondary condi-  
2                   tions and follow-up treatment.

3                   “(B) *EXCEPTION.*—Such term does not in-  
4                   clude cosmetic surgery performed to reshape nor-  
5                   mal structures of the body to improve appear-  
6                   ance or self-esteem.

7                   “(b) *NOTICE.*—A group health plan under this part  
8 shall comply with the notice requirement under section  
9 714(b) of the Employee Retirement Income Security Act of  
10 1974 with respect to the requirements of this section as if  
11 such section applied to such plan.”.

12                   (b) *INDIVIDUAL HEALTH INSURANCE.*—Subpart 2 of  
13 part B of title XXVII of the Public Health Service Act, as  
14 amended by section 161(b), is further amended by adding  
15 at the end the following new section:

16                   “**SEC. 2755. STANDARDS RELATING TO BENEFITS FOR**  
17                                   **MINOR CHILD’S CONGENITAL OR DEVELOP-**  
18                                   **MENTAL DEFORMITY OR DISORDER.**

19                   “(a) *REQUIREMENTS FOR RECONSTRUCTIVE SUR-*  
20 *GERY.*—

21                   “(1) *IN GENERAL.*—A health insurance issuer of-  
22                   fering health insurance coverage in the individual  
23                   market that provides coverage for surgical benefits  
24                   shall provide coverage for outpatient and inpatient  
25                   diagnosis and treatment of a minor child’s congenital

1       or developmental deformity, disease, or injury. A  
2       minor child shall include any individual through 21  
3       years of age.

4               “(2) *REQUIREMENTS.*—Any coverage provided  
5       under paragraph (1) shall be subject to pre-authorization  
6       or pre-certification as required by the insurance  
7       issuer offering such coverage, and such coverage shall  
8       include any surgical treatment which, in the opinion  
9       of the treating physician, is medically necessary to  
10       approximate a normal appearance.

11               “(3) *TREATMENT DEFINED.*—

12               “(A) *IN GENERAL.*—In this section, the  
13       term ‘treatment’ includes reconstructive surgical  
14       procedures (procedures that are generally per-  
15       formed to improve function, but may also be per-  
16       formed to approximate a normal appearance)  
17       that are performed on abnormal structures of the  
18       body caused by congenital defects, developmental  
19       abnormalities, trauma, infection, tumors, or dis-  
20       ease, including—

21               “(i) procedures that do not materially  
22       affect the function of the body part being  
23       treated; and

24               “(ii) procedures for secondary condi-  
25       tions and follow-up treatment.

1           “(B) *EXCEPTION.*—*Such term does not in-*  
2           *clude cosmetic surgery performed to reshape nor-*  
3           *mal structures of the body to improve appear-*  
4           *ance or self-esteem.*”

5           “(b) *NOTICE.*—*A health insurance issuer under this*  
6           *part shall comply with the notice requirement under section*  
7           *714(b) of the Employee Retirement Income Security Act of*  
8           *1974 with respect to the requirements referred to in sub-*  
9           *section (a) as if such section applied to such issuer and*  
10          *such issuer were a group health plan.*”

11          (c) *CONFORMING AMENDMENTS.*—

12           (1) *Section 2723(c) of such Act (42 U.S.C.*  
13           *300gg-23(c)) is amended by striking “section 2704”*  
14           *and inserting “sections 2704 and 2708”.*

15           (2) *Section 2762(b)(2) of such Act (42 U.S.C.*  
16           *300gg-62(b)(2)) is amended by striking “section*  
17           *2751” and inserting “sections 2751 and 2754”.*

18          (d) *EFFECTIVE DATES.*—

19           (1) *The amendments made by subsection (a)*  
20           *shall apply with respect to group health plans for*  
21           *plan years beginning on or after January 1, 2010.*

22           (2) *The amendment made by subsection (b) shall*  
23           *apply with respect to health insurance coverage of-*  
24           *fered, sold, issued, renewed, in effect, or operated in*  
25           *the individual market on or after such date.*

1       (e) *COORDINATION RULES.*—

2           (1) *The amendments made by subsection (a)*  
 3 *shall remain in effect until such time as benefit*  
 4 *standards are adopted subject to section 124 of this*  
 5 *title.*

6           (2) *Section 104(1) of the Health Insurance Port-*  
 7 *ability and Accountability Act of 1996 is amended by*  
 8 *striking “this subtitle (and the amendments made by*  
 9 *this subtitle and section 401)” and inserting “the pro-*  
 10 *visions of part 7 of subtitle B of title I of the Em-*  
 11 *ployee Retirement Income Security Act of 1974, the*  
 12 *provisions of parts A and C of title XXVII of the Pub-*  
 13 *lic Health Service Act, and chapter 100 of the Inter-*  
 14 *nal Revenue Code of 1986”.*

15 **SEC. 164. ADMINISTRATIVE SIMPLIFICATION.**

16       (a) *STANDARDIZING ELECTRONIC ADMINISTRATIVE*  
 17 *TRANSACTIONS.*—

18           (1) *IN GENERAL.*—*Part C of title XI of the So-*  
 19 *cial Security Act (42 U.S.C. 1320d et seq.) is amend-*  
 20 *ed by inserting after section 1173 the following new*  
 21 *sections:*

22 **“SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE**  
 23 **TRANSACTIONS.**

24       “(a) *STANDARDS FOR FINANCIAL AND ADMINISTRA-*  
 25 *TIVE TRANSACTIONS.*—

1           “(1) *IN GENERAL.*—*The Secretary shall adopt*  
2           *and regularly update standards consistent with the*  
3           *goals described in paragraph (2).*

4           “(2) *GOALS FOR FINANCIAL AND ADMINISTRA-*  
5           *TIVE TRANSACTIONS.*—*The goals for standards under*  
6           *paragraph (1) are that such standards shall—*

7                   “(A) *be unique with no conflicting or re-*  
8                   *dundant standards;*

9                   “(B) *be authoritative, permitting no addi-*  
10                   *tions or constraints for electronic transactions,*  
11                   *including companion guides;*

12                   “(C) *be comprehensive, efficient and robust,*  
13                   *requiring minimal augmentation by paper*  
14                   *transactions or clarification by further commu-*  
15                   *nications;*

16                   “(D) *enable the real-time (or near real-*  
17                   *time) determination of an individual’s financial*  
18                   *responsibility at the point of service and, to the*  
19                   *extent possible, prior to service, including wheth-*  
20                   *er the individual is eligible for a specific service*  
21                   *with a specific physician at a specific facility,*  
22                   *which may include utilization of a machine-*  
23                   *readable health plan beneficiary identification*  
24                   *card;*

1           “(E) enable, where feasible, near real-time  
2 adjudication of claims;

3           “(F) provide for timely acknowledgment, re-  
4 sponse, and status reporting applicable to any  
5 electronic transaction deemed appropriate by the  
6 Secretary;

7           “(G) describe all data elements (such as rea-  
8 son and remark codes) in unambiguous terms,  
9 not permit optional fields, require that data ele-  
10 ments be either required or conditioned upon set  
11 values in other fields, and prohibit additional  
12 conditions; and

13           “(H) harmonize all common data elements  
14 across administrative and clinical transaction  
15 standards.

16           “(3) *TIME FOR ADOPTION.*—Not later than 2  
17 years after the date of implementation of the X12  
18 Version 5010 transaction standards implemented  
19 under this part, the Secretary shall adopt standards  
20 under this section.

21           “(4) *REQUIREMENTS FOR SPECIFIC STAND-*  
22 *ARDS.*—The standards under this section shall be de-  
23 veloped, adopted, and enforced so as to—

1           “(A) clarify, refine, complete, and expand,  
2 as needed, the standards required under section  
3 1173;

4           “(B) require paper versions of standardized  
5 transactions to comply with the same standards  
6 as to data content such that a fully compliant,  
7 equivalent electronic transaction can be popu-  
8 lated from the data from a paper version;

9           “(C) enable electronic funds transfers, in  
10 order to allow automated reconciliation with the  
11 related health care payment and remittance ad-  
12 vice;

13           “(D) require timely and transparent claim  
14 and denial management processes, including  
15 tracking, adjudication, and appeal processing;

16           “(E) require the use of a standard electronic  
17 transaction with which health care providers  
18 may quickly and efficiently enroll with a health  
19 plan to conduct the other electronic transactions  
20 provided for in this part; and

21           “(F) provide for other requirements relating  
22 to administrative simplification as identified by  
23 the Secretary, in consultation with stakeholders.

24           “(5) BUILDING ON EXISTING STANDARDS.—In  
25 developing the standards under this section, the Sec-



1        *retary shall build upon existing and planned stand-*  
2        *ards.*

3                *“(6) IMPLEMENTATION AND ENFORCEMENT.—Not*  
4        *later than 6 months after the date of the enactment*  
5        *of this section, the Secretary shall submit to the ap-*  
6        *propriate committees of Congress a plan for the im-*  
7        *plementation and enforcement, by not later than 5*  
8        *years after such date of enactment, of the standards*  
9        *under this section. Such plan shall include—*

10                *“(A) a process and timeframe with mile-*  
11        *stones for developing the complete set of stand-*  
12        *ards;*

13                *“(B) an expedited upgrade program for*  
14        *continually developing and approving additions*  
15        *and modifications to the standards as often as*  
16        *annually to improve their quality and extend*  
17        *their functionality to meet evolving requirements*  
18        *in health care;*

19                *“(C) programs to provide incentives for,*  
20        *and ease the burden of, implementation for cer-*  
21        *tain health care providers, with special consider-*  
22        *ation given to such providers serving rural or*  
23        *underserved areas and ensure coordination with*  
24        *standards, implementation specifications, and*

1           *certification criteria being adopted under the*  
2           *HITECH Act;*

3           “(D) *programs to provide incentives for,*  
4           *and ease the burden of, health care providers who*  
5           *volunteer to participate in the process of setting*  
6           *standards for electronic transactions;*

7           “(E) *an estimate of total funds needed to*  
8           *ensure timely completion of the implementation*  
9           *plan; and*

10           “(F) *an enforcement process that includes*  
11           *timely investigation of complaints, random au-*  
12           *ditions to ensure compliance, civil monetary and*  
13           *programmatic penalties for non-compliance con-*  
14           *sistent with existing laws and regulations, and a*  
15           *fair and reasonable appeals process building off*  
16           *of enforcement provisions under this part.*

17           “(b) *LIMITATIONS ON USE OF DATA.—Nothing in this*  
18           *section shall be construed to permit the use of information*  
19           *collected under this section in a manner that would ad-*  
20           *versely affect any individual.*

21           “(c) *PROTECTION OF DATA.—The Secretary shall en-*  
22           *sure (through the promulgation of regulations or otherwise)*  
23           *that all data collected pursuant to subsection (a) are—*

24           “(1) *used and disclosed in a manner that meets*  
25           *the HIPAA privacy and security law (as defined in*

1 *section 3009(a)(2) of the Public Health Service Act),*  
2 *including any privacy or security standard adopted*  
3 *under section 3004 of such Act; and*

4 *“(2) protected from all inappropriate internal*  
5 *use by any entity that collects, stores, or receives the*  
6 *data, including use of such data in determinations of*  
7 *eligibility (or continued eligibility) in health plans,*  
8 *and from other inappropriate uses, as defined by the*  
9 *Secretary.*

10 **“SEC. 1173B. OPERATING RULES.**

11 *“(a) IN GENERAL.—The Secretary shall adopt oper-*  
12 *ating rules for each transaction described in section*  
13 *1173(a)(2) of the Social Security Act (42 U.S.C. 1320d-*  
14 *2(a))*

15 *“(b) OPERATING RULES DEVELOPMENT.—In adopting*  
16 *such rules, the Secretary shall take into account the develop-*  
17 *ment of operating rules that have been developed by a non-*  
18 *profit entity that meets the following criteria:*

19 *“(1) The entity focuses its mission on adminis-*  
20 *trative simplification.*

21 *“(2) The entity demonstrates a established multi-*  
22 *stakeholder process that creates consensus based oper-*  
23 *ating rules using a voting policy with balanced rep-*  
24 *resentation by the critical stakeholders (including*  
25 *health plans and health care providers) so that no one*

1 *group dominates the entity and shall include others*  
2 *such as standards development organizations, and rel-*  
3 *evant Federal agencies.*

4 *“(3) The entity has in place a public set of guid-*  
5 *ing principles that ensure the operating rules and*  
6 *process are open and transparent.*

7 *“(4) The entity shall coordinate its activities*  
8 *with the HIT Policy Committee and the HIT Stand-*  
9 *ards Committee (established under title XXX of the*  
10 *Public Health Service Act) and complements the ef-*  
11 *forts of the Office of the National Healthcare Coordi-*  
12 *nator and its related health information exchange*  
13 *goals.*

14 *“(5) The entity incorporates national standards,*  
15 *including the transaction standards issued under*  
16 *Health Insurance Portability and Accountability Act*  
17 *of 1996.*

18 *“(6) The entity uses existing market research*  
19 *and proven best practices.*

20 *“(7) The entity has a set of measures that allow*  
21 *for the evaluation of their market impact and public*  
22 *reporting of aggregate stakeholder impact.*

23 *“(8) The entity supports nondiscrimination and*  
24 *conflict of interest policies that demonstrate a com-*

1        *mitment to open, fair, and nondiscriminatory prac-*  
2        *tices.*

3                *“(9) The entity allows for public reviews and up-*  
4        *dates of the operating rules.*

5                *“(c) IMPLEMENTATION.—The Secretary shall adopt op-*  
6        *erating rules under this section, by regulation or otherwise,*  
7        *only after taking into account the rules developed by the*  
8        *entity under subsection (b) and having ensured consultation*  
9        *with providers. The first set of operating rules for the trans-*  
10        *actions for eligibility for health plan and health claims sta-*  
11        *tus under this section shall be adopted not later than Octo-*  
12        *ber 1, 2011, in a manner such that such set of rules is effec-*  
13        *tive beginning not later than January 1, 2013. The second*  
14        *set of operating rules for the remainder of the transactions*  
15        *described in section 1173(a)(2) of the Social Security Act*  
16        *(42 U.S.C. 1320d-2(a)) shall be adopted not later than Oc-*  
17        *tober 1, 2012, in a manner such that such set of rules is*  
18        *effective beginning not later than January 1, 2014.”.*

19                *(2) DEFINITIONS.—Section 1171 of such Act (42*  
20        *U.S.C. 1320d) is amended—*

21                        *(A) in paragraph (7), by striking “with ref-*  
22                        *erence to” and all that follows and inserting*  
23                        *“with reference to a transaction or data element*  
24                        *of health information in section 1173 means im-*  
25                        *plementation specifications, certification criteria,*

1           *operating rules, messaging formats, codes, and*  
2           *code sets adopted or established by the Secretary*  
3           *for the electronic exchange and use of informa-*  
4           *tion.”; and*

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

7           “(9) *OPERATING RULES.—The term ‘operating*  
8           *rules’ means business rules for using and processing*  
9           *transactions. Operating rules should address the fol-*  
10          *lowing:*

11                     “(A) *Requirements for data content using*  
12          *available and established national standards.*

13                     “(B) *Infrastructure requirements that estab-*  
14          *lish best practices for streamlining data flow to*  
15          *yield timely execution of transactions.*

16                     “(C) *Policies defining the transaction re-*  
17          *lated rights and responsibilities for entities that*  
18          *are transmitting or receiving data.”.*

19           (3) *CONFORMING AMENDMENT.—Section 1179 of*  
20          *such Act (42 U.S.C. 1320d–8) is amended, in the*  
21          *matter before paragraph (1)—*

22                     (A) *by inserting “on behalf of an indi-*  
23          *vidual” after “1978”;* and

24                     (B) *by inserting “on behalf of an indi-*  
25          *vidual” after “for a financial institution”.*

1           (b) *STANDARDS FOR CLAIMS ATTACHMENTS AND CO-*  
2 *ORDINATION OF BENEFITS.*—

3           (1) *STANDARD FOR HEALTH CLAIMS ATTACH-*  
4 *MENTS.*—*Not later than 1 year after the date of the*  
5 *enactment of this Act, the Secretary of Health and*  
6 *Human Services shall promulgate a final rule to es-*  
7 *tablish a standard for health claims attachment*  
8 *transaction described in section 1173(a)(2)(B) of the*  
9 *Social Security Act (42 U.S.C. 1320d-2(a)(2)(B)) and*  
10 *coordination of benefits.*

11           (2) *REVISION IN PROCESSING PAYMENT TRANS-*  
12 *ACTIONS BY FINANCIAL INSTITUTIONS.*—

13           (A) *IN GENERAL.*—*Section 1179 of the So-*  
14 *cial Security Act (42 U.S.C. 1320d-8) is amend-*  
15 *ed, in the matter before paragraph (1)—*

16                   (i) *by striking “or is engaged” and in-*  
17 *serting “and is engaged”; and*

18                   (ii) *by inserting “(other than as a*  
19 *business associate for a covered entity)”*  
20 *after “for a financial institution”.*

21           (B) *EFFECTIVE DATE.*—*The amendments*  
22 *made by paragraph (1) shall apply to trans-*  
23 *actions occurring on or after such date (not later*  
24 *than 6 months after the date of the enactment of*

1           *this Act) as the Secretary of Health and Human*  
2           *Services shall specify.*

3           (c) *UNIQUE HEALTH PLAN IDENTIFIER.*—*Not later*  
4 *than 2 years after the date of the enactment of this Act,*  
5 *the Secretary of Health and Human Services shall promul-*  
6 *gate a final rule to establish a unique health plan identifier*  
7 *described in section 1173(b) of the Social Security Act (42*  
8 *U.S.C. 1320d-2(b)) based on the input of the National Com-*  
9 *mittee of Vital and Health Statistics and consultation with*  
10 *health plans. The Secretary may do so on an interim final*  
11 *basis and effective not later than October 1, 2012.*

12 **SEC. 165. EXPANSION OF ELECTRONIC TRANSACTIONS IN**  
13 **MEDICARE.**

14           (a) *IN GENERAL.*—*Section 1862(a) of the Social Secu-*  
15 *rity Act (42 U.S.C. 1395y(a)) is amended—*

16           (1) *in paragraph (23), by striking the “or” at*  
17 *the end;*

18           (2) *in paragraph (24), by striking the period*  
19 *and inserting “; or”; and*

20           (3) *by inserting after paragraph (24) the fol-*  
21 *lowing new paragraph:*

22           “(25) *subject to subsection (h), not later than*  
23 *January 1, 2015, for which the payment is other than*  
24 *by electronic funds transfer (EFT) or an electronic re-*  
25 *mittance in a form as specified in ASC X12 835*



1       *Health Care Payment and Remittance Advice or sub-*  
2       *sequent standard.”.*

3       **(b) EFFECTIVE DATE.**—*The amendments made by sub-*  
4       *section (a) shall take effect upon the date of the enactment*  
5       *of this Act.*

6       **SEC. 166. REINSURANCE PROGRAM FOR RETIREES.**

7       **(a) ESTABLISHMENT.**—

8               **(1) IN GENERAL.**—*Not later than 90 days after*  
9       *the date of the enactment of this Act, the Secretary of*  
10       *Health and Human Services shall establish a tem-*  
11       *porary reinsurance program (in this section referred*  
12       *to as the “reinsurance program”) to provide reim-*  
13       *bursement to assist participating employment-based*  
14       *plans with the cost of providing health benefits to re-*  
15       *tirees and to eligible spouses, surviving spouses and*  
16       *dependents of such retirees.*

17               **(2) DEFINITIONS.**—*For purposes of this section:*

18                       **(A)** *The term “eligible employment-based*  
19       *plan” means a group health benefits plan that—*

20                               **(i)** *is maintained by one or more em-*  
21       *ployers, former employers or employee asso-*  
22       *ciations, or a voluntary employees’ bene-*  
23       *ficiary association, or a committee or board*  
24       *of individuals appointed to administer such*  
25       *plan, and*

1                   (ii) provides health benefits to retirees.

2                   (B) The term “health benefits” means med-  
3 ical, surgical, hospital, prescription drug, and  
4 such other benefits as shall be determined by the  
5 Secretary, whether self-funded or delivered  
6 through the purchase of insurance or otherwise.

7                   (C) The term “participating employment-  
8 based plan” means an eligible employment-based  
9 plan that is participating in the reinsurance  
10 program.

11                   (D) The term “retiree” means, with respect  
12 to a participating employment-benefit plan, an  
13 individual who—

14                   (i) is 55 years of age or older;

15                   (ii) is not eligible for coverage under  
16 title XVIII of the Social Security Act; and

17                   (iii) is not an active employee of an  
18 employer maintaining the plan or of any  
19 employer that makes or has made substan-  
20 tial contributions to fund such plan.

21                   (E) The term “Secretary” means Secretary  
22 of Health and Human Services.

23                   (b) PARTICIPATION.—To be eligible to participate in  
24 the reinsurance program, an eligible employment-based  
25 plan shall submit to the Secretary an application for par-

1 *ticipation in the program, at such time, in such manner,*  
2 *and containing such information as the Secretary shall re-*  
3 *quire.*

4 *(c) PAYMENT.—*

5 *(1) SUBMISSION OF CLAIMS.—*

6 *(A) IN GENERAL.—Under the reinsurance*  
7 *program, a participating employment-based*  
8 *plan shall submit claims for reimbursement to*  
9 *the Secretary which shall contain documentation*  
10 *of the actual costs of the items and services for*  
11 *which each claim is being submitted.*

12 *(B) BASIS FOR CLAIMS.—Each claim sub-*  
13 *mitted under subparagraph (A) shall be based on*  
14 *the actual amount expended by the participating*  
15 *employment-based plan involved within the plan*  
16 *year for the appropriate employment based*  
17 *health benefits provided to a retiree or to the*  
18 *spouse, surviving spouse, or dependent of a re-*  
19 *tiree. In determining the amount of any claim*  
20 *for purposes of this subsection, the participating*  
21 *employment-based plan shall take into account*  
22 *any negotiated price concessions (such as dis-*  
23 *counts, direct or indirect subsidies, rebates, and*  
24 *direct or indirect remunerations) obtained by*  
25 *such plan with respect to such health benefits.*

1           *For purposes of calculating the amount of any*  
2           *claim, the costs paid by the retiree or by the*  
3           *spouse, surviving spouse, or dependent of the re-*  
4           *tiree in the form of deductibles, co-payments, and*  
5           *co-insurance shall be included along with the*  
6           *amounts paid by the participating employment-*  
7           *based plan.*

8           (2) *PROGRAM PAYMENTS AND LIMIT.*—*If the Sec-*  
9           *retary determines that a participating employment-*  
10          *based plan has submitted a valid claim under para-*  
11          *graph (1), the Secretary shall reimburse such plan for*  
12          *80 percent of that portion of the costs attributable to*  
13          *such claim that exceeds \$15,000, but is less than*  
14          *\$90,000. Such amounts shall be adjusted each year*  
15          *based on the percentage increase in the medical care*  
16          *component of the Consumer Price Index (rounded to*  
17          *the nearest multiple of \$1,000) for the year involved.*

18          (3) *USE OF PAYMENTS.*—*Amounts paid to a par-*  
19          *ticipating employment-based plan under this sub-*  
20          *section shall be used to lower the costs borne directly*  
21          *by the participants and beneficiaries for health bene-*  
22          *fits provided under such plan in the form of pre-*  
23          *miums, co-payments, deductibles, co-insurance, or*  
24          *other out-of-pocket costs. Such payments shall not be*  
25          *used to reduce the costs of an employer maintaining*

1 *the participating employment-based plan. The Sec-*  
2 *retary shall develop a mechanism to monitor the ap-*  
3 *propriate use of such payments by such plans.*

4 (4) *APPEALS AND PROGRAM PROTECTIONS.—The*  
5 *Secretary shall establish—*

6 (A) *an appeals process to permit partici-*  
7 *parting employment-based plans to appeal a de-*  
8 *termination of the Secretary with respect to*  
9 *claims submitted under this section; and*

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

12 (5) *AUDITS.—The Secretary shall conduct an-*  
13 *ual audits of claims data submitted by participating*  
14 *employment-based plans under this section to ensure*  
15 *that they are in compliance with the requirements of*  
16 *this section.*

17 (d) *RETIREE RESERVE TRUST FUND.—*

18 (1) *ESTABLISHMENT.—*

19 (A) *IN GENERAL.—There is established in*  
20 *the Treasury of the United States a trust fund*  
21 *to be known as the “Retiree Reserve Trust Fund”*  
22 *(referred to in this section as the “Trust Fund”),*  
23 *that shall consist of such amounts as may be ap-*  
24 *propriated or credited to the Trust Fund as pro-*  
25 *vided for in this subsection to enable the Sec-*

1           *retary to carry out the reinsurance program.*  
2           *Such amounts shall remain available until ex-*  
3           *pended.*

4           *(B) FUNDING.—There are hereby appro-*  
5           *priated to the Trust Fund, out of any moneys in*  
6           *the Treasury not otherwise appropriated, an*  
7           *amount requested by the Secretary as necessary*  
8           *to carry out this section, except that the total of*  
9           *all such amounts requested shall not exceed*  
10          *\$10,000,000,000.*

11          *(C) APPROPRIATIONS FROM THE TRUST*  
12          *FUND.—*

13           *(i) IN GENERAL.—Amounts in the*  
14           *Trust Fund are appropriated to provide*  
15           *funding to carry out the reinsurance pro-*  
16           *gram and shall be used to carry out such*  
17           *program.*

18           *(ii) BUDGETARY IMPLICATIONS.—*  
19           *Amounts appropriated under clause (i), and*  
20           *outlays flowing from such appropriations,*  
21           *shall not be taken into account for purposes*  
22           *of any budget enforcement procedures in-*  
23           *cluding allocations under section 302(a)*  
24           *and (b) of the Balanced Budget and Emer-*  
25           *gency Deficit Control Act and budget resolu-*

1            *tions for fiscal years during which appro-*  
 2            *priations are made from the Trust Fund.*

3            *(iii) LIMITATION TO AVAILABLE*  
 4            *FUNDS.—The Secretary has the authority to*  
 5            *stop taking applications for participation*  
 6            *in the program or take such other steps in*  
 7            *reducing expenditures under the reinsurance*  
 8            *program in order to ensure that expendi-*  
 9            *tures under the reinsurance program do not*  
 10           *exceed the funds available under this sub-*  
 11           *section.*

12 **SEC. 167. LIMITATIONS ON PREEXISTING CONDITION EX-**  
 13           **CLUSIONS IN GROUP HEALTH PLANS AND**  
 14           **HEALTH INSURANCE COVERAGE IN THE**  
 15           **GROUP AND INDIVIDUAL MARKETS IN AD-**  
 16           **VANCE OF APPLICABILITY OF NEW PROHIBI-**  
 17           **TION OF PREEXISTING CONDITION EXCLU-**  
 18           **SIONS.**

19           *(a) AMENDMENTS RELATING TO PREEXISTING CONDI-*  
 20           *TION EXCLUSIONS UNDER GROUP HEALTH PLANS.—*

21           *(1) REDUCTION IN LOOK-BACK PERIOD.—Section*  
 22           *2701(a)(1) of the Public Health Service Act (42*  
 23           *U.S.C. 300gg(a)(1)) is amended by striking “6-month*  
 24           *period” and inserting “30-day period”.*

1           (2) *REDUCTION IN PERMITTED PREEXISTING*  
2           *CONDITION LIMITATION PERIOD.*—Section 2701(a)(2)  
3           of such Act (42 U.S.C. 300gg(a)(2)) is amended by  
4           striking “12 months” and inserting “3 months”, and  
5           by striking “18 months” and inserting “9 months”.

6           (3) *EFFECTIVE DATE.*—

7           (A) *IN GENERAL.*—Except as provided in  
8           subparagraph (B), the amendments made by this  
9           subsection shall apply with respect to group  
10          health plans for plan years beginning after the  
11          end of the 6th calendar month following the date  
12          of the enactment of this Act.

13          (B) *SPECIAL RULE FOR COLLECTIVE BAR-*  
14          *GAINING AGREEMENTS.*—In the case of a group  
15          health plan maintained pursuant to one or more  
16          collective bargaining agreements between em-  
17          ployee representatives and one or more employers  
18          ratified before the date of the enactment of this  
19          Act, the amendments made by this subsection  
20          shall not apply to plan years beginning before  
21          the earlier of—

22                  (i) the date on which the last of the col-  
23                  lective bargaining agreements relating to  
24                  the plan terminates (determined without re-



1           *gard to any extension thereof agreed to after*  
2           *the date of the enactment of this Act), or*

3                   *(ii) 3 years after the date of the enact-*  
4                   *ment of this Act.*

5           *For purposes of clause (i), any plan amendment*  
6           *made pursuant to a collective bargaining agree-*  
7           *ment relating to the plan which amends the plan*  
8           *solely to conform to any requirement added by*  
9           *the amendments made by this section shall not*  
10           *be treated as a termination of such collective bar-*  
11           *gaining agreement.*

12           ***(b) AMENDMENTS RELATING TO PREEXISTING CONDI-***  
13           ***TION EXCLUSIONS IN HEALTH INSURANCE COVERAGE IN***  
14           ***THE INDIVIDUAL MARKET UNDER GRANDFATHERED***  
15           ***HEALTH INSURANCE COVERAGE.—***

16                   ***(1) APPLICABILITY OF GROUP HEALTH INSUR-***  
17                   ***ANCE LIMITATIONS ON IMPOSITION OF PREEXISTING***  
18                   ***CONDITION EXCLUSIONS.—***

19                           ***(A) IN GENERAL.—Section 2741 of the Pub-***  
20                           ***lic Health Service Act (42 U.S.C. 300gg–41) is***  
21                           ***amended—***

22                                   ***(i) by redesignating the second sub-***  
23                                   ***section (e) (relating to market requirements)***  
24                                   ***and subsection (f) as subsections (f) and (g),***  
25                                   ***respectively; and***

1                   (ii) by adding at the end the following  
2                   new subsection:

3           “(h) *APPLICATION OF GROUP HEALTH INSURANCE*  
4 *LIMITATIONS ON IMPOSITION OF PREEXISTING CONDITION*  
5 *EXCLUSIONS.*—

6                   “(1) *IN GENERAL.*—Subject to paragraph (2), a  
7           health insurance issuer that provides individual  
8           health insurance coverage may not impose a pre-  
9           existing condition exclusion (as defined in subsection  
10          (b)(1)(A) of section 2701) with respect to such cov-  
11          erage except to the extent that such exclusion could be  
12          imposed consistent with such section if such coverage  
13          were group health insurance coverage.

14                  “(2) *LIMITATION.*—In the case of an individual  
15          who—

16                       “(A) is enrolled in individual health insur-  
17                       ance coverage;

18                       “(B) during the period of such enrollment  
19                       has a condition for which no medical advice, di-  
20                       agnosis, care, or treatment had been rec-  
21                       ommended or received as of the enrollment date;  
22                       and

23                       “(C) seeks to enroll under other individual  
24                       health insurance coverage which provides benefits  
25                       different from those provided under the coverage

1           referred to in subparagraph (A) with respect to  
2           such condition,  
3           the issuer of the individual health insurance coverage  
4           described in subparagraph (C) may impose a pre-  
5           existing condition exclusion with respect to such con-  
6           dition and any benefits in addition to those provided  
7           under the coverage referred to in subparagraph (A),  
8           but such exclusion may not extend for a period of  
9           more than 3 months.”.

10                   (B) *ELIMINATION OF COBRA REQUIRE-*  
11                   *MENT.*—Subsection (b) of such section is amend-  
12                   ed—

13                           (i) by adding “and” at the end of  
14                           paragraph (2);

15                           (ii) by striking the semicolon at the  
16                           end of paragraph (3) and inserting a pe-  
17                           riod; and

18                           (iii) by striking paragraphs (4) and  
19                           (5).

20                   (C) *CONFORMING AMENDMENT.*—Section  
21                   2744(a)(1) of such Act (42 U.S.C. 300gg-  
22                   44(a)(1)) is amended by inserting “(other than  
23                   subsection (h))” after “section 2741”.

24                   (2) *EFFECTIVE DATE.*—The amendments made  
25                   by this subsection shall apply with respect to health

1        *insurance coverage offered, sold, issued, renewed, in*  
 2        *effect, or operated in the individual market beginning*  
 3        *after the end of the 6th calendar month following the*  
 4        *date of the enactment of this Act.*

5        *(c) INAPPLICABILITY OF INTERIM LIMITATIONS UPON*  
 6        *APPLICABILITY OF TOTAL PROHIBITION OF EXCLUSION.—*  
 7        *Section 2701 of such Act and the amendments made by sub-*  
 8        *section (b) of this section to sections 2741 and 2744 of such*  
 9        *Act shall cease to be effective in the case of any health bene-*  
 10       *fits plan as of the date on which such plan becomes subject*  
 11       *to the requirements of section 111 of this Act (relating to*  
 12       *prohibiting preexisting condition exclusions).*

13       ***TITLE II—HEALTH INSURANCE***  
 14       ***EXCHANGE AND RELATED***  
 15       ***PROVISIONS***

16       ***Subtitle A—Health Insurance***  
 17       ***Exchange***

18       ***SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EX-***  
 19       ***CHANGE; OUTLINE OF DUTIES; DEFINITIONS.***

20       *(a) ESTABLISHMENT.—There is established within the*  
 21       *Health Choices Administration and under the direction of*  
 22       *the Commissioner a Health Insurance Exchange in order*  
 23       *to facilitate access of individuals and employers, through*  
 24       *a transparent process, to a variety of choices of affordable,*

1 *quality health insurance coverage, including a public health*  
2 *insurance option.*

3 (b) *OUTLINE OF DUTIES OF COMMISSIONER.—In ac-*  
4 *cordance with this subtitle and in coordination with appro-*  
5 *priate Federal and State officials as provided under section*  
6 *143(b), the Commissioner shall—*

7 (1) *under section 204 establish standards for, ac-*  
8 *cept bids from, and negotiate and enter into contracts*  
9 *with, QHBP offering entities for the offering of health*  
10 *benefits plans through the Health Insurance Ex-*  
11 *change, with different levels of benefits required under*  
12 *section 203, and including with respect to oversight*  
13 *and enforcement;*

14 (2) *under section 205 facilitate outreach and en-*  
15 *rollment in such plans of Exchange-eligible individ-*  
16 *uals and employers described in section 202; and*

17 (3) *conduct such activities related to the Health*  
18 *Insurance Exchange as required, including establish-*  
19 *ment of a risk pooling mechanism under section 206*  
20 *and consumer protections under subtitle D of title I.*

21 (c) *EXCHANGE-PARTICIPATING HEALTH BENEFITS*  
22 *PLAN DEFINED.—In this division, the term “Exchange-*  
23 *participating health benefits plan” means a qualified health*  
24 *benefits plan that is offered through the Health Insurance*  
25 *Exchange.*

1 **SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOY-**  
2 **ERS.**

3 (a) *ACCESS TO COVERAGE.*—*Except as provided in*  
4 *subsection (i) and in accordance with this section, all indi-*  
5 *viduals are eligible to obtain coverage through enrollment*  
6 *in an Exchange-participating health benefits plan offered*  
7 *through the Health Insurance Exchange unless such indi-*  
8 *viduals are enrolled in another qualified health benefits*  
9 *plan or other acceptable coverage.*

10 (b) *DEFINITIONS.*—*In this division:*

11 (1) *EXCHANGE-ELIGIBLE INDIVIDUAL.*—*The term*  
12 *“Exchange-eligible individual” means an individual*  
13 *who is eligible under this section to be enrolled*  
14 *through the Health Insurance Exchange in an Ex-*  
15 *change-participating health benefits plan and, with*  
16 *respect to family coverage, includes dependents of*  
17 *such individual.*

18 (2) *EXCHANGE-ELIGIBLE EMPLOYER.*—*The term*  
19 *“Exchange-eligible employer” means an employer that*  
20 *is eligible under this section to enroll through the*  
21 *Health Insurance Exchange employees of the employer*  
22 *(and their dependents) in Exchange-eligible health*  
23 *benefits plans.*

24 (3) *EMPLOYMENT-RELATED DEFINITIONS.*—*The*  
25 *terms “employer”, “employee”, “full-time employee”,*  
26 *and “part-time employee” have the meanings given*

1        *such terms by the Commissioner for purposes of this*  
2        *division.*

3        (c) *TRANSITION.—Individuals and employers shall*  
4        *only be eligible to enroll or participate in the Health Insur-*  
5        *ance Exchange in accordance with the following transition*  
6        *schedule:*

7            (1) *FIRST YEAR.—In Y1 (as defined in section*  
8        *100(c))—*

9            (A) *individuals described in subsection*  
10        *(d)(1), including individuals described in para-*  
11        *graphs (3) and (4) of subsection (d); and*

12            (B) *smallest employers described in sub-*  
13        *section (e)(1).*

14            (2) *SECOND YEAR.—In Y2—*

15            (A) *individuals and employers described in*  
16        *paragraph (1); and*

17            (B) *smaller employers described in sub-*  
18        *section (e)(2).*

19            (3) *THIRD AND SUBSEQUENT YEARS.—In Y3*  
20        *and subsequent years—*

21            (A) *individuals and employers described in*  
22        *paragraph (2); and*

23            (B) *larger employers as permitted by the*  
24        *Commissioner under subsection (e)(3).*

25        (d) *INDIVIDUALS.—*

1           (1) *INDIVIDUAL DESCRIBED.*—Subject to the suc-  
 2           ceeding provisions of this subsection, an individual  
 3           described in this paragraph is an individual who—

4                   (A) is not enrolled in coverage described in  
 5                   subparagraphs (C) through (F) of paragraph (2);  
 6                   and

7                   (B) is not enrolled in coverage as a full-  
 8                   time employee (or as a dependent of such an em-  
 9                   ployee) under a group health plan if the coverage  
 10                  and an employer contribution under the plan  
 11                  meet the requirements of section 312.

12           For purposes of subparagraph (B), in the case of an  
 13           individual who is self-employed, who has at least 1  
 14           employee, and who meets the requirements of section  
 15           312, such individual shall be deemed a full-time em-  
 16           ployee described in such subparagraph.

17           (2) *ACCEPTABLE COVERAGE.*—For purposes of  
 18           this division, the term “acceptable coverage” means  
 19           any of the following:

20                   (A) *QUALIFIED HEALTH BENEFITS PLAN*  
 21                   *COVERAGE.*—Coverage under a qualified health  
 22                   benefits plan.

23                   (B) *GRANDFATHERED HEALTH INSURANCE*  
 24                   *COVERAGE; COVERAGE UNDER CURRENT GROUP*  
 25                   *HEALTH PLAN.*—Coverage under a grandfathered



1           *health insurance coverage (as defined in sub-*  
2           *section (a) of section 102) or under a current*  
3           *group health plan (described in subsection (b) of*  
4           *such section).*

5           (C) *MEDICARE.*—*Coverage under part A of*  
6           *title XVIII of the Social Security Act.*

7           (D) *MEDICAID.*—*Coverage for medical as-*  
8           *sistance under title XIX of the Social Security*  
9           *Act, excluding such coverage that is only avail-*  
10          *able because of the application of subsection (u),*  
11          *(z), or (aa) of section 1902 of such Act*

12          (E) *MEMBERS OF THE ARMED FORCES AND*  
13          *DEPENDENTS (INCLUDING TRICARE).*—*Coverage*  
14          *under chapter 55 of title 10, United States Code,*  
15          *including similar coverage furnished under sec-*  
16          *tion 1781 of title 38 of such Code.*

17          (F) *VA.*—*Coverage under the veteran's*  
18          *health care program under chapter 17 of title 38,*  
19          *United States Code, but only if the coverage for*  
20          *the individual involved is determined by the*  
21          *Commissioner in coordination with the Sec-*  
22          *retary of Treasury to be not less than a level*  
23          *specified by the Commissioner and Secretary of*  
24          *Veteran's Affairs, in coordination with the Sec-*  
25          *retary of Treasury, based on the individual's*

1           *priority for services as provided under section*  
2           *1705(a) of such title.*

3           (G) *OTHER COVERAGE.*—*Such other health*  
4           *benefits coverage, such as a State health benefits*  
5           *risk pool, as the Commissioner, in coordination*  
6           *with the Secretary of the Treasury, recognizes for*  
7           *purposes of this paragraph.*

8           *The Commissioner shall make determinations under*  
9           *this paragraph in coordination with the Secretary of*  
10          *the Treasury.*

11          (3) *TREATMENT OF CERTAIN NON-TRADITIONAL*  
12          *MEDICAID ELIGIBLE INDIVIDUALS.*—*An individual*  
13          *who is a non-traditional Medicaid eligible individual*  
14          *(as defined in section 205(e)(4)(C)) in a State may*  
15          *be an Exchange-eligible individual if the individual*  
16          *was enrolled in a qualified health benefits plan,*  
17          *grandfathered health insurance coverage, or current*  
18          *group health plan during the 6 months before the in-*  
19          *dividual became a non-traditional Medicaid eligible*  
20          *individual. During the period in which such an indi-*  
21          *vidual has chosen to enroll in an Exchange-partici-*  
22          *pating health benefits plan, the individual is not also*  
23          *eligible for medical assistance under Medicaid.*

24          (4) *CONTINUING ELIGIBILITY PERMITTED.*—

1           (A) *IN GENERAL.*—*Except as provided in*  
2 *subparagraph (B), once an individual qualifies*  
3 *as an Exchange-eligible individual under this*  
4 *subsection (including as an employee or depend-*  
5 *ent of an employee of an Exchange-eligible em-*  
6 *ployer) and enrolls under an Exchange-partici-*  
7 *parting health benefits plan through the Health*  
8 *Insurance Exchange, the individual shall con-*  
9 *tinue to be treated as an Exchange-eligible indi-*  
10 *vidual until the individual is no longer enrolled*  
11 *with an Exchange-participating health benefits*  
12 *plan.*

13           (B) *EXCEPTIONS.*—

14           (i) *IN GENERAL.*—*Subparagraph (A)*  
15 *shall not apply to an individual once the*  
16 *individual becomes eligible for coverage—*

17                   (I) *under part A of the Medicare*  
18 *program;*

19                   (II) *under the Medicaid program*  
20 *as a Medicaid eligible individual, ex-*  
21 *cept as permitted under paragraph (3)*  
22 *or clause (ii); or*

23                   (III) *in such other circumstances*  
24 *as the Commissioner may provide.*

1                   (ii) *TRANSITION PERIOD.*—*In the case*  
2                   *described in clause (i)(II), the Commis-*  
3                   *sioner shall permit the individual to con-*  
4                   *tinue treatment under subparagraph (A)*  
5                   *until such limited time as the Commissioner*  
6                   *determines it is administratively feasible,*  
7                   *consistent with minimizing disruption in*  
8                   *the individual’s access to health care.*

9           (e) *EMPLOYERS.*—

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

13                   (2) *SMALLER EMPLOYERS.*—*Subject to para-*  
14                   *graph (4), smaller employers described in this para-*  
15                   *graph are employers that are not smallest employers*  
16                   *described in paragraph (1) and have 20 or fewer em-*  
17                   *ployees.*

18                   (3) *LARGER EMPLOYERS.*—

19                           (A) *IN GENERAL.*—*Beginning with Y3, the*  
20                   *Commissioner may permit employers not de-*  
21                   *scribed in paragraph (1) or (2) to be Exchange-*  
22                   *eligible employers.*

23                           (B) *PHASE-IN.*—*In applying subparagraph*  
24                   *(A), the Commissioner may phase-in the appli-*  
25                   *cation of such subparagraph based on the num-*

1           *ber of full-time employees of an employer and*  
2           *such other considerations as the Commissioner*  
3           *deems appropriate.*

4           (4) *CONTINUING ELIGIBILITY.*—Once an em-  
5           *ployer is permitted to be an Exchange-eligible em-*  
6           *ployer under this subsection and enrolls employees*  
7           *through the Health Insurance Exchange, the employer*  
8           *shall continue to be treated as an Exchange-eligible*  
9           *employer for each subsequent plan year regardless of*  
10          *the number of employees involved unless and until the*  
11          *employer meets the requirement of section 311(a)*  
12          *through paragraph (1) of such section by offering a*  
13          *group health plan and not through offering an Ex-*  
14          *change-participating health benefits plan.*

15          (5) *EMPLOYER PARTICIPATION AND CONTRIBU-*  
16          *TIONS.*—

17                 (A) *SATISFACTION OF EMPLOYER RESPONSI-*  
18                 *BILITY.*—For any year in which an employer is  
19                 *an Exchange-eligible employer, such employer*  
20                 *may meet the requirements of section 312 with*  
21                 *respect to employees of such employer by offering*  
22                 *such employees the option of enrolling with Ex-*  
23                 *change-participating health benefits plans*  
24                 *through the Health Insurance Exchange con-*

1           *sistent with the provisions of subtitle B of title*  
2           *III.*

3                   *(B) EMPLOYEE CHOICE.—Any employee of-*  
4           *ferred Exchange-participating health benefits*  
5           *plans by the employer of such employee under*  
6           *subparagraph (A) may choose coverage under*  
7           *any such plan. That choice includes, with respect*  
8           *to family coverage, coverage of the dependents of*  
9           *such employee.*

10                   *(6) AFFILIATED GROUPS.—Any employer which*  
11           *is part of a group of employers who are treated as a*  
12           *single employer under subsection (b), (c), (m), or (o)*  
13           *of section 414 of the Internal Revenue Code of 1986*  
14           *shall be treated, for purposes of this subtitle, as a sin-*  
15           *gle employer.*

16                   *(7) OTHER COUNTING RULES.—The Commis-*  
17           *sioner shall establish rules relating to how employees*  
18           *are counted for purposes of carrying out this sub-*  
19           *section.*

20                   *(f) SPECIAL SITUATION AUTHORITY.—The Commis-*  
21           *sioner shall have the authority to establish such rules as*  
22           *may be necessary to deal with special situations with re-*  
23           *gard to uninsured individuals and employers participating*  
24           *as Exchange-eligible individuals and employers, such as*  
25           *transition periods for individuals and employers who gain,*

1 *or lose, Exchange-eligible participation status, and to estab-*  
2 *lish grace periods for premium payment.*

3 *(g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The*  
4 *Commissioner shall provide for periodic surveys of Ex-*  
5 *change-eligible individuals and employers concerning satis-*  
6 *faction of such individuals and employers with the Health*  
7 *Insurance Exchange and Exchange-participating health*  
8 *benefits plans.*

9 *(h) EXCHANGE ACCESS STUDY.—*

10 *(1) IN GENERAL.—The Commissioner shall con-*  
11 *duct a study of access to the Health Insurance Ex-*  
12 *change for individuals and for employers, including*  
13 *individuals and employers who are not eligible and*  
14 *enrolled in Exchange-participating health benefits*  
15 *plans. The goal of the study is to determine if there*  
16 *are significant groups and types of individuals and*  
17 *employers who are not Exchange-eligible individuals*  
18 *or employers, but who would have improved benefits*  
19 *and affordability if made eligible for coverage in the*  
20 *Exchange.*

21 *(2) ITEMS INCLUDED IN STUDY.—Such study*  
22 *also shall examine—*

23 *(A) the terms, conditions, and affordability*  
24 *of group health coverage offered by employers*  
25 *and QHBP offering entities outside of the Ex-*

1           *change compared to Exchange-participating*  
2           *health benefits plans; and*

3                   *(B) the affordability-test standard for access*  
4           *of certain employed individuals to coverage in*  
5           *the Health Insurance Exchange.*

6           *(3) REPORT.—Not later than January 1 of Y3,*  
7           *in Y6, and thereafter, the Commissioner shall submit*  
8           *to Congress on the study conducted under this sub-*  
9           *section and shall include in such report recommenda-*  
10          *tions regarding changes in standards for Exchange*  
11          *eligibility for individuals and employers.*

12          *(i) EXCEPTION FOR VETERANS AND MEMBERS OF*  
13          *ARMED FORCES.—Notwithstanding any other provision of*  
14          *this Act, an individual with acceptable coverage described*  
15          *in subparagraph (E) or (F) of subsection (d)(2) is eligible*  
16          *to obtain coverage through enrollment in an Exchange-par-*  
17          *ticipating health benefits plan offered through the Health*  
18          *Insurance Exchange.*

19          *(j) DEPARTMENT OF VETERANS AFFAIRS AND DE-*  
20          *PARTMENT OF DEFENSE HEALTH PROGRAMS.—Nothing in*  
21          *this section shall be construed as affecting any authority*  
22          *under title 38, United States Code, or chapter 55 of title*  
23          *10, United States Code.*

24          *(k) REPORT ON COMPARABLE COVERAGE FOR CHIP*  
25          *CHILDREN; SPECIAL RULE FOR CHIP CHILDREN.—*



1           (1) *REPORT.*—No later than December 31, 2011,  
2           the Secretary of Health and Human Services shall  
3           submit to Congress a report that compares the benefits  
4           packages offered in 2011 to an average State child  
5           health plan under title XXI of the Social Security Act  
6           and to the benefit standards adopted under section  
7           124 for the essential benefits package and the afford-  
8           ability credits under subtitle C.

9           (2) *CERTIFICATION OF SECRETARY.*—Notwith-  
10          standing the previous provisions of this section, no  
11          child who would be eligible for coverage under title  
12          XXI of the Social Security Act shall be enrolled in an  
13          Exchange participating health benefits plan until the  
14          Secretary of Health and Human Services has cer-  
15          tified, based on the findings in the report under para-  
16          graph (1) and changes made pursuant to the rec-  
17          ommendations in the report, if any, that the coverage  
18          (as described in section 121(a)) is at least comparable  
19          to the coverage provided to children under an average  
20          State child health plan under such title as in effect  
21          in 2011.

22 **SEC. 203. BENEFITS PACKAGE LEVELS.**

23          (a) *IN GENERAL.*—The Commissioner shall specify the  
24          benefits to be made available under Exchange-participating

1 *health benefits plans during each plan year, consistent with*  
2 *subtitle C of title I and this section.*

3 (b) *LIMITATION ON HEALTH BENEFITS PLANS OF-*  
4 *FERED BY OFFERING ENTITIES.—The Commissioner may*  
5 *not enter into a contract with a QHBP offering entity*  
6 *under section 204(c) for the offering of an Exchange-partici-*  
7 *pating health benefits plan in a service area unless the fol-*  
8 *lowing requirements are met:*

9 (1) *REQUIRED OFFERING OF BASIC PLAN.—The*  
10 *entity offers only one basic plan for such service area.*

11 (2) *OPTIONAL OFFERING OF ENHANCED PLAN.—*  
12 *If and only if the entity offers a basic plan for such*  
13 *service area, the entity may offer one enhanced plan*  
14 *for such area.*

15 (3) *OPTIONAL OFFERING OF PREMIUM PLAN.—If*  
16 *and only if the entity offers an enhanced plan for*  
17 *such service area, the entity may offer one premium*  
18 *plan for such area.*

19 (4) *OPTIONAL OFFERING OF PREMIUM-PLUS*  
20 *PLANS.—If and only if the entity offers a premium*  
21 *plan for such service area, the entity may offer one*  
22 *or more premium-plus plans for such area.*

23 *All such plans may be offered under a single contract with*  
24 *the Commissioner.*

1           (c) *SPECIFICATION OF BENEFIT LEVELS FOR*  
2 *PLANS.—*

3           (1) *IN GENERAL.—The Commissioner shall estab-*  
4 *lish the following standards consistent with this sub-*  
5 *section and title I:*

6           (A) *BASIC, ENHANCED, AND PREMIUM*  
7 *PLANS.—Standards for 3 levels of Exchange-par-*  
8 *ticipating health benefits plans: basic, enhanced,*  
9 *and premium (in this division referred to as a*  
10 *“basic plan”, “enhanced plan”, and “premium*  
11 *plan”, respectively).*

12           (B) *PREMIUM-PLUS PLAN BENEFITS.—*  
13 *Standards for additional benefits that may be of-*  
14 *fered, consistent with this subsection and subtitle*  
15 *C of title I, under a premium plan (such a plan*  
16 *with additional benefits referred to in this divi-*  
17 *sion as a “premium-plus plan”).*

18           (2) *BASIC PLAN.—*

19           (A) *IN GENERAL.—A basic plan shall offer*  
20 *the essential benefits package required under title*  
21 *I for a qualified health benefits plan.*

22           (B) *TIERED COST-SHARING FOR AFFORD-*  
23 *ABLE CREDIT ELIGIBLE INDIVIDUALS.—In the*  
24 *case of an affordable credit eligible individual*  
25 *(as defined in section 242(a)(1)) enrolled in an*

1           *Exchange-participating health benefits plan, the*  
2           *benefits under a basic plan are modified to pro-*  
3           *vide for the reduced cost-sharing for the income*  
4           *tier applicable to the individual under section*  
5           *244(c).*

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

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

14          (5) *PREMIUM-PLUS PLAN.*—*A premium-plus*  
15          *plan is a premium plan that also provides additional*  
16          *benefits, such as adult oral health and vision care,*  
17          *approved by the Commissioner. The portion of the*  
18          *premium that is attributable to such additional bene-*  
19          *fits shall be separately specified.*

20          (6) *RANGE OF PERMISSIBLE VARIATION IN COST-*  
21          *SHARING.*—*The Commissioner shall establish a per-*  
22          *missible range of variation of cost-sharing for each*  
23          *basic, enhanced, and premium plan, except with re-*  
24          *spect to any benefit for which there is no cost-sharing*  
25          *permitted under the essential benefits package. Such*

1       *variation shall permit a variation of not more than*  
2       *plus (or minus) 10 percent in cost-sharing with re-*  
3       *spect to each benefit category specified under section*  
4       *122.*

5       *(d) TREATMENT OF STATE BENEFIT MANDATES.—In-*  
6       *sofar as a State requires a health insurance issuer offering*  
7       *health insurance coverage to include benefits beyond the es-*  
8       *sential benefits package, such requirement shall continue to*  
9       *apply to an Exchange-participating health benefits plan,*  
10      *if the State has entered into an arrangement satisfactory*  
11      *to the Commissioner to reimburse the Commissioner for the*  
12      *amount of any net increase in affordability premium cred-*  
13      *its under subtitle C as a result of an increase in premium*  
14      *in basic plans as a result of application of such require-*  
15      *ment.*

16      *(e) RULES REGARDING COVERAGE OF AND AFFORD-*  
17      *ABILITY CREDITS FOR SPECIFIED SERVICES.—*

18            *(1) ASSURED AVAILABILITY OF VARIED COV-*  
19            *ERAGE THROUGH THE HEALTH INSURANCE EX-*  
20            *CHANGE.—The Commissioner shall assure that, of the*  
21            *Exchange participating health benefits plan offered in*  
22            *each premium rating area of the Health Insurance*  
23            *Exchange—*

1           (A) there is at least one such plan that pro-  
 2           vides coverage of services described in subpara-  
 3           graphs (A) and (B) of section 122(d)(4); and

4           (B) there is at least one such plan that does  
 5           not provide coverage of services described in sec-  
 6           tion 122(d)(4)(A) which plan may also be one  
 7           that does not provide coverage of services de-  
 8           scribed in section 122(d)(4)(B).

9           (2) *SEGREGATION OF FUNDS.*—If a qualified  
 10          health benefits plan provides coverage of services de-  
 11          scribed in section 122(d)(4)(A), the plan shall provide  
 12          assurances satisfactory to the Commissioner that—

13           (A) any affordability credits provided under  
 14           subtitle C of title II are not used for purposes of  
 15           paying for such services; and

16           (B) only premium amounts attributable to  
 17           the actuarial value described in section 113(b)  
 18           are used for such purpose.

19 **SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-**  
 20 **PARTICIPATING HEALTH BENEFITS PLANS.**

21          (a) *CONTRACTING DUTIES.*—In carrying out section  
 22          201(b)(1) and consistent with this subtitle:

23           (1) *OFFERING ENTITY AND PLAN STANDARDS.*—

24          The Commissioner shall—

1           (A) establish standards necessary to imple-  
2           ment the requirements of this title and title I  
3           for—

4                   (i) QHBP offering entities for the of-  
5                   fering of an Exchange-participating health  
6                   benefits plan; and

7                   (ii) for Exchange-participating health  
8                   benefits plans; and

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

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

15                   (A) solicit bids from QHBP offering entities  
16                   for the offering of Exchange-participating health  
17                   benefits plans;

18                   (B) based upon a review of such bids, nego-  
19                   tiate with such entities for the offering of such  
20                   plans; and

21                   (C) enter into contracts with such entities  
22                   for the offering of such plans through the Health  
23                   Insurance Exchange under terms (consistent  
24                   with this title) negotiated between the Commis-  
25                   sioner and such entities.

1           (3) *FAR NOT APPLICABLE.*—*The provisions of*  
2           *the Federal Acquisition Regulation shall not apply to*  
3           *contracts between the Commissioner and QHBP offer-*  
4           *ing entities for the offering of Exchange-participating*  
5           *health benefits plans under this title.*

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

12           (1) *LICENSED.*—*The entity shall be licensed to*  
13           *offer health insurance coverage under State law for*  
14           *each State in which it is offering such coverage.*

15           (2) *DATA REPORTING.*—*The entity shall provide*  
16           *for the reporting of such information as the Commis-*  
17           *sioner may specify, including information necessary*  
18           *to administer the risk pooling mechanism described*  
19           *in section 206(b) and information to address dispari-*  
20           *ties in health and health care.*

21           (3) *IMPLEMENTING AFFORDABILITY CREDITS.*—  
22           *The entity shall provide for implementation of the af-*  
23           *fordability credits provided for enrollees under sub-*  
24           *title C, including the reduction in cost-sharing under*  
25           *section 244(c).*



1           (4) *ENROLLMENT.*—*The entity shall accept all*  
2 *enrollments under this subtitle, subject to such excep-*  
3 *tions (such as capacity limitations) in accordance*  
4 *with the requirements under title I for a qualified*  
5 *health benefits plan. The entity shall notify the Com-*  
6 *missioner if the entity projects or anticipates reaching*  
7 *such a capacity limitation that would result in a lim-*  
8 *itation in enrollment.*

9           (5) *RISK POOLING PARTICIPATION.*—*The entity*  
10 *shall participate in such risk pooling mechanism as*  
11 *the Commissioner establishes under section 206(b).*

12           (6) *ESSENTIAL COMMUNITY PROVIDERS.*—*With*  
13 *respect to the basic plan offered by the entity, the en-*  
14 *tity shall contract for outpatient services with covered*  
15 *entities (as defined in section 340B(a)(4) of the Pub-*  
16 *lic Health Service Act, as in effect as of July 1,*  
17 *2009). The Commissioner shall specify the extent to*  
18 *which and manner in which the previous sentence*  
19 *shall apply in the case of a basic plan with respect*  
20 *to which the Commissioner determines provides sub-*  
21 *stantially all benefits through a health maintenance*  
22 *organization, as defined in section 2791(b)(3) of the*  
23 *Public Health Service Act.*

24           (7) *CULTURALLY AND LINGUISTICALLY APPRO-*  
25 *PRIATE SERVICES AND COMMUNICATIONS.*—*The entity*

1     *shall provide for culturally and linguistically appro-*  
2     *prate communication and health services.*

3           (8) *ADDITIONAL REQUIREMENTS.*—*The entity*  
4     *shall comply with other applicable requirements of*  
5     *this title, as specified by the Commissioner, which*  
6     *shall include standards regarding billing and collec-*  
7     *tion practices for premiums and related grace periods*  
8     *and which may include standards to ensure that the*  
9     *entity does not use coercive practices to force pro-*  
10    *viders not to contract with other entities offering cov-*  
11    *erage through the Health Insurance Exchange.*

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 such*  
16    *time, in such manner, and containing such informa-*  
17    *tion 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 not*  
20    *less than one year, but may be made automatically*  
21    *renewable from term to term in the absence of notice*  
22    *of termination by either party.*

23           (3) *ENFORCEMENT OF NETWORK ADEQUACY.*—*In*  
24    *the case of a health benefits plan of a QHBP offering*  
25    *entity that uses a provider network, the contract*

1 under this section with the entity shall provide that  
2 if—

3 (A) the Commissioner determines that such  
4 provider network does not meet such standards  
5 as the Commissioner shall establish under section  
6 115; and

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

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

14 (4) *OVERSIGHT AND ENFORCEMENT RESPON-*  
15 *SIBILITIES.*—The Commissioner shall establish proc-  
16 esses, in coordination with State insurance regulators,  
17 to oversee, monitor, and enforce applicable require-  
18 ments of this title with respect to QHBP offering enti-  
19 ties offering Exchange-participating health benefits  
20 plans and such plans, including the marketing of  
21 such plans. Such processes shall include the following:

22 (A) *GRIEVANCE AND COMPLAINT MECHA-*  
23 *NISMS.*—The Commissioner shall establish, in co-  
24 ordination 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 one or more of the intermediate*  
7           *sanctions described in section 142(c).*

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 offer-*  
12           *ing 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 made*  
17           *in accordance with formal investigation*  
18           *and compliance procedures established by*  
19           *the Commissioner under which—*

20           *(I) the Commissioner provides the*  
21           *entity with the reasonable opportunity*  
22           *to develop and implement a corrective*  
23           *action plan to correct the deficiencies*  
24           *that were the basis of the Commis-*  
25           *sioner'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 clause prior to termi-*  
12                  *nation, would pose an imminent and seri-*  
13                  *ous risk to the health of individuals enrolled*  
14                  *under the qualified health benefits plan of*  
15                  *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 E of*  
19                  *title I with respect to an entity for a violation*  
20                  *of such a requirement.*

21                  (d) *NO DISCRIMINATION ON THE BASIS OF PROVISION*  
22                  *OF ABORTION.—No Exchange participating health benefits*  
23                  *plan may discriminate against any individual health care*  
24                  *provider or health care facility because of its willingness*

1 *or unwillingness to provide, pay for, provide coverage of,*  
2 *or refer for abortions.*

3 **SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELI-**  
4 **GIBLE INDIVIDUALS AND EMPLOYERS IN EX-**  
5 **CHANGE-PARTICIPATING HEALTH BENEFITS**  
6 **PLANS.**

7 *(a) IN GENERAL.—*

8 *(1) OUTREACH.—The Commissioner shall con-*  
9 *duct outreach activities consistent with subsection (c),*  
10 *including through use of appropriate entities as de-*  
11 *scribed in paragraph (3) of such subsection, to inform*  
12 *and educate individuals and employers about the*  
13 *Health Insurance Exchange and Exchange-partici-*  
14 *pating health benefits plan options. Such outreach*  
15 *shall include outreach specific to vulnerable popu-*  
16 *lations, such as children, individuals with disabil-*  
17 *ities, individuals with mental illness, and individuals*  
18 *with other cognitive impairments.*

19 *(2) ELIGIBILITY.—The Commissioner shall make*  
20 *timely determinations of whether individuals and em-*  
21 *ployers are Exchange-eligible individuals and employ-*  
22 *ers (as defined in section 202).*

23 *(3) ENROLLMENT.—The Commissioner shall es-*  
24 *tablish and carry out an enrollment process for Ex-*  
25 *change-eligible individuals and employers, including*

1       *at community locations, in accordance with sub-*  
2       *section (b).*

3       **(b) ENROLLMENT PROCESS.—**

4           **(1) IN GENERAL.—***The Commissioner shall estab-*  
5       *lish a process consistent with this title for enrollments*  
6       *in Exchange-participating health benefits plans. Such*  
7       *process shall provide for enrollment through means*  
8       *such as the mail, by telephone, electronically, and in*  
9       *person.*

10       **(2) ENROLLMENT PERIODS.—**

11           **(A) OPEN ENROLLMENT PERIOD.—***The*  
12       *Commissioner shall establish an annual open en-*  
13       *rollment period during which an Exchange-eligi-*  
14       *ble individual or employer may elect to enroll in*  
15       *an Exchange-participating health benefits plan*  
16       *for the following plan year and an enrollment*  
17       *period for affordability credits under subtitle C.*  
18       *Such periods shall be during September through*  
19       *November of each year, or such other time that*  
20       *would maximize timeliness of income*  
21       *verification for purposes of such subtitle. The*  
22       *open enrollment period shall not be less than 30*  
23       *days.*

24           **(B) SPECIAL ENROLLMENT.—***The Commis-*  
25       *sioner shall also provide for special enrollment*

1           *periods to take into account special cir-*  
2           *cumstances of individuals and employers, such*  
3           *as an individual who—*

4                     *(i) loses acceptable coverage;*

5                     *(ii) experiences a change in marital or*  
6                     *other dependent status;*

7                     *(iii) moves outside the service area of*  
8                     *the Exchange-participating health benefits*  
9                     *plan in which the individual is enrolled; or*

10                    *(iv) experiences a significant change in*  
11                    *income.*

12            (C) *ENROLLMENT INFORMATION.—The*  
13            *Commissioner shall provide for the broad dis-*  
14            *semination of information to prospective enroll-*  
15            *ees on the enrollment process, including before*  
16            *each open enrollment period. In carrying out the*  
17            *previous sentence, the Commissioner may work*  
18            *with other appropriate entities to facilitate such*  
19            *provision of information.*

20            (3) *AUTOMATIC ENROLLMENT FOR NON-MEDICAID*  
21            *ELIGIBLE INDIVIDUALS.—*

22                    (A) *IN GENERAL.—The Commissioner shall*  
23                    *provide for a process under which individuals*  
24                    *who are Exchange-eligible individuals described*  
25                    *in subparagraph (B) are automatically enrolled*



1           under an appropriate Exchange-participating  
2           health benefits plan. Such process may involve a  
3           random assignment or some other form of as-  
4           signment that takes into account the health care  
5           providers used by the individual involved or such  
6           other relevant factors as the Commissioner may  
7           specify.

8           (B)       SUBSIDIZED       INDIVIDUALS       DE-  
9           SCRIBED.—An individual described in this sub-  
10          paragraph is an Exchange-eligible individual  
11          who is either of the following:

12               (i) AFFORDABILITY CREDIT ELIGIBLE  
13               INDIVIDUALS.—The individual—

14                       (I) has applied for, and been de-  
15                       termined eligible for, affordability  
16                       credits under subtitle C;

17                       (II) has not opted out from receiv-  
18                       ing such affordability credit; and

19                       (III) does not otherwise enroll in  
20                       another Exchange-participating health  
21                       benefits plan.

22               (ii) INDIVIDUALS ENROLLED IN A TER-  
23               MINATED PLAN.—The individual is enrolled  
24               in an Exchange-participating health bene-  
25               fits plan that is terminated (during or at

1           the end of a plan year) and who does not  
2           otherwise enroll in another Exchange-par-  
3           ticipating health benefits plan.

4           (4) *DIRECT PAYMENT OF PREMIUMS TO PLANS.*—  
5           Under the enrollment process, individuals enrolled in  
6           an Exchange-participating health benefits plan shall  
7           pay such plans directly, and not through the Commis-  
8           sioner or the Health Insurance Exchange.

9           (c) *COVERAGE INFORMATION AND ASSISTANCE.*—

10           (1) *COVERAGE INFORMATION.*—The Commis-  
11           sioner shall provide for the broad dissemination of in-  
12           formation on Exchange-participating health benefits  
13           plans offered under this title. Such information shall  
14           be provided in a comparative manner, and shall in-  
15           clude information on benefits, premiums, cost-shar-  
16           ing, quality, provider networks, and consumer satis-  
17           faction.

18           (2) *CONSUMER ASSISTANCE WITH CHOICE.*—To  
19           provide assistance to Exchange-eligible individuals  
20           and employers, the Commissioner shall—

21           (A) provide for the operation of a toll-free  
22           telephone hotline to respond to requests for assist-  
23           ance and maintain an Internet website through  
24           which individuals may obtain information on

1 coverage under Exchange-participating health  
2 benefits plans and file complaints;

3 (B) develop and disseminate information to  
4 Exchange-eligible enrollees on their rights and  
5 responsibilities;

6 (C) assist Exchange-eligible individuals in  
7 selecting Exchange-participating health benefits  
8 plans and obtaining benefits through such plans;  
9 and

10 (D) ensure that the Internet website de-  
11 scribed in subparagraph (A) and the information  
12 described in subparagraph (B) is developed using  
13 plain language (as defined in section 133(a)(2)).

14 (3) USE OF OTHER ENTITIES.—In carrying out  
15 this subsection, the Commissioner may work with  
16 other appropriate entities to facilitate the dissemina-  
17 tion of information under this subsection and to pro-  
18 vide assistance as described in paragraph (2).

19 (d) SPECIAL DUTIES RELATED TO MEDICAID AND  
20 CHIP.—

21 (1) COVERAGE FOR CERTAIN NEWBORNS.—

22 (A) IN GENERAL.—In the case of a child  
23 born in the United States who at the time of  
24 birth is not otherwise covered under acceptable  
25 coverage, for the period of time beginning on the

1           *date of birth and ending on the date the child*  
2           *otherwise is covered under acceptable coverage*  
3           *(or, if earlier, the end of the month in which the*  
4           *60-day period, beginning on the date of birth,*  
5           *ends), the child shall be deemed—*

6                     *(i) to be a non-traditional Medicaid el-*  
7                     *igible individual (as defined in subsection*  
8                     *(e)(5)) for purposes of this division and*  
9                     *Medicaid; and*

10                    *(ii) to have elected to enroll in Med-*  
11                    *icaid through the application of paragraph*  
12                    *(3).*

13            *(B) EXTENDED TREATMENT AS TRADI-*  
14            *TIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In the*  
15            *case of a child described in subparagraph (A)*  
16            *who at the end of the period referred to in such*  
17            *subparagraph is not otherwise covered under ac-*  
18            *ceptable coverage, the child shall be deemed*  
19            *(until such time as the child obtains such cov-*  
20            *erage or the State otherwise makes a determina-*  
21            *tion of the child's eligibility for medical assist-*  
22            *ance under its Medicaid plan pursuant to sec-*  
23            *tion 1943(c)(1) of the Social Security Act) to be*  
24            *a traditional Medicaid eligible individual de-*  
25            *scribed in section 1902(l)(1)(B) of such Act.*

1           (2) *CHIP TRANSITION.*—A child who, as of the  
2           day before the first day of Y1, is eligible for child  
3           health assistance under title XXI of the Social Secu-  
4           rity Act (including a child receiving coverage under  
5           an arrangement described in section 2101(a)(2) of  
6           such Act) is deemed as of such first day to be an Ex-  
7           change-eligible individual unless the individual is a  
8           traditional Medicaid eligible individual as of such  
9           day.

10           (3) *AUTOMATIC ENROLLMENT OF MEDICAID ELI-*  
11           *GIBLE INDIVIDUALS INTO MEDICAID.*—The Commis-  
12           sioner shall provide for a process under which an in-  
13           dividual who is described in section 202(d)(3) and  
14           has not elected to enroll in an Exchange-participating  
15           health benefits plan is automatically enrolled under  
16           Medicaid.

17           (4) *NOTIFICATIONS.*—The Commissioner shall  
18           notify each State in Y1 and for purposes of section  
19           1902(gg)(1) of the Social Security Act (as added by  
20           section 1703(a)) whether the Health Insurance Ex-  
21           change can support enrollment of children described  
22           in paragraph (2) in such State in such year.

23           (e) *MEDICAID COVERAGE FOR MEDICAID ELIGIBLE IN-*  
24           *DIVIDUALS.*—

25           (1) *IN GENERAL.*—

1           (A) *CHOICE FOR LIMITED EXCHANGE-ELIGI-*  
2           *BLE INDIVIDUALS.*—As part of the enrollment  
3           process under subsection (b), the Commissioner  
4           shall provide the option, in the case of an *Ex-*  
5           *change-eligible individual* described in section  
6           202(d)(3), for the individual to elect to enroll  
7           under Medicaid instead of under an *Exchange-*  
8           *participating health benefits plan.* Such an indi-  
9           vidual may change such election during an en-  
10          rollment period under subsection (b)(2).

11          (B) *MEDICAID ENROLLMENT OBLIGATION.*—  
12          An *Exchange eligible individual* may apply, in  
13          the manner described in section 241(b)(1), for a  
14          determination of whether the individual is a  
15          *Medicaid-eligible individual.* If the individual is  
16          determined to be so eligible, the Commissioner,  
17          through the Medicaid memorandum of under-  
18          standing, shall provide for the enrollment of the  
19          individual under the State Medicaid plan in ac-  
20          cordance with the Medicaid memorandum of un-  
21          derstanding under paragraph (4). In the case of  
22          such an enrollment, the State shall provide for  
23          the same periodic redetermination of eligibility  
24          under Medicaid as would otherwise apply if the

1           *individual had directly applied for medical as-*  
2           *sistance to the State Medicaid agency.*

3           (2) *NON-TRADITIONAL MEDICAID ELIGIBLE INDI-*  
4           *VIDUALS.—In the case of a non-traditional Medicaid*  
5           *eligible individual described in section 202(d)(3) who*  
6           *elects to enroll under Medicaid under paragraph*  
7           *(1)(A), the Commissioner shall provide for the enroll-*  
8           *ment of the individual under the State Medicaid plan*  
9           *in accordance with the Medicaid memorandum of un-*  
10          *derstanding under paragraph (3).*

11          (3) *COORDINATED ENROLLMENT WITH STATE*  
12          *THROUGH MEMORANDUM OF UNDERSTANDING.—The*  
13          *Commissioner, in consultation with the Secretary of*  
14          *Health and Human Services, shall enter into a*  
15          *memorandum of understanding with each State (each*  
16          *in this division referred to as a “Medicaid memo-*  
17          *randum of understanding”)* with respect to coordi-  
18          *nating enrollment of individuals in Exchange-partici-*  
19          *pating health benefits plans and under the State’s*  
20          *Medicaid program consistent with this section and to*  
21          *otherwise coordinate the implementation of the provi-*  
22          *sions of this division with respect to the Medicaid*  
23          *program. Such memorandum shall permit the ex-*  
24          *change of information consistent with the limitations*  
25          *described in section 1902(a)(7) of the Social Security*

1 *Act. Nothing in this section shall be construed as per-*  
2 *mitting such memorandum to modify or vitiate any*  
3 *requirement of a State Medicaid plan.*

4 (4) *MEDICAID ELIGIBLE INDIVIDUALS.—For pur-*  
5 *poses of this division:*

6 (A) *MEDICAID ELIGIBLE INDIVIDUAL.—The*  
7 *term “Medicaid eligible individual” means an*  
8 *individual who is eligible for medical assistance*  
9 *under Medicaid.*

10 (B) *TRADITIONAL MEDICAID ELIGIBLE INDI-*  
11 *VIDUAL.—The term “traditional Medicaid eligi-*  
12 *ble individual” means a Medicaid eligible indi-*  
13 *vidual other than an individual who is—*

14 (i) *a Medicaid eligible individual by*  
15 *reason of the application of subclause (VIII)*  
16 *of section 1902(a)(10)(A)(i) of the Social*  
17 *Security Act; or*

18 (ii) *a childless adult not described in*  
19 *section 1902(a)(10)(A) or (C) of such Act*  
20 *(as in effect as of the day before the date of*  
21 *the enactment of this Act).*

22 (C) *NON-TRADITIONAL MEDICAID ELIGIBLE*  
23 *INDIVIDUAL.—The term “non-traditional Med-*  
24 *icaid eligible individual” means a Medicaid eli-*



1           gible individual who is not a traditional Med-  
2           icaid eligible individual.

3           (f) *EFFECTIVE CULTURALLY AND LINGUISTICALLY AP-*  
4 *PROPRIATE COMMUNICATION.*—*In carrying out this section,*  
5 *the Commissioner shall establish effective methods for com-*  
6 *municating in plain language and a culturally and lin-*  
7 *guistically appropriate manner.*

8           (g) *ROLE FOR ENROLLMENT AGENTS AND BRO-*  
9 *KERS.*—*Nothing in this division shall be construed to affect*  
10 *the role of enrollment agents and brokers under State law,*  
11 *including with regard to the enrollment of individuals and*  
12 *employers in qualified health benefits plans including the*  
13 *public health insurance option.*

14 **SEC. 206. OTHER FUNCTIONS.**

15           (a) *COORDINATION OF AFFORDABILITY CREDITS.*—  
16 *The Commissioner shall coordinate the distribution of af-*  
17 *fordability premium and cost-sharing credits under subtitle*  
18 *C to QHBP offering entities offering Exchange-participi-*  
19 *ating health benefits plans.*

20           (b) *COORDINATION OF RISK POOLING.*—*The Commis-*  
21 *sioner shall establish a mechanism whereby there is an ad-*  
22 *justment made of the premium amounts payable among*  
23 *QHBP offering entities offering Exchange-participating*  
24 *health benefits plans of premiums collected for such plans*  
25 *that takes into account (in a manner specified by the Com-*

1 *missioner) the differences in the risk characteristics of indi-*  
2 *viduals and employers enrolled under the different Ex-*  
3 *change-participating health benefits plans offered by such*  
4 *entities so as to minimize the impact of adverse selection*  
5 *of enrollees among the plans offered by such entities.*

6 (c) *SPECIAL INSPECTOR GENERAL FOR THE HEALTH*  
7 *INSURANCE EXCHANGE.—*

8 (1) *ESTABLISHMENT; APPOINTMENT.—There is*  
9 *hereby established the Office of the Special Inspector*  
10 *General for the Health Insurance Exchange, to be*  
11 *headed by a Special Inspector General for the Health*  
12 *Insurance Exchange (in this subsection referred to as*  
13 *the “Special Inspector General”) to be appointed by*  
14 *the President, by and with the advice and consent of*  
15 *the Senate. The nomination of an individual as Spe-*  
16 *cial Inspector General shall be made as soon as prac-*  
17 *ticable after the establishment of the program under*  
18 *this subtitle.*

19 (2) *DUTIES.—The Special Inspector General*  
20 *shall—*

21 (A) *conduct, supervise, and coordinate au-*  
22 *ditions, evaluations and investigations of the Health*  
23 *Insurance Exchange to protect the integrity of*  
24 *the Health Insurance Exchange, as well as the*

1           *health and welfare of participants in the Ex-*  
2           *change;*

3           *(B) report both to the Commissioner and to*  
4           *the Congress regarding program and manage-*  
5           *ment problems and recommendations to correct*  
6           *them;*

7           *(C) have other duties (described in para-*  
8           *graphs (2) and (3) of section 121 of division A*  
9           *of Public Law 110–343) in relation to the duties*  
10          *described in the previous subparagraphs; and*

11          *(D) have the authorities provided in section*  
12          *6 of the Inspector General Act of 1978 in car-*  
13          *rying out duties under this paragraph.*

14          (3) *APPLICATION OF OTHER SPECIAL INSPECTOR*  
15          *GENERAL PROVISIONS.—The provisions of subsections*  
16          *(b) (other than paragraphs (1) and (3)), (d) (other*  
17          *than paragraph (1)), and (e) of section 121 of divi-*  
18          *sion A of the Emergency Economic Stabilization Act*  
19          *of 2009 (Public Law 110–343) shall apply to the Spe-*  
20          *cial Inspector General under this subsection in the*  
21          *same manner as such provisions apply to the Special*  
22          *Inspector General under such section.*

23          (4) *REPORTS.—Not later than one year after the*  
24          *confirmation of the Special Inspector General, and*  
25          *annually thereafter, the Special Inspector General*

1       *shall submit to the appropriate committees of Con-*  
2       *gress a report summarizing the activities of the Spe-*  
3       *cial Inspector General during the one year period*  
4       *ending on the date such report is submitted.*

5               (5) *TERMINATION.*—*The Office of the Special In-*  
6       *spector General shall terminate five years after the*  
7       *date of the enactment of this Act.*

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

9               (a) *ESTABLISHMENT OF HEALTH INSURANCE EX-*  
10       *CHANGE TRUST FUND.*—*There is created within the Treas-*  
11       *ury of the United States a trust fund to be known as the*  
12       *“Health Insurance Exchange Trust Fund” (in this section*  
13       *referred to as the “Trust Fund”), consisting of such*  
14       *amounts as may be appropriated or credited to the Trust*  
15       *Fund under this section or any other provision of law.*

16              (b) *PAYMENTS FROM TRUST FUND.*—*The Commis-*  
17       *sioner shall pay from time to time from the Trust Fund*  
18       *such amounts as the Commissioner determines are nec-*  
19       *essary to make payments to operate the Health Insurance*  
20       *Exchange, including payments under subtitle C (relating*  
21       *to affordability credits).*

22              (c) *TRANSFERS TO TRUST FUND.*—

23                      (1) *DEDICATED PAYMENTS.*—*There is hereby ap-*  
24       *propriated to the Trust Fund amounts equivalent to*  
25       *the following:*

1           (A) *TAXES ON INDIVIDUALS NOT OBTAINING*  
2           *ACCEPTABLE COVERAGE.*—*The amounts received*  
3           *in the Treasury under section 59B of the Inter-*  
4           *nal Revenue Code of 1986 (relating to require-*  
5           *ment of health insurance coverage for individ-*  
6           *uals).*

7           (B) *EMPLOYMENT TAXES ON EMPLOYERS*  
8           *NOT PROVIDING ACCEPTABLE COVERAGE.*—*The*  
9           *amounts received in the Treasury under section*  
10           *3111(c) of the Internal Revenue Code of 1986*  
11           *(relating to employers electing to not provide*  
12           *health benefits).*

13           (C) *EXCISE TAX ON FAILURES TO MEET*  
14           *CERTAIN HEALTH COVERAGE REQUIREMENTS.*—  
15           *The amounts received in the Treasury under sec-*  
16           *tion 4980H(b) (relating to excise tax with re-*  
17           *spect to failure to meet health coverage partici-*  
18           *pation requirements).*

19           (2) *APPROPRIATIONS TO COVER GOVERNMENT*  
20           *CONTRIBUTIONS.*—*There are hereby appropriated, out*  
21           *of any moneys in the Treasury not otherwise appro-*  
22           *riated, to the Trust Fund, an amount equivalent to*  
23           *the amount of payments made from the Trust Fund*  
24           *under subsection (b) plus such amounts as are nec-*

1       *essary reduced by the amounts deposited under para-*  
2       *graph (1).*

3       *(d) APPLICATION OF CERTAIN RULES.—Rules similar*  
4       *to the rules of subchapter B of chapter 98 of the Internal*  
5       *Revenue Code of 1986 shall apply with respect to the Trust*  
6       *Fund.*

7       ***SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH***  
8                                   ***INSURANCE EXCHANGES.***

9       *(a) IN GENERAL.—If—*

10               *(1) a State (or group of States, subject to the ap-*  
11               *proval of the Commissioner) applies to the Commis-*  
12               *sioner for approval of a State-based Health Insurance*  
13               *Exchange to operate in the State (or group of States);*  
14               *and*

15               *(2) the Commissioner approves such State-based*  
16               *Health Insurance Exchange,*

17       *then, subject to subsections (c) and (d), the State-based*  
18       *Health Insurance Exchange shall operate, instead of the*  
19       *Health Insurance Exchange, with respect to such State (or*  
20       *group of States). The Commissioner shall approve a State-*  
21       *based Health Insurance Exchange if it meets the require-*  
22       *ments for approval under subsection (b).*

23       *(b) REQUIREMENTS FOR APPROVAL.—*

24               *(1) IN GENERAL.—The Commissioner may not*  
25               *approve a State-based Health Insurance Exchange*

1        *under this section unless the following requirements*  
2        *are met:*

3                *(A) The State-based Health Insurance Ex-*  
4                *change must demonstrate the capacity to and*  
5                *provide assurances satisfactory to the Commis-*  
6                *sioner that the State-based Health Insurance Ex-*  
7                *change will carry out the functions specified for*  
8                *the Health Insurance Exchange in the State (or*  
9                *States) involved, including—*

10                    *(i) negotiating and contracting with*  
11                    *QHBP offering entities for the offering of*  
12                    *Exchange-participating health benefits*  
13                    *plan, which satisfy the standards and re-*  
14                    *quirements of this title and title I;*

15                    *(ii) enrolling Exchange-eligible indi-*  
16                    *viduals and employers in such State in such*  
17                    *plans;*

18                    *(iii) the establishment of sufficient*  
19                    *local offices to meet the needs of Exchange-*  
20                    *eligible individuals and employers;*

21                    *(iv) administering affordability credits*  
22                    *under subtitle B using the same methodolo-*  
23                    *gies (and at least the same income*  
24                    *verification methods) as would otherwise*  
25                    *apply under such subtitle and at a cost to*

1           *the Federal Government which does exceed*  
2           *the cost to the Federal Government if this*  
3           *section did not apply; and*

4                     *(v) enforcement activities consistent*  
5                     *with federal requirements.*

6           *(B) There is no more than one Health In-*  
7           *surance Exchange operating with respect to any*  
8           *one State.*

9                     *(C) The State provides assurances satisfac-*  
10           *tory to the Commissioner that approval of such*  
11           *an Exchange will not result in any net increase*  
12           *in expenditures to the Federal Government.*

13                    *(D) The State provides for reporting of such*  
14           *information as the Commissioner determines and*  
15           *assurances satisfactory to the Commissioner that*  
16           *it will vigorously enforce violations of applicable*  
17           *requirements.*

18                    *(E) The State is eligible to receive an incen-*  
19           *tive payment for enacting and implementing*  
20           *medical liability reforms as specified in sub-*  
21           *section (g).*

22                    *(F) Such other requirements as the Commis-*  
23           *sioner may specify.*

24                    *(2) PRESUMPTION FOR CERTAIN STATE-OPER-*  
25            *ATED EXCHANGES.—*



1           (A) *IN GENERAL.*—*In the case of a State*  
2           *operating an Exchange prior to January 1, 2010*  
3           *that seeks to operate the State-based Health In-*  
4           *surance Exchange under this section, the Com-*  
5           *missioner shall presume that such Exchange*  
6           *meets the standards under this section unless the*  
7           *Commissioner determines, after completion of the*  
8           *process established under subparagraph (B), that*  
9           *the Exchange does not comply with such stand-*  
10           *ards.*

11           (B) *PROCESS.*—*The Commissioner shall es-*  
12           *tablish a process to work with a State described*  
13           *in subparagraph (A) to provide assistance nec-*  
14           *essary to assure that the State’s Exchange comes*  
15           *into compliance with the standards for approval*  
16           *under this section.*

17           (c) *CEASING OPERATION.*—

18           (1) *IN GENERAL.*—*A State-based Health Insur-*  
19           *ance Exchange may, at the option of each State in-*  
20           *volved, and only after providing timely and reason-*  
21           *able notice to the Commissioner, cease operation as*  
22           *such an Exchange, in which case the Health Insur-*  
23           *ance Exchange shall operate, instead of such State-*  
24           *based Health Insurance Exchange, with respect to*  
25           *such State (or States).*

1           (2) *TERMINATION; HEALTH INSURANCE EX-*  
2           *CHANGE RESUMPTION OF FUNCTIONS.*—*The Commis-*  
3           *sioner may terminate the approval (for some or all*  
4           *functions) of a State-based Health Insurance Ex-*  
5           *change under this section if the Commissioner deter-*  
6           *mines that such Exchange no longer meets the re-*  
7           *quirements of subsection (b) or is no longer capable*  
8           *of carrying out such functions in accordance with the*  
9           *requirements of this subtitle. In lieu of terminating*  
10           *such approval, the Commissioner may temporarily*  
11           *assume some or all functions of the State-based*  
12           *Health Insurance Exchange until such time as the*  
13           *Commissioner determines the State-based Health In-*  
14           *surance Exchange meets such requirements of sub-*  
15           *section (b) and is capable of carrying out such func-*  
16           *tions in accordance with the requirements of this sub-*  
17           *title.*

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

22           (d) *RETENTION OF AUTHORITY.*—

23           (1) *AUTHORITY RETAINED.*—*Enforcement au-*  
24           *thorities of the Commissioner shall be retained by the*  
25           *Commissioner.*

1           (2) *DISCRETION TO RETAIN ADDITIONAL AU-*  
2           *THORITY.—The Commissioner may specify functions*  
3           *of the Health Insurance Exchange that—*

4                     (A) *may not be performed by a State-based*  
5                     *Health Insurance Exchange under this section;*

6                     *or*

7                     (B) *may be performed by the Commissioner*  
8                     *and by such a State-based Health Insurance Ex-*  
9                     *change.*

10           (e) *REFERENCES.—In the case of a State-based Health*  
11           *Insurance Exchange, except as the Commissioner may oth-*  
12           *erwise specify under subsection (d), any references in this*  
13           *subtitle to the Health Insurance Exchange or to the Com-*  
14           *missioner in the area in which the State-based Health In-*  
15           *surance Exchange operates shall be deemed a reference to*  
16           *the State-based Health Insurance Exchange and the head*  
17           *of such Exchange, respectively.*

18           (f) *FUNDING.—In the case of a State-based Health In-*  
19           *surance Exchange, there shall be assistance provided for the*  
20           *operation of such Exchange in the form of a matching grant*  
21           *with a State share of expenditures required.*

22           (g) *MEDICAL LIABILITY ALTERNATIVES.—*

23                     (1) *PURPOSES.—The purposes of this subsection*  
24                     *are—*

1           (A) to ensure quality healthcare is readily  
2 available by providing an alternative framework  
3 to reduce the costs of defensive medicine and  
4 allow victims of malpractice to be fairly com-  
5 pensated; and

6           (B) to do the above without limiting attor-  
7 neys fees or imposing caps on damages.

8           (2) *INCENTIVE PAYMENTS FOR MEDICAL LIABIL-*  
9 *ITY REFORM.—*

10           (A) *IN GENERAL.—*Each State is eligible to  
11 receive an incentive payment, in an amount de-  
12 termined by the Secretary subject to the avail-  
13 ability of appropriations, if the State enacts  
14 after the date of the enactment of this subsection,  
15 and is implementing, an alternative medical li-  
16 ability law that complies with this subsection.

17           (B) *DETERMINATION BY SECRETARY.—*The  
18 Secretary shall determine that a State's alter-  
19 native medical liability law complies with this  
20 subsection if the Secretary is satisfied that the  
21 State—

22                   (i) has enacted and is currently imple-  
23 menting that law; and

24                   (ii) that law is effective.

1           (C) *CONSIDERATIONS FOR DETERMINA-*  
2           *TION.—In making a determination of the effec-*  
3           *tiveness of a law, the Secretary shall consider*  
4           *whether the law—*

5                     (i) *makes the medical liability system*  
6                     *more reliable through prevention of or*  
7                     *prompt and fair resolution of disputes;*

8                     (ii) *encourages the disclosure of health*  
9                     *care errors; and*

10                    (iii) *maintains access to affordable li-*  
11                    *ability insurance.*

12           (D) *OPTIONAL CONTENTS OF ALTERNATIVE*  
13           *MEDICAL LIABILITY LAW.—An alternative med-*  
14           *ical liability law shall contain any one or a*  
15           *combination of the following litigation alter-*  
16           *natives:*

17                     (i) *Certificate of Merit.*

18                     (ii) *Early offer.*

19           (E) *USE OF INCENTIVE PAYMENTS.—The*  
20           *State shall use an incentive payment received*  
21           *under this subsection to improve health care in*  
22           *that State.*

23           (3) *APPLICATION.—Each State seeking an incen-*  
24           *tive payment under this subsection shall submit to the*  
25           *Secretary an application, at such time, in such man-*

1        *ner, and containing such information as the Sec-*  
2        *retary may require.*

3            (4) *TECHNICAL ASSISTANCE.—The Secretary*  
4        *may provide technical assistance to the States apply-*  
5        *ing for or awarded an incentive payment under this*  
6        *subsection.*

7            (5) *REPORTS.—Beginning not later than one*  
8        *year after the date of the enactment of this subsection,*  
9        *the Secretary shall submit to Congress an annual re-*  
10       *port on the progress States have made in adopting*  
11       *and implementing alternative medical liability laws*  
12       *that comply with this subsection. Such reports shall*  
13       *contain sufficient documentation regarding the effec-*  
14       *tiveness of such laws to enable an objective compara-*  
15       *tive analysis of them.*

16           (6) *RULEMAKING.—The Secretary may make*  
17       *rules to carry out this subsection.*

18           (7) *DEFINITION.—In this subsection—*

19                (A) *the term “Secretary” means the Sec-*  
20        *retary of Health and Human Services; and*

21                (B) *the term “State” includes the District of*  
22        *Columbia, Puerto Rico, and each other territory*  
23        *or possession of the United States.*

24           (8) *AUTHORIZATION OF APPROPRIATIONS.—*  
25       *There are authorized to be appropriated to carry out*

1        *this subsection such sums as may be necessary, to re-*  
2        *main available until expended.*

3        **SEC. 209. LIMITATION ON PREMIUM INCREASES UNDER EX-**  
4                    **CHANGE-PARTICIPATING HEALTH BENEFITS**  
5                    **PLANS.**

6        (a) *IN GENERAL.*—*The annual increase in the pre-*  
7        *miums charged under any Exchange-participating health*  
8        *benefits plan may not exceed 150 percent of the annual per-*  
9        *centage increase in medical inflation for the 12-month pe-*  
10       *riod ending in June of the prior year, unless the plan re-*  
11       *ceives approval for a higher rate increase in accordance*  
12       *with subsection (b) or (c).*

13       (b) *EXCEPTION FOR ADDITIONAL REQUIRED BENE-*  
14       *FITS.*—*If the Health Choices Commissioner requires Ex-*  
15       *change-participating health benefits plans to provide addi-*  
16       *tional benefits, the annual increase permitted under sub-*  
17       *section (a) with respect to the first year to which such bene-*  
18       *fits are required shall be increased to take into account the*  
19       *costs of such additional benefits.*

20       (c) *EXCEPTION TO WHERE FINANCIAL VIABILITY*  
21       *THREATENED.*—*Subsection (a) shall not apply to any Ex-*  
22       *change-participating health benefits plan for any year if*  
23       *such plan demonstrates to the Commissioner (or, if deter-*  
24       *mined appropriate by the Commissioner, the insurance*  
25       *commissioner for the State in which the plan is offered)*

1 *that complying with subsection (a) for such year would*  
 2 *threaten its financial viability or its ability to provide*  
 3 *timely benefits to plan participants.*

4 *(d) NON-PREEMPTION.—Nothing in this section shall*  
 5 *be construed as preempting existing State prior approval*  
 6 *laws.*

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

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

13 *(a) ESTABLISHMENT.—For years beginning with Y1,*  
 14 *the Secretary of Health and Human Services (in this sub-*  
 15 *title referred to as the “Secretary”) shall provide for the*  
 16 *offering of an Exchange-participating health benefits plan*  
 17 *(in this division referred to as the “public health insurance*  
 18 *option”) that ensures choice, competition, and stability of*  
 19 *affordable, high quality coverage throughout the United*  
 20 *States in accordance with this subtitle. In designing the op-*  
 21 *tion, the Secretary’s primary responsibility is to create a*  
 22 *low-cost plan without compromising quality or access to*  
 23 *care.*

24 *(b) OFFERING AS AN EXCHANGE-PARTICIPATING*  
 25 *HEALTH BENEFITS PLAN.—*



1           (1) *EXCLUSIVE TO THE EXCHANGE.*—*The public*  
2           *health insurance option shall only be made available*  
3           *through the Health Insurance Exchange.*

4           (2) *ENSURING A LEVEL PLAYING FIELD.*—*Con-*  
5           *sistent with this subtitle, the public health insurance*  
6           *option shall comply with requirements that are appli-*  
7           *cable under this title to an Exchange-participating*  
8           *health benefits plan, including requirements related to*  
9           *benefits, benefit levels, provider networks, notices, con-*  
10          *sumer protections, and cost sharing.*

11          (3) *PROVISION OF BENEFIT LEVELS.*—*The public*  
12          *health insurance option—*

13                 (A) *shall offer basic, enhanced, and pre-*  
14                 *mium plans; and*

15                 (B) *may offer premium-plus plans.*

16          (c) *ADMINISTRATIVE CONTRACTING.*—*The Secretary*  
17          *may enter into contracts for the purpose of performing ad-*  
18          *ministrative functions (including functions described in*  
19          *subsection (a)(4) of section 1874A of the Social Security*  
20          *Act) with respect to the public health insurance option in*  
21          *the same manner as the Secretary may enter into contracts*  
22          *under subsection (a)(1) of such section. The Secretary has*  
23          *the same authority with respect to the public health insur-*  
24          *ance option as the Secretary has under subsections (a)(1)*  
25          *and (b) of section 1874A of the Social Security Act with*

1 *respect to title XVIII of such Act. Contracts under this sub-*  
2 *section shall not involve the transfer of insurance risk to*  
3 *such entity.*

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

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

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

20 (g) *ACCESS TO FEDERAL COURTS.*—*The provisions of*  
21 *Medicare (and related provisions of title II of the Social*  
22 *Security Act) relating to access of Medicare beneficiaries*  
23 *to Federal courts for the enforcement of rights under Medi-*  
24 *care, including with respect to amounts in controversy,*  
25 *shall apply to the public health insurance option and indi-*

1 *viduals enrolled under such option under this title in the*  
2 *same manner as such provisions apply to Medicare and*  
3 *Medicare beneficiaries.*

4 **SEC. 222. PREMIUMS AND FINANCING.**

5 *(a) ESTABLISHMENT OF PREMIUMS.—*

6 *(1) IN GENERAL.—The Secretary shall establish*  
7 *geographically-adjusted premium rates for the public*  
8 *health insurance option in a manner—*

9 *(A) that complies with the premium rules*  
10 *established by the Commissioner under section*  
11 *113 for Exchange-participating health benefit*  
12 *plans; and*

13 *(B) at a level sufficient to fully finance the*  
14 *costs of—*

15 *(i) health benefits provided by the pub-*  
16 *lic health insurance option; and*

17 *(ii) administrative costs related to op-*  
18 *erating the public health insurance option.*

19 *(2) CONTINGENCY MARGIN.—In establishing pre-*  
20 *mium rates under paragraph (1), the Secretary shall*  
21 *include an appropriate amount for a contingency*  
22 *margin (which shall be not less than 90 days of esti-*  
23 *mated claims). Before setting such appropriate*  
24 *amount for years starting with Y3, the Secretary*

1 *shall solicit a recommendation on such amount from*  
2 *the American Academy of Actuaries.*

3 *(b) ACCOUNT.—*

4 *(1) ESTABLISHMENT.—There is established in*  
5 *the Treasury of the United States an Account for the*  
6 *receipts and disbursements attributable to the oper-*  
7 *ation of the public health insurance option, including*  
8 *the start-up funding under paragraph (2). Section*  
9 *1854(g) of the Social Security Act shall apply to re-*  
10 *ceipts described in the previous sentence in the same*  
11 *manner as such section applies to payments or pre-*  
12 *miums described in such section.*

13 *(2) START-UP FUNDING.—*

14 *(A) IN GENERAL.—In order to provide for*  
15 *the establishment of the public health insurance*  
16 *option there is hereby appropriated to the Sec-*  
17 *retary, out of any funds in the Treasury not oth-*  
18 *erwise appropriated, \$2,000,000,000. In order to*  
19 *provide for initial claims reserves before the col-*  
20 *lection of premiums, there is hereby appro-*  
21 *priated to the Secretary, out of any funds in the*  
22 *Treasury not otherwise appropriated, such sums*  
23 *as necessary to cover 90 days worth of claims re-*  
24 *serves based on projected enrollment.*

1           (B) *AMORTIZATION OF START-UP FUND-*  
2           *ING.—The Secretary shall provide for the repay-*  
3           *ment of the startup funding provided under sub-*  
4           *paragraph (A) to the Treasury in an amortized*  
5           *manner over the 10-year period beginning with*  
6           *Y1.*

7           (C) *LIMITATION ON FUNDING.—Nothing in*  
8           *this section shall be construed as authorizing any*  
9           *additional appropriations to the Account, other*  
10          *than such amounts as are otherwise provided*  
11          *with respect to other Exchange-participating*  
12          *health benefits plans.*

13          (3) *NO BAILOUTS.—In no case shall the public*  
14          *health insurance option receive any Federal funds for*  
15          *purposes of insolvency in any manner similar to the*  
16          *manner in which entities receive Federal funding*  
17          *under the Troubled Assets Relief Program of the Sec-*  
18          *retary of the Treasury.*

19 **SEC. 223. NEGOTIATED PAYMENT RATES FOR ITEMS AND**  
20                 **SERVICES.**

21          (a) *NEGOTIATION OF PAYMENT RATES.—*

22                 (1) *IN GENERAL.—The Secretary shall negotiate*  
23                 *payment rates for the public health insurance option*  
24                 *for services and health care providers consistent with*  
25                 *this section and section 224.*

1           (2) *MANNER OF NEGOTIATION.*—*The Secretary*  
2           *shall negotiate such rates in a manner that results in*  
3           *payment rates that are not lower, in the aggregate,*  
4           *than rates under title XVIII of the Social Security*  
5           *Act, and not higher, in the aggregate, than the aver-*  
6           *age rates paid by other QHBP offering entities for*  
7           *services and health care providers.*

8           (3) *INNOVATIVE PAYMENT METHODS.*—*Nothing*  
9           *in this subsection shall be construed as preventing the*  
10          *use of innovative payment methods such as those de-*  
11          *scribed in section 224 in connection with the negotia-*  
12          *tion of payment rates under this subsection.*

13          (4) *PRESCRIPTION DRUGS.*—*Notwithstanding*  
14          *any other provision of law, the Secretary shall estab-*  
15          *lish a particular formulary for prescription drugs*  
16          *under the public health insurance option.*

17          (b) *ESTABLISHMENT OF A PROVIDER NETWORK.*—

18                 (1) *IN GENERAL.*—*Health care providers (includ-*  
19                 *ing physicians and hospitals) participating in Medi-*  
20                 *care are participating providers in the public health*  
21                 *insurance option unless they opt out in a process es-*  
22                 *tablished by the Secretary consistent with this sub-*  
23                 *section.*

24                 (2) *REQUIREMENTS FOR OPT-OUT PROCESS.*—  
25                 *Under the process established under paragraph (1)—*

1           (A) providers described in such subpara-  
2 graph shall be provided at least a 1-year period  
3 prior to the first day of Y1 to opt out of partici-  
4 pating in the public health insurance option;

5           (B) no provider shall be subject to a penalty  
6 for not participating in the public health insur-  
7 ance option;

8           (C) the Secretary shall include information  
9 on how providers participating in Medicare who  
10 chose to opt out of participating in the public  
11 health insurance option may opt back in; and

12           (D) there shall be an annual enrollment pe-  
13 riod in which providers may decide whether to  
14 participate in the public health insurance op-  
15 tion.

16           (3) RULEMAKING.—Not later than 18 months be-  
17 fore the first day of Y1, the Secretary shall promul-  
18 gate rules (pursuant to notice and comment) for the  
19 process described in paragraph (1).

20           (c) LIMITATIONS ON REVIEW.—There shall be no ad-  
21 ministrative or judicial review of a payment rate or meth-  
22 odology established under this section or under section 224.

1 **SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIV-**  
2 **ERY SYSTEM REFORM.**

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

13 (b) *REQUIREMENTS FOR INNOVATIVE PAYMENTS.*—The  
14 Secretary shall design and implement the payment mecha-  
15 nisms and policies under this section in a manner that—

16 (1) seeks to—

17 (A) improve health outcomes;

18 (B) reduce health disparities (including ra-  
19 cial, ethnic, and other disparities);

20 (C) provide efficient and affordable care;

21 (D) address geographic variation in the  
22 provision of health services; or

23 (E) prevent or manage chronic illness; and

24 (2) promotes care that is integrated, patient-cen-  
25 tered, quality, and efficient.



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

7           (d) *PROMOTION OF DELIVERY SYSTEM REFORM.—The*  
8 *Secretary shall monitor and evaluate the progress of pay-*  
9 *ment and delivery system reforms under this section and*  
10 *shall seek to implement such reforms subject to the fol-*  
11 *lowing:*

12                 (1) *To the extent that the Secretary finds a pay-*  
13 *ment and delivery system reform successful in im-*  
14 *proving quality and reducing costs, the Secretary*  
15 *shall implement such reform on as large a geographic*  
16 *scale as practical and economical.*

17                 (2) *The Secretary may delay the implementation*  
18 *of such a reform in geographic areas in which such*  
19 *implementation would place the public health insur-*  
20 *ance option at a competitive disadvantage.*

21                 (3) *The Secretary may prioritize implementation*  
22 *of such a reform in high cost geographic areas or oth-*  
23 *erwise in order to reduce total program costs or to*  
24 *promote high value care.*

1       (e) *NON-UNIFORMITY PERMITTED.*—*Nothing in this*  
2 *subtitle shall prevent the Secretary from varying payments*  
3 *based on different payment structure models (such as ac-*  
4 *countable care organizations and medical homes) under the*  
5 *public health insurance option for different geographic*  
6 *areas.*

7 **SEC. 225. PROVIDER PARTICIPATION.**

8       (a) *IN GENERAL.*—*The Secretary shall establish condi-*  
9 *tions of participation for health care providers under the*  
10 *public health insurance option.*

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

15       (c) *PAYMENT TERMS FOR PROVIDERS.*—*The Secretary*  
16 *shall establish terms and conditions for the participation*  
17 *(on an annual or other basis specified by the Secretary)*  
18 *of physicians and other health care providers under the*  
19 *public health insurance option, for which payment may be*  
20 *made for services furnished during the year.*

21       (d) *EXCLUSION OF CERTAIN PROVIDERS.*—*The Sec-*  
22 *retary shall exclude from participation under the public*  
23 *health insurance option a health care provider that is ex-*  
24 *cluded from participation in a Federal health care program*  
25 *(as defined in section 1128B(f) of the Social Security Act).*

1 **SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.**

2 *Provisions of law (other than criminal law provisions)*  
3 *identified by the Secretary by regulation, in consultation*  
4 *with the Inspector General of the Department of Health and*  
5 *Human Services, that impose sanctions with respect to*  
6 *waste, fraud, and abuse under Medicare, such as the False*  
7 *Claims Act (31 U.S.C. 3729 et seq.), shall also apply to*  
8 *the public health insurance option.*

9 **SEC. 227. APPLICATION OF HIPAA INSURANCE REQUIRE-**  
10 **MENTS.**

11 *The requirements of sections 2701 through 2792 of the*  
12 *Public Health Service Act shall apply to the public health*  
13 *insurance option in the same manner as they apply to*  
14 *health insurance coverage offered by a health insurance*  
15 *issuer in the individual market.*

16 **SEC. 228. APPLICATION OF HEALTH INFORMATION PRI-**  
17 **VACY, SECURITY, AND ELECTRONIC TRANS-**  
18 **ACTION REQUIREMENTS.**

19 *Part C of title XI of the Social Security Act, relating*  
20 *to standards for protections against the wrongful disclosure*  
21 *of individually identifiable health information, health in-*  
22 *formation security, and the electronic exchange of health*  
23 *care information, shall apply to the public health insurance*  
24 *option in the same manner as such part applies to other*  
25 *health plans (as defined in section 1171(5) of such Act).*

1 **SEC. 229. ENROLLMENT IN PUBLIC HEALTH INSURANCE OP-**  
2 **TION IS VOLUNTARY.**

3 *Nothing in this division shall be construed as requir-*  
4 *ing anyone to enroll in the public health insurance option.*  
5 *Enrollment in such option is voluntary.*

6 ***Subtitle C—Individual***  
7 ***Affordability Credits***

8 **SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EX-**  
9 **CHANGE.**

10 *(a) IN GENERAL.—Subject to the succeeding provisions*  
11 *of this subtitle, in the case of an affordable credit eligible*  
12 *individual enrolled in an Exchange-participating health*  
13 *benefits plan—*

14 *(1) the individual shall be eligible for, in accord-*  
15 *ance with this subtitle, affordability credits consisting*  
16 *of—*

17 *(A) an affordability premium credit under*  
18 *section 243 to be applied against the premium*  
19 *for the Exchange-participating health benefits*  
20 *plan in which the individual is enrolled; and*

21 *(B) an affordability cost-sharing credit*  
22 *under section 244 to be applied as a reduction*  
23 *of the cost-sharing otherwise applicable to such*  
24 *plan; and*

25 *(2) the Commissioner shall pay the QHBP offer-*  
26 *ing entity that offers such plan from the Health In-*

1        *urance Exchange Trust Fund the aggregate amount*  
2        *of affordability credits for all affordable credit eligible*  
3        *individuals enrolled in such plan.*

4        *(b) APPLICATION.—*

5            *(1) IN GENERAL.—An Exchange eligible indi-*  
6        *vidual may apply to the Commissioner through the*  
7        *Health Insurance Exchange or through another entity*  
8        *under an arrangement made with the Commissioner,*  
9        *in a form and manner specified by the Commissioner.*  
10        *The Commissioner through the Health Insurance Ex-*  
11        *change or through another public entity under an ar-*  
12        *rangement made with the Commissioner shall make a*  
13        *determination as to eligibility of an individual for af-*  
14        *fordability credits under this subtitle. The Commis-*  
15        *sioner shall establish a process whereby, on the basis*  
16        *of information otherwise available, individuals may*  
17        *be deemed to be affordable credit eligible individuals.*  
18        *In carrying this subtitle, the Commissioner shall es-*  
19        *tablish effective methods that ensure that individuals*  
20        *with limited English proficiency are able to apply for*  
21        *affordability credits.*

22            *(2) USE OF STATE MEDICAID AGENCIES.—If the*  
23        *Commissioner determines that a State Medicaid agen-*  
24        *cy has the capacity to make a determination of eligi-*  
25        *bility for affordability credits under this subtitle and*

1        *under the same standards as used by the Commis-*  
2        *sioner, under the Medicaid memorandum of under-*  
3        *standing (as defined in section 205(c)(4))—*

4                *(A) the State Medicaid agency is authorized*  
5                *to conduct such determinations for any Ex-*  
6                *change-eligible individual who requests such a*  
7                *determination; and*

8                *(B) the Commissioner shall reimburse the*  
9                *State Medicaid agency for the costs of conducting*  
10               *such determinations.*

11               *(3) MEDICAID SCREEN AND ENROLL OBLIGA-*  
12               *TION.—In the case of an application made under*  
13               *paragraph (1), there shall be a determination of*  
14               *whether the individual is a Medicaid-eligible indi-*  
15               *vidual. If the individual is determined to be so eligi-*  
16               *ble, the Commissioner, through the Medicaid memo-*  
17               *randum of understanding, shall provide for the enroll-*  
18               *ment of the individual under the State Medicaid plan*  
19               *in accordance with the Medicaid memorandum of un-*  
20               *derstanding. In the case of such an enrollment, the*  
21               *State shall provide for the same periodic redetermina-*  
22               *tion of eligibility under Medicaid as would otherwise*  
23               *apply if the individual had directly applied for med-*  
24               *ical assistance to the State Medicaid agency.*

25               *(c) USE OF AFFORDABILITY CREDITS.—*

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

4           (2) *FLEXIBILITY IN PLAN ENROLLMENT AUTHOR-*  
5 *IZED.*—*Beginning with Y3, the Commissioner shall*  
6 *establish a process to allow an affordability credit to*  
7 *be used for enrollees in enhanced or premium plans.*  
8 *In the case of an affordable credit eligible individual*  
9 *who enrolls in an enhanced or premium plan, the in-*  
10 *dividual shall be responsible for any difference be-*  
11 *tween the premium for such plan and the affordable*  
12 *credit amount otherwise applicable if the individual*  
13 *had enrolled in a basic plan.*

14           (3) *PROHIBITION OF USE OF PUBLIC FUNDS FOR*  
15 *ABORTION COVERAGE.*—*An affordability credit may*  
16 *not be used for payment for services described in sec-*  
17 *tion 122(d)(4)(A).*

18           (d) *ACCESS TO DATA.*—*In carrying out this subtitle,*  
19 *the Commissioner shall request from the Secretary of the*  
20 *Treasury consistent with section 6103 of the Internal Rev-*  
21 *enue Code of 1986 such information as may be required*  
22 *to carry out this subtitle.*

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

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

2 (a) *DEFINITION.*—

3 (1) *IN GENERAL.*—*For purposes of this division,*  
4 *the term “affordable credit eligible individual” means,*  
5 *subject to subsection (b), an individual who is law-*  
6 *fully present in a State in the United States (other*  
7 *than as a nonimmigrant described in a subparagraph*  
8 *(excluding subparagraphs (K), (T), (U), and (V)) of*  
9 *section 101(a)(15) of the Immigration and Nation-*  
10 *ality Act)—*

11 (A) *who is enrolled under an Exchange-par-*  
12 *ticipating health benefits plan and is not en-*  
13 *rolled under such plan as an employee (or de-*  
14 *pendent of an employee) through an employer*  
15 *qualified health benefits plan that meets the re-*  
16 *quirements of section 312;*

17 (B) *with family income below 400 percent*  
18 *of the Federal poverty level for a family of the*  
19 *size involved; and*

20 (C) *who is not a Medicaid eligible indi-*  
21 *vidual, other than an individual described in*  
22 *section 202(d)(3) or an individual during a*  
23 *transition period under section 202(d)(4)(B)(i).*

24 (2) *TREATMENT OF FAMILY.*—*Except as the*  
25 *Commissioner may otherwise provide, members of the*  
26 *same family who are affordable credit eligible indi-*



1        *viduals shall be treated as a single affordable credit*  
 2        *individual eligible for the applicable credit for such a*  
 3        *family under this subtitle.*

4            (3) *EQUAL TREATMENT OF CERTAIN EMPLOYED*  
 5        *INDIVIDUALS.—*

6            (A) *IN GENERAL.—For purposes of apply-*  
 7        *ing this section with respect to an individual*  
 8        *who is an employee of an employer that has an*  
 9        *annual payroll (for the preceding calendar year)*  
 10       *which does not exceed \$750,000 and that makes*  
 11       *the contribution which would be required under*  
 12       *section 313(a) if the table specified in subpara-*  
 13       *graph (B) were substituted for the table specified*  
 14       *in section 313(b)(1) (and if, in applying section*  
 15       *313(b)(2), \$750,000 were substituted for*  
 16       *\$400,000), such individual shall be treated in the*  
 17       *same manner as an employee of an employer*  
 18       *that makes the contribution described in section*  
 19       *313(a) (without regard to this paragraph).*

20            (B) *TABLE.—The table specified in this sub-*  
 21        *paragraph is the following:*

<b><i>If the annual payroll of such employer for the preceding calendar year:</i></b>	<b><i>The applicable percentage is:</i></b>
<i>Does not exceed \$500,000 .....</i>	<i>0 percent</i>
<i>Exceeds \$500,000, but does not exceed \$585,000 .....</i>	<i>2 percent</i>
<i>Exceeds \$585,000, but does not exceed \$670,000 .....</i>	<i>4 percent</i>
<i>Exceeds \$670,000, but does not exceed \$750,000 .....</i>	<i>6 percent</i>

1           (b) *LIMITATIONS ON EMPLOYEE AND DEPENDENT DIS-*  
2 *QUALIFICATION.*—

3           (1) *IN GENERAL.*—Subject to paragraph (2), the  
4 term “affordable credit eligible individual” does not  
5 include a full-time employee of an employer if the em-  
6 ployer offers the employee coverage (for the employee  
7 and dependents) as a full-time employee under a  
8 group health plan if the coverage and employer con-  
9 tribution under the plan meet the requirements of sec-  
10 tion 312.

11           (2) *EXCEPTIONS.*—

12           (A) *FOR CERTAIN FAMILY CIR-*  
13 *CUMSTANCES.*—The Commissioner shall establish  
14 such exceptions and special rules in the case de-  
15 scribed in paragraph (1) as may be appropriate  
16 in the case of a divorced or separated individual  
17 or such a dependent of an employee who would  
18 otherwise be an affordable credit eligible indi-  
19 vidual.

20           (B) *FOR UNAFFORDABLE EMPLOYER COV-*  
21 *ERAGE.*—Beginning in Y2, in the case of full-  
22 time employees for which the cost of the employee  
23 premium for coverage under a group health plan  
24 would exceed 12 percent of current family in-  
25 come (determined by the Commissioner on the

1           *basis of verifiable documentation and without re-*  
2           *gard to section 245), paragraph (1) shall not*  
3           *apply.*

4           *(c) INCOME DEFINED.—*

5           *(1) IN GENERAL.—In this title, the term “in-*  
6           *come” means modified adjusted gross income (as de-*  
7           *finied in section 59B of the Internal Revenue Code of*  
8           *1986).*

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

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

22          **SEC. 243. AFFORDABLE PREMIUM CREDIT.**

23          *(a) IN GENERAL.—The affordability premium credit*  
24          *under this section for an affordable credit eligible indi-*  
25          *vidual enrolled in an Exchange-participating health bene-*

1 *fits plan is in an amount equal to the amount (if any)*  
2 *by which the premium for the plan (or, if less, the reference*  
3 *premium amount specified in subsection (c)), exceeds the*  
4 *affordable premium amount specified in subsection (b) for*  
5 *the individual.*

6 *(b) AFFORDABLE PREMIUM AMOUNT.—*

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

11 *(A) the premium percentage limit specified*  
12 *in paragraph (2) for the individual based upon*  
13 *the individual's family income for the plan year;*  
14 *and*

15 *(B) the individual's family income for such*  
16 *plan year.*

17 *(2) PREMIUM PERCENTAGE LIMITS BASED ON*  
18 *TABLE.—The Commissioner shall establish premium*  
19 *percentage limits so that for individuals whose family*  
20 *income is within an income tier specified in the table*  
21 *in subsection (d) such percentage limits shall increase,*  
22 *on a sliding scale in a linear manner, from the ini-*  
23 *tial premium percentage to the final premium per-*  
24 *centage specified in such table for such income tier.*

1           (c) *REFERENCE PREMIUM AMOUNT.*—*The reference*  
 2 *premium amount specified in this subsection for a plan*  
 3 *year for an individual in a premium rating area is equal*  
 4 *to the average premium for the 3 basic plans in the area*  
 5 *for the plan year with the lowest premium levels. In com-*  
 6 *puting such amount the Commissioner may exclude plans*  
 7 *with extremely limited enrollments.*

8           (d) *TABLE OF PREMIUM PERCENTAGE LIMITS AND AC-*  
 9 *TUARIAL VALUE PERCENTAGES BASED ON INCOME TIER.*—

10           (1) *IN GENERAL.*—*For purposes of this subtitle,*  
 11 *subject to paragraphs (3) and (4), the table specified*  
 12 *in this subsection is as follows:*

<i>In the case of family in-</i> <i>come (expressed as a per-</i> <i>cent of FPL) within the</i> <i>following income tier:</i>	<i>The initial pre-</i> <i>mium percent-</i> <i>age is—</i>	<i>The final pre-</i> <i>mium percent-</i> <i>age is—</i>	<i>The actuarial</i> <i>value percentage</i> <i>is—</i>
<i>133% through 150%</i>	<i>1.5%</i>	<i>3.0%</i>	<i>97%</i>
<i>150% through 200%</i>	<i>3.0%</i>	<i>5.5%</i>	<i>93%</i>
<i>200% through 250%</i>	<i>5.5%</i>	<i>8%</i>	<i>85%</i>
<i>250% through 300%</i>	<i>8%</i>	<i>10%</i>	<i>78%</i>
<i>300% through 350%</i>	<i>10%</i>	<i>11%</i>	<i>72%</i>
<i>350% through 400%</i>	<i>11%</i>	<i>12%</i>	<i>70%</i>

13           (2) *SPECIAL RULES.*—*For purposes of applying*  
 14 *the table under paragraph (1)—*

15           (A) *FOR LOWEST LEVEL OF INCOME.*—*In*  
 16 *the case of an individual with income that does*  
 17 *not exceed 133 percent of FPL, the individual*  
 18 *shall be considered to have income that is 133%*  
 19 *of FPL.*

1                   (B) *APPLICATION OF HIGHER ACTUARIAL*  
2                   *VALUE PERCENTAGE AT TIER TRANSITION*  
3                   *POINTS.—If two actuarial value percentages may*  
4                   *be determined with respect to an individual, the*  
5                   *actuarial value percentage shall be the higher of*  
6                   *such percentages.*

7                   (3) *INDEXING.—For years after Y1, the Commis-*  
8                   *sioner shall adjust the initial and final premium per-*  
9                   *centages to maintain the ratio of governmental to en-*  
10                   *rollee shares of premiums over time, for each income*  
11                   *tier identified in the table in paragraph (1).*

12                   (4) *CONTINGENT ADJUSTMENT FOR ADDITIONAL*  
13                   *SAVINGS.—*

14                   (A) *IN GENERAL.—Before the beginning of*  
15                   *each year beginning with Y2—*

16                   (i) *the Chief Actuary of the Centers of*  
17                   *Medicare & Medicaid Services shall esti-*  
18                   *mate the amount of savings in the previous*  
19                   *year under this division resulting from the*  
20                   *application of the provisions described in*  
21                   *subparagraph (B) and shall report such es-*  
22                   *timate to the Commissioner; and*

23                   (ii) *the Commissioner, based upon such*  
24                   *estimate, shall provide for an appropriate*  
25                   *increase in the initial and final premium*

1                   percentages in the table specified in para-  
2                   graph (1) in a manner that is designed to  
3                   result in an increase in aggregate afford-  
4                   ability credits equivalent to the amount so  
5                   estimated.

6                   (B) *PROVISIONS DESCRIBED.*—The provi-  
7                   sions described in this subparagraph are as fol-  
8                   lows:

9                   (i) *FORMULARY UNDER PUBLIC OP-*  
10                  *TION.*—Section 223(a)(4).

11                  (ii) *PBM TRANSPARENCY.*—Section  
12                  133(d).

13                  (iii) *ACO IN MEDICAID.*—Section  
14                  1730.

15                  (iv) *ADMINISTRATIVE SIMPLIFICA-*  
16                  *TION.*—

17                               (I) *Section 1173A of the Social*  
18                               *Security Act, as added by section*  
19                               *163(a)(1).*

20                               (II) *Section 163(c).*

21                               (III) *Section 164.*

22                  (v) *LIMITATION ON PREMIUM IN-*  
23                  *CREASES IN EXCHANGE-PARTICIPATING*  
24                  *PLANS.*—Section 209.

1 (vi) *NEGOTIATION OF LOWER PART D*  
2 *DRUG PRICES.—Section 1186.*

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

4 (a) *IN GENERAL.—The affordability cost-sharing cred-*  
5 *it under this section for an affordable credit eligible indi-*  
6 *vidual enrolled in an Exchange-participating health bene-*  
7 *fits plan is in the form of the cost-sharing reduction de-*  
8 *scribed in subsection (b) provided under this section for the*  
9 *income tier in which the individual is classified based on*  
10 *the individual's family income.*

11 (b) *COST-SHARING REDUCTIONS.—The Commissioner*  
12 *shall specify a reduction in cost-sharing amounts and the*  
13 *annual limitation on cost-sharing specified in section*  
14 *122(c)(2)(B) under a basic plan for each income tier speci-*  
15 *fied in the table under section 243(d), with respect to a*  
16 *year, in a manner so that, as estimated by the Commis-*  
17 *sioner, the actuarial value of the coverage with such reduced*  
18 *cost-sharing amounts (and the reduced annual cost-sharing*  
19 *limit) is equal to the actuarial value percentage (specified*  
20 *in the table under section 243(d) for the income tier in-*  
21 *volved) of the full actuarial value if there were no cost-shar-*  
22 *ing imposed under the plan.*

23 (c) *DETERMINATION AND PAYMENT OF COST-SHARING*  
24 *AFFORDABILITY CREDIT.—In the case of an affordable cred-*  
25 *it eligible individual in a tier enrolled in an Exchange-*



1 *participating health benefits plan offered by a QHBP offer-*  
2 *ing entity, the Commissioner shall provide for payment to*  
3 *the offering entity of an amount equivalent to the increased*  
4 *actuarial value of the benefits under the plan provided*  
5 *under section 203(c)(2)(B) resulting from the reduction in*  
6 *cost-sharing described in subsection (b).*

7 **SEC. 245. INCOME DETERMINATIONS.**

8       *(a) IN GENERAL.—In applying this subtitle for an af-*  
9 *fordability credit for an individual for a plan year, the in-*  
10 *dividual's income shall be the income (as defined in section*  
11 *242(c)) for the individual for the most recent taxable year*  
12 *(as determined in accordance with rules of the Commis-*  
13 *sioner). The Federal poverty level applied shall be such level*  
14 *in effect as of the date of the application.*

15       *(b) PROGRAM INTEGRITY; INCOME VERIFICATION PRO-*  
16 *CEDURES.—*

17           *(1) PROGRAM INTEGRITY.—The Commissioner*  
18 *shall take such steps as may be appropriate to ensure*  
19 *the accuracy of determinations and redeterminations*  
20 *under this subtitle.*

21           *(2) INCOME VERIFICATION.—*

22           *(A) IN GENERAL.—Upon an initial appli-*  
23 *cation of an individual for an affordability cred-*  
24 *it under this subtitle (or in applying section*  
25 *242(b)) or upon an application for a change in*

1           *the affordability credit based upon a significant*  
2           *change in family income described in subpara-*  
3           *graph (A)—*

4                     *(i) the Commissioner shall request from*  
5                     *the Secretary of the Treasury the disclosure*  
6                     *to the Commissioner of such information as*  
7                     *may be permitted to verify the information*  
8                     *contained in such application; and*

9                     *(ii) the Commissioner shall use the in-*  
10                    *formation so disclosed to verify such infor-*  
11                    *mation.*

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

17            *(c) SPECIAL RULES.—*

18                    *(1) CHANGES IN INCOME AS A PERCENT OF*  
19                    *FPL.—In the case that an individual's income (ex-*  
20                    *pressed as a percentage of the Federal poverty level*  
21                    *for a family of the size involved) for a plan year is*  
22                    *expected (in a manner specified by the Commissioner)*  
23                    *to be significantly different from the income (as so ex-*  
24                    *pressed) used under subsection (a), the Commissioner*  
25                    *shall establish rules requiring an individual to report,*

1 consistent with the mechanism established under  
2 paragraph (2), significant changes in such income  
3 (including a significant change in family composi-  
4 tion) to the Commissioner and requiring the substi-  
5 tution of such income for the income otherwise appli-  
6 cable.

7 (2) *REPORTING OF SIGNIFICANT CHANGES IN IN-*  
8 *COME.*—The Commissioner shall establish rules under  
9 which an individual determined to be an affordable  
10 credit eligible individual would be required to inform  
11 the Commissioner when there is a significant change  
12 in the family income of the individual (expressed as  
13 a percentage of the FPL for a family of the size in-  
14 volved) and of the information regarding such change.  
15 Such mechanism shall provide for guidelines that  
16 specify the circumstances that qualify as a significant  
17 change, the verifiable information required to docu-  
18 ment such a change, and the process for submission  
19 of such information. If the Commissioner receives new  
20 information from an individual regarding the family  
21 income of the individual, the Commissioner shall pro-  
22 vide for a redetermination of the individual's eligi-  
23 bility to be an affordable credit eligible individual.

24 (3) *TRANSITION FOR CHIP.*—In the case of a  
25 child described in section 205(d)(2), the Commissioner

1       *shall establish rules under which the family income of*  
2       *the child is deemed to be no greater than the family*  
3       *income of the child as most recently determined before*  
4       *Y1 by the State under title XXI of the Social Security*  
5       *Act.*

6               (4) *STUDY OF GEOGRAPHIC VARIATION IN APPLI-*  
7       *CATION OF FPL.—*

8               (A) *IN GENERAL.—The Commissioner shall*  
9       *examine the feasibility and implication of ad-*  
10       *justing the application of the Federal poverty*  
11       *level under this subtitle for different geographic*  
12       *areas so as to reflect the variations in cost-of-liv-*  
13       *ing among different areas within the United*  
14       *States. If the Commissioner determines that an*  
15       *adjustment is feasible, the study should include*  
16       *a methodology to make such an adjustment. Not*  
17       *later than the first day of Y2, the Commissioner*  
18       *shall submit to Congress a report on such study*  
19       *and shall include such recommendations as the*  
20       *Commissioner determines appropriate.*

21               (B) *INCLUSION OF TERRITORIES.—*

22               (i) *IN GENERAL.—The Commissioner*  
23       *shall ensure that the study under subpara-*  
24       *graph (A) covers the territories of the*  
25       *United States and that special attention is*

1           *paid to the disparity that exists among pov-*  
2           *erty levels and the cost of living in such ter-*  
3           *ritories and to the impact of such disparity*  
4           *on efforts to expand health coverage and en-*  
5           *sure health care.*

6           (ii) *TERRITORIES DEFINED.*—*In this*  
7           *subparagraph, the term “territories of the*  
8           *United States” includes the Commonwealth*  
9           *of Puerto Rico, the United States Virgin Is-*  
10          *lands, Guam, the Northern Mariana Is-*  
11          *lands, and any other territory or possession*  
12          *of the United States.*

13          (d) *PENALTIES FOR MISREPRESENTATION.*—*In the*  
14          *case of an individual intentionally misrepresents family in-*  
15          *come or the individual fails (without regard to intent) to*  
16          *disclose to the Commissioner a significant change in family*  
17          *income under subsection (c) in a manner that results in*  
18          *the individual becoming an affordable credit eligible indi-*  
19          *vidual when the individual is not or in the amount of the*  
20          *affordability credit exceeding the correct amount—*

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

23                 (2) *in the case of such an intentional misrepre-*  
24                 *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                    **Subtitle D—Health Insurance**  
9                    **Cooperatives**

10        **SEC. 251. ESTABLISHMENT.**

11        *Not later than 6 months after the date of the enactment*  
12        *of this Act, the Commissioner, in consultation with the Sec-*  
13        *retary of the Treasury, shall establish a Consumer Operated*  
14        *and Oriented Plan program (in this subtitle referred to as*  
15        *the “CO–OP program”) under which the Commissioner*  
16        *may make grants and loans for the establishment and ini-*  
17        *tial operation of not-for-profit, member–run health insur-*  
18        *ance cooperatives (in this subtitle individually referred to*  
19        *as a “cooperative”) that provide insurance through the*  
20        *Health Insurance Exchange or a State-based Health Insur-*  
21        *ance Exchange under section 208. Nothing in this subtitle*  
22        *shall be construed as requiring a State to establish such a*  
23        *cooperative.*

1 **SEC. 252. START-UP AND SOLVENCY GRANTS AND LOANS.**

2 (a) *IN GENERAL.*—Not later than 36 months after the  
3 date of the enactment of this Act, the Commissioner, acting  
4 through the CO-OP program, may make—

5 (1) *loans (of such period and with such terms as*  
6 *the Secretary may specify) to cooperatives to assist*  
7 *such cooperatives with start-up costs; and*

8 (2) *grants to cooperatives to assist such coopera-*  
9 *tives in meeting State solvency requirements in the*  
10 *States in which such cooperative offers or issues in-*  
11 *surance coverage.*

12 (b) *CONDITIONS.*—A grant or loan may not be award-  
13 ed under this section with respect to a cooperative unless  
14 the following conditions are met:

15 (1) *The cooperative is structured as a not-for-*  
16 *profit, member organization under the law of each*  
17 *State in which such cooperative offers, intends to*  
18 *offer, or issues insurance coverage, with the member-*  
19 *ship of the cooperative being made up entirely of*  
20 *beneficiaries of the insurance coverage offered by such*  
21 *cooperative.*

22 (2) *The cooperative did not offer insurance on or*  
23 *before July 16, 2009, and the cooperatives is not an*  
24 *affiliate or successor to an insurance company offer-*  
25 *ing insurance on or before such date.*

1           (3) *The governing documents of the cooperatives*  
2 *incorporate ethical and conflict of interest standards*  
3 *designed to protect against insurance industry in-*  
4 *volvement and interference in the governance of the*  
5 *cooperative.*

6           (4) *The cooperative is not sponsored by a State*  
7 *government.*

8           (5) *Substantially all of the activities of the coop-*  
9 *erative consist of the issuance of qualified health ben-*  
10 *efit plans through the Health Insurance Exchange or*  
11 *a State-based health insurance exchange.*

12           (6) *The cooperative is licenced to offer insurance*  
13 *in each State in which it offers insurance.*

14           (7) *The governance of the cooperative must be*  
15 *subject to a majority vote of its members.*

16           (8) *As provided in guidance issued by the Sec-*  
17 *retary of Health and Human Services, the cooperative*  
18 *operates with a strong consumer focus, including*  
19 *timeliness, responsiveness, and accountability to*  
20 *members.*

21           (9) *Any profits made by the cooperative are used*  
22 *to lower premiums, improve benefits, or to otherwise*  
23 *improve the quality of health care delivered to mem-*  
24 *bers.*



1           (c) *PRIORITY.*—*The Commissioner, in making grants*  
2 *and loans under this section, shall give priority to coopera-*  
3 *tives that—*

4                   (1) *operate on a Statewide basis;*

5                   (2) *use an integrated delivery system; or*

6                   (3) *have a significant level of financial support*  
7 *from non-governmental sources.*

8           (d) *RULES OF CONSTRUCTION.*—*Nothing in this sub-*  
9 *title shall be construed to prevent a cooperative established*  
10 *in one State from integrating with a cooperative established*  
11 *in another State the administration, issuance of coverage,*  
12 *or other activities related to acting as a QHBP offering en-*  
13 *tity. Nothing in this subtitle shall be construed as pre-*  
14 *venting State governments from taking actions to permit*  
15 *such integration.*

16           (e) *REPAYMENT FOR VIOLATIONS OF TERMS OF PRO-*  
17 *GRAM.*—*If a cooperative violates the terms of the CO-OP*  
18 *program and fails to correct the violation within a reason-*  
19 *able period of time, as determined by the Commissioner,*  
20 *the cooperative shall repay the total amount of any loan*  
21 *or grant received by such cooperative under this section,*  
22 *plus interest (at a rate determined by the Secretary).*

23           (f) *AUTHORIZATION OF APPROPRIATIONS.*—*There are*  
24 *authorized to be appropriated \$5,000,000,000 for the period*

1 of fiscal years 2010 through 2014 to provide for grants and  
2 loans under this section.

3 **SEC. 253. DEFINITIONS.**

4 *For purposes of this subtitle:*

5 (1) *STATE.*—The term “State” means each of the  
6 50 States and the District of Columbia.

7 (2) *MEMBER.*—The term “member”, with respect  
8 to a cooperative, means an individual who, after the  
9 cooperative offers health insurance coverage, is en-  
10 rolled in such coverage.

11 **TITLE III—SHARED**  
12 **RESPONSIBILITY**  
13 **Subtitle A—Individual**  
14 **Responsibility**

15 **SEC. 301. INDIVIDUAL RESPONSIBILITY.**

16 *For an individual’s responsibility to obtain acceptable*  
17 *coverage, see section 59B of the Internal Revenue Code of*  
18 *1986 (as added by section 401 of this Act).*

19 **Subtitle B—Employer Responsibility**

20 **PART 1—HEALTH COVERAGE PARTICIPATION**  
21 **REQUIREMENTS**

22 **SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIRE-**  
23 **MENTS.**

24 *An employer meets the requirements of this section if*  
25 *such employer does all of the following:*

1           (1) *OFFER OF COVERAGE.*—*The employer offers*  
2 *each employee individual and family coverage under*  
3 *a qualified health benefits plan (or under a current*  
4 *employment-based health plan (within the meaning of*  
5 *section 102(b))) in accordance with section 312.*

6           (2) *CONTRIBUTION TOWARDS COVERAGE.*—*If an*  
7 *employee accepts such offer of coverage, the employer*  
8 *makes timely contributions towards such coverage in*  
9 *accordance with section 312.*

10          (3) *CONTRIBUTION IN LIEU OF COVERAGE.*—*Be-*  
11 *ginning with Y2, if an employee declines such offer*  
12 *but otherwise obtains coverage in an Exchange-par-*  
13 *ticipating health benefits plan (other than by reason*  
14 *of being covered by family coverage as a spouse or de-*  
15 *pendent of the primary insured), the employer shall*  
16 *make a timely contribution to the Health Insurance*  
17 *Exchange with respect to each such employee in ac-*  
18 *cordance with section 313.*

19 **SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TO-**  
20 **WARDS EMPLOYEE AND DEPENDENT COV-**  
21 **ERAGE.**

22          (a) *IN GENERAL.*—*An employer meets the require-*  
23 *ments of this section with respect to an employee if the fol-*  
24 *lowing requirements are met:*

1           (1) *OFFERING OF COVERAGE.*—*The employer of-*  
2           *fers the coverage described in section 311(1) either*  
3           *through an Exchange-participating health benefits*  
4           *plan or other than through such a plan.*

5           (2) *EMPLOYER REQUIRED CONTRIBUTION.*—*The*  
6           *employer timely pays to the issuer of such coverage*  
7           *an amount not less than the employer required con-*  
8           *tribution specified in subsection (b) for such coverage.*

9           (3) *PROVISION OF INFORMATION.*—*The employer*  
10          *provides the Health Choices Commissioner, the Sec-*  
11          *retary of Labor, the Secretary of Health and Human*  
12          *Services, and the Secretary of the Treasury, as appli-*  
13          *cable, with such information as the Commissioner*  
14          *may require to ascertain compliance with the require-*  
15          *ments of this section.*

16          (4) *AUTOENROLLMENT OF EMPLOYEES.*—*The*  
17          *employer provides for autoenrollment of the employee*  
18          *in accordance with subsection (c).*

19          (b) *REDUCTION OF EMPLOYEE PREMIUMS THROUGH*  
20 *MINIMUM EMPLOYER CONTRIBUTION.*—

21               (1) *FULL-TIME EMPLOYEES.*—*The minimum em-*  
22               *ployer contribution described in this subsection for*  
23               *coverage of a full-time employee (and, if any, the em-*  
24               *ployee's spouse and qualifying children (as defined in*  
25               *section 152(c) of the Internal Revenue Code of 1986)*

1 under a qualified health benefits plan (or current em-  
2 ployment-based health plan) is equal to—

3 (A) in case of individual coverage, not less  
4 than 72.5 percent of the applicable premium (as  
5 defined in section 4980B(f)(4) of such Code, sub-  
6 ject to paragraph (2)) of the lowest cost plan of-  
7 fered by the employer that is a qualified health  
8 benefits plan (or is such current employment-  
9 based health plan); and

10 (B) in the case of family coverage which in-  
11 cludes coverage of such spouse and children, not  
12 less 65 percent of such applicable premium of  
13 such lowest cost plan.

14 (2) *APPLICABLE PREMIUM FOR EXCHANGE COV-*  
15 *ERAGE.*—*In this subtitle, the amount of the applicable*  
16 *premium of the lowest cost plan with respect to cov-*  
17 *erage of an employee under an Exchange-partici-*  
18 *parting health benefits plan is the reference premium*  
19 *amount under section 243(c) for individual coverage*  
20 *(or, if elected, family coverage) for the premium rat-*  
21 *ing area in which the individual or family resides.*

22 (3) *MINIMUM EMPLOYER CONTRIBUTION FOR EM-*  
23 *PLOYEES OTHER THAN FULL-TIME EMPLOYEES.*—*In*  
24 *the case of coverage for an employee who is not a full-*  
25 *time employee, the amount of the minimum employer*

1        *contribution under this subsection shall be a propor-*  
2        *tion (as determined in accordance with rules of the*  
3        *Health Choices Commissioner, the Secretary of Labor,*  
4        *the Secretary of Health and Human Services, and the*  
5        *Secretary of the Treasury, as applicable) of the min-*  
6        *imum employer contribution under this subsection*  
7        *with respect to a full-time employee that reflects the*  
8        *proportion of—*

9                    *(A) the average weekly hours of employment*  
10                  *of the employee by the employer, to*

11                   *(B) the minimum weekly hours specified by*  
12                  *the Commissioner for an employee to be a full-*  
13                  *time employee.*

14                  *(4) SALARY REDUCTIONS NOT TREATED AS EM-*  
15                  *PLOYER CONTRIBUTIONS.—For purposes of this sec-*  
16                  *tion, any contribution on behalf of an employee with*  
17                  *respect to which there is a corresponding reduction in*  
18                  *the compensation of the employee shall not be treated*  
19                  *as an amount paid by the employer.*

20                  *(c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPON-*  
21                  *SORED HEALTH BENEFITS.—*

22                   *(1) IN GENERAL.—The requirement of this sub-*  
23                  *section with respect to an employer and an employee*  
24                  *is that the employer automatically enroll such em-*  
25                  *ployee into the employment-based health benefits plan*

1     *for individual coverage under the plan option with*  
2     *the lowest applicable employee premium.*

3           (2) *OPT-OUT.*—*In no case may an employer*  
4     *automatically enroll an employee in a plan under*  
5     *paragraph (1) if such employee makes an affirmative*  
6     *election to opt out of such plan or to elect coverage*  
7     *under an employment-based health benefits plan of-*  
8     *fered by such employer. An employer shall provide an*  
9     *employee with a 30-day period to make such an af-*  
10    *firmative election before the employer may automati-*  
11    *cally enroll the employee in such a plan.*

12           (3) *NOTICE REQUIREMENTS.*—

13           (A) *IN GENERAL.*—*Each employer described*  
14    *in paragraph (1) who automatically enrolls an*  
15    *employee into a plan as described in such para-*  
16    *graph shall provide the employees, within a rea-*  
17    *sonable period before the beginning of each plan*  
18    *year (or, in the case of new employees, within a*  
19    *reasonable period before the end of the enrollment*  
20    *period for such a new employee), written notice*  
21    *of the employees' rights and obligations relating*  
22    *to the automatic enrollment requirement under*  
23    *such paragraph. Such notice must be comprehen-*  
24    *sive and understood by the average employee to*

1           whom the automatic enrollment requirement ap-  
2           plies.

3                   (B) *INCLUSION OF SPECIFIC INFORMA-*  
4           *TION.—The written notice under subparagraph*  
5           *(A) must explain an employee’s right to opt out*  
6           *of being automatically enrolled in a plan and in*  
7           *the case that more than one level of benefits or*  
8           *employee premium level is offered by the em-*  
9           *ployer involved, the notice must explain which*  
10          *level of benefits and employee premium level the*  
11          *employee will be automatically enrolled in the*  
12          *absence of an affirmative election by the em-*  
13          *ployee.*

14 **SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COV-**  
15                   **ERAGE.**

16           (a) *IN GENERAL.—A contribution is made in accord-*  
17          *ance with this section with respect to an employee if such*  
18          *contribution is equal to an amount equal to 8 percent of*  
19          *the average wages paid by the employer during the period*  
20          *of enrollment (determined by taking into account all em-*  
21          *ployees of the employer and in such manner as the Commis-*  
22          *sioner provides, including rules providing for the appro-*  
23          *priate aggregation of related employers). Any such con-*  
24          *tribution—*



1           (1) shall be paid to the Health Choices Commis-  
2           sioner for deposit into the Health Insurance Exchange  
3           Trust Fund, and

4           (2) shall not be applied against the premium of  
5           the employee under the Exchange-participating health  
6           benefits plan in which the employee is enrolled.

7           (b) *SPECIAL RULES FOR SMALL EMPLOYERS.*—

8           (1) *IN GENERAL.*—In the case of any employer  
9           who is a small employer for any calendar year, sub-  
10          section (a) shall be applied by substituting the appli-  
11          cable percentage determined in accordance with the  
12          following table for “8 percent”:

<b><i>If the annual payroll of such employer for the preceding calendar year:</i></b>	<b><i>The applicable percentage is:</i></b>
<i>Does not exceed \$250,000 .....</i>	<i>0 percent</i>
<i>Exceeds \$250,000, but does not exceed \$300,000 .....</i>	<i>2 percent</i>
<i>Exceeds \$300,000, but does not exceed \$350,000 .....</i>	<i>4 percent</i>
<i>Exceeds \$350,000, but does not exceed \$400,000 .....</i>	<i>6 percent</i>

13          (2) *SMALL EMPLOYER.*—For purposes of this  
14          subsection, the term “small employer” means any em-  
15          ployer for any calendar year if the annual payroll of  
16          such employer for the preceding calendar year does  
17          not exceed \$400,000.

18          (3) *ANNUAL PAYROLL.*—For purposes of this  
19          paragraph, the term “annual payroll” means, with  
20          respect to any employer for any calendar year, the  
21          aggregate wages paid by the employer during such  
22          calendar year.

1           (4) *AGGREGATION RULES.*—*Related employers*  
2           *and predecessors shall be treated as a single employer*  
3           *for purposes of this subsection.*

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

5           *The Health Choices Commissioner (in coordination*  
6           *with the Secretary of Labor, the Secretary of Health and*  
7           *Human Services, and the Secretary of the Treasury) shall*  
8           *have authority to set standards for determining whether em-*  
9           *ployers or insurers are undertaking any actions to affect*  
10           *the risk pool within the Health Insurance Exchange by in-*  
11           *ducing individuals to decline coverage under a qualified*  
12           *health benefits plan (or current employment-based health*  
13           *plan (within the meaning of section 102(b)) offered by the*  
14           *employer and instead to enroll in an Exchange-partici-*  
15           *pating health benefits plan. An employer violating such*  
16           *standards shall be treated as not meeting the requirements*  
17           *of this section.*

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

19 **PARTICIPATION REQUIREMENTS**

20           ***【For sections 321 and 322, see text of bill as intro-***  
21           ***duced on July 14, 2009.】***

1 **SEC. 323. SATISFACTION OF HEALTH COVERAGE PARTICI-**  
2 **PATION REQUIREMENTS UNDER THE PUBLIC**  
3 **HEALTH SERVICE ACT.**

4 (a) *IN GENERAL.*—Part C of title XXVII of the Public  
5 Health Service Act is amended by adding at the end the  
6 following new section:

7 **“SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION**  
8 **REQUIREMENTS.**

9 “(a) *ELECTION OF EMPLOYER TO BE SUBJECT TO NA-*  
10 *TIONAL HEALTH COVERAGE PARTICIPATION REQUIRE-*  
11 *MENTS.*—

12 “(1) *IN GENERAL.*—An employer may make an  
13 election with the Secretary to be subject to the health  
14 coverage participation requirements.

15 “(2) *TIME AND MANNER.*—An election under  
16 paragraph (1) may be made at such time and in such  
17 form and manner as the Secretary may prescribe.

18 “(b) *TREATMENT OF COVERAGE RESULTING FROM*  
19 *ELECTION.*—

20 “(1) *IN GENERAL.*—If an employer makes an  
21 election to the Secretary under subsection (a)—

22 “(A) such election shall be treated as the es-  
23 tablishment and maintenance of a group health  
24 plan for purposes of this title, subject to section  
25 151 of the America’s Affordable Health Choices  
26 Act of 2009, and

1           “(B) the health coverage participation re-  
2           quirements shall be deemed to be included as  
3           terms and conditions of such plan.

4           “(2) *PERIODIC INVESTIGATIONS TO DETERMINE*  
5           *COMPLIANCE WITH HEALTH COVERAGE PARTICIPATION*  
6           *REQUIREMENTS.—The Secretary shall regularly audit*  
7           *a representative sampling of employers and conduct*  
8           *investigations and other activities with respect to*  
9           *such sampling of employers so as to discover non-*  
10           *compliance with the health coverage participation re-*  
11           *quirements in connection with such employers (dur-*  
12           *ing any period with respect to which an election*  
13           *under subsection (a) is in effect). The Secretary shall*  
14           *communicate findings of noncompliance made by the*  
15           *Secretary under this subsection to the Secretary of the*  
16           *Treasury and the Health Choices Commissioner. The*  
17           *Secretary shall take such timely enforcement action as*  
18           *appropriate to achieve compliance.*

19           “(c) *HEALTH COVERAGE PARTICIPATION REQUIRE-*  
20           *MENTS.—For purposes of this section, the term ‘health cov-*  
21           *erage participation requirements’ means the requirements*  
22           *of part 1 of subtitle B of title III of division A of the Amer-*  
23           *ica’s Affordable Health Choices Act of 2009 (as in effect on*  
24           *the date of the enactment of this section).*

1       “(d) *SEPARATE ELECTIONS.*—Under regulations pre-  
2 scribed by the Secretary, separate elections may be made  
3 under subsection (a) with respect to full-time employees and  
4 employees who are not full-time employees.

5       “(e) *TERMINATION OF ELECTION IN CASES OF SUB-*  
6 *STANTIAL NONCOMPLIANCE.*—The Secretary may terminate  
7 the election of any employer under subsection (a) if the Sec-  
8 retary (in coordination with the Health Choices Commis-  
9 sioner) determines that such employer is in substantial non-  
10 compliance with the health coverage participation require-  
11 ments and shall refer any such determination to the Sec-  
12 retary of the Treasury as appropriate.

13       “(f) *ENFORCEMENT OF HEALTH COVERAGE PARTICI-*  
14 *PATION REQUIREMENTS.*—

15               “(1) *CIVIL PENALTIES.*—In the case of any em-  
16 ployer who fails (during any period with respect to  
17 which the election under subsection (a) is in effect) to  
18 satisfy the health coverage participation requirements  
19 with respect to any employee, the Secretary may as-  
20 sess a civil penalty against the employer of \$100 for  
21 each day in the period beginning on the date such  
22 failure first occurs and ending on the date such fail-  
23 ure is corrected.

24               “(2) *LIMITATIONS ON AMOUNT OF PENALTY.*—

1           “(A) *PENALTY NOT TO APPLY WHERE FAIL-*  
2           *URE NOT DISCOVERED EXERCISING REASONABLE*  
3           *DILIGENCE.—No penalty shall be assessed under*  
4           *paragraph (1) with respect to any failure during*  
5           *any period for which it is established to the sat-*  
6           *isfaction of the Secretary that the employer did*  
7           *not know, or exercising reasonable diligence*  
8           *would not have known, that such failure existed.*

9           “(B) *PENALTY NOT TO APPLY TO FAILURES*  
10           *CORRECTED WITHIN 30 DAYS.—No penalty shall*  
11           *be assessed under paragraph (1) with respect to*  
12           *any failure if—*

13                   “(i) *such failure was due to reasonable*  
14                   *cause and not to willful neglect, and*

15                   “(ii) *such failure is corrected during*  
16                   *the 30-day period beginning on the 1st date*  
17                   *that the employer knew, or exercising rea-*  
18                   *sonable diligence would have known, that*  
19                   *such failure existed.*

20           “(C) *OVERALL LIMITATION FOR UNINTEN-*  
21           *TIONAL FAILURES.—In the case of failures which*  
22           *are due to reasonable cause and not to willful ne-*  
23           *glect, the penalty assessed under paragraph (1)*  
24           *for failures during any 1-year period shall not*  
25           *exceed the amount equal to the lesser of—*

1           “(i) 10 percent of the aggregate  
2           amount paid or incurred by the employer  
3           (or predecessor employer) during the pre-  
4           ceding taxable year for group health plans,  
5           or

6           “(ii) \$500,000.

7           “(3) *ADVANCE NOTIFICATION OF FAILURE PRIOR*  
8           *TO ASSESSMENT.*—*Before a reasonable time prior to*  
9           *the assessment of any penalty under paragraph (1)*  
10          *with respect to any failure by an employer, the Sec-*  
11          *retary shall inform the employer in writing of such*  
12          *failure and shall provide the employer information*  
13          *regarding efforts and procedures which may be under-*  
14          *taken by the employer to correct such failure.*

15          “(4) *ACTIONS TO ENFORCE ASSESSMENTS.*—*The*  
16          *Secretary may bring a civil action in any District*  
17          *Court of the United States to collect any civil penalty*  
18          *under this subsection.*

19          “(5) *COORDINATION WITH EXCISE TAX.*—*Under*  
20          *regulations prescribed in accordance with section 324*  
21          *of the America’s Affordable Health Choices Act of*  
22          *2009, the Secretary and the Secretary of the Treasury*  
23          *shall coordinate the assessment of penalties under*  
24          *paragraph (1) in connection with failures to satisfy*  
25          *health coverage participation requirements with the*

1 *imposition of excise taxes on such failures under sec-*  
2 *tion 4980H(b) of the Internal Revenue Code of 1986*  
3 *so as to avoid duplication of penalties with respect to*  
4 *such failures.*

5 “(6) *DEPOSIT OF PENALTY COLLECTED.*—*Any*  
6 *amount of penalty collected under this subsection*  
7 *shall be deposited as miscellaneous receipts in the*  
8 *Treasury of the United States.*

9 “(g) *REGULATIONS.*—*The Secretary may promulgate*  
10 *such regulations as may be necessary or appropriate to*  
11 *carry out the provisions of this section, in accordance with*  
12 *section 324(a) of the America’s Affordable Health Choices*  
13 *Act of 2009. The Secretary may promulgate any interim*  
14 *final rules as the Secretary determines are appropriate to*  
15 *carry out this section.”.*

16 (b) *EFFECTIVE DATE.*—*The amendments made by sub-*  
17 *section (a) shall apply to periods beginning after December*  
18 *31, 2012.*

19 **SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COV-**  
20 **ERAGE PARTICIPATION REQUIREMENTS.**

21 (a) *ASSURING COORDINATION.*—*The officers consisting*  
22 *of the Secretary of Labor, the Secretary of the Treasury,*  
23 *the Secretary of Health and Human Services, and the*  
24 *Health Choices Commissioner shall ensure, through the exe-*



1 *ction of an interagency memorandum of understanding*  
2 *among such officers, that—*

3           (1) *regulations, rulings, and interpretations*  
4 *issued by such officers relating to the same matter*  
5 *over which two or more of such officers have responsi-*  
6 *bility under subpart B of part 6 of subtitle B of title*  
7 *I of the Employee Retirement Income Security Act of*  
8 *1974, section 4980H of the Internal Revenue Code of*  
9 *1986, and section 2793 of the Public Health Service*  
10 *Act are administered so as to have the same effect at*  
11 *all times; and*

12           (2) *coordination of policies relating to enforcing*  
13 *the same requirements through such officers in order*  
14 *to have a coordinated enforcement strategy that*  
15 *avoids duplication of enforcement efforts and assigns*  
16 *priorities in enforcement.*

17           (b) *MULTIEMPLOYER PLANS.—In the case of a group*  
18 *health plan that is a multiemployer plan (as defined in*  
19 *section 3(37) of the Employee Retirement Income Security*  
20 *Act of 1974), the regulations prescribed in accordance with*  
21 *subsection (a) by the officers referred to in subsection (a)*  
22 *shall provide for the application of the health coverage par-*  
23 *ticipation requirements to the plan sponsor and contrib-*  
24 *uting sponsors of such plan.*

1 **[TITLE IV—AMENDMENTS TO IN-**  
 2 **TERNAL REVENUE CODE OF**  
 3 **1986]**

4 *[For title IV, see text of bill as introduced on July*  
 5 *14, 2009.]*

6 **DIVISION B—MEDICARE AND**  
 7 **MEDICAID IMPROVEMENTS**

8 **SEC. 1001. TABLE OF CONTENTS OF DIVISION.**

9 *The table of contents for this division is as follows:*

*DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS*

*Sec. 1001. Table of contents of division.*

*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 and payment adjustments in response to coverage expansion.*

*Subtitle B—Provisions Related to Medicare 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.*

*Sec. 1126. Resource-based feedback program for physicians in Medicare.*

*PART 2—MARKET BASKET UPDATES*

*Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.*

## PART 3—OTHER PROVISIONS

- Sec. 1141. Rental and purchase of power-driven wheelchairs.*
- Sec. 1141A. Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends.*
- Sec. 1142. Extension of payment rule for brachytherapy.*
- 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.*
- Sec. 1148. Durable medical equipment program improvements.*
- Sec. 1149. MedPAC study and report on bone mass measurement.*
- Sec. 1149A. Exclusion of customary prompt pay discounts extended to wholesalers from manufacturer's average sales price for payments for drugs and biologicals under Medicare part B.*
- Sec. 1149B. Timely access to postmastectomy items.*
- Sec. 1149C. Moratorium on Medicare reductions in payment rates for certain interventional pain management procedures covered under the ASC fee schedule.*
- Sec. 1149D. Medicare coverage of services of qualified respiratory therapists performed under the general supervision of a physician.*

## 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 and bundling pilot program.*
- Sec. 1153. Home health payment update for 2010.*
- Sec. 1154. Payment adjustments for home health care.*
- Sec. 1155. Incorporating productivity improvements into market basket update for home health services.*
- Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.*
- Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.*
- Sec. 1158. Revision of Medicare payment systems to address geographic inequities.*

## 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. Simplification of annual beneficiary election periods.*
- Sec. 1165. Extension of reasonable cost contracts.*
- Sec. 1166. Limitation of waiver authority for employer group plans.*
- Sec. 1167. Improving risk adjustment for payments.*
- Sec. 1168. Elimination of MA Regional Plan Stabilization Fund.*
- Sec. 1169. Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates.*

## PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

- Sec. 1171. Limitation on cost-sharing 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 PLANS

- 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.*

## Subtitle E—Improvements to Medicare Part D

- Sec. 1181. Elimination of coverage gap.*  
*Sec. 1182. Discounts for certain part D drugs in original 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 that adversely impact an enrollee.*  
*Sec. 1186. Negotiation of lower covered part D drug prices on behalf of Medicare beneficiaries.*  
*Sec. 1187. State certification prior to waiver of licensure requirements under Medicare prescription drug program.*

## 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.*  
*Sec. 1197. Ensuring proportional representation of interests of rural areas on MedPAC.*

## 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 noninstitutionalized 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. Special enrollment period and 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. Advance care planning consultation.*
- Sec. 1234. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.*
- Sec. 1235. Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related premium.*
- Sec. 1236. Demonstration program on use of patient decisions aids.*

**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. Independence at home pilot program.*
- Sec. 1304. Payment incentive for selected primary care services.*
- Sec. 1305. Increased reimbursement rate for certified nurse-midwives.*
- Sec. 1306. Coverage and waiver of cost-sharing for preventive services.*
- Sec. 1307. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.*
- Sec. 1308. Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment.*
- Sec. 1309. Coverage of marriage and family therapist services and mental health counselor services.*
- Sec. 1310. Extension of physician fee schedule mental health add-on.*
- Sec. 1311. Expanding access to vaccines.*
- Sec. 1312. Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services.*

**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.*
- Sec. 1433. Qualification of director of food services of a Medicaid nursing facility.*

*Subtitle C—Quality Measurements*

- Sec. 1441. Establishment of national priorities for quality improvement.*
- Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement.*
- Sec. 1443. Multistakeholder prerulemaking input into selection of quality measures.*
- Sec. 1444. Application of quality measures.*
- Sec. 1445. Consensus-based entity funding.*
- Sec. 1446. Quality indicators for care of people with Alzheimer’s disease.*
- Sec. 1447. Study on five star quality rating system.*

*Subtitle D—Physician Payments Sunshine Provision*

- 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.*

*Subtitle E—Public Reporting on Health Care-Associated Infections*

- Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on health care-associated infections.*

*TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION*

- Sec. 1501. Distribution of unused residency positions.*
- Sec. 1502. Increasing training in nonprovider 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 and flexibility to fight fraud and abuse.*

*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 statements material to a false claim.*

*Sec. 1613. Enhanced penalties for delaying inspections.*

*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.*

*Sec. 1619. Exclusion of certain individuals and entities from participation in Medicare and State health care programs.*

*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-enrolled physicians or eligible professionals.*

*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 or durable medical equipment 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. Access to certain information on renal dialysis facilities.*

*Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.*

*Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.*

*Subtitle D—Access to Information Needed To Prevent Fraud, Waste, and Abuse*

- Sec. 1651. Access to information necessary to identify fraud, 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—MEDICAID AND CHIP**Subtitle A—Medicaid and Health Reform*

- Sec. 1701. Eligibility for individuals with income below 133<sup>1</sup>/<sub>3</sub> percent of the Federal poverty level.*  
*Sec. 1702. Requirements and special rules for certain Medicaid eligible individuals.*  
*Sec. 1703. CHIP and Medicaid maintenance of eligibility.*  
*Sec. 1704. Reduction in Medicaid DSH.*  
*Sec. 1705. Expanded outstationing.*

*Subtitle B—Prevention*

- Sec. 1711. Required coverage of preventive services.*  
*Sec. 1712. Tobacco cessation.*  
*Sec. 1713. Optional coverage of nurse home visitation services.*  
*Sec. 1714. State eligibility option for family planning services.*

*Subtitle C—Access*

- Sec. 1721. Payments to primary care practitioners.*  
*Sec. 1722. Medical home pilot program.*  
*Sec. 1723. Translation or interpretation services.*  
*Sec. 1724. Optional coverage for freestanding birth center services.*  
*Sec. 1725. Inclusion of public health clinics under the vaccines for children program.*  
*Sec. 1726. Requiring coverage of services of podiatrists.*  
*Sec. 1726A. Requiring coverage of services of optometrists.*  
*Sec. 1727. Therapeutic foster care.*  
*Sec. 1728. Assuring adequate payment levels for services.*  
*Sec. 1729. Preserving Medicaid coverage for youths upon release from public institutions.*  
*Sec. 1730. Quality measures for maternity and adult health services under Medicaid and CHIP.*  
*Sec. 1730A. Accountable care organization pilot program.*

*Subtitle D—Coverage*

- Sec. 1731. Optional Medicaid coverage of low-income HIV-infected individuals.*  
*Sec. 1732. Extending transitional Medicaid Assistance (TMA).*  
*Sec. 1733. Requirement of 12-month continuous coverage under certain CHIP programs.*  
*Sec. 1734. Preventing the application under CHIP of coverage waiting periods for certain children.*  
*Sec. 1735. Adult day health care services.*  
*Sec. 1736. Medicaid coverage for citizens of Freely Associated States.*  
*Sec. 1737. Continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services.*



*Sec. 1738. State option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high prescription costs.*

*Subtitle E—Financing*

*Sec. 1741. Payments to pharmacists.*

*Sec. 1742. Prescription drug rebates.*

*Sec. 1743. Extension of prescription drug discounts to enrollees of Medicaid managed care organizations.*

*Sec. 1744. Payments for graduate medical education.*

*Sec. 1745. Report on Medicaid payments.*

*Sec. 1746. Reviews of Medicaid.*

*Sec. 1747. Extension of delay in managed care organization provider tax elimination.*

*Subtitle F—Waste, Fraud, and Abuse*

*Sec. 1751. Health care acquired conditions.*

*Sec. 1752. Evaluations and reports required under Medicaid Integrity Program.*

*Sec. 1753. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.*

*Sec. 1754. Overpayments.*

*Sec. 1755. Managed care organizations.*

*Sec. 1756. Termination of provider participation under Medicaid and CHIP if terminated under Medicare or other State plan or child health plan.*

*Sec. 1757. Medicaid and CHIP exclusion from participation relating to certain ownership, control, and management affiliations.*

*Sec. 1758. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.*

*Sec. 1759. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.*

*Sec. 1760. Denial of payments for litigation-related misconduct.*

*Sec. 1761. Mandatory State use of national correct coding initiative.*

*Subtitle G—Payments to the Territories*

*Sec. 1771. Payment to territories.*

*Subtitle H—Miscellaneous*

*Sec. 1781. Technical corrections.*

*Sec. 1782. Extension of QI program.*

*Sec. 1783. Outreach and enrollment of Medicaid and CHIP eligible individuals.*

*Sec. 1784. Prohibitions on Federal Medicaid and CHIP payment for undocumented aliens.*

*Sec. 1785. Demonstration project for stabilization of emergency medical conditions by nonpublicly owned or operated institutions for mental diseases.*

**TITLE VIII—REVENUE-RELATED PROVISIONS**

*Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration's outreach to eligible individuals.*

*Sec. 1802. Comparative Effectiveness Research Trust Fund; financing for Trust Fund.*

**TITLE IX—MISCELLANEOUS PROVISIONS**

*Sec. 1901. Repeal of trigger provision.*

*Sec. 1902. Repeal of comparative cost adjustment (CCA) program.*

*Sec. 1903. Extension of gainsharing demonstration.*

*Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.*

*Sec. 1905. Improved coordination and protection for dual eligibles.*

*Sec. 1906. Standardized marketing requirements under the Medicare Advantage and Medicare prescription drug programs.*

*Sec. 1907. NAIC recommendations on the establishment of standardized benefit packages for Medicare Advantage plans and prescription drug plans.*

*Sec. 1908. Application of emergency services laws.*

*Sec. 1909. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers.*

*Sec. 1910. Establishment of Center for Medicare and Medicaid Payment Innovation within CMS.*

1     **TITLE I—IMPROVING HEALTH**  
 2                     **CARE VALUE**  
 3     **[Subtitle A—Provisions Related to**  
 4                     **Medicare Part A]**

5             **[For subtitle A of title I of division B, see text of bill**  
 6 *as introduced on July 14, 2009.]*

7     **Subtitle B—Provisions Related to**  
 8                     **Medicare Part B**

9                     **PART 1—PHYSICIANS’ SERVICES**

10    **SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.**

11             **(a) TRANSITIONAL UPDATE FOR 2010.—Section**  
 12 *1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d))*  
 13 *is amended by adding at the end the following new para-*  
 14 *graph:*

1           “(10) *UPDATE FOR 2010.*—*The update to the sin-*  
2           *gle conversion factor established in paragraph (1)(C)*  
3           *for 2010 shall be the percentage increase in the MEI*  
4           *(as defined in section 1842(i)(3)) for that year.*”.

5           **(b) *REBASING SGR USING 2009; LIMITATION ON CU-***  
6           ***MULATIVE ADJUSTMENT PERIOD.***—*Section 1848(d)(4) of*  
7           *such Act (42 U.S.C. 1395w-4(d)(4)) is amended—*

8                   (1) *in subparagraph (B), by striking “subpara-*  
9                   *graph (D)” and inserting “subparagraphs (D) and*  
10                   *(G)”;* and

11                   (2) *by adding at the end the following new sub-*  
12                   *paragraph:*

13                           “(G) *REBASING USING 2009 FOR FUTURE*  
14                           *UPDATE ADJUSTMENTS.*—*In determining the up-*  
15                           *date adjustment factor under subparagraph (B)*  
16                           *for 2011 and subsequent years—*

17                                   “(i) *the allowed expenditures for 2009*  
18                                   *shall be equal to the amount of the actual*  
19                                   *expenditures for physicians’ services during*  
20                                   *2009; and*

21   “(ii) *the reference in subparagraph*  
22   *(B)(ii)(I) to ‘April 1, 1996’ shall be treated*  
23   *as a reference to ‘January 1, 2009 (or, if*  
24   *later, the first day of the fifth year before*  
25   *the year involved)’.*”.

1           (c) *LIMITATION ON PHYSICIANS' SERVICES INCLUDED*  
2 *IN TARGET GROWTH RATE COMPUTATION TO SERVICES*  
3 *COVERED UNDER PHYSICIAN FEE SCHEDULE.—Effective*  
4 *for services furnished on or after January 1, 2009, section*  
5 *1848(f)(4)(A) of such Act is amended by striking “(such as*  
6 *clinical” and all that follows through “in a physician’s of-*  
7 *fice” and inserting “for which payment under this part is*  
8 *made under the fee schedule under this section, for services*  
9 *for practitioners described in section 1842(b)(18)(C) on a*  
10 *basis related to such fee schedule, or for services described*  
11 *in section 1861(p) (other than such services when furnished*  
12 *in the facility of a provider of services)”.*

13           (d) *ESTABLISHMENT OF SEPARATE TARGET GROWTH*  
14 *RATES FOR CATEGORIES OF SERVICES.—*

15                 (1) *ESTABLISHMENT OF SERVICE CATEGORIES.—*  
16           Subsection (j) of section 1848 of the Social Security  
17           Act (42 U.S.C. 1395w-4) is amended by adding at  
18           the end the following new paragraph:

19                 “(5) *SERVICE CATEGORIES.—For services fur-*  
20           *nished on or after January 1, 2009, each of the fol-*  
21           *lowing categories of physicians’ services (as defined in*  
22           *paragraph (3)) shall be treated as a separate ‘service*  
23           *category’:*

1           “(A) *Evaluation and management services*  
2           *that are procedure codes (for services covered*  
3           *under this title) for—*

4                   “(i) *services in the category designated*  
5                   *Evaluation and Management in the Health*  
6                   *Care Common Procedure Coding System*  
7                   *(established by the Secretary under sub-*  
8                   *section (c)(5) as of December 31, 2009, and*  
9                   *as subsequently modified by the Secretary);*  
10                  *and*

11                  “(ii) *preventive services (as defined in*  
12                  *section 1861(iii)) for which payment is*  
13                  *made under this section.*

14           “(B) *All other services not described in sub-*  
15           *paragraph (A).*

16           *Service categories established under this paragraph*  
17           *shall apply without regard to the specialty of the phy-*  
18           *sician furnishing the service.”.*

19           (2) *ESTABLISHMENT OF SEPARATE CONVERSION*  
20           *FACTORS FOR EACH SERVICE CATEGORY.—Subsection*  
21           *(d)(1) of section 1848 of the Social Security Act (42*  
22           *U.S.C. 1395w-4) is amended—*

23                   (A) *in subparagraph (A)—*

24                           (i) *by designating the sentence begin-*  
25                           *ning “The conversion factor” as clause (i)*

1           with the heading “APPLICATION OF SINGLE  
2           CONVERSION FACTOR.—” and with appro-  
3           priate indentation;

4           (ii) by striking “The conversion factor”  
5           and inserting “Subject to clause (i), the  
6           conversion factor”; and

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

9           “(i) APPLICATION OF MULTIPLE CON-  
10          VERSION FACTORS BEGINNING WITH 2011.—

11           “(I) IN GENERAL.—In applying  
12           clause (i) for years beginning with  
13           2011, separate conversion factors shall  
14           be established for each service category  
15           of physicians’ services (as defined in  
16           subsection (j)(5)) and any reference in  
17           this section to a conversion factor for  
18           such years shall be deemed to be a ref-  
19           erence to the conversion factor for each  
20           of such categories.

21           “(II) INITIAL CONVERSION FAC-  
22           TORS.—Such factors for 2011 shall be  
23           based upon the single conversion factor  
24           for the previous year multiplied by the

1            *update established under paragraph*  
2            *(11) for such category for 2011.*

3            *“(III) UPDATING OF CONVERSION*  
4            *FACTORS.—Such factor for a service*  
5            *category for a subsequent year shall be*  
6            *based upon the conversion factor for*  
7            *such category for the previous year and*  
8            *adjusted by the update established for*  
9            *such category under paragraph (11)*  
10           *for the year involved.”; and*

11           *(B) in subparagraph (D), by striking “other*  
12           *physicians’ services” and inserting “physicians’*  
13           *services described in the service category de-*  
14           *scribed in subsection (j)(5)(B)”.*

15           *(3) ESTABLISHING UPDATES FOR CONVERSION*  
16           *FACTORS FOR SERVICE CATEGORIES.—Section*  
17           *1848(d) of the Social Security Act (42 U.S.C. 1395w-*  
18           *4(d)), as amended by subsection (a), is amended—*

19           *(A) in paragraph (4)(C)(iii), by striking*  
20           *“The allowed” and inserting “Subject to para-*  
21           *graph (11)(B), the allowed”; and*

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

24           *“(11) UPDATES FOR SERVICE CATEGORIES BE-*  
25           *GINNING WITH 2011.—*

1           “(A) *IN GENERAL.*—*In applying paragraph*  
2           *(4) for a year beginning with 2011, the following*  
3           *rules apply:*

4                   “(i) *APPLICATION OF SEPARATE UP-*  
5                   *DATE ADJUSTMENTS FOR EACH SERVICE*  
6                   *CATEGORY.*—*Pursuant to paragraph*  
7                   *(1)(A)(ii)(I), the update shall be made to*  
8                   *the conversion factor for each service cat-*  
9                   *egory (as defined in subsection (j)(5)) based*  
10                   *upon an update adjustment factor for the*  
11                   *respective category and year and the update*  
12                   *adjustment factor shall be computed, for a*  
13                   *year, separately for each service category.*

14                   “(ii) *COMPUTATION OF ALLOWED AND*  
15                   *ACTUAL EXPENDITURES BASED ON SERVICE*  
16                   *CATEGORIES.*—*In computing the prior year*  
17                   *adjustment component and the cumulative*  
18                   *adjustment component under clauses (i) and*  
19                   *(ii) of paragraph (4)(B), the following rules*  
20                   *apply:*

21                           “(I) *APPLICATION BASED ON*  
22                           *SERVICE CATEGORIES.*—*The allowed*  
23                           *expenditures and actual expenditures*  
24                           *shall be the allowed and actual expend-*



1            *itures for the service category, as deter-*  
2            *mined under subparagraph (B).*

3            *“(II) APPLICATION OF CATEGORY*  
4            *SPECIFIC TARGET GROWTH RATE.—The*  
5            *growth rate applied under clause*  
6            *(ii)(II) of such paragraph shall be the*  
7            *target growth rate for the service cat-*  
8            *egory involved under subsection (f)(5).*

9            *“(B) DETERMINATION OF ALLOWED EX-*  
10           *PENDITURES.—In applying paragraph (4) for a*  
11           *year beginning with 2010, notwithstanding sub-*  
12           *paragraph (C)(iii) of such paragraph, the al-*  
13           *lowed expenditures for a service category for a*  
14           *year is an amount computed by the Secretary as*  
15           *follows:*

16           *“(i) FOR 2010.—For 2010:*

17           *“(I) TOTAL 2009 ACTUAL EXPENDI-*  
18           *TURES FOR ALL SERVICES INCLUDED*  
19           *IN SGR COMPUTATION FOR EACH SERV-*  
20           *ICE CATEGORY.—Compute total actual*  
21           *expenditures for physicians’ services*  
22           *(as defined in subsection (f)(4)(A)) for*  
23           *2009 for each service category.*

24           *“(II) INCREASE BY GROWTH RATE*  
25           *TO OBTAIN 2010 ALLOWED EXPENDI-*

1                   *TURES FOR SERVICE CATEGORY.—*  
2                   *Compute allowed expenditures for the*  
3                   *service category for 2010 by increasing*  
4                   *the allowed expenditures for the service*  
5                   *category for 2009 computed under sub-*  
6                   *clause (I) by the target growth rate for*  
7                   *such service category under subsection*  
8                   *(f) for 2010.*

9                   *“(ii) FOR SUBSEQUENT YEARS.—For a*  
10                  *subsequent year, take the amount of allowed*  
11                  *expenditures for such category for the pre-*  
12                  *ceding year (under clause (i) or this clause)*  
13                  *and increase it by the target growth rate de-*  
14                  *termined under subsection (f) for such cat-*  
15                  *egory and year.”.*

16                  (4) *APPLICATION OF SEPARATE TARGET GROWTH*  
17                  *RATES FOR EACH CATEGORY.—*

18                  (A) *IN GENERAL.—Section 1848(f) of the*  
19                  *Social Security Act (42 U.S.C. 1395w-4(f)) is*  
20                  *amended by adding at the end the following new*  
21                  *paragraph:*

22                  (5) *APPLICATION OF SEPARATE TARGET*  
23                  *GROWTH RATES FOR EACH SERVICE CATEGORY BEGIN-*  
24                  *NING WITH 2010.—The target growth rate for a year*  
25                  *beginning with 2010 shall be computed and applied*

1       *separately under this subsection for each service cat-*  
2       *egory (as defined in subsection (j)(5)) and shall be*  
3       *computed using the same method for computing the*  
4       *target growth rate except that the factor described in*  
5       *paragraph (2)(C) for—*

6               *“(A) the service category described in sub-*  
7               *section (j)(5)(A) shall be increased by 0.02; and*

8               *“(B) the service category described in sub-*  
9               *section (j)(5)(B) shall be increased by 0.01.”.*

10               *(B) USE OF TARGET GROWTH RATES.—Sec-*  
11               *tion 1848 of such Act is further amended—*

12                       *(i) in subsection (d)—*

13                               *(I) in paragraph (1)(E)(ii), by*  
14                               *inserting “or target” after “sustain-*  
15                               *able”;* and

16                               *(II) in paragraph (4)(B)(ii)(II),*  
17                               *by inserting “or target” after “sustain-*  
18                               *able”;* and

19                               *(ii) in the heading of subsection (f), by*  
20                               *inserting “AND TARGET GROWTH RATE”*  
21                               *after “SUSTAINABLE GROWTH RATE”;*

22                               *(iii) in subsection (f)(1)—*

23                                       *(I) by striking “and” at the end*  
24                                       *of subparagraph (A);*

1                   (II) in subparagraph (B), by in-  
2                   serting “before 2010” after “each suc-  
3                   ceeding year” and by striking the pe-  
4                   riod at the end and inserting “; and”;  
5                   and

6                   (III) by adding at the end the fol-  
7                   lowing new subparagraph:

8                   “(C) November 1 of each succeeding year the  
9                   target growth rate for such succeeding year and  
10                  each of the 2 preceding years.”; and

11                  (iv) in subsection (f)(2), in the matter  
12                  before subparagraph (A), by inserting after  
13                  “beginning with 2000” the following: “and  
14                  ending with 2009”.

15                  (e) *APPLICATION TO ACCOUNTABLE CARE ORGANIZA-*  
16                  *TION PILOT PROGRAM.*—In applying the target growth rate  
17                  under subsections (d) and (f) of section 1848 of the Social  
18                  Security Act to services furnished by a practitioner to bene-  
19                  ficiaries who are attributable to an accountable care organi-  
20                  zation under the pilot program provided under section  
21                  1866D of such Act, the Secretary of Health and Human  
22                  Services shall develop, not later than January 1, 2012, for  
23                  application beginning with 2012, a method that—

24                  (1) allows each such organization to have its own  
25                  expenditure targets and updates for such practi-

1        *tioners, with respect to beneficiaries who are attrib-*  
 2        *utable to that organization, that are consistent with*  
 3        *the methodologies described in such subsection (f); and*

4            *(2) provides that the target growth rate applica-*  
 5        *ble to other physicians shall not apply to such physi-*  
 6        *cians to the extent that the physicians' services are*  
 7        *furnished through the accountable care organization.*

8        *In applying paragraph (1), the Secretary of Health and*  
 9        *Human Services may apply the difference in the update*  
 10        *under such paragraph on a claim-by-claim or lump sum*  
 11        *basis and such a payment shall be taken into account under*  
 12        *the pilot program.*

13        **SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE**  
 14            **SCHEDULE.**

15            *(a) IN GENERAL.—Section 1848(c)(2) of the Social Se-*  
 16        *curity Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding*  
 17        *at the end the following new subparagraphs:*

18            *“(K) POTENTIALLY MISVALUED CODES.—*

19                    *“(i) IN GENERAL.—The Secretary*  
 20                    *shall—*

21                            *“(I) periodically identify services*  
 22                            *as being potentially misvalued using*  
 23                            *criteria specified in clause (ii); and*

24                            *“(II) review and make appro-*  
 25                            *priate adjustments to the relative val-*

1            *ues established under this paragraph*  
2            *for services identified as being poten-*  
3            *tially misvalued under subclause (I).*

4            *“(i) IDENTIFICATION OF POTENTIALLY*  
5            *MISVALUED CODES.—For purposes of iden-*  
6            *tifying potentially misvalued services pur-*  
7            *suant to clause (i)(I), the Secretary shall ex-*  
8            *amine (as the Secretary determines to be*  
9            *appropriate) codes (and families of codes as*  
10           *appropriate) for which there has been the*  
11           *fastest growth; codes (and families of codes*  
12           *as appropriate) that have experienced sub-*  
13           *stantial changes in practice expenses; codes*  
14           *for new technologies or services within an*  
15           *appropriate period (such as three years)*  
16           *after the relative values are initially estab-*  
17           *lished for such codes; multiple codes that are*  
18           *frequently billed in conjunction with fur-*  
19           *nishing a single service; codes with low rel-*  
20           *ative values, particularly those that are*  
21           *often billed multiple times for a single treat-*  
22           *ment; codes which have not been subject to*  
23           *review since the implementation of the*  
24           *RBRVS (the so-called ‘Harvard-valued*

1                   *codes’); and such other codes determined to*  
2                   *be appropriate by the Secretary.*

3                   “(iii) *REVIEW AND ADJUSTMENTS.—*

4                   “(I) *The Secretary may use exist-*  
5                   *ing processes to receive recommenda-*  
6                   *tions on the review and appropriate*  
7                   *adjustment of potentially misvalued*  
8                   *services described clause (i)(II).*

9                   “(II) *The Secretary may conduct*  
10                   *surveys, other data collection activities,*  
11                   *studies, or other analyses as the Sec-*  
12                   *retary determines to be appropriate to*  
13                   *facilitate the review and appropriate*  
14                   *adjustment described in clause (i)(II).*

15                   “(III) *The Secretary may use*  
16                   *analytic contractors to identify and*  
17                   *analyze services identified under clause*  
18                   *(i)(I), conduct surveys or collect data,*  
19                   *and make recommendations on the re-*  
20                   *view and appropriate adjustment of*  
21                   *services described in clause (i)(II).*

22                   “(IV) *The Secretary may coordi-*  
23                   *nate the review and appropriate ad-*  
24                   *justment described in clause (i)(II)*

1                   with the periodic review described in  
2                   subparagraph (B).

3                   “(V) As part of the review and  
4                   adjustment described in clause (i)(II),  
5                   including with respect to codes with  
6                   low relative values described in clause  
7                   (ii), the Secretary may make appro-  
8                   priate coding revisions (including  
9                   using existing processes for consider-  
10                  ation of coding changes) which may  
11                  include consolidation of individual  
12                  services into bundled codes for payment  
13                  under the fee schedule under subsection  
14                  (b).

15                  “(VI) The provisions of subpara-  
16                  graph (B)(ii)(II) shall apply to adjust-  
17                  ments to relative value units made  
18                  pursuant to this subparagraph in the  
19                  same manner as such provisions apply  
20                  to adjustments under subparagraph  
21                  (B)(ii)(II).

22                  “(L)   VALIDATING   RELATIVE   VALUE  
23                  UNITS.—

24                  “(i) IN GENERAL.—The Secretary shall  
25                  establish a process to validate relative value



1            *units under the fee schedule under sub-*  
2            *section (b).*

3            “(ii) *COMPONENTS AND ELEMENTS OF*  
4            *WORK.—The process described in clause (i)*  
5            *may include validation of work elements*  
6            *(such as time, mental effort and profes-*  
7            *sional judgment, technical skill and phys-*  
8            *ical effort, and stress due to risk) involved*  
9            *with furnishing a service and may include*  
10           *validation of the pre, post, and intra-service*  
11           *components of work.*

12           “(iii) *SCOPE OF CODES.—The valida-*  
13           *tion of work relative value units shall in-*  
14           *clude a sampling of codes for services that*  
15           *is the same as the codes listed under sub-*  
16           *paragraph (K)(ii)*

17           “(iv) *METHODS.—The Secretary may*  
18           *conduct the validation under this subpara-*  
19           *graph using methods described in subclauses*  
20           *(I) through (V) of subparagraph (K)(iii) as*  
21           *the Secretary determines to be appropriate.*

22           “(v) *ADJUSTMENTS.—The Secretary*  
23           *shall make appropriate adjustments to the*  
24           *work relative value units under the fee*  
25           *schedule under subsection (b). The provi-*

1           sions of subparagraph (B)(ii)(II) shall  
2           apply to adjustments to relative value units  
3           made pursuant to this subparagraph in the  
4           same manner as such provisions apply to  
5           adjustments under subparagraph  
6           (B)(ii)(II).”.

7           (b) IMPLEMENTATION.—

8           (1) FUNDING.—For purposes of carrying out the  
9           provisions of subparagraphs (K) and (L) of  
10          1848(c)(2) of the Social Security Act, as added by  
11          subsection (a), in addition to funds otherwise avail-  
12          able, out of any funds in the Treasury not otherwise  
13          appropriated, there are appropriated to the Secretary  
14          of Health and Human Services for the Center for  
15          Medicare & Medicaid Services Program Management  
16          Account \$20,000,000 for fiscal year 2010 and each  
17          subsequent fiscal year. Amounts appropriated under  
18          this paragraph for a fiscal year shall be available  
19          until expended.

20          (2) ADMINISTRATION.—

21                (A) Chapter 35 of title 44, United States  
22                Code and the provisions of the Federal Advisory  
23                Committee Act (5 U.S.C. App.) shall not apply  
24                to this section or the amendment made by this  
25                section.

1           (B) Notwithstanding any other provision of  
2 law, the Secretary may implement subpara-  
3 graphs (K) and (L) of 1848(c)(2) of the Social  
4 Security Act, as added by subsection (a), by pro-  
5 gram instruction or otherwise.

6           (C) Section 4505(d) of the Balanced Budget  
7 Act of 1997 is repealed.

8           (D) Except for provisions related to con-  
9 fidentiality of information, the provisions of the  
10 Federal Acquisition Regulation shall not apply  
11 to this section or the amendment made by this  
12 section.

13           (3) *FOCUSING CMS RESOURCES ON POTENTIALLY*  
14 *OVERVALUED CODES.*—Section 1868(a) of the Social  
15 Security Act (42 1395ee(a)) is repealed.

16 **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.**

17           Section 1833 of the Social Security Act (42 U.S.C.  
18 1395l) is amended by adding at the end the following new  
19 subsection:

20           “(x) *INCENTIVE PAYMENTS FOR EFFICIENT AREAS.*—

21           “(1) *IN GENERAL.*—In the case of services fur-  
22 nished under the physician fee schedule under section  
23 1848 on or after January 1, 2011, and before Janu-  
24 ary 1, 2013, by a supplier that is paid under such  
25 fee schedule in an efficient area (as identified under

1 paragraph (2)), in addition to the amount of pay-  
2 ment that would otherwise be made for such services  
3 under this part, there also shall be paid (on a month-  
4 ly or quarterly basis) an amount equal to 5 percent  
5 of the payment amount for the services under this  
6 part.

7 “(2) IDENTIFICATION OF EFFICIENT AREAS.—

8 “(A) IN GENERAL.—Based upon available  
9 data, the Secretary shall identify those counties  
10 or equivalent areas in the United States in the  
11 lowest fifth percentile of utilization based on per  
12 capita spending under this part and part A for  
13 services provided in the most recent year for  
14 which data are available as of the date of the en-  
15 actment of this subsection, as standardized to  
16 eliminate the effect of geographic adjustments in  
17 payment rates.

18 “(B) IDENTIFICATION OF COUNTIES WHERE  
19 SERVICE IS FURNISHED.—For purposes of pay-  
20 ing the additional amount specified in para-  
21 graph (1), if the Secretary uses the 5-digit postal  
22 ZIP Code where the service is furnished, the  
23 dominant county of the postal ZIP Code (as de-  
24 termined by the United States Postal Service, or  
25 otherwise) shall be used to determine whether the

1           *postal ZIP Code is in a county described in sub-*  
2           *paragraph (A).*

3           “(C) *LIMITATION ON REVIEW.—There shall*  
4           *be no administrative or judicial review under*  
5           *section 1869, 1878, or otherwise, respecting—*

6                     *“(i) the identification of a county or*  
7                     *other area under subparagraph (A); or*

8                     *“(ii) the assignment of a postal ZIP*  
9                     *Code to a county or other area under sub-*  
10                    *paragraph (B).*

11           “(D) *PUBLICATION OF LIST OF COUNTIES;*  
12            *POSTING ON WEBSITE.—With respect to a year*  
13            *for which a county or area is identified under*  
14            *this paragraph, the Secretary shall identify such*  
15            *counties or areas as part of the proposed and*  
16            *final rule to implement the physician fee sched-*  
17            *ule under section 1848 for the applicable year.*  
18            *The Secretary shall post the list of counties iden-*  
19            *tified under this paragraph on the Internet*  
20            *website of the Centers for Medicare & Medicaid*  
21            *Services.”.*

1 **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY RE-**  
2 **PORTING INITIATIVE (PQRI).**

3 (a) *FEEDBACK.*—Section 1848(m)(5) of the Social Se-  
4 curity Act (42 U.S.C. 1395w-4(m)(5)) is amended by add-  
5 ing at the end the following new subparagraph:

6 “(H) *FEEDBACK.*—The Secretary shall pro-  
7 vide timely feedback to eligible professionals on  
8 the performance of the eligible professional with  
9 respect to satisfactorily submitting data on qual-  
10 ity measures under this subsection.”.

11 (b) *APPEALS.*—Such section is further amended—

12 (1) in subparagraph (E), by striking “There  
13 shall be” and inserting “Subject to subparagraph (I),  
14 there shall be”; and

15 (2) by adding at the end the following new sub-  
16 paragraph:

17 “(I) *INFORMAL APPEALS PROCESS.*—Not-  
18 withstanding subparagraph (E), by not later  
19 than January 1, 2011, the Secretary shall estab-  
20 lish and have in place an informal process for  
21 eligible professionals to appeal the determination  
22 that an eligible professional did not satisfactorily  
23 submit data on quality measures under this sub-  
24 section.”.

1           (c) *INTEGRATION OF PHYSICIAN QUALITY REPORTING*  
2 *AND EHR REPORTING.*—Section 1848(m) of such Act is  
3 amended by adding at the end the following new paragraph:

4           “(7) *INTEGRATION OF PHYSICIAN QUALITY RE-*  
5 *PORTING AND EHR REPORTING.*—Not later than Jan-  
6 uary 1, 2012, the Secretary shall develop a plan to  
7 integrate clinical reporting on quality measures  
8 under this subsection with reporting requirements  
9 under subsection (o) relating to the meaningful use of  
10 electronic health records. Such integration shall con-  
11 sist of the following:

12           “(A) The development of measures, the re-  
13 porting of which would both demonstrate—

14           “(i) meaningful use of an electronic  
15 health record for purposes of subsection (o);  
16 and

17           “(ii) clinical quality of care furnished  
18 to an individual.

19           “(B) The collection of health data to iden-  
20 tify deficiencies in the quality and coordination  
21 of care for individuals eligible for benefits under  
22 this part.

23           “(C) Such other activities as specified by  
24 the Secretary.”.

1       (d) *EXTENSION OF INCENTIVE PAYMENTS.*—Section  
 2 1848(m)(1) of such Act (42 U.S.C. 1395w-4(m)(1)) is  
 3 amended—

4           (1) in subparagraph (A), by striking “2010” and  
 5 inserting “2012”; and

6           (2) in subparagraph (B)(ii), by striking “2009  
 7 and 2010” and inserting “each of the years 2009  
 8 through 2012”.

9 **SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**  
 10 **ITIES.**

11       (a) *IN GENERAL.*—Section 1848(e) of the Social Secu-  
 12 rity Act (42 U.S.C.1395w-4(e)) is amended by adding at  
 13 the end the following new paragraph:

14           “(6) *TRANSITION TO USE OF MSAS AS FEE*  
 15 *SCHEDULE AREAS IN CALIFORNIA.*—

16           “(A) *IN GENERAL.*—

17                   “(i) *REVISION.*—Subject to clause (ii)  
 18 and notwithstanding the previous provi-  
 19 sions of this subsection, for services fur-  
 20 nished on or after January 1, 2011, the  
 21 Secretary shall revise the fee schedule areas  
 22 used for payment under this section appli-  
 23 cable to the State of California using the  
 24 Metropolitan Statistical Area (MSA)



1            *iterative Geographic Adjustment Factor*  
2            *methodology as follows:*

3            “(I) *The Secretary shall configure*  
4            *the physician fee schedule areas using*  
5            *the Core-Based Statistical Areas-Metro-*  
6            *politan Statistical Areas (each in this*  
7            *paragraph referred to as an ‘MSA’), as*  
8            *defined by the Director of the Office of*  
9            *Management and Budget, as the basis*  
10           *for the fee schedule areas. The Sec-*  
11           *retary shall employ an iterative proc-*  
12           *ess to transition fee schedule areas.*  
13           *First, the Secretary shall list all MSAs*  
14           *within the State by Geographic Adjust-*  
15           *ment Factor described in paragraph*  
16           *(2) (in this paragraph referred to as a*  
17           *‘GAF’) in descending order. In the first*  
18           *iteration, the Secretary shall compare*  
19           *the GAF of the highest cost MSA in the*  
20           *State to the weighted-average GAF of*  
21           *the group of remaining MSAs in the*  
22           *State. If the ratio of the GAF of the*  
23           *highest cost MSA to the weighted-aver-*  
24           *age GAF of the rest of State is 1.05 or*

1 greater than the highest cost MSA be-  
2 comes a separate fee schedule area.

3 “(II) In the next iteration, the  
4 Secretary shall compare the MSA of  
5 the second-highest GAF to the weight-  
6 ed-average GAF of the group of re-  
7 maining MSAs. If the ratio of the sec-  
8 ond-highest MSA’s GAF to the weight-  
9 ed-average of the remaining lower cost  
10 MSAs is 1.05 or greater, the second-  
11 highest MSA becomes a separate fee  
12 schedule area. The iterative process  
13 continues until the ratio of the GAF of  
14 the highest-cost remaining MSA to the  
15 weighted-average of the remaining  
16 lower-cost MSAs is less than 1.05, and  
17 the remaining group of lower cost  
18 MSAs form a single fee schedule area.  
19 If two MSAs have identical GAFs, they  
20 shall be combined in the iterative com-  
21 parison.

22 “(i) *TRANSITION.*—For services fur-  
23 nished on or after January 1, 2011, and be-  
24 fore January 1, 2016, in the State of Cali-  
25 fornia, after calculating the work, practice

1 *expense, and malpractice geographic indices*  
2 *described in clauses (i), (ii), and (iii) of*  
3 *paragraph (1)(A) that would otherwise*  
4 *apply through application of this para-*  
5 *graph, the Secretary shall increase any such*  
6 *index to the county-based fee schedule area*  
7 *value on December 31, 2009, if such index*  
8 *would otherwise be less than the value on*  
9 *January 1, 2010.*

10 *“(B) SUBSEQUENT REVISIONS.—*

11 *“(i) PERIODIC REVIEW AND ADJUST-*  
12 *MENTS IN FEE SCHEDULE AREAS.—Subse-*  
13 *quent to the process outlined in paragraph*  
14 *(1)(C), not less often than every three years,*  
15 *the Secretary shall review and update the*  
16 *California Rest-of-State fee schedule area*  
17 *using MSAs as defined by the Director of*  
18 *the Office of Management and Budget and*  
19 *the iterative methodology described in sub-*  
20 *paragraph (A)(i).*

21 *“(ii) LINK WITH GEOGRAPHIC INDEX*  
22 *DATA REVISION.—The revision described in*  
23 *clause (i) shall be made effective concu-*  
24 *rently with the application of the periodic*  
25 *review of the adjustment factors required*

1                   under paragraph (1)(C) for California for  
2                   2012 and subsequent periods. Upon request,  
3                   the Secretary shall make available to the  
4                   public any county-level or MSA derived  
5                   data used to calculate the geographic prac-  
6                   tice cost index.

7                   “(C) REFERENCES TO FEE SCHEDULE  
8                   AREAS.—Effective for services furnished on or  
9                   after January 1, 2010, for the State of Cali-  
10                   fornia, any reference in this section to a fee  
11                   schedule area shall be deemed a reference to an  
12                   MSA in the State.”.

13                   (b) CONFORMING AMENDMENT TO DEFINITION OF FEE  
14                   SCHEDULE AREA.—Section 1848(j)(2) of the Social Secu-  
15                   rity Act (42 U.S.C. 1395w(j)(2)) is amended by striking  
16                   “the term” and inserting “Except as provided in sub-  
17                   section (e)(6)(C), the term”.

18                   **SEC. 1126. RESOURCE-BASED FEEDBACK PROGRAM FOR**  
19                   **PHYSICIANS IN MEDICARE.**

20                   (a) *IN GENERAL*.—The Secretary of Health and  
21                   Human Services (in this section referred to as the “Sec-  
22                   retary”) shall provide for the measurement and confidential  
23                   communication of reports (each in this section referred to  
24                   as a “feedback report”) to physicians and other practi-  
25                   tioners regarding the utilization of services under the Medi-

1 *care program under title XVIII of the Social Security Act.*  
2 *Such reports shall be based upon claims data and shall in-*  
3 *clude quality data reported under section 1848(m)(5) of*  
4 *such Act (42 U.S.C. 1395w-4(m)(5)) and such other infor-*  
5 *mation as the Secretary determines appropriate.*

6 *(b) TIMELINE FOR FEEDBACK PROGRAM.—*

7 *(1) ANALYSIS TOOL.—Not later than December*  
8 *31, 2010, the Secretary shall initially develop an epi-*  
9 *sode grouper or other initial resource analysis tool de-*  
10 *scribed in subsection (c)(4).*

11 *(2) EVALUATION.—During 2011 the Secretary*  
12 *shall conduct the evaluation specified in subsection*  
13 *(e)(1).*

14 *(3) EXPANSION.—The Secretary shall expand the*  
15 *program as specified in subsection (e)(2).*

16 *(c) FEEDBACK REPORTS.—*

17 *(1) COMPARISON OF RESOURCE USE PAT-*  
18 *TERNS.—Feedback reports shall include information*  
19 *allowing the comparison of a physician's resource use*  
20 *pattern to such pattern for peers. Such reports may*  
21 *include resource use data on—*

22 *(A) a per capita basis;*

23 *(B) a per episode basis; or*

24 *(C) both.*

1           (2) *PEER COMPARISON.*—*Reports under this sec-*  
2           *tion shall include information regarding nationwide*  
3           *groups of similarly situated physicians (taking into*  
4           *consideration specialty, practice setting, and such*  
5           *other criteria as the Secretary finds appropriate) and*  
6           *comparing the pattern of services of each physician in*  
7           *the group to the group average pattern of services.*

8           (3) *DETAILED INFORMATION.*—*The Secretary*  
9           *shall include in feedback reports details about the*  
10          *services, procedures, and relevant clinical information*  
11          *to identify factors that may account for significant*  
12          *variation of a physician from national norms, such*  
13          *as high rates of elective surgeries, diagnostic services,*  
14          *or other utilization attributable to the judgment of the*  
15          *physician.*

16          (4) *DEVELOPMENT OF EPISODE GROUPEUR.*—*The*  
17          *Secretary shall, in consultation with physicians and*  
18          *others as the Secretary determines to be appropriate,*  
19          *develop an episode grouper or other resource analysis*  
20          *tool that could be used to measure physician resource*  
21          *use. The Secretary may update such grouper from*  
22          *time to time as appropriate.*

23          (d) *FEEDBACK PROGRAM.*—*The Secretary shall engage*  
24          *in efforts to disseminate feedback reports. In disseminating*  
25          *such reports, the Secretary shall seek to establish their valid-*

1 *ity and credibility to physicians and shall experiment with*  
2 *communications methods such as the following:*

3           (1) *Direct meetings between contracted physi-*  
4 *cians, facilitated by the Secretary, to discuss the con-*  
5 *tents of feedback reports, including any reasons for*  
6 *divergence from national averages.*

7           (2) *Contracts with local, non-profit entities en-*  
8 *gaged in quality improvement efforts at the commu-*  
9 *nity level. Such entities shall use the feedback reports,*  
10 *or such equivalent tool as specified by the Secretary.*  
11 *Any exchange of data under this paragraph shall be*  
12 *protected by appropriate privacy safeguards.*

13           (3) *Mailings or other methods of communication*  
14 *that facilitate large-scale dissemination.*

15           (4) *Other methods specified by the Secretary.*

16 *(e) EVALUATION AND EXPANSION.—*

17           (1) *EVALUATION.—The Secretary shall evaluate*  
18 *the methods specified in subsection (d) with regard to*  
19 *their efficacy in changing practice patterns to im-*  
20 *prove quality and decrease costs.*

21           (2) *EXPANSION.—Taking into account the cost of*  
22 *each method, the Secretary shall develop a plan to*  
23 *disseminate such reports in a significant manner in*  
24 *the regions and cities of the country with the highest*  
25 *utilization of services under Medicare. The Secretary*

1       *shall disseminate, to the extent practicable, feedback*  
2       *reports in a manner consistent with the following:*

3               *(A) During 2011, at least 1,000 reports.*

4               *(B) During 2012, at least 10,000 reports.*

5               *(C) During 2013, at least 25,000 reports.*

6               *(D) During 2014 and subsequent years, re-*  
7       *ports to the physicians with utilization within*  
8       *the highest 5 percent of physicians, subject to the*  
9       *authority to focus under subsection (f).*

10              *(3) OPT OUT.—The Secretary shall establish a*  
11       *process by which a physician may opt not to receive*  
12       *feedback reports under this section.*

13              *(f) AUTHORITY TO FOCUS PROGRAM APPLICATION.—*  
14       *The secretary may focus the application of the program*  
15       *under this section and dissemination of feedback reports on*  
16       *physicians, as appropriate, such as on physicians who—*

17                      *(1) practice in geographic areas that account for*  
18                      *unusually high rates of spending per capita;*

19                      *(2) treat conditions that have a high cost or vol-*  
20                      *ume under Medicare;*

21                      *(3) use a high amount of resources compared to*  
22                      *other physicians; or*

23                      *(4) treat at least a minimum number of Medi-*  
24                      *care beneficiaries.*



1       (g) *INCLUSION OF CERTAIN PRACTITIONERS.*—For  
2 purposes of this section, the term “physician” includes a  
3 practitioner who furnishes services for which payment is  
4 made under Medicare and for which such payment would  
5 be made if furnished by a physician.

6       (h) *ADMINISTRATION.*—

7           (1) Chapter 35 of title 44, United States Code  
8 shall not apply to this section.

9           (2) Notwithstanding any other provision of law,  
10 the Secretary may implement the provisions of this  
11 section by program instruction or otherwise.

12           **PART 2—MARKET BASKET UPDATES**

13 **SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVE-**  
14 **MENTS INTO MARKET BASKET UPDATES THAT**  
15 **DO NOT ALREADY INCORPORATE SUCH IM-**  
16 **PROVEMENTS.**

17       (a) *OUTPATIENT HOSPITALS.*—

18           (1) *IN GENERAL.*—The first sentence of section  
19 1833(t)(3)(C)(iv) of the Social Security Act (42  
20 U.S.C. 1395l(t)(3)(C)(iv)) is amended—

21           (A) by inserting “(which is subject to the  
22 productivity adjustment described in subclause  
23 (II) of such section)” after “1886(b)(3)(B)(iii);”  
24 and

1                   (B) by inserting “(but not below 0)” after  
2                   “reduced”.

3                   (2) *EFFECTIVE DATE.*—*The amendments made*  
4                   *by paragraph (1) shall apply to increase factors for*  
5                   *services furnished in years beginning with 2010.*

6                   (b) *AMBULANCE SERVICES.*—*Section 1834(l)(3)(B) of*  
7                   *such Act (42 U.S.C. 1395m(l)(3)(B)) is amended by insert-*  
8                   *ing before the period at the end the following: “and, in the*  
9                   *case of years beginning with 2010, subject to the produc-*  
10                   *tivity adjustment described in section*  
11                   *1886(b)(3)(B)(iii)(II)”.*

12                   (c) *AMBULATORY SURGICAL CENTER SERVICES.*—*Sec-*  
13                   *tion 1833(i)(2)(D) of such Act (42 U.S.C. 1395l(i)(2)(D))*  
14                   *is amended—*

15                   (1) *by redesignating clause (v) as clause (vi);*  
16                   *and*

17                   (2) *by inserting after clause (iv) the following*  
18                   *new clause:*

19                   “*(v) In implementing the system described in clause*  
20                   *(i), for services furnished during 2010 or any subsequent*  
21                   *year, to the extent that an annual percentage change factor*  
22                   *applies, such factor shall be subject to the productivity ad-*  
23                   *justment described in section 1886(b)(3)(B)(iii)(II).”.*

24                   (d) *LABORATORY SERVICES.*—*Section 1833(h)(2)(A)*  
25                   *of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—*

1           (1) in clause (i), by striking “for each of the  
2           years 2009 through 2013” and inserting “for 2009”;  
3           and

4           (2) clause (ii)—

5                 (A) by striking “and” at the end of sub-  
6                 clause (III);

7                 (B) by striking the period at the end of sub-  
8                 clause (IV) and inserting “; and”; and

9                 (C) by adding at the end the following new  
10                subclause:

11                “(V) the annual adjustment in the fee schedules  
12                determined under clause (i) for years beginning with  
13                2010 shall be subject to the productivity adjustment  
14                described in section 1886(b)(3)(B)(iii)(II).”.

15           (e) *CERTAIN DURABLE MEDICAL EQUIPMENT*.—Sec-  
16           tion 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is  
17           amended—

18                (1) in subparagraph (K), by inserting before the  
19                semicolon at the end the following: “, subject to the  
20                productivity adjustment described in section  
21                1886(b)(3)(B)(iii)(II)”;

22                (2) in subparagraph (L)(i), by inserting after  
23                “June 2013,” the following: “subject to the produc-  
24                tivity adjustment described in section  
25                1886(b)(3)(B)(iii)(II),”;

1           (3) in subparagraph (L)(ii), by inserting after  
2           “June 2013” the following: “, subject to the produc-  
3           tivity adjustment described in section  
4           1886(b)(3)(B)(iii)(II)”; and

5           (4) in subparagraph (M), by inserting before the  
6           period at the end the following: “, subject to the pro-  
7           ductivity adjustment described in section  
8           1886(b)(3)(B)(iii)(II)”.

9                           **PART 3—OTHER PROVISIONS**

10       **SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN**  
11                           **WHEELCHAIRS.**

12           (a) *IN GENERAL.*—Section 1834(a)(7)(A)(iii) of the  
13       *Social Security Act* (42 U.S.C. 1395m(a)(7)(A)(iii)) is  
14       amended—

15                   (1) in the heading, by inserting “CERTAIN COM-  
16                   PLEX REHABILITATIVE” after “OPTION FOR”; and

17                   (2) by striking “power-driven wheelchair” and  
18                   inserting “complex rehabilitative power-driven wheel-  
19                   chair recognized by the Secretary as classified within  
20                   group 3 or higher”.

21           (b) *EFFECTIVE DATE.*—The amendments made by sub-  
22       section (a) shall take effect on January 1, 2011, and shall  
23       apply to power-driven wheelchairs furnished on or after  
24       such date. Such amendments shall not apply to contracts  
25       entered into under section 1847 of the *Social Security Act*

1 (42 U.S.C. 1395w-3) pursuant to a bid submitted under  
 2 such section before October 1, 2010, under subsection  
 3 (a)(1)(B)(i)(I) of such section.

4 **SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DE-**  
 5 **CLINE OWNERSHIP, OF A CERTAIN ITEM OF**  
 6 **COMPLEX DURABLE MEDICAL EQUIPMENT**  
 7 **AFTER THE 13-MONTH CAPPED RENTAL PE-**  
 8 **RIOD ENDS.**

9 (a) *IN GENERAL.*—Section 1834(a)(7)(A) of the Social  
 10 Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

11 (1) in clause (ii)—

12 (A) by striking “RENTAL.—On” and insert-  
 13 ing “RENTAL.—

14 “(I) *IN GENERAL.*—Except as pro-  
 15 vided in subclause (II), on”; and

16 (B) by adding at the end the following new  
 17 subclause:

18 “(II) *OPTION TO ACCEPT OR RE-*  
 19 *JECT TRANSFER OF TITLE TO GROUP 3*  
 20 *SUPPORT SURFACE.*—

21 “(aa) *IN GENERAL.*—During  
 22 the 10th continuous month during  
 23 which payment is made for the  
 24 rental of a Group 3 Support Sur-  
 25 face under clause (i), the supplier

1           *of such item shall offer the indi-*  
2           *vidual the option to accept or re-*  
3           *ject transfer of title to a Group 3*  
4           *Support Surface after the 13th*  
5           *continuous month during which*  
6           *payment is made for the rental of*  
7           *the Group 3 Support Surface*  
8           *under clause (i). Such title shall*  
9           *be transferred to the individual*  
10          *only if the individual notifies the*  
11          *supplier not later than 1 month*  
12          *after the supplier makes such offer*  
13          *that the individual agrees to ac-*  
14          *cept transfer of the title to the*  
15          *Group 3 Support Surface. Unless*  
16          *the individual accepts transfer of*  
17          *title to the Group 3 Support Sur-*  
18          *face in the manner set forth in*  
19          *this subclause, the individual*  
20          *shall be deemed to have rejected*  
21          *transfer of title. If the individual*  
22          *agrees to accept the transfer of the*  
23          *title to the Group 3 Support Sur-*  
24          *face, the supplier shall transfer*  
25          *such title to the individual on the*

1 *first day that begins after the 13th*  
2 *continuous month during which*  
3 *payment is made for the rental of*  
4 *the Group 3 Support Surface*  
5 *under clause (i). If the supplier*  
6 *transfers title to the Group 3 Sup-*  
7 *port Surface under this subclause,*  
8 *payments for maintenance and*  
9 *servicing after the transfer of title*  
10 *shall be made in accordance with*  
11 *clause (iv). If the individual re-*  
12 *jects transfer of title under this*  
13 *subclause, payments for mainte-*  
14 *nance and servicing after the end*  
15 *of the period of medical need dur-*  
16 *ing which payment is made under*  
17 *clause (i) shall be made in accord-*  
18 *ance with clause (v).*

19 *“(bb) SPECIAL RULE.—If, on*  
20 *the effective date of this subclause,*  
21 *an individual’s rental period for*  
22 *a Group 3 Support Surface has*  
23 *exceeded 10 continuous months,*  
24 *but the first day that begins after*  
25 *the 13th continuous month during*

1           *which payment is made for the*  
2           *rental under clause (i) has not*  
3           *been reached, the supplier shall,*  
4           *within 1 month following such ef-*  
5           *fective date, offer the individual*  
6           *the option to accept or reject*  
7           *transfer of title to a Group 3 Sup-*  
8           *port Surface. Such title shall be*  
9           *transferred to the individual only*  
10          *if the individual notifies the sup-*  
11          *plier not later than 1 month after*  
12          *the supplier makes such offer that*  
13          *the individual agrees to accept*  
14          *transfer of title to the Group 3*  
15          *Support Surface. Unless the indi-*  
16          *vidual accepts transfer of title to*  
17          *the Group 3 Support Surface in*  
18          *the manner set forth in this sub-*  
19          *clause, the individual shall be*  
20          *deemed to have rejected transfer of*  
21          *title. If the individual agrees to*  
22          *accept the transfer of the title to*  
23          *the Group 3 Support Surface, the*  
24          *supplier shall transfer such title*  
25          *to the individual on the first day*



1                   that begins after the 13th contin-  
2                   uous month during which pay-  
3                   ment is made for the rental of the  
4                   Group 3 Support Surface under  
5                   clause (i) unless that day has  
6                   passed, in which case the supplier  
7                   shall transfer such title to the in-  
8                   dividual not later than 1 month  
9                   after notification that the indi-  
10                  vidual accepts transfer of title. If  
11                  the supplier transfers title to the  
12                  Group 3 Support Surface under  
13                  this subclause, payments for  
14                  maintenance and servicing after  
15                  the transfer of title shall be made  
16                  in accordance with clause (iv). If  
17                  the individual rejects transfer of  
18                  title under this subclause, pay-  
19                  ments for maintenance and serv-  
20                  icing after the end of the period of  
21                  medical need during which pay-  
22                  ment is made under clause (i)  
23                  shall be made in accordance with  
24                  clause (v).”;

1           (2) *in clause (iv), in the heading, by inserting*  
2           *“AFTER TRANSFER OF TITLE” after “SERVICING”; and*  
3           (3) *by adding at the end the following new*  
4           *clause:*

5                           *“(v) MAINTENANCE AND SERVICING OF*  
6                           *GROUP 3 SUPPORT SURFACE IF INDIVIDUAL*  
7                           *REJECTS TRANSFER OF TITLE.—In the case*  
8                           *of a Group 3 Support Surface for which the*  
9                           *individual has rejected transfer of title*  
10                           *under subclause (ii)(II)—*

11                           *“(I) during the first 6-month pe-*  
12                           *riod of medical need that follows the*  
13                           *period of medical need during which*  
14                           *payment is made under clause (i), no*  
15                           *payment shall be made for rental or*  
16                           *maintenance and servicing of the*  
17                           *Group 3 Support Surface; and*

18                           *“(II) during the first month of*  
19                           *each succeeding 6-month period of*  
20                           *medical need, a maintenance and serv-*  
21                           *icing payment may be made (for parts*  
22                           *and labor not covered by the supplier’s*  
23                           *or manufacturer’s warranty, as deter-*  
24                           *mined by the Secretary to be appro-*  
25                           *priate for the Group 3 Support Sur-*

1                   *face) and the amount recognized for*  
2                   *each such 6-month period is the lower*  
3                   *of—*

4                                 *“(aa) a reasonable and nec-*  
5                                 *essary maintenance and servicing*  
6                                 *fee or fees established by the Sec-*  
7                                 *retary; or*

8                                 *“(bb) 10 percent of the total*  
9                                 *of the purchase price recognized*  
10                                *under paragraph (8) with respect*  
11                                *to the Group 3 Support Surface.”.*

12            ***(b) EFFECTIVE DATE.—****The amendments made by this*  
13 *section shall take effect on the date of enactment of this Act.*

14 ***SEC. 1142. EXTENSION OF PAYMENT RULE FOR***  
15 ***BRACHYTHERAPY.***

16            *Section 1833(t)(16)(C) of the Social Security Act (42*  
17 *U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the*  
18 *Medicare Improvements for Patients and Providers Act of*  
19 *2008 (Public Law 110–275), is amended by striking, the*  
20 *first place it appears, “January 1, 2010” and inserting*  
21 *“January 1, 2012”.*

1 **SEC. 1143. HOME INFUSION THERAPY REPORT TO CON-**  
2 **GRESS.**

3 *Not later than 12 months after the date of enactment*  
4 *of this Act, the Medicare Payment Advisory Commission*  
5 *shall submit to Congress a report on the following:*

6 (1) *The scope of coverage for home infusion ther-*  
7 *apy in the fee-for-service Medicare program under*  
8 *title XVIII of the Social Security Act, Medicare Ad-*  
9 *vantage under part C of such title, the veteran's*  
10 *health care program under chapter 17 of title 38,*  
11 *United States Code, and among private payers, in-*  
12 *cluding an analysis of the scope of services provided*  
13 *by home infusion therapy providers to their patients*  
14 *in such programs.*

15 (2) *The benefits and costs of providing such cov-*  
16 *erage under the Medicare program, including a cal-*  
17 *culatation of the potential savings achieved through*  
18 *avoided or shortened hospital and nursing home stays*  
19 *as a result of Medicare coverage of home infusion*  
20 *therapy.*

21 (3) *An assessment of sources of data on the costs*  
22 *of home infusion therapy that might be used to con-*  
23 *struct payment mechanisms in the Medicare program.*

24 (4) *Recommendations, if any, on the structure of*  
25 *a payment system under the Medicare program for*  
26 *home infusion therapy, including an analysis of the*

1       *payment methodologies used under Medicare Advan-*  
2       *tage plans and private health plans for the provision*  
3       *of home infusion therapy and their applicability to*  
4       *the Medicare program.*

5       **SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS**  
6                   **(ASCS) TO SUBMIT COST DATA AND OTHER**  
7                   **DATA.**

8       *(a) COST REPORTING.—*

9               *(1) IN GENERAL.—Section 1833(i) of the Social*  
10       *Security Act (42 U.S.C. 1395l(i)) is amended by add-*  
11       *ing at the end the following new paragraph:*

12       *“(8) The Secretary shall require, as a condition of the*  
13       *agreement described in section 1832(a)(2)(F)(i), the submis-*  
14       *sion of such cost report as the Secretary may specify, taking*  
15       *into account the requirements for such reports under section*  
16       *1815 in the case of a hospital.”*

17               *(2) DEVELOPMENT OF COST REPORT.—Not later*  
18       *than 3 years after the date of the enactment of this*  
19       *Act, the Secretary of Health and Human Services*  
20       *shall develop a cost report form for use under section*  
21       *1833(i)(8) of the Social Security Act, as added by*  
22       *paragraph (1).*

23               *(3) AUDIT REQUIREMENT.—The Secretary shall*  
24       *provide for periodic auditing of cost reports submitted*

1        *under section 1833(i)(8) of the Social Security Act, as*  
2        *added by paragraph (1).*

3            (4) *EFFECTIVE DATE.*—*The amendment made by*  
4        *paragraph (1) shall apply to agreements applicable to*  
5        *cost reporting periods beginning 18 months after the*  
6        *date the Secretary develops the cost report form under*  
7        *paragraph (2).*

8        (b) *ADDITIONAL DATA ON QUALITY.*—

9            (1) *IN GENERAL.*—*Section 1833(i)(7) of such Act*  
10        *(42 U.S.C. 1395l(i)(7)) is amended—*

11            (A) *in subparagraph (B), by inserting “sub-*  
12        *ject to subparagraph (C),” after “may otherwise*  
13        *provide,”; and*

14            (B) *by adding at the end the following new*  
15        *subparagraph:*

16        *“(C) Under subparagraph (B) the Secretary shall re-*  
17        *quire the reporting of such additional data relating to qual-*  
18        *ity of services furnished in an ambulatory surgical facility,*  
19        *including data on health care associated infections, as the*  
20        *Secretary may specify.”.*

21            (2) *EFFECTIVE DATE.*—*The amendment made by*  
22        *paragraph (1) shall to reporting for years beginning*  
23        *with 2012.*

1 **SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.**

2 *Section 1833(t) of the Social Security Act (42 U.S.C.*  
3 *1395l(t)) is amended by adding at the end the following*  
4 *new paragraph:*

5 “(18) *AUTHORIZATION OF ADJUSTMENT FOR*  
6 *CANCER HOSPITALS.—*

7 “(A) *STUDY.—The Secretary shall conduct*  
8 *a study to determine if, under the system under*  
9 *this subsection, costs incurred by hospitals de-*  
10 *scribed in section 1886(d)(1)(B)(v) with respect*  
11 *to ambulatory payment classification groups ex-*  
12 *ceed those costs incurred by other hospitals fur-*  
13 *nishing services under this subsection (as deter-*  
14 *mined appropriate by the Secretary).*

15 “(B) *AUTHORIZATION OF ADJUSTMENT.—*  
16 *Insofar as the Secretary determines under sub-*  
17 *paragraph (A) that costs incurred by hospitals*  
18 *described in section 1886(d)(1)(B)(v) exceed those*  
19 *costs incurred by other hospitals furnishing serv-*  
20 *ices under this subsection, the Secretary shall*  
21 *provide for an appropriate adjustment under*  
22 *paragraph (2)(E) to reflect those higher costs ef-*  
23 *fective for services furnished on or after January*  
24 *1, 2011.”.*

1 **SEC. 1146. MEDICARE IMPROVEMENT FUND.**

2 *Section 1898(b)(1)(A) of the Social Security Act (42*  
3 *U.S.C. 1395iii(b)(1)(A)) is amended to read as follows:*

4 *“(A) the period beginning with fiscal year*  
5 *2011 and ending with fiscal year 2019,*  
6 *\$8,000,000,000; and”.*

7 **SEC. 1147. PAYMENT FOR IMAGING SERVICES.**

8 *(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT*  
9 *HIGHER PRESUMED UTILIZATION.—Section 1848 of the*  
10 *Social Security Act (42 U.S.C. 1395w) is amended—*

11 *(1) in subsection (b)(4)—*

12 *(A) in subparagraph (B), by striking “sub-*  
13 *paragraph (A)” and inserting “this paragraph”;*  
14 *and*

15 *(B) by adding at the end the following new*  
16 *subparagraph:*

17 *“(C) ADJUSTMENT IN PRACTICE EXPENSE*  
18 *TO REFLECT HIGHER PRESUMED UTILIZATION.—*  
19 *In computing the number of practice expense rel-*  
20 *ative value units under subsection (c)(2)(C)(ii)*  
21 *with respect to advanced diagnostic imaging*  
22 *services (as defined in section 1834(e)(1)(B)) ,*  
23 *the Secretary shall adjust such number of units*  
24 *so it reflects a 75 percent (rather than 50 per-*  
25 *cent) presumed rate of utilization of imaging*  
26 *equipment.”; and*



1           (2) *in subsection (c)(2)(B)(v)(II), by inserting*  
2           “AND OTHER PROVISIONS” after “OPD PAYMENT  
3           CAP”.

4           (b) *ADJUSTMENT IN TECHNICAL COMPONENT “DIS-*  
5 *COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE*  
6 *BODY PARTS.—Section 1848(b)(4) of such Act is further*  
7 *amended by adding at the end the following new subpara-*  
8 *graph:*

9                   “(D) *ADJUSTMENT IN TECHNICAL COMPO-*  
10                   *NENT DISCOUNT ON SINGLE-SESSION IMAGING IN-*  
11                   *VOLVING CONSECUTIVE BODY PARTS.—The Sec-*  
12                   *retary shall increase the reduction in expendi-*  
13                   *tures attributable to the multiple procedure pay-*  
14                   *ment reduction applicable to the technical com-*  
15                   *ponent for imaging under the final rule pub-*  
16                   *lished by the Secretary in the Federal Register*  
17                   *on November 21, 2005 (part 405 of title 42, Code*  
18                   *of Federal Regulations) from 25 percent to 50*  
19                   *percent.”.*

20           (c) *EFFECTIVE DATE.—Except as otherwise provided,*  
21 *this section, and the amendments made by this section, shall*  
22 *apply to services furnished on or after January 1, 2011.*

1 **SEC. 1148. DURABLE MEDICAL EQUIPMENT PROGRAM IM-**  
2 **PROVEMENTS.**

3 (a) *WAIVER OF SURETY BOND REQUIREMENT.*—Sec-  
4 *tion 1834(a)(16) of the Social Security Act (42 U.S.C.*  
5 *1395m(a)(16)) is amended by adding at the end the fol-*  
6 *lowing: “The requirement for a surety bond described in*  
7 *subparagraph (B) shall not apply in the case of a pharmacy*  
8 *(i) that has been enrolled under section 1866(j) as a sup-*  
9 *plier of durable medical equipment, prosthetics, orthotics,*  
10 *and supplies and has been issued (which may include re-*  
11 *newal of) a provider number (as described in the first sen-*  
12 *tence of this paragraph) for at least 5 years, and (ii) for*  
13 *which a final adverse action (as defined in section*  
14 *424.57(a) of title 42, Code of Federal Regulations) has never*  
15 *been imposed.”.*

16 (b) *ENSURING SUPPLY OF OXYGEN EQUIPMENT.*—

17 (1) *IN GENERAL.*—Section 1834(a)(5)(F) of the  
18 *Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is*  
19 *amended—*

20 (A) *in clause (i), by striking “After the”*  
21 *and inserting “Except as provided in clause*  
22 *(iii), after the”; and*

23 (B) *by adding at the end the following new*  
24 *clause:*

25 “(iii) *CONTINUATION OF SUPPLY.*—*In*  
26 *the case of a supplier furnishing such equip-*

1                    *ment to an individual under this subsection*  
2                    *as of the 27th month of the 36 months de-*  
3                    *scribed in clause (i), the supplier furnishing*  
4                    *such equipment as of such month shall con-*  
5                    *tinue to furnish such equipment to such in-*  
6                    *dividual (either directly or through arrange-*  
7                    *ments with other suppliers of such equip-*  
8                    *ment) during any subsequent period of med-*  
9                    *ical need for the remainder of the reasonable*  
10                   *useful lifetime of the equipment, as deter-*  
11                   *mined by the Secretary, regardless of the lo-*  
12                   *cation of the individual, unless another sup-*  
13                   *plier has accepted responsibility for con-*  
14                   *tinuing to furnish such equipment during*  
15                   *the remainder of such period.”.*

16                   (2) *EFFECTIVE DATE.*—*The amendments made*  
17                   *by paragraph (1) shall take effect as of the date of the*  
18                   *enactment of this Act and shall apply to the fur-*  
19                   *nishing of equipment to individuals for whom the*  
20                   *27th month of a continuous period of use of oxygen*  
21                   *equipment described in section 1834(a)(5)(F) of the*  
22                   *Social Security Act occurs on or after July 1, 2010.*

23                   (c) *TREATMENT OF CURRENT ACCREDITATION APPLI-*  
24                   *CATIONS.*—*Section 1834(a)(20)(F) of such Act (42 U.S.C.*  
25                   *1395m(a)(20)(F)) is amended—*

1 (1) *in clause (i)—*

2 (A) *by striking “clause (ii)” and inserting*  
3 *“clauses (ii) and (iii)”;* and

4 (B) *by striking “and” at the end;*

5 (2) *by striking the period at the end of clause*  
6 *(ii)(II) and by inserting “; and”;* and

7 (3) *by adding at the end the following:*

8 “(iii) *the requirement for accreditation*  
9 *described in clause (i) shall not apply for*  
10 *purposes of supplying diabetic testing sup-*  
11 *plies, canes, and crutches in the case of a*  
12 *pharmacy that is enrolled under section*  
13 *1866(j) as a supplier of durable medical*  
14 *equipment, prosthetics, orthotics, and sup-*  
15 *plies.*

16 *Any supplier that has submitted an application*  
17 *for accreditation before August 1, 2009, shall be*  
18 *deemed as meeting applicable standards and ac-*  
19 *creditation requirement under this subparagraph*  
20 *until such time as the independent accreditation*  
21 *organization takes action on the supplier’s appli-*  
22 *cation.”.*

23 (d) *RESTORING 36-MONTH OXYGEN RENTAL PERIOD*  
24 *IN CASE OF SUPPLIER BANKRUPTCY FOR CERTAIN INDIVID-*  
25 *UALS.—Section 1834(a)(5)(F) of such Act (42 U.S.C.*

1 1395m(a)(5)(F)) is amended by adding at the end the fol-  
2 lowing new clause:

3 “(iv) *EXCEPTION FOR BANKRUPTCY.*—  
4 *If a supplier of oxygen to an individual is*  
5 *declared bankrupt and its assets are liq-*  
6 *uidated and at the time of such declaration*  
7 *and liquidation more than 24 months of*  
8 *rental payments have been made, the indi-*  
9 *vidual may begin under this subparagraph*  
10 *a new 36-month rental period with another*  
11 *supplier of oxygen.”.*

12 (e) *PAYMENT ADJUSTMENT.*—Section 1834(a)(14)(K)  
13 of such Act (42 U.S.C. 1395m(a)(14)(K)), as amended by  
14 section 1131(e), is amended by inserting before the semi-  
15 colon at the end the following: “, -0.5 percent”.

16 **SEC. 1149. MEDPAC STUDY AND REPORT ON BONE MASS**  
17 **MEASUREMENT.**

18 (a) *IN GENERAL.*—The Medicare Payment Advisory  
19 Commission shall conduct a study regarding bone mass  
20 measurement, including computed tomography, dual-energy  
21 x-ray absorptriometry, and vertebral fracture assessment.  
22 The study shall focus on the following:

23 (1) *An assessment of the adequacy of Medicare*  
24 *payment rates for such services, taking into account*

1 *costs of acquiring the necessary equipment, profes-*  
2 *sional work time, and practice expense costs.*

3 *(2) The impact of Medicare payment changes*  
4 *since 2006 on beneficiary access to bone mass meas-*  
5 *urement benefits in general and in rural and minor-*  
6 *ity communities specifically.*

7 *(3) A review of the clinically appropriate and*  
8 *recommended use among Medicare beneficiaries and*  
9 *how usage rates among such beneficiaries compares to*  
10 *such recommendations.*

11 *(4) In conjunction with the findings under (3),*  
12 *recommendations, if necessary, regarding methods for*  
13 *reaching appropriate use of bone mass measurement*  
14 *studies among Medicare beneficiaries.*

15 *(b) REPORT.—The Commission shall submit a report*  
16 *to the Congress, not later than 9 months after the date of*  
17 *the enactment of this Act, containing a description of the*  
18 *results of the study conducted under subsection (a) and the*  
19 *conclusions and recommendations, if any, regarding each*  
20 *of the issues described in paragraphs (1), (2) (3) and (4)*  
21 *of such subsection.*

1 **SEC. 1149A. EXCLUSION OF CUSTOMARY PROMPT PAY DIS-**  
2 **COUNTS EXTENDED TO WHOLESALERS FROM**  
3 **MANUFACTURER’S AVERAGE SALES PRICE**  
4 **FOR PAYMENTS FOR DRUGS AND**  
5 **BIOLOGICALS UNDER MEDICARE PART B.**

6 *Section 1847A(c)(3) of the Social Security Act (42*  
7 *U.S.C. 1395w–3a(c)(3)) is amended—*

8 *(1) in the first sentence, by inserting after*  
9 *“prompt pay discounts” the following: “(other than,*  
10 *for drugs and biologicals that are sold on or after*  
11 *January 1, 2011, and before January 1, 2016, cus-*  
12 *tomary prompt pay discounts extended to wholesalers,*  
13 *but only to the extent such discounts do not exceed 2*  
14 *percent of the wholesale acquisition cost)”;* and

15 *(2) in the second sentence, by inserting after*  
16 *“other price concessions” the following: “(other than,*  
17 *for drugs and biologicals that are sold on or after*  
18 *January 1, 2011, and before January 1, 2016, cus-*  
19 *tomary prompt pay discounts extended to wholesalers,*  
20 *but only to the extent such discounts do not exceed 2*  
21 *percent of the wholesale acquisition cost)”.*

22 **SEC. 1149B. TIMELY ACCESS TO POSTMASTECTOMY ITEMS.**

23 *(a) IN GENERAL.—Section 1834(h)(1) of the Social Se-*  
24 *curity Act (42 U.S.C. 1395m(h)(1)) is amended—*

25 *(1) by redesignating subparagraph (H) as sub-*  
26 *paragraph (I); and*

1           (2) *by inserting after subparagraph (G) the fol-*  
2 *lowing new subparagraph:*

3                   “(H) *SPECIAL PAYMENT RULE FOR*  
4 *POSTMASTECTOMY EXTERNAL BREAST PROS-*  
5 *THESIS GARMENTS.—Payment for*  
6 *postmastectomy external breast prosthesis gar-*  
7 *ments shall be made regardless of whether such*  
8 *items are supplied to the beneficiary prior to or*  
9 *after the mastectomy procedure or other breast*  
10 *cancer surgical procedure. The Secretary shall*  
11 *develop policies to ensure appropriate beneficiary*  
12 *access and utilization safeguards for such items*  
13 *supplied to a beneficiary prior to the mastec-*  
14 *tomy or other breast cancer surgical procedure.”*

15           (b) *EFFECTIVE DATE.—The amendment made by sub-*  
16 *section (a) shall take effect the date of the enactment of this*  
17 *Act.*

18 **SEC. 1149C. MORATORIUM ON MEDICARE REDUCTIONS IN**  
19 **PAYMENT RATES FOR CERTAIN INTER-**  
20 **VENTIONAL PAIN MANAGEMENT PROCE-**  
21 **DURES COVERED UNDER THE ASC FEE**  
22 **SCHEDULE.**

23           (a) *IN GENERAL.—Notwithstanding any other provi-*  
24 *sion of law, the payment rate applied under section*  
25 *1833(i)(2) of the Social Security Act (42 U.S.C.*



1 13951(i)(2)) for interventional pain management proce-  
2 dures specified in subsection (b) which are furnished on or  
3 after January 1, 2010, and before January 1, 2012, shall  
4 not be less than the payment rate applied under such sec-  
5 tion for such procedures in effect as of January 1, 2007.

6 (b) *PROCEDURES SPECIFIED.*—For purposes of this  
7 section, the interventional pain management procedures  
8 specified in this subsection are the following:

9 (1) *Epidural injections (CPT 62310, 62311,*  
10 *64483, 64484).*

11 (2) *Facet joint injections (CPT 64470, 64472,*  
12 *64475, 64476).*

13 (3) *Sacroiliac joint injection (CPT 27096).*

14 **SEC. 1149D. MEDICARE COVERAGE OF SERVICES OF QUALI-**  
15 **FIED RESPIRATORY THERAPISTS PERFORMED**  
16 **UNDER THE GENERAL SUPERVISION OF A**  
17 **PHYSICIAN.**

18 (a) *IN GENERAL.*—Section 1861 of the Social Security  
19 Act (42 U.S.C. 1395x), as amended by sections 1233(a) and  
20 1309, is amended—

21 (1) *in subsection (s)(2)—*

22 (A) *by striking “and” at the end of sub-*  
23 *paragraph (GG);*

24 (B) *by adding “and” at the end of subpara-*  
25 *graph (HH); and*

1           (C) by adding at the end the following new  
2           subparagraph:

3           “(II) respiratory therapy services which would  
4           be physicians’ services if furnished by a physician (as  
5           defined in subsection (r)(1)) for the diagnosis and  
6           treatment of respiratory illnesses and which are per-  
7           formed by a respiratory therapist (as defined in sub-  
8           section (mmm)) under the general supervision of a  
9           physician and which the respiratory therapist is le-  
10          gally authorized to perform by the State in which the  
11          services are performed, but only if no facility or other  
12          provider charges or is paid any amounts with respect  
13          to the furnishing of such services;” and

14          (2) by adding after subsection (lll) the following  
15          new subsection:

16                                   “Respiratory Therapist

17          “(mmm) For purposes of subsection (s)(2)(II) and sec-  
18          tion 1833(a)(1)(X) only, the term ‘respiratory therapist’  
19          means an individual who—

20                                   “(1) is credentialed by a national credentialing  
21                                   board recognized by the Secretary;

22                                   “(2)(A) is licensed to practice respiratory ther-  
23                                   apy in the State in which the respiratory therapy  
24                                   services are performed, or

1           “(B) *in the case of an individual in a State*  
2           *which does not provide for such licensure, is legally*  
3           *authorized to perform respiratory therapy services (in*  
4           *the State in which the individual performed such*  
5           *services) under State law (or the State regulatory*  
6           *mechanism provided by State law);*

7           “(3) *is a registered respiratory therapist; and*

8           “(4) *holds a bachelor’s degree.*”

9           (b) *PAYMENT.*—Section 1833(a)(1) of such Act (42  
10 *U.S.C. 1395l(a)(1)), as amended by sections 1309(a)(4) and*  
11 *1309(b)(4), is amended—*

12           (1) *by striking “and” before “(Y)”;* and

13           (2) *by inserting before the semicolon at the end*  
14 *the following: “, and (Z) with respect to services de-*  
15 *scribed in section 1861(s)(2)(II) (relating to services*  
16 *furnished by a respiratory therapist) that are fur-*  
17 *nished by a respiratory therapist (as defined in sec-*  
18 *tion 1861(mmm)), the amount paid shall be equal to*  
19 *80 percent of the lesser of the actual charge for the*  
20 *services or 85 percent of the fee schedule amount pro-*  
21 *vided under section 1848 for the same services if fur-*  
22 *nished by a physician”.*

23           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
24 *section shall apply to services furnished on or after January*  
25 *1, 2010.*

1     ***Subtitle C—Provisions Related to***  
2             ***Medicare Parts A and B***

3     ***SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOS-***  
4             ***PITAL READMISSIONS.***

5             *(a) HOSPITALS.—*

6                 *(1) IN GENERAL.—Section 1886 of the Social Se-*  
7             *curity Act (42 U.S.C. 1395ww), as amended by sec-*  
8             *tion 1103(a), is amended by adding at the end the*  
9             *following new subsection:*

10             *“(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EX-*  
11             *CESS READMISSIONS.—*

12                 *“(1) IN GENERAL.—With respect to payment for*  
13             *discharges from an applicable hospital (as defined in*  
14             *paragraph (5)(C)) occurring during a fiscal year be-*  
15             *ginning on or after October 1, 2011, in order to ac-*  
16             *count for excess readmissions in the hospital, the Sec-*  
17             *retary shall reduce the payments that would otherwise*  
18             *be made to such hospital under subsection (d) (or sec-*  
19             *tion 1814(b)(3), as the case may be) for such a dis-*  
20             *charge by an amount equal to the product of—*

21                 *“(A) the base operating DRG payment*  
22             *amount (as defined in paragraph (2)) for the*  
23             *discharge; and*

1           “(B) *the adjustment factor (described in*  
2 *paragraph (3)(A)) for the hospital for the fiscal*  
3 *year.*

4           “(2) *BASE OPERATING DRG PAYMENT AMOUNT.—*

5           “(A) *IN GENERAL.—Except as provided in*  
6 *subparagraph (B), for purposes of this sub-*  
7 *section, the term ‘base operating DRG payment*  
8 *amount’ means, with respect to a hospital for a*  
9 *fiscal year, the payment amount that would oth-*  
10 *erwise be made under subsection (d) for a dis-*  
11 *charge if this subsection did not apply, reduced*  
12 *by any portion of such amount that is attrib-*  
13 *utable to payments under subparagraphs (B)*  
14 *and (F) of paragraph (5).*

15           “(B) *ADJUSTMENTS.—For purposes of sub-*  
16 *paragraph (A), in the case of a hospital that is*  
17 *paid under section 1814(b)(3), the term ‘base op-*  
18 *erating DRG payment amount’ means the pay-*  
19 *ment amount under such section.*

20           “(3) *ADJUSTMENT FACTOR.—*

21           “(A) *IN GENERAL.—For purposes of para-*  
22 *graph (1), the adjustment factor under this para-*  
23 *graph for an applicable hospital for a fiscal year*  
24 *is equal to the greater of—*

1           “(i) the ratio described in subpara-  
2           graph (B) for the hospital for the applicable  
3           period (as defined in paragraph (5)(D)) for  
4           such fiscal year; or

5           “(ii) the floor adjustment factor speci-  
6           fied in subparagraph (C).

7           “(B) *RATIO*.—The ratio described in this  
8           subparagraph for a hospital for an applicable  
9           period is equal to 1 minus the ratio of—

10           “(i) the aggregate payments for excess  
11           readmissions (as defined in paragraph  
12           (4)(A)) with respect to an applicable hos-  
13           pital for the applicable period; and

14           “(ii) the aggregate payments for all  
15           discharges (as defined in paragraph (4)(B))  
16           with respect to such applicable hospital for  
17           such applicable period.

18           “(C) *FLOOR ADJUSTMENT FACTOR*.—For  
19           purposes of subparagraph (A), the floor adjust-  
20           ment factor specified in this subparagraph for—

21           “(i) fiscal year 2012 is 0.99;

22           “(ii) fiscal year 2013 is 0.98;

23           “(iii) fiscal year 2014 is 0.97; or

24           “(iv) a subsequent fiscal year is 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 for*  
7                   *a fiscal year, the sum, for applicable conditions*  
8                   *(as defined in paragraph (5)(A)), of the product,*  
9                   *for each applicable condition, of—*

10                           “(i) *the base operating DRG payment*  
11                           *amount for such hospital for such fiscal*  
12                           *year for such condition;*

13                           “(ii) *the number of admissions for such*  
14                           *condition for such hospital for such fiscal*  
15                           *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 all*  
22                   *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) of—*

7                   “(I) *the risk adjusted readmis-*  
8                   *sions based on actual readmissions, as*  
9                   *determined consistent with a readmis-*  
10                   *sion measure methodology that has*  
11                   *been endorsed under paragraph*  
12                   *(5)(A)(ii)(I), for an applicable hospital*  
13                   *for such condition with respect to the*  
14                   *applicable period; to*

15                   “(II) *the risk adjusted expected re-*  
16                   *admissions (as determined consistent*  
17                   *with such a methodology) for such hos-*  
18                   *pital for such condition with respect to*  
19                   *such applicable period.*

20                   “(ii) *EXCLUSION OF CERTAIN RE-*  
21                   *ADMISSIONS.*—*For purposes of clause (i),*  
22                   *with respect to a hospital, excess readmis-*  
23                   *sions shall not include readmissions for an*  
24                   *applicable condition for which there are*  
25                   *fewer than a minimum number (as deter-*



1           mined by the Secretary) of discharges for  
2           such applicable condition for the applicable  
3           period and such hospital.

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 2014, for the  
9           determination of the excess readmissions  
10          ratio under subparagraph (C) to be based  
11          on a ranking of hospitals by readmission  
12          ratios (from lower to higher readmission ra-  
13          tios) normalized to a benchmark that is  
14          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 subpara-  
19                 graph (B), a condition or procedure selected by  
20                 the Secretary among conditions and procedures  
21                 for which—

22                         “(i) readmissions (as defined in sub-  
23                         paragraph (E)) that represent conditions or  
24                         procedures that are high volume or high ex-

1            *penditures under this title (or other criteria*  
2            *specified by the Secretary); and*

3            *“(ii) measures of such readmissions—*

4            *“(I) have been endorsed by the en-*  
5            *tity with a contract under section*  
6            *1890(a); and*

7            *“(II) such endorsed measures have*  
8            *appropriate exclusions for readmis-*  
9            *sions that are unrelated to the prior*  
10           *discharge (such as a planned readmis-*  
11           *sion or transfer to another applicable*  
12           *hospital).*

13           *“(B) EXPANSION OF APPLICABLE CONDI-*  
14           *TIONS.—Beginning with fiscal year 2013, the*  
15           *Secretary shall expand the applicable conditions*  
16           *beyond the 3 conditions for which measures have*  
17           *been endorsed as described in subparagraph*  
18           *(A)(ii)(I) as of the date of the enactment of this*  
19           *subsection to the additional 4 conditions that*  
20           *have been so identified by the Medicare Payment*  
21           *Advisory Commission in its report to Congress*  
22           *in June 2007 and to other conditions and proce-*  
23           *dures which may include an all-condition meas-*  
24           *ure of readmissions, as determined appropriate*  
25           *by the Secretary. In expanding such applicable*

1           *conditions, the Secretary shall seek the endorse-*  
2           *ment described in subparagraph (A)(ii)(I) but*  
3           *may apply such measures without such an en-*  
4           *dorsement.*

5           “(C) *APPLICABLE HOSPITAL.*—*The term*  
6           *‘applicable hospital’ means a subsection (d) hos-*  
7           *pital or a hospital that is paid under section*  
8           *1814(b)(3).*

9           “(D) *APPLICABLE PERIOD.*—*The term ‘ap-*  
10          *plicable period’ means, with respect to a fiscal*  
11          *year, such period as the Secretary shall specify*  
12          *for purposes of determining excess readmissions.*

13          “(E) *READMISSION.*—*The term ‘readmis-*  
14          *sion’ means, in the case of an individual who is*  
15          *discharged from an applicable hospital, the ad-*  
16          *mission of the individual to the same or another*  
17          *applicable hospital within a time period speci-*  
18          *fied by the Secretary from the date of such dis-*  
19          *charge. Insofar as the discharge relates to an ap-*  
20          *plicable condition for which there is an endorsed*  
21          *measure described in subparagraph (A)(ii)(I),*  
22          *such time period (such as 30 days) shall be con-*  
23          *sistent with the time period specified for such*  
24          *measure.*

1           “(6) *LIMITATIONS ON REVIEW.*—*There shall be*  
2           *no administrative or judicial review under section*  
3           *1869, section 1878, or otherwise of—*

4                     “(A) *the determination of base operating*  
5                     *DRG payment amounts;*

6                     “(B) *the methodology for determining the*  
7                     *adjustment factor under paragraph (3), includ-*  
8                     *ing excess readmissions ratio under paragraph*  
9                     *(4)(C), aggregate payments for excess readmis-*  
10                    *sions under paragraph (4)(A), and aggregate*  
11                    *payments for all discharges under paragraph*  
12                    *(4)(B), and applicable periods and applicable*  
13                    *conditions under paragraph (5);*

14                    “(C) *the measures of readmissions as de-*  
15                    *scribed in paragraph (5)(A)(ii); and*

16                    “(D) *the determination of a targeted hos-*  
17                    *pital under paragraph (8)(B)(i), the increase in*  
18                    *payment under paragraph (8)(B)(ii), the aggre-*  
19                    *gate cap under paragraph (8)(C)(i), the hospital-*  
20                    *specific limit under paragraph (8)(C)(ii), and*  
21                    *the form of payment made by the Secretary*  
22                    *under paragraph (8)(D).*

23           “(7) *MONITORING INAPPROPRIATE CHANGES IN*  
24            *ADMISSIONS PRACTICES.*—*The Secretary shall mon-*  
25            *itor the activities of applicable hospitals to determine*

1 *if such hospitals have taken steps to avoid patients at*  
2 *risk in order to reduce the likelihood of increasing re-*  
3 *admissions for applicable conditions. If the Secretary*  
4 *determines that such a hospital has taken such a step,*  
5 *after notice to the hospital and opportunity for the*  
6 *hospital to undertake action to alleviate such steps,*  
7 *the Secretary may impose an appropriate sanction.*

8 “(8) ASSISTANCE TO CERTAIN HOSPITALS.—

9 “(A) IN GENERAL.—For purposes of pro-  
10 viding funds to applicable hospitals to take steps  
11 described in subparagraph (E) to address factors  
12 that may impact readmissions of individuals  
13 who are discharged from such a hospital, for fis-  
14 cal years beginning on or after October 1, 2011,  
15 the Secretary shall make a payment adjustment  
16 for a hospital described in subparagraph (B),  
17 with respect to each such fiscal year, by a per-  
18 cent estimated by the Secretary to be consistent  
19 with subparagraph (C).

20 “(B) TARGETED HOSPITALS.—Subpara-  
21 graph (A) shall apply to an applicable hospital  
22 that—

23 “(i) received (or, in the case of an  
24 1814(b)(3) hospital, otherwise would have  
25 been eligible to receive) \$10,000,000 or more

1           *in disproportionate share payments using*  
2           *the latest available data as estimated by the*  
3           *Secretary; and*

4           “(i) *provides assurances satisfactory*  
5           *to the Secretary that the increase in pay-*  
6           *ment under this paragraph shall be used for*  
7           *purposes described in subparagraph (E).*

8           “(C) *CAPS.—*

9           “(i) *AGGREGATE CAP.—The aggregate*  
10           *amount of the payment adjustment under*  
11           *this paragraph for a fiscal year shall not*  
12           *exceed 5 percent of the estimated difference*  
13           *in the spending that would occur for such*  
14           *fiscal year with and without application of*  
15           *the adjustment factor described in para-*  
16           *graph (3) and applied pursuant to para-*  
17           *graph (1).*

18           “(ii) *HOSPITAL-SPECIFIC LIMIT.—The*  
19           *aggregate amount of the payment adjust-*  
20           *ment for a hospital under this paragraph*  
21           *shall not exceed the estimated difference in*  
22           *spending that would occur for such fiscal*  
23           *year for such hospital with and without ap-*  
24           *plication of the adjustment factor described*

1           *in paragraph (3) and applied pursuant to*  
2           *paragraph (1).*

3           “(D) *FORM OF PAYMENT.*—*The Secretary*  
4           *may make the additional payments under this*  
5           *paragraph on a lump sum basis, a periodic*  
6           *basis, a claim by claim basis, or otherwise.*

7           “(E) *USE OF ADDITIONAL PAYMENT.*—  
8           *Funding under this paragraph shall be used by*  
9           *targeted hospitals for transitional care activities*  
10          *designed to address the patient noncompliance*  
11          *issues that result in higher than normal read-*  
12          *mission rates, such as one or more of the fol-*  
13          *lowing:*

14                  “(i) *Providing care coordination serv-*  
15                  *ices to assist in transitions from the tar-*  
16                  *geted hospital to other settings.*

17                  “(ii) *Hiring translators and inter-*  
18                  *preters.*

19                  “(iii) *Increasing services offered by*  
20                  *discharge planners.*

21                  “(iv) *Ensuring that individuals receive*  
22                  *a summary of care and medication orders*  
23                  *upon discharge.*

1                   “(v) *Developing a quality improvement*  
2                   *plan to assess and remedy preventable read-*  
3                   *mission rates.*

4                   “(vi) *Assigning discharged individuals*  
5                   *to a medical home.*

6                   “(vii) *Doing other activities as deter-*  
7                   *mined appropriate by the Secretary.*

8                   “(F) *GAO REPORT ON USE OF FUNDS.—Not*  
9                   *later than 3 years after the date on which funds*  
10                   *are first made available under this paragraph,*  
11                   *the Comptroller General of the United States*  
12                   *shall submit to Congress a report on the use of*  
13                   *such funds.*

14                   “(G) *DISPROPORTIONATE SHARE HOSPITAL*  
15                   *PAYMENT.—In this paragraph, the term ‘dis-*  
16                   *proportionate share hospital payment’ means an*  
17                   *additional payment amount under subsection*  
18                   *(d)(5)(F).”.*

19                   “(b) *APPLICATION TO CRITICAL ACCESS HOSPITALS.—*  
20                   *Section 1814(l) of the Social Security Act (42 U.S.C.*  
21                   *1395f(l)) is amended—*

22                   (1) *in paragraph (5)—*

23                   (A) *by striking “and” at the end of sub-*  
24                   *paragraph (C);*



1           (B) by striking the period at the end of sub-  
2           paragraph (D) and inserting “; and”;

3           (C) by inserting at the end the following  
4           new subparagraph:

5           “(E) the methodology for determining the adjust-  
6           ment factor under paragraph (5), including the deter-  
7           mination of aggregate payments for actual and ex-  
8           pected readmissions, applicable periods, applicable  
9           conditions and measures of readmissions.”; and

10           (D) by redesignating such paragraph as  
11           paragraph (6); and

12           (2) by inserting after paragraph (4) the fol-  
13           lowing new paragraph:

14           “(5) The adjustment factor described in section  
15           1886(p)(3) shall apply to payments with respect to a crit-  
16           ical access hospital with respect to a cost reporting period  
17           beginning in fiscal year 2012 and each subsequent fiscal  
18           year (after application of paragraph (4) of this subsection)  
19           in a manner similar to the manner in which such section  
20           applies with respect to a fiscal year to an applicable hos-  
21           pital as described in section 1886(p)(2).”.

22           (c) *POST ACUTE CARE PROVIDERS.*—

23           (1) *INTERIM POLICY.*—

24           (A) *IN GENERAL.*—With respect to a read-  
25           mission to an applicable hospital or a critical

1           *access hospital (as described in section 1814(l) of*  
2           *the Social Security Act) from a post acute care*  
3           *provider (as defined in paragraph (3)) and such*  
4           *a readmission is not governed by section 412.531*  
5           *of title 42, Code of Federal Regulations, if the*  
6           *claim submitted by such a post-acute care pro-*  
7           *vider under title XVIII of the Social Security*  
8           *Act indicates that the individual was readmitted*  
9           *to a hospital from such a post-acute care pro-*  
10          *vider or admitted from home and under the care*  
11          *of a home health agency within 30 days of an*  
12          *initial discharge from an applicable hospital or*  
13          *critical access hospital, the payment under such*  
14          *title on such claim shall be the applicable per-*  
15          *cent specified in subparagraph (B) of the pay-*  
16          *ment that would otherwise be made under the re-*  
17          *spective payment system under such title for*  
18          *such post-acute care provider if this subsection*  
19          *did not apply.*

20                   *(B) APPLICABLE PERCENT DEFINED.—For*  
21                   *purposes of subparagraph (A), the applicable*  
22                   *percent is—*

23                           *(i) for fiscal or rate year 2012 is*  
24                           *0.996;*

1                   (ii) for fiscal or rate year 2013 is  
2                   0.993; and

3                   (iii) for fiscal or rate year 2014 is  
4                   0.99.

5                   (C) *EFFECTIVE DATE.*—Subparagraph (1)  
6                   shall apply to discharges or services furnished  
7                   (as the case may be with respect to the applicable  
8                   post acute care provider) on or after the first day  
9                   of the fiscal year or rate year, beginning on or  
10                  after October 1, 2011, with respect to the appli-  
11                  cable post acute care provider.

12                  (2) *DEVELOPMENT AND APPLICATION OF PER-*  
13                  *FORMANCE MEASURES.*—

14                  (A) *IN GENERAL.*—The Secretary of Health  
15                  and Human Services shall develop appropriate  
16                  measures of readmission rates for post acute care  
17                  providers. The Secretary shall seek endorsement  
18                  of such measures by the entity with a contract  
19                  under section 1890(a) of the Social Security Act  
20                  but may adopt and apply such measures under  
21                  this paragraph without such an endorsement.  
22                  The Secretary shall expand such measures in a  
23                  manner similar to the manner in which applica-  
24                  ble conditions are expanded under paragraph

1           *(5)(B) of section 1886(p) of the Social Security*  
2           *Act, as added by subsection (a).*

3           *(B) IMPLEMENTATION.—The Secretary shall*  
4           *apply, on or after October 1, 2014, with respect*  
5           *to post acute care providers, policies similar to*  
6           *the policies applied with respect to applicable*  
7           *hospitals and critical access hospitals under the*  
8           *amendments made by subsection (a). The provi-*  
9           *sions of paragraph (1) shall apply with respect*  
10           *to any period on or after October 1, 2014, and*  
11           *before such application date described in the pre-*  
12           *vious sentence in the same manner as such pro-*  
13           *visions apply with respect to fiscal or rate year*  
14           *2014.*

15           *(C) MONITORING AND PENALTIES.—The*  
16           *provisions of paragraph (7) of such section*  
17           *1886(p) shall apply to providers under this*  
18           *paragraph in the same manner as they apply to*  
19           *hospitals under such section.*

20           *(3) DEFINITIONS.—For purposes of this sub-*  
21           *section:*

22           *(A) POST ACUTE CARE PROVIDER.—The*  
23           *term “post acute care provider” means—*

1                   (i) a skilled nursing facility (as de-  
2                   fined in section 1819(a) of the Social Secu-  
3                   rity Act);

4                   (ii) an inpatient rehabilitation facility  
5                   (described in section 1886(h)(1)(A) of such  
6                   Act);

7                   (iii) a home health agency (as defined  
8                   in section 1861(o) of such Act); and

9                   (iv) a long term care hospital (as de-  
10                  fined in section 1861(ccc) of such Act).

11                  (B) *OTHER TERMS*.—The terms “applica-  
12                  ble condition”, “applicable hospital”, and “read-  
13                  mission” have the meanings given such terms in  
14                  section 1886(p)(5) of the Social Security Act, as  
15                  added by subsection (a)(1).

16                  (d) *PHYSICIANS*.—

17                   (1) *STUDY*.—The Secretary of Health and  
18                   Human Services shall conduct a study to determine  
19                   how the readmissions policy described in the previous  
20                   subsections could be applied to physicians.

21                   (2) *CONSIDERATIONS*.—In conducting the study,  
22                   the Secretary shall consider approaches such as—

23                           (A) creating a new code (or codes) and pay-  
24                           ment amount (or amounts) under the fee sched-  
25                           ule in section 1848 of the Social Security Act (in

1           *a budget neutral manner) for services furnished*  
2           *by an appropriate physician who sees an indi-*  
3           *vidual within the first week after discharge from*  
4           *a hospital or critical access hospital;*

5                   *(B) developing measures of rates of readmis-*  
6                   *sion for individuals treated by physicians;*

7                   *(C) applying a payment reduction for phy-*  
8                   *sicians who treat the patient during the initial*  
9                   *admission that results in a readmission; and*

10                   *(D) methods for attributing payments or*  
11                   *payment reductions to the appropriate physician*  
12                   *or physicians.*

13           *(3) REPORT.—The Secretary shall issue a public*  
14           *report on such study not later than the date that is*  
15           *one year after the date of the enactment of this Act.*

16           *(e) FUNDING.—For purposes of carrying out the provi-*  
17           *sions of this section, in addition to funds otherwise avail-*  
18           *able, out of any funds in the Treasury not otherwise appro-*  
19           *priated, there are appropriated to the Secretary of Health*  
20           *and Human Services for the Center for Medicare & Med-*  
21           *icaid Services Program Management Account \$25,000,000*  
22           *for each fiscal year beginning with 2010. Amounts appro-*  
23           *priated under this subsection for a fiscal year shall be avail-*  
24           *able until expended.*

1 **SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM**  
2 **PLAN AND BUNDLING PILOT PROGRAM.**

3 (a) *PLAN.*—

4 (1) *IN GENERAL.*—*The Secretary of Health and*  
5 *Human Services (in this section referred to as the*  
6 *“Secretary”)* shall develop a detailed plan to reform  
7 *payment for post acute care (PAC) services under the*  
8 *Medicare program under title XVIII of the Social Se-*  
9 *curity Act (in this section referred to as the “Medi-*  
10 *care program”). The goals of such payment reform*  
11 *are to—*

12 (A) *improve the coordination, quality, and*  
13 *efficiency of such services; and*

14 (B) *improve outcomes for individuals such*  
15 *as reducing the need for readmission to hospitals*  
16 *from providers of such services.*

17 (2) *BUNDLING POST ACUTE SERVICES.*—*The*  
18 *plan described in paragraph (1) shall include detailed*  
19 *specifications for a bundled payment for post acute*  
20 *services (in this section referred to as the “post acute*  
21 *care bundle”), and may include other approaches de-*  
22 *termined appropriate by the Secretary.*

23 (3) *POST ACUTE SERVICES.*—*For purposes of*  
24 *this section, the term “post acute services” means*  
25 *services for which payment may be made under the*  
26 *Medicare program that are furnished by skilled nurs-*

1        *ing facilities, inpatient rehabilitation facilities, long*  
2        *term care hospitals, hospital based outpatient reha-*  
3        *bilitation facilities and home health agencies to an*  
4        *individual after discharge of such individual from a*  
5        *hospital, and such other services determined appro-*  
6        *priate by the Secretary.*

7        *(b) DETAILS.—The plan described in subsection (a)(1)*  
8        *shall include consideration of the following issues:*

9                *(1) The nature of payments under a post acute*  
10              *care bundle, including the type of provider or entity*  
11              *to whom payment should be made, the scope of activi-*  
12              *ties and services included in the bundle, whether pay-*  
13              *ment for physicians' services should be included in the*  
14              *bundle, and the period covered by the bundle.*

15              *(2) Whether the payment should be consolidated*  
16              *with the payment under the inpatient prospective sys-*  
17              *tem under section 1886 of the Social Security Act (in*  
18              *this section referred to as MS-DRGs) or a separate*  
19              *payment should be established for such bundle, and if*  
20              *a separate payment is established, whether it should*  
21              *be made only upon use of post acute care services or*  
22              *for every discharge.*

23              *(3) Whether the bundle should be applied across*  
24              *all categories of providers of inpatient services (in-*  
25              *cluding critical access hospitals) and post acute care*



1 *services or whether it should be limited to certain cat-*  
2 *egories of providers, services, or discharges, such as*  
3 *high volume or high cost MS-DRGs.*

4 *(4) The extent to which payment rates could be*  
5 *established to achieve offsets for efficiencies that could*  
6 *be expected to be achieved with a bundle payment,*  
7 *whether such rates should be established on a national*  
8 *basis or for different geographic areas, should vary*  
9 *according to discharge, case mix, outliers, and geo-*  
10 *graphic differences in wages or other appropriate ad-*  
11 *justments, and how to update such rates.*

12 *(5) The nature of protections needed for individ-*  
13 *uals under a system of bundled payments to ensure*  
14 *that individuals receive quality care, are furnished*  
15 *the level and amount of services needed as determined*  
16 *by an appropriate assessment instrument, are offered*  
17 *choice of provider, and the extent to which transi-*  
18 *tional care services would improve quality of care for*  
19 *individuals and the functioning of a bundled post-*  
20 *acute system.*

21 *(6) The nature of relationships that may be re-*  
22 *quired between hospitals and providers of post acute*  
23 *care services to facilitate bundled payments, including*  
24 *the application of gainsharing, anti-referral, anti-*  
25 *kickback, and anti-trust laws.*

1           (7) *Quality measures that would be appropriate*  
2 *for reporting by hospitals and post acute providers*  
3 *(such as measures that assess changes in functional*  
4 *status and quality measures appropriate for each*  
5 *type of post acute services provider including how the*  
6 *reporting of such quality measures could be coordi-*  
7 *nated with other reporting of such quality measures*  
8 *by such providers otherwise required).*

9           (8) *How cost-sharing for a post acute care bun-*  
10 *dle should be treated relative to current rules for cost-*  
11 *sharing for inpatient hospital, home health, skilled*  
12 *nursing facility, and other services.*

13           (9) *How other programmatic issues should be*  
14 *treated in a post acute care bundle, including rules*  
15 *specific to various types of post-acute providers such*  
16 *as the post-acute transfer policy, three-day hospital*  
17 *stay to qualify for services furnished by skilled nurs-*  
18 *ing facilities, and the coordination of payments and*  
19 *care under the Medicare program and the Medicaid*  
20 *program.*

21           (10) *Such other issues as the Secretary deems*  
22 *appropriate.*

23           (c) *CONSULTATIONS AND ANALYSIS.—*

24           (1) *CONSULTATION WITH STAKEHOLDERS.—In*  
25 *developing the plan under subsection (a)(1), the Sec-*

1        *retary shall consult with relevant stakeholders and*  
2        *shall consider experience with such research studies*  
3        *and demonstrations that the Secretary determines ap-*  
4        *propriate.*

5                (2) *ANALYSIS AND DATA COLLECTION.—In devel-*  
6        *oping such plan, the Secretary shall—*

7                        (A) *analyze the issues described in sub-*  
8                        *section (b) and other issues that the Secretary*  
9                        *determines appropriate;*

10                      (B) *analyze the impacts (including geo-*  
11                      *graphic impacts) of post acute service reform ap-*  
12                      *proaches, including bundling of such services on*  
13                      *individuals, hospitals, post acute care providers,*  
14                      *and physicians;*

15                      (C) *use existing data (such as data sub-*  
16                      *mitted on claims) and collect such data as the*  
17                      *Secretary determines are appropriate to develop*  
18                      *such plan required in this section; and*

19                      (D) *if patient functional status measures*  
20                      *are appropriate for the analysis, to the extent*  
21                      *practical, build upon the CARE tool being devel-*  
22                      *oped pursuant to section 5008 of the Deficit Re-*  
23                      *duction Act of 2005.*

24                (d) *ADMINISTRATION.—*

1           (1) *FUNDING.*—*For purposes of carrying out the*  
2           *provisions of this section, in addition to funds other-*  
3           *wise available, out of any funds in the Treasury not*  
4           *otherwise appropriated, there are appropriated to the*  
5           *Secretary for the Center for Medicare & Medicaid*  
6           *Services Program Management Account \$15,000,000*  
7           *for each of the fiscal years 2010 through 2012.*  
8           *Amounts appropriated under this paragraph for a*  
9           *fiscal year shall be available until expended.*

10           (2) *EXPEDITED DATA COLLECTION.*—*Chapter 35*  
11           *of title 44, United States Code shall not apply to this*  
12           *section.*

13           (e) *PUBLIC REPORTS.*—

14           (1) *INTERIM REPORTS.*—*The Secretary shall*  
15           *issue interim public reports on a periodic basis on the*  
16           *plan described in subsection (a)(1), the issues de-*  
17           *scribed in subsection (b), and impact analyses as the*  
18           *Secretary determines appropriate.*

19           (2) *FINAL REPORT.*—*Not later than the date that*  
20           *is 3 years after the date of the enactment of this Act,*  
21           *the Secretary shall issue a final public report on such*  
22           *plan, including analysis of issues described in sub-*  
23           *section (b) and impact analyses.*

1           (f) *CONVERSION OF ACUTE CARE EPISODE DEM-*  
2 *ONSTRATION TO PILOT PROGRAM AND EXPANSION TO IN-*  
3 *CLUDE POST ACUTE SERVICES.—*

4           (1) *IN GENERAL.—Part E of title XVIII of the*  
5 *Social Security Act is amended by inserting after sec-*  
6 *tion 1866C the following new section:*

7 *“CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION*  
8 *TO PILOT PROGRAM AND EXPANSION TO INCLUDE*  
9 *POST ACUTE SERVICES*

10 *“SEC. 1866D. (a) IN GENERAL.—By not later than*  
11 *January 1, 2011, the Secretary shall, for the purpose of pro-*  
12 *moting the use of bundled payments to promote efficient*  
13 *and high quality delivery of care—*

14           *“(1) convert the acute care episode demonstra-*  
15 *tion program conducted under section 1866C to a*  
16 *pilot program; and*

17           *“(2) subject to subsection (c), expand such pro-*  
18 *gram as so converted to include post acute services*  
19 *and such other services the Secretary determines to be*  
20 *appropriate, which may include transitional services.*

21           *“(b) SCOPE.—The Secretary shall set specific goals for*  
22 *the number of acute and post-acute bundling test sites under*  
23 *the pilot program to ensure that the pilot program is of*  
24 *sufficient size and scope to—*

1           “(1) test the approaches under the pilot program  
2           in a variety of settings, including urban, rural, and  
3           underserved areas;

4           “(2) include geographic areas and additional  
5           conditions that account for significant program  
6           spending, as defined by the Secretary; and

7           “(3) subject to subsection (d), disseminate the  
8           pilot program rapidly on a national basis.

9           To the extent that the Secretary finds inpatient and post-  
10          acute care bundling to be successful in improving quality  
11          and reducing costs, the Secretary shall implement such  
12          mechanisms and reforms under the pilot program on as  
13          large a geographic scale as practical and economical, con-  
14          sistent with subsection (e).

15          “(c) *LIMITATION.*—The Secretary shall only expand  
16          the pilot program under subsection (a)(2) if the Secretary  
17          finds that—

18                 “(1) the demonstration program under section  
19                 1866C and pilot program under this section maintain  
20                 or increase the quality of care received by individuals  
21                 enrolled under this title; and

22                 “(2) such demonstration program and pilot pro-  
23                 gram reduce program expenditures and, based on the  
24                 certification under subsection (d), that the expansion  
25                 of such pilot program would result in estimated

1        *spending that would be less than what spending*  
2        *would otherwise be in the absence of this section.*

3        “(d) *CERTIFICATION.*—*For purposes of subsection (c),*  
4        *the Chief Actuary of the Centers for Medicare & Medicaid*  
5        *Services shall certify whether expansion of the pilot pro-*  
6        *gram under this section would result in estimated spending*  
7        *that would be less than what spending would otherwise be*  
8        *in the absence of this section.*

9        “(e) *VOLUNTARY PARTICIPATION.*—*Nothing in this*  
10       *paragraph shall be construed as requiring the participation*  
11       *of an entity in the pilot program under this section.”.*

12            (2)        *CONFORMING        AMENDMENT.*—*Section*  
13        *1866C(b) of the Social Security Act (42 U.S.C.*  
14        *1395cc–3(b)) is amended by striking “The Secretary”*  
15        *and inserting “Subject to section 1866D, the Sec-*  
16        *retary”.*

17        **SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.**

18        *Section 1895(b)(3)(B)(ii) of the Social Security Act*  
19        *(42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—*

20            (1) *in subclause (IV), by striking “and”;*

21            (2) *by redesignating subclause (V) as subclause*  
22        *(VII); and*

23            (3) *by inserting after subclause (IV) the fol-*  
24        *lowing new subclauses:*

1                   “(V) 2007, 2008, and 2009, sub-  
2                   ject to clause (v), the home health mar-  
3                   ket basket percentage increase;

4                   “(VI) 2010, subject to clause (v), 0  
5                   percent; and”.

6 **SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH**  
7                   **CARE.**

8                   (a) *ACCELERATION OF ADJUSTMENT FOR CASE MIX*  
9 *CHANGES.*—Section 1895(b)(3)(B) of the Social Security  
10 Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

11                   (1) in clause (iv), by striking “Insofar as” and  
12                   inserting “Subject to clause (vi), insofar as”; and

13                   (2) by adding at the end the following new  
14                   clause:

15                   “(vi) *SPECIAL RULE FOR CASE MIX*  
16                   *CHANGES FOR 2011.*—

17                   “(I) *IN GENERAL.*—With respect  
18                   to the case mix adjustments established  
19                   in section 484.220(a) of title 42, Code  
20                   of Federal Regulations, the Secretary  
21                   shall apply, in 2010, the adjustment  
22                   established in paragraph (3) of such  
23                   section for 2011, in addition to apply-  
24                   ing the adjustment established in para-  
25                   graph (2) for 2010.



1                   “(II) CONSTRUCTION.—Nothing  
2                   in this clause shall be construed as  
3                   limiting the amount of adjustment for  
4                   case mix for 2010 or 2011 if more re-  
5                   cent data indicate an appropriate ad-  
6                   justment that is greater than the  
7                   amount established in the section de-  
8                   scribed in subclause (I).”.

9                   (b) REBASING HOME HEALTH PROSPECTIVE PAYMENT  
10 AMOUNT.—Section 1895(b)(3)(A) of the Social Security Act  
11 (42 U.S.C. 1395fff(b)(3)(A)) is amended—

12                   (1) in clause (i)—

13                   (A) in subclause (III), by inserting “and be-  
14                   fore 2011” after “after the period described in  
15                   subclause (II)”; and

16                   (B) by inserting after subclause (III) the  
17                   following new subclauses:

18                   “(IV) Subject to clause (iii)(I), for  
19                   2011, such amount (or amounts) shall  
20                   be adjusted by a uniform percentage  
21                   determined to be appropriate by the  
22                   Secretary based on analysis of factors  
23                   such as changes in the average number  
24                   and types of visits in an episode, the  
25                   change in intensity of visits in an epi-

1           sode, growth in cost per episode, and  
2           other factors that the Secretary con-  
3           siders to be relevant.

4           “(V) Subject to clause (iii)(II), for  
5           a year after 2011, such a amount (or  
6           amounts) shall be equal to the amount  
7           (or amounts) determined under this  
8           clause for the previous year, updated  
9           under subparagraph (B).”; and

10           (2) by adding at the end the following new  
11           clause:

12                   “(iii) SPECIAL RULE IN CASE OF IN-  
13                   ABILITY TO EFFECT TIMELY REBASING.—

14                           “(I) APPLICATION OF PROXY  
15                           AMOUNT FOR 2011.—If the Secretary is  
16                           not able to compute the amount (or  
17                           amounts) under clause (i)(IV) so as to  
18                           permit, on a timely basis, the applica-  
19                           tion of such clause for 2011, the Sec-  
20                           retary shall substitute for such amount  
21                           (or amounts) 95 percent of the amount  
22                           (or amounts) that would otherwise be  
23                           specified under clause (i)(III) if it ap-  
24                           plied for 2011.

1                   “(II) *ADJUSTMENT FOR SUBSE-*  
2                   *QUENT YEARS BASED ON DATA.*—*If the*  
3                   *Secretary applies subclause (I), the*  
4                   *Secretary before July 1, 2011, shall*  
5                   *compare the amount (or amounts) ap-*  
6                   *plied under such subclause with the*  
7                   *amount (or amounts) that should have*  
8                   *been applied under clause (i)(IV). The*  
9                   *Secretary shall decrease or increase the*  
10                  *prospective payment amount (or*  
11                  *amounts) under clause (i)(V) for 2012*  
12                  *(or, at the Secretary’s discretion, over*  
13                  *a period of several years beginning*  
14                  *with 2012) by the amount (if any) by*  
15                  *which the amount (or amounts) ap-*  
16                  *plied under subclause (I) is greater or*  
17                  *less, respectively, than the amount (or*  
18                  *amounts) that should have been ap-*  
19                  *plied under clause (i)(IV).”.*

20 **SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVE-**  
21   **MENTS INTO MARKET BASKET UPDATE FOR**  
22   **HOME HEALTH SERVICES.**

23                   *(a) IN GENERAL.*—*Section 1895(b)(3)(B) of the Social*  
24                   *Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—*

1           (1) *in clause (iii), by inserting “(including being*  
 2 *subject to the productivity adjustment described in*  
 3 *section 1886(b)(3)(B)(iii)(II)” after “in the same*  
 4 *manner”;* and

5           (2) *in clause (v)(I), by inserting “(but not below*  
 6 *0)” after “reduced”.*

7           (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
 8 *section (a) shall apply to home health market basket per-*  
 9 *centage increases for years beginning with 2010.*

10 **SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE**  
 11 **PROHIBITION ON CERTAIN PHYSICIAN RE-**  
 12 **FERRALS MADE TO HOSPITALS.**

13           (a) *IN GENERAL.*—*Section 1877 of the Social Security*  
 14 *Act (42 U.S.C. 1395nn) is amended—*

15           (1) *in subsection (d)(2)—*

16           (A) *in subparagraph (A), by striking “and”*  
 17 *at the end;*

18           (B) *in subparagraph (B), by striking the*  
 19 *period at the end and inserting “; and”;* and

20           (C) *by adding at the end the following new*  
 21 *subparagraph:*

22           “*(C) in the case where the entity is a hos-*  
 23 *pital, the hospital meets the requirements of*  
 24 *paragraph (3)(D).”;*

25           (2) *in subsection (d)(3)—*

1           (A) in subparagraph (B), by striking “and”  
2           at the end;

3           (B) in subparagraph (C), by striking the  
4           period at the end and inserting “; and”; and

5           (C) by adding at the end the following new  
6           subparagraph:

7           “(D) the hospital meets the requirements de-  
8           scribed in subsection (i)(1).”;

9           (3) by amending subsection (f) to read as follows:

10          “(f) *REPORTING AND DISCLOSURE REQUIREMENTS.*—

11           “(1) *IN GENERAL.*—Each entity providing cov-  
12          ered items or services for which payment may be  
13          made under this title shall provide the Secretary with  
14          the information concerning the entity’s ownership, in-  
15          vestment, and compensation arrangements, includ-  
16          ing—

17           “(A) the covered items and services provided  
18          by the entity, and

19           “(B) the names and unique physician iden-  
20          tification numbers of all physicians with an  
21          ownership or investment interest (as described in  
22          subsection (a)(2)(A)), or with a compensation  
23          arrangement (as described in subsection  
24          (a)(2)(B)), in the entity, or whose immediate rel-  
25          atives have such an ownership or investment in-

1           *terest or who have such a compensation relation-*  
2           *ship with the entity.*

3           *Such information shall be provided in such form,*  
4           *manner, and at such times as the Secretary shall*  
5           *specify. The requirement of this subsection shall not*  
6           *apply to designated health services provided outside*  
7           *the United States or to entities which the Secretary*  
8           *determines provide services for which payment may*  
9           *be made under this title very infrequently.*

10           “(2) *REQUIREMENTS FOR HOSPITALS WITH PHY-*  
11           *SICIAN OWNERSHIP OR INVESTMENT.—In the case of*  
12           *a hospital that meets the requirements described in*  
13           *subsection (i)(1), the hospital shall—*

14                   “(A) *submit to the Secretary an initial re-*  
15                   *port, and periodic updates at a frequency deter-*  
16                   *mined by the Secretary, containing a detailed*  
17                   *description of the identity of each physician*  
18                   *owner and physician investor and any other*  
19                   *owners or investors of the hospital;*

20                   “(B) *require that any referring physician*  
21                   *owner or investor discloses to the individual*  
22                   *being referred, by a time that permits the indi-*  
23                   *vidual to make a meaningful decision regarding*  
24                   *the receipt of services, as determined by the Sec-*  
25                   *retary, the ownership or investment interest, as*

1 applicable, of such referring physician in the  
2 hospital; and

3 “(C) disclose the fact that the hospital is  
4 partially or wholly owned by one or more physi-  
5 cians or has one or more physician investors—

6 “(i) on any public website for the hos-  
7 pital; and

8 “(ii) in any public advertising for the  
9 hospital.

10 *The information to be reported or disclosed under this*  
11 *paragraph shall be provided in such form, manner,*  
12 *and at such times as the Secretary shall specify. The*  
13 *requirements of this paragraph shall not apply to des-*  
14 *ignated health services furnished outside the United*  
15 *States or to entities which the Secretary determines*  
16 *provide services for which payment may be made*  
17 *under this title very infrequently.*

18 “(3) *PUBLICATION OF INFORMATION.—The Sec-*  
19 *retary shall publish, and periodically update, the in-*  
20 *formation submitted by hospitals under paragraph*  
21 *(2)(A) on the public Internet website of the Centers*  
22 *for Medicare & Medicaid Services.”;*

23 (4) *by amending subsection (g)(5) to read as fol-*  
24 *lows:*

1           “(5) *FAILURE TO REPORT OR DISCLOSE INFOR-*  
2           *MATION.—*

3           “(A) *REPORTING.—Any person who is re-*  
4           *quired, but fails, to meet a reporting requirement*  
5           *of paragraphs (1) and (2)(A) of subsection (f) is*  
6           *subject to a civil money penalty of not more than*  
7           *\$10,000 for each day for which reporting is re-*  
8           *quired to have been made.*

9           “(B) *DISCLOSURE.—Any physician who is*  
10           *required, but fails, to meet a disclosure require-*  
11           *ment of subsection (f)(2)(B) or a hospital that is*  
12           *required, but fails, to meet a disclosure require-*  
13           *ment of subsection (f)(2)(C) is subject to a civil*  
14           *money penalty of not more than \$10,000 for each*  
15           *case in which disclosure is required to have been*  
16           *made.*

17           “(C) *APPLICATION.—The provisions of sec-*  
18           *tion 1128A (other than the first sentence of sub-*  
19           *section (a) and other than subsection (b)) shall*  
20           *apply to a civil money penalty under subpara-*  
21           *graphs (A) and (B) in the same manner as such*  
22           *provisions apply to a penalty or proceeding*  
23           *under section 1128A(a).”;* and

24           (5) *by adding at the end the following new sub-*  
25           *section:*



1       “(i) *REQUIREMENTS TO QUALIFY FOR RURAL PRO-*  
2 *VIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-*  
3 *REFERRAL PROHIBITION.*—

4               “(1) *REQUIREMENTS DESCRIBED.*—*For purposes*  
5 *of subsection (d)(3)(D), the requirements described in*  
6 *this paragraph are as follows:*

7                       “(A) *PROVIDER AGREEMENT.*—*The hospital*  
8 *had—*

9                               “(i) *physician ownership or investment*  
10 *on January 1, 2009; and*

11                               “(ii) *a provider agreement under sec-*  
12 *tion 1866 in effect on such date.*

13                       “(B) *PROHIBITION ON PHYSICIAN OWNER-*  
14 *SHIP OR INVESTMENT.*—*The percentage of the*  
15 *total value of the ownership or investment inter-*  
16 *ests held in the hospital, or in an entity whose*  
17 *assets include the hospital, by physician owners*  
18 *or investors in the aggregate does not exceed such*  
19 *percentage as of the date of enactment of this*  
20 *subsection.*

21                       “(C) *PROHIBITION ON EXPANSION OF FACIL-*  
22 *ITY CAPACITY.*—*Except as provided in para-*  
23 *graph (2), the number of operating rooms, proce-*  
24 *dure rooms, or beds of the hospital at any time*  
25 *on or after the date of the enactment of this sub-*

1           *section are no greater than the number of oper-*  
2           *ating rooms, procedure rooms, or beds, respec-*  
3           *tively, as of such date.*

4           “(D) *ENSURING BONA FIDE OWNERSHIP*  
5           *AND INVESTMENT.—*

6           “(i) *Any ownership or investment in-*  
7           *terests that the hospital offers to a physician*  
8           *are not offered on more favorable terms*  
9           *than the terms offered to a person who is*  
10          *not in a position to refer patients or other-*  
11          *wise generate business for the hospital.*

12          “(ii) *The hospital (or any investors in*  
13          *the hospital) does not directly or indirectly*  
14          *provide loans or financing for any physi-*  
15          *cian owner or investor in the hospital.*

16          “(iii) *The hospital (or any investors in*  
17          *the hospital) does not directly or indirectly*  
18          *guarantee a loan, make a payment toward*  
19          *a loan, or otherwise subsidize a loan, for*  
20          *any physician owner or investor or group of*  
21          *physician owners or investors that is related*  
22          *to acquiring any ownership or investment*  
23          *interest in the hospital.*

24          “(iv) *Ownership or investment returns*  
25          *are distributed to each owner or investor in*

1           *the hospital in an amount that is directly*  
2           *proportional to the ownership or investment*  
3           *interest of such owner or investor in the*  
4           *hospital.*

5           “(v) *The investment interest of the*  
6           *owner or investor is directly proportional to*  
7           *the owner’s or investor’s capital contribu-*  
8           *tions made at the time the ownership or in-*  
9           *vestment interest is obtained.*

10           “(vi) *Physician owners and investors*  
11           *do not receive, directly or indirectly, any*  
12           *guaranteed receipt of or right to purchase*  
13           *other business interests related to the hos-*  
14           *pital, including the purchase or lease of any*  
15           *property under the control of other owners*  
16           *or investors in the hospital or located near*  
17           *the premises of the hospital.*

18           “(vii) *The hospital does not offer a*  
19           *physician owner or investor the opportunity*  
20           *to purchase or lease any property under the*  
21           *control of the hospital or any other owner*  
22           *or investor in the hospital on more favor-*  
23           *able terms than the terms offered to a per-*  
24           *son that is not a physician owner or inves-*  
25           *tor.*

1           “(viii) *The hospital does not condition*  
2           *any physician ownership or investment in-*  
3           *terests either directly or indirectly on the*  
4           *physician owner or investor making or in-*  
5           *fluencing referrals to the hospital or other-*  
6           *wise generating business for the hospital.*

7           “(E) *PATIENT SAFETY.—In the case of a*  
8           *hospital that does not offer emergency services,*  
9           *the hospital has the capacity to—*

10           “(i) *provide assessment and initial*  
11           *treatment for medical emergencies; and*

12           “(ii) *if the hospital lacks additional*  
13           *capabilities required to treat the emergency*  
14           *involved, refer and transfer the patient with*  
15           *the medical emergency to a hospital with*  
16           *the required capability.*

17           “(F) *LIMITATION ON APPLICATION TO CER-*  
18           *TAIN CONVERTED FACILITIES.—The hospital was*  
19           *not converted from an ambulatory surgical cen-*  
20           *ter to a hospital on or after the date of enact-*  
21           *ment of this subsection.*

22           “(2) *EXCEPTION TO PROHIBITION ON EXPANSION*  
23           *OF FACILITY CAPACITY.—*

24           “(A) *PROCESS.—*

1           “(i) *ESTABLISHMENT.*—*The Secretary*  
2           *shall establish and implement a process*  
3           *under which a hospital may apply for an*  
4           *exception from the requirement under para-*  
5           *graph (1)(C).*

6           “(ii) *OPPORTUNITY FOR COMMUNITY*  
7           *INPUT.*—*The process under clause (i) shall*  
8           *provide persons and entities in the commu-*  
9           *nity in which the hospital applying for an*  
10           *exception is located with the opportunity to*  
11           *provide input with respect to the applica-*  
12           *tion.*

13           “(iii) *TIMING FOR IMPLEMENTATION.*—  
14           *The Secretary shall implement the process*  
15           *under clause (i) on the date that is one*  
16           *month after the promulgation of regulations*  
17           *described in clause (iv).*

18           “(iv) *REGULATIONS.*—*Not later than*  
19           *the first day of the month beginning 18*  
20           *months after the date of the enactment of*  
21           *this subsection, the Secretary shall promul-*  
22           *gate regulations to carry out the process*  
23           *under clause (i). The Secretary may issue*  
24           *such regulations as interim final regula-*  
25           *tions.*

1           “(B) *FREQUENCY.*—*The process described*  
2           *in subparagraph (A) shall permit a hospital to*  
3           *apply for an exception up to once every 2 years.*

4           “(C) *PERMITTED INCREASE.*—

5           “(i) *IN GENERAL.*—*Subject to clause*  
6           *(ii) and subparagraph (D), a hospital*  
7           *granted an exception under the process de-*  
8           *scribed in subparagraph (A) may increase*  
9           *the number of operating rooms, procedure*  
10           *rooms, or beds of the hospital above the*  
11           *baseline number of operating rooms, proce-*  
12           *dure rooms, or beds, respectively, of the hos-*  
13           *pital (or, if the hospital has been granted a*  
14           *previous exception under this paragraph,*  
15           *above the number of operating rooms, proce-*  
16           *dure rooms, or beds, respectively, of the hos-*  
17           *pital after the application of the most recent*  
18           *increase under such an exception).*

19           “(ii) *100 PERCENT INCREASE LIMITA-*  
20           *TION.*—*The Secretary shall not permit an*  
21           *increase in the number of operating rooms,*  
22           *procedure rooms, or beds of a hospital under*  
23           *clause (i) to the extent such increase would*  
24           *result in the number of operating rooms,*  
25           *procedure rooms, or beds of the hospital ex-*

1            *ceeding 200 percent of the baseline number*  
2            *of operating rooms, procedure rooms, or*  
3            *beds of the hospital.*

4            *“(iii) BASELINE NUMBER OF OPER-*  
5            *ATING ROOMS, PROCEDURE ROOMS, OR*  
6            *BEDS.—In this paragraph, the term ‘base-*  
7            *line number of operating rooms, procedure*  
8            *rooms, or beds’ means the number of oper-*  
9            *ating rooms, procedure rooms, or beds of a*  
10           *hospital as of the date of enactment of this*  
11           *subsection.*

12           *“(D) INCREASE LIMITED TO FACILITIES ON*  
13           *THE MAIN CAMPUS OF THE HOSPITAL.—Any in-*  
14           *crease in the number of operating rooms, proce-*  
15           *cedure rooms, or beds of a hospital pursuant to*  
16           *this paragraph may only occur in facilities on*  
17           *the main campus of the hospital.*

18           *“(E) CONDITIONS FOR APPROVAL OF AN IN-*  
19           *CREASE IN FACILITY CAPACITY.—The Secretary*  
20           *may grant an exception under the process de-*  
21           *scribed in subparagraph (A) only to a hospital—*

22           *“(i) that is located in a county in*  
23           *which the percentage increase in the popu-*  
24           *lation during the most recent 5-year period*  
25           *for which data are available is estimated to*

1           *be at least 150 percent of the percentage in-*  
2           *crease in the population growth of the State*  
3           *in which the hospital is located during that*  
4           *period, as estimated by Bureau of the Cen-*  
5           *sus and available to the Secretary;*

6           “(ii) *whose annual percent of total in-*  
7           *patient admissions that represent inpatient*  
8           *admissions under the program under title*  
9           *XIX is estimated to be equal to or greater*  
10          *than the average percent with respect to*  
11          *such admissions for all hospitals located in*  
12          *the county in which the hospital is located;*

13          “(iii) *that does not discriminate*  
14          *against beneficiaries of Federal health care*  
15          *programs and does not permit physicians*  
16          *practicing at the hospital to discriminate*  
17          *against such beneficiaries;*

18          “(iv) *that is located in a State in*  
19          *which the average bed capacity in the State*  
20          *is estimated to be less than the national av-*  
21          *erage bed capacity;*

22          “(v) *that has an average bed occu-*  
23          *pancy rate that is estimated to be greater*  
24          *than the average bed occupancy rate in the*  
25          *State in which the hospital is located; and*



1                   “(vi) that meets other conditions as de-  
2                   termined by the Secretary.

3                   “(F) *PROCEDURE ROOMS.*—In this sub-  
4                   section, the term ‘procedure rooms’ includes  
5                   rooms in which catheterizations, angiographies,  
6                   angiograms, and endoscopies are furnished, but  
7                   such term shall not include emergency rooms or  
8                   departments (except for rooms in which catheter-  
9                   izations, angiographies, angiograms, and  
10                  endoscopies are furnished).

11                  “(G) *PUBLICATION OF FINAL DECISIONS.*—  
12                  Not later than 120 days after receiving a com-  
13                  plete application under this paragraph, the Sec-  
14                  retary shall publish on the public Internet  
15                  website of the Centers for Medicare & Medicaid  
16                  Services the final decision with respect to such  
17                  application.

18                  “(H) *LIMITATION ON REVIEW.*—There shall  
19                  be no administrative or judicial review under  
20                  section 1869, section 1878, or otherwise of the ex-  
21                  ception process under this paragraph, including  
22                  the establishment of such process, and any deter-  
23                  mination made under such process.

24                  “(3) *PHYSICIAN OWNER OR INVESTOR DE-*  
25                  *FINED.*—For purposes of this subsection and sub-

1        *section (f)(2), the term ‘physician owner or investor’*  
2        *means a physician (or an immediate family member*  
3        *of such physician) with a direct or an indirect owner-*  
4        *ship or investment interest in the hospital.*

5            *“(4) PATIENT SAFETY REQUIREMENT.—In the*  
6        *case of a hospital to which the requirements of para-*  
7        *graph (1) apply, insofar as the hospital admits a pa-*  
8        *tient and does not have any physician available on*  
9        *the premises 24 hours per day, 7 days per week, be-*  
10       *fore admitting the patient—*

11            *“(A) the hospital shall disclose such fact to*  
12        *the patient; and*

13            *“(B) following such disclosure, the hospital*  
14        *shall receive from the patient a signed acknowl-*  
15        *edgment that the patient understands such fact.*

16            *“(5) CLARIFICATION.—Nothing in this subsection*  
17        *shall be construed as preventing the Secretary from*  
18        *terminating a hospital’s provider agreement if the*  
19        *hospital is not in compliance with regulations pursu-*  
20        *ant to section 1866.”.*

21        *(b) VERIFYING COMPLIANCE.—The Secretary of Health*  
22        *and Human Services shall establish policies and procedures*  
23        *to verify compliance with the requirements described in sub-*  
24        *sections (i)(1) and (i)(4) of section 1877 of the Social Secu-*  
25        *rity Act, as added by subsection (a)(5). The Secretary may*

1 *use unannounced site reviews of hospitals and audits to*  
2 *verify compliance with such requirements.*

3 *(c) IMPLEMENTATION.—*

4 *(1) FUNDING.—For purposes of carrying out the*  
5 *amendments made by subsection (a) and the provi-*  
6 *sions of subsection (b), in addition to funds otherwise*  
7 *available, out of any funds in the Treasury not other-*  
8 *wise appropriated there are appropriated to the Sec-*  
9 *retary of Health and Human Services for the Centers*  
10 *for Medicare & Medicaid Services Program Manage-*  
11 *ment Account \$5,000,000 for each fiscal year begin-*  
12 *ning with fiscal year 2010. Amounts appropriated*  
13 *under this paragraph for a fiscal year shall be avail-*  
14 *able until expended.*

15 *(2) ADMINISTRATION.—Chapter 35 of title 44,*  
16 *United States Code, shall not apply to the amend-*  
17 *ments made by subsection (a) and the provisions of*  
18 *subsection (b).*

19 **SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEO-**  
20 **GRAPHIC ADJUSTMENT FACTORS UNDER**  
21 **MEDICARE.**

22 *(a) IN GENERAL.—The Secretary of Health and*  
23 *Human Services shall enter into a contract with the Insti-*  
24 *tute of Medicine of the National Academy of Science to con-*  
25 *duct a comprehensive empirical study, and provide rec-*

1 *ommendations as appropriate, on the accuracy of the geo-*  
2 *graphic adjustment factors established under sections*  
3 *1848(e) and 1886(d)(3)(E) of the Social Security Act (42*  
4 *U.S.C. 1395w-4(e), 11395ww(d)(3)).*

5 *(b) MATTERS INCLUDED.—Such study shall include*  
6 *an evaluation and assessment of the following with respect*  
7 *to such adjustment factors:*

8 *(1) Empirical validity of the adjustment factors.*

9 *(2) Methodology used to determine the adjust-*  
10 *ment factors.*

11 *(3) Measures used for the adjustment factors,*  
12 *taking into account—*

13 *(A) timeliness of data and frequency of revi-*  
14 *sions to such data;*

15 *(B) sources of data and the degree to which*  
16 *such data are representative of costs; and*

17 *(C) operational costs of providers who par-*  
18 *ticipate in Medicare.*

19 *(c) EVALUATION.—Such study shall, within the context*  
20 *of the United States health care marketplace, evaluate and*  
21 *consider the following:*

22 *(1) The effect of the adjustment factors on the*  
23 *level and distribution of the health care workforce and*  
24 *resources, including—*

1           (A) recruitment and retention that takes  
2           into account workforce mobility between urban  
3           and rural areas;

4           (B) ability of hospitals and other facilities  
5           to maintain an adequate and skilled workforce;  
6           and

7           (C) patient access to providers and needed  
8           medical technologies.

9           (2) The effect of the adjustment factors on popu-  
10          lation health and quality of care.

11          (3) The effect of the adjustment factors on the  
12          ability of providers to furnish efficient, high value  
13          care.

14          (d) *REPORT.*—The contract under subsection (a) shall  
15          provide for the Institute of Medicine to submit, not later  
16          than one year after the date of the enactment of this Act,  
17          to the Secretary and the Congress a report containing re-  
18          sults and recommendations of the study conducted under  
19          this section.

20          (e) *FUNDING.*—There are authorized to be appro-  
21          priated to carry out this section such sums as may be nec-  
22          essary.

1 **SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO**  
2 **ADDRESS GEOGRAPHIC INEQUITIES. .**

3 (a) *IN GENERAL.*—Taking into account the rec-  
4 ommendations described in the report under section  
5 1157(d), and notwithstanding the geographic adjustments  
6 that would otherwise apply under sections 1848(e) and  
7 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w-  
8 4(e), 1395ww(d)(3)(E)), the Secretary of Health and  
9 Human Services shall include in proposed rules applicable  
10 to the rulemaking cycle for payment systems for physicians'  
11 services and inpatient hospital services under sections 1848  
12 and 1886(d) of such Act, respectively, proposals (as the Sec-  
13 retary determines to be appropriate) to revise the geo-  
14 graphic adjustment factors used in such systems. Such pro-  
15 posals shall be contained in the next rulemaking cycle fol-  
16 lowing the submission to the Secretary of the report under  
17 section 1157(d).

18 (b) *PAYMENT ADJUSTMENTS.*—

19 (1) *FUNDING FOR IMPROVEMENTS.*—The Sec-  
20 retary shall use funds as provided under subsection  
21 (c) in making changes to the geographic adjustment  
22 factors pursuant to subsection (a). In making such  
23 changes to such geographic adjustment factors, the  
24 Secretary shall ensure that the estimated increased ex-  
25 penditures resulting from such changes does not ex-  
26 ceed the amounts provided under subsection (c).

1           (2) *ENSURING FAIRNESS.*—*In carrying out this*  
 2           *subsection, the Secretary shall not reduce the geo-*  
 3           *graphic adjustment below the factor that applied for*  
 4           *such payment system in the payment year before such*  
 5           *changes.*

6           (c) *FUNDING.*—*Amounts in the Medicare Improvement*  
 7           *Fund under section 1898, as amended by section 1146, shall*  
 8           *be available to the Secretary to make changes to the geo-*  
 9           *graphic adjustments factors as described in subsections (a)*  
 10          *and (b) with respect to services furnished before January*  
 11          *1, 2014. No more than one-half of such amounts shall be*  
 12          *available with respect to services furnished in any one pay-*  
 13          *ment year.*

14           ***Subtitle D—Medicare Advantage***  
 15   ***Reforms***

16           ***PART 1—PAYMENT AND ADMINISTRATION***

17          ***SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-***  
 18   ***SERVICE COSTS.***

19           *Section 1853 of the Social Security Act (42 U.S.C.*  
 20          *1395w-23) is amended—*

21                           (1) *in subsection (j)(1)(A)—*

22   (A) *by striking “beginning with 2007” and*  
 23   *inserting “for 2007, 2008, 2009, and 2010”; and*

24   (B) *by inserting after “(k)(1)” the fol-*  
 25   *lowing: “, or, beginning with 2011, 1/12 of the*

1            *blended benchmark amount determined under*  
2            *subsection (n)(1)”; and*

3            *(2) by adding at the end the following new sub-*  
4            *section:*

5            *“(n) DETERMINATION OF BLENDED BENCHMARK*  
6            *AMOUNT.—*

7            *“(1) IN GENERAL.—For purposes of subsection*  
8            *(j), subject to paragraphs (3) and (4), the term ‘blend-*  
9            *ed benchmark amount’ means for an area—*

10            *“(A) for 2011 the sum of—*

11            *“(i)  $\frac{2}{3}$  of the applicable amount (as*  
12            *defined in subsection (k)) for the area and*  
13            *year; and*

14            *“(ii)  $\frac{1}{3}$  of the amount specified in*  
15            *paragraph (2) for the area and year;*

16            *“(B) for 2012 the sum of—*

17            *“(i)  $\frac{1}{3}$  of the applicable amount for*  
18            *the area and year; and*

19            *“(ii)  $\frac{2}{3}$  of the amount specified in*  
20            *paragraph (2) for the area and year; and*

21            *“(C) for a subsequent year the amount spec-*  
22            *ified in paragraph (2) for the area and year.*

23            *“(2) SPECIFIED AMOUNT.—The amount specified*  
24            *in this paragraph for an area and year is the amount*  
25            *specified in subsection (c)(1)(D)(i) for the area and*



1 *year adjusted (in a manner specified by the Sec-*  
 2 *retary) to take into account the phase-out in the indi-*  
 3 *rect costs of medical education from capitation rates*  
 4 *described in subsection (k)(4).*

5 “(3) *FEE-FOR-SERVICE PAYMENT FLOOR.*—*In no*  
 6 *case shall the blended benchmark amount for an area*  
 7 *and year be less than the amount specified in para-*  
 8 *graph (2).*

9 “(4) *EXCEPTION FOR PACE PLANS.*—*This sub-*  
 10 *section shall not apply to payments to a PACE pro-*  
 11 *gram under section 1894.”*

12 **SEC. 1162. QUALITY BONUS PAYMENTS.**

13 (a) *IN GENERAL.*—*Section 1853 of the Social Security*  
 14 *Act (42 U.S.C. 1395w-23), as amended by section 1161, is*  
 15 *amended—*

16 (1) *in subsection (j), by inserting “subject to sub-*  
 17 *section (o),” after “For purposes of this part,”; and*

18 (2) *by adding at the end the following new sub-*  
 19 *section:*

20 “(o) *QUALITY BASED PAYMENT ADJUSTMENT.*—

21 “(1) *HIGH QUALITY PLAN ADJUSTMENT.*—*For*  
 22 *years beginning with 2011, in the case of a Medicare*  
 23 *Advantage plan that is identified (under paragraph*  
 24 *(3)(E)(ii)) as a high quality MA plan with respect to*

1 *the year, the blended benchmark amount under sub-*  
 2 *section (n)(1) shall be increased—*

3 *“(A) for 2011, by 1.0 percent;*

4 *“(B) for 2012, by 2.0 percent; and*

5 *“(C) for a subsequent year, by 3.0 percent.*

6 *“(2) IMPROVED QUALITY PLAN ADJUSTMENT.—*

7 *For years beginning with 2011, in the case of a Medi-*  
 8 *care Advantage plan that is identified (under para-*  
 9 *graph (3)(E)(iii)) as an improved quality MA plan*  
 10 *with respect to the year, blended benchmark amount*  
 11 *under subsection (n)(1) shall be increased—*

12 *“(A) for 2011, by 0.33 percent;*

13 *“(B) for 2012, by 0.66 percent; and*

14 *“(C) for a subsequent year, by 1.0 percent.*

15 *“(3) DETERMINATIONS OF QUALITY.—*

16 *“(A) QUALITY PERFORMANCE.—The Sec-*  
 17 *retary shall provide for the computation of a*  
 18 *quality performance score for each Medicare Ad-*  
 19 *vantage plan to be applied for each year begin-*  
 20 *ning with 2010.*

21 *“(B) COMPUTATION OF SCORE.—*

22 *“(i) FOR YEARS BEFORE 2014.—For*  
 23 *years before 2014, the quality performance*  
 24 *score for a Medicare Advantage plan shall*  
 25 *be computed based on a blend (as des-*

1                   *ignated by the Secretary) of the plan’s per-*  
2                   *formance on—*

3                   *“(I) HEDIS effectiveness of care*  
4                   *quality measures;*

5                   *“(II) CAHPS quality measures;*  
6                   *and*

7                   *“(III) such other measures of clin-*  
8                   *ical quality as the Secretary may*  
9                   *specify.*

10                  *Such measures shall be risk-adjusted as the*  
11                  *Secretary deems appropriate.*

12                  *“(ii) ESTABLISHMENT OF OUTCOME-*  
13                  *BASED MEASURES.—By not later than for*  
14                  *2013 the Secretary shall implement report-*  
15                  *ing requirements for quality under this sec-*  
16                  *tion on measures selected under clause (iii)*  
17                  *that reflect the outcomes of care experienced*  
18                  *by individuals enrolled in Medicare Advan-*  
19                  *tage plans (in addition to measures de-*  
20                  *scribed in clause (i)). Such measures may*  
21                  *include—*

22                  *“(I) measures of rates of admis-*  
23                  *sion and readmission to a hospital;*

24                  *“(II) measures of prevention qual-*  
25                  *ity, such as those established by the*

1                    *Agency for Healthcare Research and*  
2                    *Quality (that include hospital admis-*  
3                    *sion rates for specified conditions);*

4                    *“(III) measures of patient mor-*  
5                    *tality and morbidity following surgery;*

6                    *“(IV) measures of health func-*  
7                    *tioning (such as limitations on activi-*  
8                    *ties of daily living) and survival for*  
9                    *patients with chronic diseases;*

10                   *“(V) measures of patient safety;*  
11                   *and*

12                   *“(VI) other measure of outcomes*  
13                   *and patient quality of life as deter-*  
14                   *mined by the Secretary.*

15                   *Such measures shall be risk-adjusted as the*  
16                   *Secretary deems appropriate. In deter-*  
17                   *mining the quality measures to be used*  
18                   *under this clause, the Secretary shall take*  
19                   *into consideration the recommendations of*  
20                   *the Medicare Payment Advisory Commis-*  
21                   *sion in its report to Congress under section*  
22                   *168 of the Medicare Improvements for Pa-*  
23                   *tients and Providers Act of 2008 (Public*  
24                   *Law 110–275) and shall provide preference*  
25                   *to measures collected on and comparable to*

1           *measures used in measuring quality under*  
2           *parts A and B.*

3           “(iii) *RULES FOR SELECTION OF*  
4           *MEASURES.—The Secretary shall select*  
5           *measures for purposes of clause (ii) con-*  
6           *sistent with the following:*

7                     “(I) *The Secretary shall provide*  
8                     *preference to clinical quality measures*  
9                     *that have been endorsed by the entity*  
10                    *with a contract with the Secretary*  
11                    *under section 1890(a).*

12                   “(II) *Prior to any measure being*  
13                    *selected under this clause, the Secretary*  
14                    *shall publish in the Federal Register*  
15                    *such measure and provide for a period*  
16                    *of public comment on such measure.*

17           “(iv) *TRANSITIONAL USE OF BLEND.—*  
18            *For payments for 2014 and 2015, the Sec-*  
19            *retary may compute the quality perform-*  
20            *ance score for a Medicare Advantage plan*  
21            *based on a blend of the measures specified*  
22            *in clause (i) and the measures described in*  
23            *clause (ii) and selected under clause (iii).*

24           “(v) *USE OF QUALITY OUTCOMES*  
25            *MEASURES.—For payments beginning with*

1           2016, the preponderance of measures used  
2           under this paragraph shall be quality out-  
3           comes measures described in clause (ii) and  
4           selected under clause (iii).

5           “(C) *DATA USED IN COMPUTING SCORE.*—  
6           Such score for application for—

7                   “(i) payments in 2011 shall be based  
8                   on quality performance data for plans for  
9                   2009; and

10                   “(ii) payments in 2012 and a subse-  
11                   quent year shall be based on quality per-  
12                   formance data for plans for the second pre-  
13                   ceding year.

14           “(D) *REPORTING OF DATA.*—Each Medicare  
15           Advantage organization shall provide for the re-  
16           porting to the Secretary of quality performance  
17           data described in subparagraph (B) (in order to  
18           determine a quality performance score under this  
19           paragraph) in such time and manner as the Sec-  
20           retary shall specify.

21           “(E) *RANKING OF PLANS.*—

22                   “(i) *INITIAL RANKING.*—Based on the  
23                   quality performance score described in sub-  
24                   paragraph (B) achieved with respect to a

1           year, the Secretary shall rank plan perform-  
2           ance—

3                   “(I) from highest to lowest based  
4                   on absolute scores; and

5                   “(II) from highest to lowest based  
6                   on percentage improvement in the score  
7                   for the plan from the previous year.

8           A plan which does not report quality per-  
9           formance data under subparagraph (D)  
10          shall be counted, for purposes of such rank-  
11          ing, as having the lowest plan performance  
12          and lowest percentage improvement.

13                   “(ii) IDENTIFICATION OF HIGH QUAL-  
14                   ITY PLANS IN TOP QUINTILE BASED ON PRO-  
15                   JECTED ENROLLMENT.—The Secretary  
16                   shall, based on the scores for each plan  
17                   under clause (i)(I) and the Secretary’s pro-  
18                   jected enrollment for each plan and subject  
19                   to clause (iv), identify those Medicare Ad-  
20                   vantage plans with the highest score that,  
21                   based upon projected enrollment, are pro-  
22                   jected to include in the aggregate 20 percent  
23                   of the total projected enrollment for the  
24                   year. For purposes of this subsection, a plan

1           so identified shall be referred to in this sub-  
2           section as a ‘high quality MA plan’.

3           “(iii) IDENTIFICATION OF IMPROVED  
4           QUALITY PLANS IN TOP QUINTILE BASED ON  
5           PROJECTED ENROLLMENT.—The Secretary  
6           shall, based on the percentage improvement  
7           score for each plan under clause (i)(II) and  
8           the Secretary’s projected enrollment for each  
9           plan and subject to clause (iv), identify  
10          those Medicare Advantage plans with the  
11          greatest percentage improvement score that,  
12          based upon projected enrollment, are pro-  
13          jected to include in the aggregate 20 percent  
14          of the total projected enrollment for the  
15          year. For purposes of this subsection, a plan  
16          so identified that is not a high quality plan  
17          for the year shall be referred to in this sub-  
18          section as an ‘improved quality MA plan’.

19          “(iv) AUTHORITY TO DISQUALIFY CER-  
20          TAIN PLANS.—In applying clauses (ii) and  
21          (iii), the Secretary may determine not to  
22          identify a Medicare Advantage plan if the  
23          Secretary has identified deficiencies in the  
24          plan’s compliance with rules for such plans  
25          under this part.



1           “(F) NOTIFICATION.—The Secretary, in the  
2           annual announcement required under subsection  
3           (b)(1)(B) in 2011 and each succeeding year,  
4           shall notify the Medicare Advantage organization  
5           that is offering a high quality plan or an im-  
6           proved quality plan of such identification for the  
7           year and the quality performance payment ad-  
8           justment for such plan for the year. The Sec-  
9           retary shall provide for publication on the  
10          website for the Medicare program of the informa-  
11          tion described in the previous sentence.”.

12 **SEC. 1163. EXTENSION OF SECRETARIAL CODING INTEN-**  
13 **SITY ADJUSTMENT AUTHORITY.**

14          Section 1853(a)(1)(C)(ii) of the Social Security Act  
15          (42 U.S.C. 1395w–23(a)(1)(C)(ii) is amended—

16               (1) in the matter before subclause (I), by striking  
17               “through 2010” and inserting “and each subsequent  
18               year”; and

19               (2) in subclause (II)—

20                     (A) by inserting “periodically” before “con-  
21                     duct an analysis”;

22                     (B) by inserting “on a timely basis” after  
23                     “are incorporated”; and

1           (C) by striking “only for 2008, 2009, and  
2           2010” and inserting “for 2008 and subsequent  
3           years”.

4 **SEC. 1164. SIMPLIFICATION OF ANNUAL BENEFICIARY**  
5 **ELECTION PERIODS.**

6           (a) 2 WEEK PROCESSING PERIOD FOR ANNUAL EN-  
7 ROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section  
8 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e))  
9 is amended—

10           (1) by striking “and” at the end of clause (iii);

11           (2) in clause (iv)—

12                   (A) by striking “and succeeding years” and  
13                   inserting “, 2008, 2009, and 2010”; and

14                   (B) by striking the period at the end and  
15                   inserting “; and”; and

16           (3) by adding at the end the following new  
17 clause:

18                           “(v) with respect to 2011 and suc-  
19                           ceeding years, the period beginning on No-  
20                           vember 1 and ending on December 15 of the  
21                           year before such year.”.

22           (b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN EN-  
23 ROLLMENT PERIOD (OEP).—Effective for plan years begin-  
24 ning with 2011, paragraph (2) of such section is amended  
25 by striking subparagraph (C).

1 **SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.**

2 *Section 1876(h)(5)(C) of the Social Security Act (42*  
3 *U.S.C. 1395mm(h)(5)(C)) is amended—*

4 *(1) in clause (ii), by striking “January 1, 2010”*  
5 *and inserting “January 1, 2012”; and*

6 *(2) in clause (iii), by striking “the service area*  
7 *for the year” and inserting “the portion of the plan’s*  
8 *service area for the year that is within the service*  
9 *area of a reasonable cost reimbursement contract”.*

10 **SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EM-**  
11 **PLOYER GROUP PLANS.**

12 *(a) IN GENERAL.—The first sentence of paragraph (2)*  
13 *of section 1857(i) of the Social Security Act (42 U.S.C.*  
14 *1395w–27(i)) is amended by inserting before the period at*  
15 *the end the following: “, but only if 90 percent of the Medi-*  
16 *care Advantage eligible individuals enrolled under such*  
17 *plan reside in a county in which the MA organization offers*  
18 *an MA local plan”.*

19 *(b) EFFECTIVE DATE.—The amendment made by sub-*  
20 *section (a) shall apply for plan years beginning on or after*  
21 *January 1, 2011, and shall not apply to plans which were*  
22 *in effect as of December 31, 2010.*

23 **SEC. 1167. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.**

24 *(a) REPORT TO CONGRESS.—Not later than 1 year*  
25 *after the date of the enactment of this Act, the Secretary*  
26 *of Health and Human Services shall submit to Congress*

1 *a report that evaluates the adequacy of the risk adjustment*  
2 *system under section 1853(a)(1)(C) of the Social Security*  
3 *Act (42 U.S.C. 1395-23(a)(1)(C)) in predicting costs for*  
4 *beneficiaries with chronic or co-morbid conditions, bene-*  
5 *ficiaries dually-eligible for Medicare and Medicaid, and*  
6 *non-Medicaid eligible low-income beneficiaries; and the*  
7 *need and feasibility of including further gradations of dis-*  
8 *eases or conditions and multiple years of beneficiary data.*

9 *(b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not later*  
10 *than January 1, 2012, the Secretary shall implement nec-*  
11 *essary improvements to the risk adjustment system under*  
12 *section 1853(a)(1)(C) of the Social Security Act (42 U.S.C.*  
13 *1395–23(a)(1)(C)), taking into account the evaluation*  
14 *under subsection (a).*

15 **SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STABILIZA-**  
16 **TION FUND.**

17 *(a) IN GENERAL.—Section 1858 of the Social Security*  
18 *Act (42 U.S.C. 1395w–27a) is amended by striking sub-*  
19 *section (e).*

20 *(b) TRANSITION.—Any amount contained in the MA*  
21 *Regional Plan Stabilization Fund as of the date of the en-*  
22 *actment of this Act shall be transferred to the Federal Sup-*  
23 *plementary Medical Insurance Trust Fund.*

1 **SEC. 1169. STUDY REGARDING THE EFFECTS OF CALCU-**  
2 **LATING MEDICARE ADVANTAGE PAYMENT**  
3 **RATES ON A REGIONAL AVERAGE OF MEDI-**  
4 **CARE FEE FOR SERVICE RATES.**

5 (a) *IN GENERAL.*—*The Administrator of the Centers*  
6 *for Medicare and Medicaid Services shall conduct a study*  
7 *to determine the potential effects of calculating Medicare*  
8 *Advantage payment rates on a more aggregated geographic*  
9 *basis (such as metropolitan statistical areas or other re-*  
10 *gional delineations) rather than using county boundaries.*  
11 *In conducting such study, the Administrator shall consider*  
12 *whether such alternative geographic basis would result in*  
13 *the following:*

- 14 (1) *Improvements in the quality of care.*  
15 (2) *Greater equity among providers.*  
16 (3) *More predictable benchmark amounts for*  
17 *Medicare advantage plans.*

18 (b) *CONSULTATIONS.*—*In conducting the study, the*  
19 *Administrator shall consult with the following:*

- 20 (1) *Experts in health care financing.*  
21 (2) *Representatives of foundations and other*  
22 *nonprofit entities that have conducted or supported*  
23 *research on Medicare financing issues.*  
24 (3) *Representatives from Medicare Advantage*  
25 *plans.*

1           (4) *Such other entities or people as determined*  
2           *by the Secretary.*

3           (c) *REPORT.*—*Not later than one year after the date*  
4           *of the enactment of this Act, the Administrator shall trans-*  
5           *mit a report to the Congress on the study conducted under*  
6           *this section. The report shall contain a detailed statement*  
7           *of findings and conclusions of the study, together with its*  
8           *recommendations for such legislation and administrative*  
9           *actions as the Administrator considers appropriate.*

10       **PART 2—BENEFICIARY PROTECTIONS AND ANTI-**  
11   **FRAUD**

12       **SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL**  
13   **HEALTH SERVICES.**

14           (a) *IN GENERAL.*—*Section 1852(a)(1) of the Social Se-*  
15           *curity Act (42 U.S.C. 1395w-22(a)(1)) is amended—*

16                 (1) *in subparagraph (A), by inserting before the*  
17                 *period at the end the following: “with cost-sharing*  
18                 *that is no greater (and may be less) than the cost-*  
19                 *sharing that would otherwise be imposed under such*  
20                 *program option”;*

21                 (2) *in subparagraph (B)(i), by striking “or an*  
22                 *actuarially equivalent level of cost-sharing as deter-*  
23                 *mined in this part”; and*

24                 (3) *by amending clause (ii) of subparagraph (B)*  
25                 *to read as follows:*

1                   “(i) *PERMITTING USE OF FLAT COPAY-*  
2                   *MENT OR PER DIEM RATE.*—*Nothing in*  
3                   *clause (i) shall be construed as prohibiting*  
4                   *a Medicare Advantage plan from using a*  
5                   *flat copayment or per diem rate, in lieu of*  
6                   *the cost-sharing that would be imposed*  
7                   *under part A or B, so long as the amount*  
8                   *of the cost-sharing imposed does not exceed*  
9                   *the amount of the cost-sharing that would*  
10                   *be imposed under the respective part if the*  
11                   *individual were not enrolled in a plan*  
12                   *under this part.”.*

13           (b) *LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED*  
14 *MEDICARE BENEFICIARIES.*—*Section 1852(a) of such Act*  
15 *is amended to read as follows:*

16                   “(7) *LIMITATION ON COST-SHARING FOR DUAL*  
17                   *ELIGIBLES AND QUALIFIED MEDICARE BENE-*  
18                   *FICIARIES.*—*In the case of a individual who is a full-*  
19                   *benefit dual eligible individual (as defined in section*  
20                   *1935(c)(6)) or a qualified medicare beneficiary (as*  
21                   *defined in section 1905(p)(1)) who is enrolled in a*  
22                   *Medicare Advantage plan, the plan may not impose*  
23                   *cost-sharing that exceeds the amount of cost-sharing*  
24                   *that would be permitted with respect to the individual*

1       *under this title and title XIX if the individual were*  
2       *not enrolled with such plan.”.*

3       (c) *EFFECTIVE DATES.*—

4           (1) *The amendments made by subsection (a)*  
5       *shall apply to plan years beginning on or after Janu-*  
6       *ary 1, 2011.*

7           (2) *The amendments made by subsection (b)*  
8       *shall apply to plan years beginning on or after Janu-*  
9       *ary 1, 2011.*

10 **SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLL-**  
11                   **EES IN PLANS WITH ENROLLMENT SUSPEN-**  
12                   **SION.**

13       *Section 1851(e)(4) of the Social Security Act (42*  
14 *U.S.C. 1395w(e)(4)) is amended—*

15           (1) *in subparagraph (C), by striking at the end*  
16       *“or”;*

17           (2) *in subparagraph (D)—*

18                   (A) *by inserting “, taking into account the*  
19       *health or well-being of the individual” before the*  
20       *period; and*

21                   (B) *by redesignating such subparagraph as*  
22       *subparagraph (E); and*

23           (3) *by inserting after subparagraph (C) the fol-*  
24       *lowing new subparagraph:*



1           “(D) the individual is enrolled in an MA  
 2           plan and enrollment in the plan is suspended  
 3           under paragraph (2)(B) or (3)(C) of section  
 4           1857(g) because of a failure of the plan to meet  
 5           applicable requirements; or”.

6 **SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN**  
 7           **ADMINISTRATIVE COSTS.**

8           (a) *DISCLOSURE OF MEDICAL LOSS RATIOS AND*  
 9 *OTHER EXPENSE DATA.*—Section 1851 of the Social Secu-  
 10 rity Act (42 U.S.C. 1395w–21), as previously amended by  
 11 this subtitle, is amended by adding at the end the following  
 12 new subsection:

13           “(p) *PUBLICATION OF MEDICAL LOSS RATIOS AND*  
 14 *OTHER COST-RELATED INFORMATION.*—

15           “(1) *IN GENERAL.*—The Secretary shall publish,  
 16 not later than November 1 of each year (beginning  
 17 with 2011), for each MA plan contract, the medical  
 18 loss ratio of the plan in the previous year.

19           “(2) *SUBMISSION OF DATA.*—

20           “(A) *IN GENERAL.*—Each MA organization  
 21 shall submit to the Secretary, in a form and  
 22 manner specified by the Secretary, data nec-  
 23 essary for the Secretary to publish the medical  
 24 loss ratio on a timely basis.

1           “(B) *DATA FOR 2010 AND 2011.*—*The data*  
2           *submitted under subparagraph (A) for 2010 and*  
3           *for 2011 shall be consistent in content with the*  
4           *data reported as part of the MA plan bid in*  
5           *June 2009 for 2010.*

6           “(C) *USE OF STANDARDIZED ELEMENTS*  
7           *AND DEFINITIONS.*—*The data to be submitted*  
8           *under subparagraph (A) relating to medical loss*  
9           *ratio for a year, beginning with 2012, shall be*  
10           *submitted based on the standardized elements*  
11           *and definitions developed under paragraph (3).*

12           “(3) *DEVELOPMENT OF DATA REPORTING STAND-*  
13           *ARDS.*—

14           “(A) *IN GENERAL.*—*The Secretary shall de-*  
15           *velop and implement standardized data elements*  
16           *and definitions for reporting under this sub-*  
17           *section, for contract years beginning with 2012,*  
18           *of data necessary for the calculation of the med-*  
19           *ical loss ratio for MA plans. Not later than De-*  
20           *cember 31, 2010, the Secretary shall publish a*  
21           *report describing the elements and definitions so*  
22           *developed.*

23           “(B) *CONSULTATION.*—*The Secretary shall*  
24           *consult with the Health Choices Commissioner,*  
25           *representatives of MA organizations, experts on*

1           *health plan accounting systems, and representa-*  
2           *tives of the National Association of Insurance*  
3           *Commissioners, in the development of such data*  
4           *elements and definitions.*

5           “(4) *MEDICAL LOSS RATIO TO BE DEFINED.—*  
6           *For purposes of this part, the term ‘medical loss ratio’*  
7           *has the meaning given such term by the Secretary,*  
8           *taking into account the meaning given such term by*  
9           *the Health Choices Commissioner under section 116 of*  
10          *the America’s Affordable Health Choices Act of*  
11          *2009.”.*

12          (b) *MINIMUM MEDICAL LOSS RATIO.—Section 1857(e)*  
13          *of the Social Security Act (42 U.S.C. 1395w–27(e)) is*  
14          *amended by adding at the end the following new paragraph:*

15                 “(4) *REQUIREMENT FOR MINIMUM MEDICAL*  
16                 *LOSS RATIO.—If the Secretary determines for a con-*  
17                 *tract year (beginning with 2014) that an MA plan*  
18                 *has failed to have a medical loss ratio (as defined in*  
19                 *section 1851(p)(4)) of at least .85—*

20                         “(A) *the Secretary shall require the Medi-*  
21                         *care Advantage organization offering the plan to*  
22                         *give enrollees a rebate (in the second succeeding*  
23                         *contract year) of premiums under this part (or*  
24                         *part B or part D, if applicable) by such amount*

1 as would provide for a benefits ratio of at least  
2 .85;

3 “(B) for 3 consecutive contract years, the  
4 Secretary shall not permit the enrollment of new  
5 enrollees under the plan for coverage during the  
6 second succeeding contract year; and

7 “(C) the Secretary shall terminate the plan  
8 contract if the plan fails to have such a medical  
9 loss ratio for 5 consecutive contract years.”.

10 **SEC. 1174. STRENGTHENING AUDIT AUTHORITY.**

11 (a) *FOR PART C PAYMENTS RISK ADJUSTMENT.*—Sec-  
12 tion 1857(d)(1) of the Social Security Act (42 U.S.C.  
13 1395w–27(d)(1)) is amended by inserting after “section  
14 1858(c)” the following: “, and data submitted with respect  
15 to risk adjustment under section 1853(a)(3)”.

16 (b) *ENFORCEMENT OF AUDITS AND DEFICIENCIES.*—

17 (1) *IN GENERAL.*—Section 1857(e) of such Act,  
18 as amended by section 1173, is amended by adding  
19 at the end the following new paragraph:

20 “(5) *ENFORCEMENT OF AUDITS AND DEFICI-*  
21 *ENCIES.*—

22 “(A) *INFORMATION IN CONTRACT.*—The Sec-  
23 retary shall require that each contract with an  
24 MA organization under this section shall include

1           *terms that inform the organization of the provi-*  
2           *sions in subsection (d).*

3           “(B) *ENFORCEMENT AUTHORITY.*—*The Sec-*  
4           *retary is authorized, in connection with con-*  
5           *ducting audits and other activities under sub-*  
6           *section (d), to take such actions, including pur-*  
7           *suit of financial recoveries, necessary to address*  
8           *deficiencies identified in such audits or other ac-*  
9           *tivities.”.*

10          (2) *APPLICATION UNDER PART D.*—*For provision*  
11          *applying the amendment made by paragraph (1) to*  
12          *prescription drug plans under part D, see section*  
13          *1860D–12(b)(3)(D) of the Social Security Act.*

14          (c) *EFFECTIVE DATE.*—*The amendments made by this*  
15          *section shall take effect on the date of the enactment of this*  
16          *Act and shall apply to audits and activities conducted for*  
17          *contract years beginning on or after January 1, 2011.*

18          **SEC. 1175. AUTHORITY TO DENY PLAN BIDS.**

19          (a) *IN GENERAL.*—*Section 1854(a)(5) of the Social Se-*  
20          *curity Act (42 U.S.C. 1395w–24(a)(5)) is amended by add-*  
21          *ing at the end the following new subparagraph:*

22                 “(C) *REJECTION OF BIDS.*—*Nothing in this*  
23                 *section shall be construed as requiring the Sec-*  
24                 *retary to accept any or every bid by an MA or-*  
25                 *ganization under this subsection.”.*

1           (b) *APPLICATION UNDER PART D.—Section 1860D–*  
 2 *11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended*  
 3 *by adding at the end the following new paragraph:*

4                   “(3) *REJECTION OF BIDS.—Paragraph (5)(C) of*  
 5 *section 1854(a) shall apply with respect to bids under*  
 6 *this section in the same manner as it applies to bids*  
 7 *by an MA organization under such section.”.*

8           (c) *EFFECTIVE DATE.—The amendments made by this*  
 9 *section shall apply to bids for contract years beginning on*  
 10 *or after January 1, 2011.*

11    ***PART 3—TREATMENT OF SPECIAL NEEDS PLANS***

12    ***SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN***  
 13                   ***ENROLLMENT PERIOD OF INDIVIDUALS INTO***  
 14                   ***CHRONIC CARE SPECIALIZED MA PLANS FOR***  
 15                   ***SPECIAL NEEDS INDIVIDUALS.***

16           *Section 1859(f)(4) of the Social Security Act (42*  
 17 *U.S.C. 1395w–28(f)(4)) is amended by adding at the end*  
 18 *the following new subparagraph:*

19                   “(C) *The plan does not enroll an individual*  
 20 *on or after January 1, 2011, other than during*  
 21 *an annual, coordinated open enrollment period*  
 22 *or when at the time of the diagnosis of the dis-*  
 23 *ease or condition that qualifies the individual as*  
 24 *an individual described in subsection*  
 25 *(b)(6)(B)(iii).”.*

1 **SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS**  
2 **PLANS TO RESTRICT ENROLLMENT.**

3 (a) *IN GENERAL.*—Section 1859(f)(1) of the Social Se-  
4 curity Act (42 U.S.C. 1395w–28(f)(1)) is amended by strik-  
5 ing “January 1, 2011” and inserting “January 1, 2013  
6 (or January 1, 2016, in the case of a plan described in  
7 section 1177(b)(1) of the America’s Affordable Health  
8 Choices Act of 2009)”.

9 (b) *GRANDFATHERING OF CERTAIN PLANS.*—

10 (1) *PLANS DESCRIBED.*—For purposes of section  
11 1859(f)(1) of the Social Security Act (42 U.S.C.  
12 1395w–28(f)(1)), a plan described in this paragraph  
13 is a plan that had a contract with a State that had  
14 a State program to operate an integrated Medicaid-  
15 Medicare program that had been approved by the  
16 Centers for Medicare & Medicaid Services as of Janu-  
17 ary 1, 2004.

18 (2) *ANALYSIS; REPORT.*—The Secretary of  
19 Health and Human Services shall provide, through a  
20 contract with an independent health services evalua-  
21 tion organization, for an analysis of the plans de-  
22 scribed in paragraph (1) with regard to the impact  
23 of such plans on cost, quality of care, patient satisfac-  
24 tion, and other subjects as specified by the Secretary.  
25 Not later than December 31, 2011, the Secretary shall  
26 submit to Congress a report on such analysis and

1 shall include in such report such recommendations  
2 with regard to the treatment of such plans as the Sec-  
3 retary deems appropriate.

4 ***Subtitle E—Improvements to***  
5 ***Medicare Part D***

6 **SEC. 1181. ELIMINATION OF COVERAGE GAP.**

7 (a) *IN GENERAL.*—Section 1860D–2(b) of such Act (42  
8 U.S.C. 1395w–102(b)) is amended—

9 (1) in paragraph (3)(A), by striking “paragraph  
10 (4)” and inserting “paragraphs (4) and (7)”;

11 (2) in paragraph (4)(B)(i), by inserting “subject  
12 to paragraph (7),” after “purposes of this part,”; and

13 (3) by adding at the end the following new para-  
14 graph:

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 (described in subsection  
21 (b)(3)) and decrease the annual out-of-pocket  
22 threshold from the amounts otherwise computed  
23 until there is a continuation of coverage from the  
24 initial coverage limit for expenditures incurred  
25 through the total amount of expenditures at



1           *which benefits are available under paragraph*  
2           *(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)*  
9           *times the out-of-pocket gap amount (as defined*  
10           *in subparagraph (E)) for the year.*

11           “(C) *DECREASE IN ANNUAL OUT-OF-POCKET*  
12           *THRESHOLD.—For a year beginning with 2011,*  
13           *the annual out-of-pocket threshold otherwise com-*  
14           *puted without regard to this paragraph shall be*  
15           *decreased by  $\frac{1}{2}$  of the cumulative phase-in per-*  
16           *centage of the out-of-pocket gap amount for the*  
17           *year multiplied by 1.75.*

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, 7.5  
2                   percent; and

3                   “(IV) for 2019 and each subse-  
4                   quent year, 10 percent.

5                   “(ii) *CUMULATIVE PHASE-IN PERCENT-*  
6                   *AGE.—The term ‘cumulative phase-in per-*  
7                   *centage’ means for a year the sum of the*  
8                   *annual phase-in percentage for the year and*  
9                   *the annual phase-in percentages for each*  
10                  *previous year beginning with 2011, but in*  
11                  *no case more than 100 percent.*

12                  “(E) *OUT-OF-POCKET GAP AMOUNT.—For*  
13                  *purposes of this paragraph, the term ‘out-of-*  
14                  *pocket gap amount’ means for a year the amount*  
15                  *by which—*

16                  “(i) *the annual out-of-pocket threshold*  
17                  *specified in paragraph (4)(B) for the year*  
18                  *(as determined as if this paragraph did not*  
19                  *apply), exceeds*

20                  “(ii) *the sum of—*

21                  “(I) *the annual deductible under*  
22                  *paragraph (1) for the year; and*

23                  “(II)  $\frac{1}{4}$  *of the amount by which*  
24                  *the initial coverage limit under para-*  
25                  *graph (3) for the year (as determined*

1                   as if this paragraph did not apply) ex-  
2                   ceeds such annual deductible.”.

3           (b) *REQUIRING DRUG MANUFACTURERS TO PROVIDE*  
4 *DRUG REBATES FOR FULL-BENEFIT DUAL ELIGIBLES.*—

5                   (1) *IN GENERAL.*—Section 1860D–2 of the Social  
6                   Security Act (42 U.S.C. 1396r–8) is amended—

7                           (A) in subsection (e)(1), in the matter before  
8                           subparagraph (A), by inserting “and subsection  
9                           (f)” after “this subsection”; and

10                           (B) by adding at the end the following new  
11                           subsection:

12                   “(f) *PRESCRIPTION DRUG REBATE AGREEMENT FOR*  
13 *FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.*—

14                           “(1) *IN GENERAL.*—In this part, the term ‘cov-  
15                           ered part D drug’ does not include any drug or bio-  
16                           logic that is manufactured by a manufacturer that  
17                           has not entered into and have in effect a rebate agree-  
18                           ment described in paragraph (2).

19                           “(2) *REBATE AGREEMENT.*—A rebate agreement  
20                           under this subsection shall require the manufacturer  
21                           to provide to the Secretary a rebate for each rebate  
22                           period (as defined in paragraph (6)(B)) ending after  
23                           December 31, 2010, in the amount specified in para-  
24                           graph (3) for any covered part D drug of the manu-  
25                           facturer dispensed after December 31, 2010, to any

1 *full-benefit dual eligible individual (as defined in*  
2 *paragraph (6)(A)) for which payment was made by*  
3 *a PDP sponsor under part D or a MA organization*  
4 *under part C for such period. Such rebate shall be*  
5 *paid by the manufacturer to the Secretary not later*  
6 *than 30 days after the date of receipt of the informa-*  
7 *tion described in section 1860D–12(b)(7), including*  
8 *as such section is applied under section 1857(f)(3).*

9 “(3) *REBATE FOR FULL-BENEFIT DUAL ELIGIBLE*  
10 *MEDICARE DRUG PLAN ENROLLEES.—*

11 “(A) *IN GENERAL.—The amount of the re-*  
12 *bate specified under this paragraph for a manu-*  
13 *facturer for a rebate period, with respect to each*  
14 *dosage form and strength of any covered part D*  
15 *drug provided by such manufacturer and dis-*  
16 *persed to a full-benefit dual eligible individual,*  
17 *shall be equal to the product of—*

18 “(i) *the total number of units of such*  
19 *dosage form and strength of the drug so pro-*  
20 *vided and dispensed for which payment was*  
21 *made by a PDP sponsor under part D or*  
22 *a MA organization under part C for the re-*  
23 *bate period (as reported under section*  
24 *1860D–12(b)(7), including as such section*  
25 *is applied under section 1857(f)(3)); and*

1           “(i) the amount (if any) by which—

2                   “(I) the Medicaid rebate amount  
3                   (as defined in subparagraph (B)) for  
4                   such form, strength, and period, ex-  
5                   ceeds

6                   “(II) the average Medicare drug  
7                   program full-benefit dual eligible re-  
8                   bate amount (as defined in subpara-  
9                   graph (C)) for such form, strength, and  
10                  period.

11               “(B) *MEDICAID REBATE AMOUNT*.—For  
12               purposes of this paragraph, the term ‘Medicaid  
13               rebate amount’ means, with respect to each dos-  
14               age form and strength of a covered part D drug  
15               provided by the manufacturer for a rebate pe-  
16               riod—

17                   “(i) in the case of a single source drug  
18                   or an innovator multiple source drug, the  
19                   amount specified in paragraph (1)(A)(ii) of  
20                   section 1927(c) plus the amount, if any,  
21                   specified in paragraph (2)(A)(ii) of such  
22                   section, for such form, strength, and period;  
23                   or

24                   “(ii) in the case of any other covered  
25                   outpatient drug, the amount specified in

1 paragraph (3)(A)(i) of such section for such  
2 form, strength, and period.

3 “(C) *AVERAGE MEDICARE DRUG PROGRAM*  
4 *FULL-BENEFIT DUAL ELIGIBLE REBATE*  
5 *AMOUNT.*—For purposes of this subsection, the  
6 term ‘average Medicare drug program full-benefit  
7 dual eligible rebate amount’ means, with respect  
8 to each dosage form and strength of a covered  
9 part D drug provided by a manufacturer for a  
10 rebate period, the sum, for all PDP sponsors  
11 under part D and MA organizations admin-  
12 istering a MA–PD plan under part C, of—

13 “(i) the product, for each such sponsor  
14 or organization, of—

15 “(I) the sum of all rebates, dis-  
16 counts, or other price concessions (not  
17 taking into account any rebate pro-  
18 vided under paragraph (2) for such  
19 dosage form and strength of the drug  
20 dispensed, calculated on a per-unit  
21 basis, but only to the extent that any  
22 such rebate, discount, or other price  
23 concession applies equally to drugs dis-  
24 pensed to full-benefit dual eligible  
25 Medicare drug plan enrollees and

1                    *drugs dispensed to PDP and MA–PD*  
2                    *enrollees who are not full-benefit dual*  
3                    *eligible individuals; and*

4                    “(II) *the number of the units of*  
5                    *such dosage and strength of the drug*  
6                    *dispensed during the rebate period to*  
7                    *full-benefit dual eligible individuals en-*  
8                    *rolled in the prescription drug plans*  
9                    *administered by the PDP sponsor or*  
10                   *the MA–PD plans administered by the*  
11                   *MA–PD organization; divided by*

12                   “(ii) *the total number of units of such*  
13                   *dosage and strength of the drug dispensed*  
14                   *during the rebate period to full-benefit dual*  
15                   *eligible individuals enrolled in all prescrip-*  
16                   *tion drug plans administered by PDP spon-*  
17                   *sors and all MA–PD plans administered by*  
18                   *MA–PD organizations.*

19                   “(4) *LENGTH OF AGREEMENT.—The provisions*  
20                   *of paragraph (4) of section 1927(b) (other than*  
21                   *clauses (iv) and (v) of subparagraph (B)) shall apply*  
22                   *to rebate agreements under this subsection in the same*  
23                   *manner as such paragraph applies to a rebate agree-*  
24                   *ment under such section.*

1           “(5) *OTHER TERMS AND CONDITIONS.*—*The Sec-*  
2           *retary shall establish other terms and conditions of*  
3           *the rebate agreement under this subsection, including*  
4           *terms and conditions related to compliance, that are*  
5           *consistent with this subsection.*

6           “(6) *DEFINITIONS.*—*In this subsection and sec-*  
7           *tion 1860D–12(b)(7):*

8                   “(A) *FULL-BENEFIT DUAL ELIGIBLE INDI-*  
9                   *VIDUAL.*—*The term ‘full-benefit dual eligible in-*  
10                   *dividual’ has the meaning given such term in*  
11                   *section 1935(c)(6).*

12                   “(B) *REBATE PERIOD.*—*The term ‘rebate*  
13                   *period’ has the meaning given such term in sec-*  
14                   *tion 1927(k)(8).”.*

15           (2) *REPORTING REQUIREMENT FOR THE DETER-*  
16           *MINATION AND PAYMENT OF REBATES BY MANUFAC-*  
17           *TURES RELATED TO REBATE FOR FULL-BENEFIT*  
18           *DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.*—

19                   (A) *REQUIREMENTS FOR PDP SPONSORS.*—  
20                   *Section 1860D–12(b) of the Social Security Act*  
21                   *(42 U.S.C. 1395w–112(b)) is amended by adding*  
22                   *at the end the following new paragraph:*

23                   “(7) *REPORTING REQUIREMENT FOR THE DE-*  
24                   *TERMINATION AND PAYMENT OF REBATES BY MANU-*



1        *FACTURERS RELATED TO REBATE FOR FULL-BENEFIT*  
2        *DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—*

3                *“(A) IN GENERAL.—For purposes of the re-*  
4                *bate under section 1860D–2(f) for contract years*  
5                *beginning on or after January 1, 2011, each con-*  
6                *tract entered into with a PDP sponsor under*  
7                *this part with respect to a prescription drug*  
8                *plan shall require that the sponsor comply with*  
9                *subparagraphs (B) and (C).*

10               *“(B) REPORT FORM AND CONTENTS.—Not*  
11               *later than 60 days after the end of each rebate*  
12               *period (as defined in section 1860D–2(f)(6)(B))*  
13               *within such a contract year to which such sec-*  
14               *tion applies, a PDP sponsor of a prescription*  
15               *drug plan under this part shall report to each*  
16               *manufacturer—*

17                        *“(i) information (by National Drug*  
18                        *Code number) on the total number of units*  
19                        *of each dosage, form, and strength of each*  
20                        *drug of such manufacturer dispensed to full-*  
21                        *benefit dual eligible Medicare drug plan en-*  
22                        *rollees under any prescription drug plan*  
23                        *operated by the PDP sponsor during the re-*  
24                        *bate period;*

1           “(ii) information on the price dis-  
2           counts, price concessions, and rebates for  
3           such drugs for such form, strength, and pe-  
4           riod;

5           “(iii) information on the extent to  
6           which such price discounts, price conces-  
7           sions, and rebates apply equally to full-ben-  
8           efit dual eligible Medicare drug plan enroll-  
9           ees and PDP enrollees who are not full-ben-  
10          efit dual eligible Medicare drug plan enroll-  
11          ees; and

12          “(iv) any additional information that  
13          the Secretary determines is necessary to en-  
14          able the Secretary to calculate the average  
15          Medicare drug program full-benefit dual eli-  
16          gible rebate amount (as defined in para-  
17          graph (3)(C) of such section), and to deter-  
18          mine the amount of the rebate required  
19          under this section, for such form, strength,  
20          and period.

21          Such report shall be in a form consistent with a  
22          standard reporting format established by the Sec-  
23          retary.

24          “(C) SUBMISSION TO SECRETARY.—Each  
25          PDP sponsor shall promptly transmit a copy of

1           *the information reported under subparagraph*  
2           *(B) to the Secretary for the purpose of audit*  
3           *oversight and evaluation.*

4           “(D) *CONFIDENTIALITY OF INFORMATION.*—  
5           *The provisions of subparagraph (D) of section*  
6           *1927(b)(3), relating to confidentiality of infor-*  
7           *mation, shall apply to information reported by*  
8           *PDP sponsors under this paragraph in the same*  
9           *manner that such provisions apply to informa-*  
10           *tion disclosed by manufacturers or wholesalers*  
11           *under such section, except—*

12                   “(i) *that any reference to ‘this section’*  
13                   *in clause (i) of such subparagraph shall be*  
14                   *treated as being a reference to this section;*

15                   “(ii) *the reference to the Director of the*  
16                   *Congressional Budget Office in clause (iii)*  
17                   *of such subparagraph shall be treated as in-*  
18                   *cluding a reference to the Medicare Pay-*  
19                   *ment Advisory Commission; and*

20                   “(iii) *clause (iv) of such subparagraph*  
21                   *shall not apply.*

22           “(E) *OVERSIGHT.*—*Information reported*  
23           *under this paragraph may be used by the Inspec-*  
24           *tor General of the Department of Health and*

1           *Human Services for the statutorily authorized*  
2           *purposes of audit, investigation, and evaluations.*

3           “(F) *PENALTIES FOR FAILURE TO PROVIDE*  
4           *TIMELY INFORMATION AND PROVISION OF FALSE*  
5           *INFORMATION.—In the case of a PDP sponsor—*

6                   “(i) *that fails to provide information*  
7                   *required under subparagraph (B) on a*  
8                   *timely basis, the sponsor is subject to a civil*  
9                   *money penalty in the amount of \$10,000 for*  
10                   *each day in which such information has not*  
11                   *been provided; or*

12                   “(ii) *that knowingly (as defined in sec-*  
13                   *tion 1128A(i)) provides false information*  
14                   *under such subparagraph, the sponsor is*  
15                   *subject to a civil money penalty in an*  
16                   *amount not to exceed \$100,000 for each*  
17                   *item of false information.*

18           *Such civil money penalties are in addition to*  
19           *other penalties as may be prescribed by law. The*  
20           *provisions of section 1128A (other than sub-*  
21           *sections (a) and (b)) shall apply to a civil money*  
22           *penalty under this subparagraph in the same*  
23           *manner as such provisions apply to a penalty or*  
24           *proceeding under section 1128A(a).”.*

1                   (B) *APPLICATION TO MA ORGANIZATIONS.*—  
 2                   Section 1857(f)(3) of the Social Security Act (42  
 3                   U.S.C. 1395w–27(f)(3)) is amended by adding at  
 4                   the end the following:

5                   “(D) *REPORTING REQUIREMENT RELATED*  
 6                   *TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE*  
 7                   *MEDICARE DRUG PLAN ENROLLEES.*—Section  
 8                   1860D–12(b)(7).”.

9                   (3) *DEPOSIT OF REBATES INTO MEDICARE PRE-*  
 10                  *SCRIPTION DRUG ACCOUNT.*—Section 1860D–16(c) of  
 11                  such Act (42 U.S.C. 1395w–116(c)) is amended by  
 12                  adding at the end the following new paragraph:

13                  “(6) *REBATE FOR FULL-BENEFIT DUAL ELIGIBLE*  
 14                  *MEDICARE DRUG PLAN ENROLLEES.*—Amounts paid  
 15                  under a rebate agreement under section 1860D–2(f)  
 16                  shall be deposited into the Account and shall be used  
 17                  to pay for all or part of the gradual elimination of  
 18                  the coverage gap under section 1860D–2(b)(7).”.

19 **SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN**  
 20                   **ORIGINAL COVERAGE GAP.**

21                  Section 1860D–2 of the Social Security Act (42 U.S.C.  
 22                  1395w–102), as amended by section 1181, is amended—

23                  (1) in subsection (b)(4)(C)(ii), by inserting “sub-  
 24                  ject to subsection (g)(2)(C),” after “(i)”;

1           (2) *in subsection (e)(1), in the matter before sub-*  
2           *paragraph (A), by striking “subsection (f)” and in-*  
3           *serting “subsections (f) and (g)”;* and

4           (3) *by adding at the end the following new sub-*  
5           *section:*

6           “(g) *REQUIREMENT FOR MANUFACTURER DISCOUNT*  
7           *AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—*

8           “(1) *IN GENERAL.—In this part, the term ‘cov-*  
9           *ered part D drug’ does not include any drug or bio-*  
10           *logic that is manufactured by a manufacturer that*  
11           *has not entered into and have in effect for all quali-*  
12           *fying drugs (as defined in paragraph (5)(A)) a dis-*  
13           *count agreement described in paragraph (2).*

14           “(2) *DISCOUNT AGREEMENT.—*

15           “(A) *PERIODIC DISCOUNTS.—A discount*  
16           *agreement under this paragraph shall require the*  
17           *manufacturer involved to provide, to each PDP*  
18           *sponsor with respect to a prescription drug plan*  
19           *or each MA organization with respect to each*  
20           *MA-PD plan, a discount in an amount specified*  
21           *in paragraph (3) for qualifying drugs (as de-*  
22           *fined in paragraph (5)(A)) of the manufacturer*  
23           *dispensed to a qualifying enrollee after December*  
24           *31, 2010, insofar as the individual is in the*

1           *original gap in coverage (as defined in para-*  
2           *graph (5)(E)).*

3           “(B) *DISCOUNT AGREEMENT.*—*Insofar as*  
4           *not inconsistent with this subsection, the Sec-*  
5           *retary shall establish terms and conditions of*  
6           *such agreement, including terms and conditions*  
7           *relating to compliance, similar to the terms and*  
8           *conditions for rebate agreements under para-*  
9           *graphs (2), (3), and (4) of section 1927(b), except*  
10          *that—*

11                   “(i) *discounts shall be applied under*  
12                   *this subsection to prescription drug plans*  
13                   *and MA-PD plans instead of State plans*  
14                   *under title XIX;*

15                   “(ii) *PDP sponsors and MA organiza-*  
16                   *tions shall be responsible, instead of States,*  
17                   *for provision of necessary utilization infor-*  
18                   *mation to drug manufacturers; and*

19                   “(iii) *sponsors and MA organizations*  
20                   *shall be responsible for reporting informa-*  
21                   *tion on drug-component negotiated price,*  
22                   *instead of other manufacturer prices.*

23           “(C) *COUNTING DISCOUNT TOWARD TRUE*  
24           *OUT-OF-POCKET COSTS.*—*Under the discount*  
25           *agreement, in applying subsection (b)(4), with*

1           *regard to subparagraph (C)(i) of such subsection,*  
2           *if a qualified enrollee purchases the qualified*  
3           *drug insofar as the enrollee is in an actual gap*  
4           *of coverage (as defined in paragraph (5)(D)), the*  
5           *amount of the discount under the agreement*  
6           *shall be treated and counted as costs incurred by*  
7           *the plan enrollee.*

8           “(3) *DISCOUNT AMOUNT.*—*The amount of the*  
9           *discount specified in this paragraph for a discount*  
10           *period for a plan is equal to 50 percent of the amount*  
11           *of the drug-component negotiated price (as defined in*  
12           *paragraph (5)(C)) for qualifying drugs for the period*  
13           *involved.*

14           “(4) *ADDITIONAL TERMS.*—*In the case of a dis-*  
15           *count provided under this subsection with respect to*  
16           *a prescription drug plan offered by a PDP sponsor or*  
17           *an MA-PD plan offered by an MA organization, if a*  
18           *qualified enrollee purchases the qualified drug—*

19                   “(A) *insofar as the enrollee is in an actual*  
20                   *gap of coverage (as defined in paragraph*  
21                   *(5)(D)), the sponsor or plan shall provide the*  
22                   *discount to the enrollee at the time the enrollee*  
23                   *pays for the drug; and*

24                   “(B) *insofar as the enrollee is in the portion*  
25                   *of the original gap in coverage (as defined in*



1 paragraph (5)(E)) that is not in the actual gap  
2 in coverage, the discount shall not be applied  
3 against the negotiated price (as defined in sub-  
4 section (d)(1)(B)) for the purpose of calculating  
5 the beneficiary payment.

6 “(5) DEFINITIONS.—In this subsection:

7 “(A) QUALIFYING DRUG.—The term ‘quali-  
8 fying drug’ means, with respect to a prescription  
9 drug plan or MA-PD plan, a drug or biological  
10 product that—

11 “(i)(I) is a drug produced or distrib-  
12 uted under an original new drug applica-  
13 tion approved by the Food and Drug Ad-  
14 ministration, including a drug product  
15 marketed by any cross-licensed producers or  
16 distributors operating under the new drug  
17 application;

18 “(II) is a drug that was originally  
19 marketed under an original new drug ap-  
20 plication approved by the Food and Drug  
21 Administration; or

22 “(III) is a biological product as ap-  
23 proved under section 351(a) of the Public  
24 Health Services Act;

1                   “(ii) is covered under the formulary of  
2                   the plan; and

3                   “(iii) is dispensed to an individual  
4                   who is in the original gap in coverage.

5                   “(B) *QUALIFYING ENROLLEE*.—The term  
6                   ‘qualifying enrollee’ means an individual en-  
7                   rolled in a prescription drug plan or MA-PD  
8                   plan other than such an individual who is a sub-  
9                   sidy-eligible individual (as defined in section  
10                  1860D–14(a)(3)).

11                  “(C) *DRUG-COMPONENT NEGOTIATED*  
12                  *PRICE*.—The term ‘drug-component negotiated  
13                  price’ means, with respect to a qualifying drug,  
14                  the negotiated price (as defined in subsection  
15                  (d)(1)(B)), as determined without regard to any  
16                  dispensing fee, of the drug under the prescription  
17                  drug plan or MA-PD plan involved.

18                  “(D) *ACTUAL GAP IN COVERAGE*.—The term  
19                  ‘actual gap in coverage’ means the gap in pre-  
20                  scription drug coverage that occurs between the  
21                  initial coverage limit (as modified under sub-  
22                  paragraph (B) of subsection (b)(7)) and the an-  
23                  nual out-of-pocket threshold (as modified under  
24                  subparagraph (C) of such subsection).

1           “(E) ORIGINAL GAP IN COVERAGE.—The  
2           term ‘original in gap coverage’ means the gap in  
3           prescription drug coverage that would occur be-  
4           tween the initial coverage limit (described in  
5           subsection (b)(3)) and the annual out-of-pocket  
6           threshold (as defined in subsection (b)(4)(B)) if  
7           subsection (b)(7) did not apply.”.

8   **SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMIS-**  
9                   **SION OF CLAIMS BY PHARMACIES LOCATED**  
10                   **IN OR CONTRACTING WITH LONG-TERM CARE**  
11                   **FACILITIES.**

12           (a) PART D SUBMISSION.—Section 1860D–12(b) of the  
13           Social Security Act (42 U.S.C. 1395w–112(b)), as amended  
14           by section 172(a)(1) of Public Law 110-275, is amended  
15           by striking paragraph (5) and redesignating paragraph (6)  
16           and paragraph (7), as added by section 1181(b)(2), as  
17           paragraph (5) and paragraph (6), respectively.

18           (b) SUBMISSION TO MA-PD PLANS.—Section  
19           1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-  
20           27(f)(3)), as added by section 171(b) of Public Law 110-  
21           275 and amended by section 172(a)(2) of such Public Law  
22           and section 1181 of this Act, is amended by striking sub-  
23           paragraph (B) and redesignating subparagraphs (C) and  
24           (D) as subparagraphs (B) and (C), respectively.

1           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall apply for contract years beginning with 2010.*

3 **SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**  
4 **SISTANCE PROGRAMS AND INDIAN HEALTH**  
5 **SERVICE IN PROVIDING PRESCRIPTION**  
6 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**  
7 **ET THRESHOLD UNDER PART D.**

8           (a) *IN GENERAL.*—*Section 1860D–2(b)(4)(C) of the*  
9 *Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is*  
10 *amended—*

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

12           (2) *in clause (ii)—*

13                   (A) *by striking “such costs shall be treated*  
14 *as incurred only if” and inserting “subject to*  
15 *clause (iii), such costs shall be treated as in-*  
16 *curring only if”;*

17                   (B) *by striking “, under section 1860D–14,*  
18 *or under a State Pharmaceutical Assistance Pro-*  
19 *gram”;* and

20                   (C) *by striking the period at the end and*  
21 *inserting “; and”;* and

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

24                           “*(iii) such costs shall be treated as in-*  
25 *curring and shall not be considered to be re-*

1                    *imbursed under clause (ii) if such costs are*  
2                    *borne or paid—*

3                    *“(I) under section 1860D–14;*

4                    *“(II) under a State Pharma-*  
5                    *ceutical Assistance Program;*

6                    *“(III) by the Indian Health Serv-*  
7                    *ice, an Indian tribe or tribal organiza-*  
8                    *tion, or an urban Indian organization*  
9                    *(as defined in section 4 of the Indian*  
10                   *Health Care Improvement Act); or*

11                   *“(IV) under an AIDS Drug As-*  
12                   *sistance Program under part B of title*  
13                   *XXVI of the Public Health Service*  
14                   *Act.”.*

15                   *(b) EFFECTIVE DATE.—The amendments made by sub-*  
16                   *section (a) shall apply to costs incurred on or after January*  
17                   *1, 2011.*

18                   **SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLL-**  
19                   **MENT FOR FORMULARY CHANGES THAT AD-**  
20                   **VERSELY IMPACT AN ENROLLEE.**

21                   *(a) IN GENERAL.—Section 1860D–1(b)(3) of the So-*  
22                   *cial Security Act (42 U.S.C. 1395w–101(b)(3)) is amended*  
23                   *by adding at the end the following new subparagraph:*

24                   *“(F) CHANGE IN FORMULARY RESULTING IN*  
25                   *INCREASE IN COST-SHARING.—*

1           “(i) *IN GENERAL.*—*Except as provided*  
2           *in clause (ii), in the case of an individual*  
3           *enrolled in a prescription drug plan (or*  
4           *MA–PD plan) who has been prescribed and*  
5           *is using a covered part D drug while so en-*  
6           *rolled, if the formulary of the plan is mate-*  
7           *rially changed (other than at the end of a*  
8           *contract year) so to reduce the coverage (or*  
9           *increase the cost-sharing) of the drug under*  
10           *the plan.*

11           “(ii) *EXCEPTION.*—*Clause (i) shall not*  
12           *apply in the case that a drug is removed*  
13           *from the formulary of a plan because of a*  
14           *recall or withdrawal of the drug issued by*  
15           *the Food and Drug Administration, because*  
16           *the drug is replaced with a generic drug*  
17           *that is a therapeutic equivalent, or because*  
18           *of utilization management applied to—*

19                   “(I) *a drug whose labeling in-*  
20                   *cludes a boxed warning required by the*  
21                   *Food and Drug Administration under*  
22                   *section 210.57(c)(1) of title 21, Code of*  
23                   *Federal Regulations (or a successor*  
24                   *regulation); or*

1                   “(II) a drug required under sub-  
2                   section (c)(2) of section 505–1 of the  
3                   Federal Food, Drug, and Cosmetic Act  
4                   to have a Risk Evaluation and Man-  
5                   agement Strategy that includes ele-  
6                   ments under subsection (f) of such sec-  
7                   tion.”.

8                   (b) *EFFECTIVE DATE.*—The amendment made by sub-  
9                   section (a) shall apply to contract years beginning on or  
10                  after January 1, 2011.

11                  **SEC. 1186. NEGOTIATION OF LOWER COVERED PART D**  
12                                   **DRUG PRICES ON BEHALF OF MEDICARE**  
13                                   **BENEFICIARIES.**

14                  (a) *NEGOTIATION BY SECRETARY.*—Section 1860D–11  
15                  of the Social Security Act (42 U.S.C. 1395w–111) is  
16                  amended by striking subsection (i) (relating to noninter-  
17                  ference) and inserting the following:

18                  “(i) *NEGOTIATION OF LOWER DRUG PRICES.*—

19                                 “(1) *IN GENERAL.*—Notwithstanding any other  
20                                 provision of law, the Secretary shall negotiate with  
21                                 pharmaceutical manufacturers the prices (including  
22                                 discounts, rebates, and other price concessions) that  
23                                 may be charged to PDP sponsors and MA organiza-  
24                                 tions for covered part D drugs for part D eligible in-

1 *dividuals who are enrolled under a prescription drug*  
2 *plan or under an MA-PD plan.*

3 “(2) NO CHANGE IN RULES FOR  
4 FORMULARIES.—

5 “(A) IN GENERAL.—*Nothing in paragraph*  
6 *(1) shall be construed to authorize the Secretary*  
7 *to establish or require a particular formulary.*

8 “(B) CONSTRUCTION.—*Subparagraph (A)*  
9 *shall not be construed as affecting the Secretary’s*  
10 *authority to ensure appropriate and adequate*  
11 *access to covered part D drugs under prescrip-*  
12 *tion drug plans and under MA-PD plans, in-*  
13 *cluding compliance of such plans with formulary*  
14 *requirements under section 1860D–4(b)(3).*

15 “(3) CONSTRUCTION.—*Nothing in this subsection*  
16 *shall be construed as preventing the sponsor of a pre-*  
17 *scription drug plan, or an organization offering an*  
18 *MA-PD plan, from obtaining a discount or reduction*  
19 *of the price for a covered part D drug below the price*  
20 *negotiated under paragraph (1).*

21 “(4) SEMI-ANNUAL REPORTS TO CONGRESS.—*Not*  
22 *later than June 1, 2011, and every six months there-*  
23 *after, the Secretary shall submit to the Committees on*  
24 *Ways and Means, Energy and Commerce, and Over-*  
25 *sight and Government Reform of the House of Rep-*



1        *representatives and the Committee on Finance of the*  
2        *Senate a report on negotiations conducted by the Sec-*  
3        *retary to achieve lower prices for Medicare bene-*  
4        *ficiaries, and the prices and price discounts achieved*  
5        *by the Secretary as a result of such negotiations.”.*

6        *(b) EFFECTIVE DATE.—The amendment made by sub-*  
7        *section (a) shall take effect on the date of the enactment*  
8        *of this Act and shall first apply to negotiations and prices*  
9        *for plan years beginning on January 1, 2011.*

10    **SEC. 1187. STATE CERTIFICATION PRIOR TO WAIVER OF LI-**  
11                            **CENSURE REQUIREMENTS UNDER MEDICARE**  
12                            **PRESCRIPTION DRUG PROGRAM.**

13        *(a) IN GENERAL.—Section 1860D–12(c) of the Social*  
14        *Security Act (42 U.S.C. 1395w–112(c)) is amended—*

15                *(1) in paragraph (1)(A), by striking “In the*  
16                *case” and inserting “Subject to paragraph (5), in the*  
17                *case”; and*

18                *(2) by adding at the end the following new para-*  
19                *graph:*

20                        *“(5) STATE CERTIFICATION REQUIRED.—*

21                        *“(A) IN GENERAL.—The Secretary may*  
22                        *only grant a waiver under paragraph (1)(A) if*  
23                        *the Secretary has received a certification from*  
24                        *the State insurance commissioner that the pre-*

1           *scription drug plan has a substantially complete*  
 2           *application pending in the State.*

3           “(B) *REVOCATION OF WAIVER UPON FIND-*  
 4           *ING OF FRAUD AND ABUSE.—The Secretary shall*  
 5           *revoke a waiver granted under paragraph (1)(A)*  
 6           *if the State insurance commissioner submits a*  
 7           *certification to the Secretary that the recipient of*  
 8           *such a waiver—*

9                     *“(i) has committed fraud or abuse with*  
 10                    *respect to such waiver;*

11                    *“(ii) has failed to make a good faith ef-*  
 12                    *fort to satisfy State licensing requirements;*

13                    *or*

14                    *“(iii) was determined ineligible for li-*  
 15                    *censure by the State.”.*

16           ***(b) EFFECTIVE DATE.—The amendments made by sub-***  
 17           ***section (a) shall apply with respect to plan years beginning***  
 18           ***on or after January 1, 2010.***

19           ***Subtitle F—Medicare Rural Access***  
 20           ***Protections***

21           ***SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.***

22                     .

23           ***(a) ADDITIONAL TELEHEALTH SITE.—***

24                    ***(1) IN GENERAL.—Paragraph (4)(C)(ii) of sec-***  
 25                    ***tion 1834(m) of the Social Security Act (42 U.S.C.***

1       1395m(m)) is amended by adding at the end the fol-  
2       lowing new subclause:

3                               “(IX) A renal dialysis facility.”

4               (2) *EFFECTIVE DATE.*—The amendment made by  
5       paragraph (1) shall apply to services furnished on or  
6       after January 1, 2011.

7       (b) *TELEHEALTH ADVISORY COMMITTEE.*—

8               (1) *ESTABLISHMENT.*—Section 1868 of the So-  
9       cial Security Act (42 U.S.C. 1395ee) is amended—

10                   (A) in the heading, by adding at the end the  
11       following: “*TELEHEALTH ADVISORY COM-*  
12       *MITTEE*”; and

13                   (B) by adding at the end the following new  
14       subsection:

15       “(c) *TELEHEALTH ADVISORY COMMITTEE.*—

16               “(1) *IN GENERAL.*—The Secretary shall appoint  
17       a Telehealth Advisory Committee (in this subsection  
18       referred to as the ‘Advisory Committee’) to make rec-  
19       ommendations to the Secretary on policies of the Cen-  
20       ters for Medicare & Medicaid Services regarding tele-  
21       health services as established under section 1834(m),  
22       including the appropriate addition or deletion of  
23       services (and HCPCS codes) to those specified in  
24       paragraphs (4)(F)(i) and (4)(F)(ii) of such section

1 *and for authorized payment under paragraph (1) of*  
2 *such section.*

3 “(2) *MEMBERSHIP; TERMS.—*

4 “(A) *MEMBERSHIP.—*

5 “(i) *IN GENERAL.—The Advisory Com-*  
6 *mittee shall be composed of 9 members, to be*  
7 *appointed by the Secretary, of whom—*

8 “(I) *5 shall be practicing physi-*  
9 *cians;*

10 “(II) *2 shall be practicing non-*  
11 *physician health care practitioners;*  
12 *and*

13 “(III) *2 shall be administrators of*  
14 *telehealth programs.*

15 “(ii) *REQUIREMENTS FOR APPOINTING*  
16 *MEMBERS.—In appointing members of the*  
17 *Advisory Committee, the Secretary shall—*

18 “(I) *ensure that each member has*  
19 *prior experience with the practice of*  
20 *telemedicine or telehealth;*

21 “(II) *give preference to individ-*  
22 *uals who are currently providing tele-*  
23 *medicine or telehealth services or who*  
24 *are involved in telemedicine or tele-*  
25 *health programs;*

1                   “(III) ensure that the membership  
2                   of the Advisory Committee represents a  
3                   balance of specialties and geographic  
4                   regions; and

5                   “(IV) take into account the rec-  
6                   ommendations of stakeholders.

7                   “(B) TERMS.—The members of the Advisory  
8                   Committee shall serve for such term as the Sec-  
9                   retary may specify.

10                  “(C) CONFLICTS OF INTEREST.—An advi-  
11                  sory committee member may not participate  
12                  with respect to a particular matter considered in  
13                  an advisory committee meeting if such member  
14                  (or an immediate family member of such mem-  
15                  ber) has a financial interest that could be af-  
16                  fected by the advice given to the Secretary with  
17                  respect to such matter.

18                  “(3) MEETINGS.—The Advisory Committee shall  
19                  meet twice each calendar year and at such other times  
20                  as the Secretary may provide.

21                  “(4) PERMANENT COMMITTEE.—Section 14 of the  
22                  Federal Advisory Committee Act (5 U.S.C. App.)  
23                  shall not apply to the Advisory Committee.”

24                  (2) FOLLOWING RECOMMENDATIONS.—Section  
25                  1834(m)(4)(F) of such Act (42 U.S.C.

1     1395m(m)(4)(F)) is amended by adding at the end  
2     the following new clause:

3             “(iii) *RECOMMENDATIONS OF THE*  
4             *TELEHEALTH ADVISORY COMMITTEE.*—*In*  
5             *making determinations under clauses (i)*  
6             *and (ii), the Secretary shall take into ac-*  
7             *count the recommendations of the Telehealth*  
8             *Advisory Committee (established under sec-*  
9             *tion 1868(c)) when adding or deleting serv-*  
10            *ices (and HCPCS codes) and in establishing*  
11            *policies of the Centers for Medicare & Med-*  
12            *icaid Services regarding the delivery of tele-*  
13            *health services. If the Secretary does not im-*  
14            *plement such a recommendation, the Sec-*  
15            *retary shall publish in the Federal Register*  
16            *a statement regarding the reason such rec-*  
17            *ommendation was not implemented.”*

18            (3) *WAIVER OF ADMINISTRATIVE LIMITATION.*—

19            *The Secretary of Health and Human Services shall*  
20            *establish the Telehealth Advisory Committee under the*  
21            *amendment made by paragraph (1) notwithstanding*  
22            *any limitation that may apply to the number of ad-*  
23            *visory committees that may be established (within the*  
24            *Department of Health and Human Services or other-*  
25            *wise).*

1 **SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS**  
2 **PROVISION.**

3 *Section 1833(t)(7)(D)(i) of the Social Security Act (42*  
4 *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 note),*  
17 *as amended by section 117 of the Medicare, Medicaid, and*  
18 *SCHIP Extension Act of 2007 (Public Law 110–173) and*  
19 *section 124 of the Medicare Improvements for Patients and*  
20 *Providers Act of 2008 (Public Law 110–275), is amended*  
21 *by striking “September 30, 2009” and inserting “September*  
22 *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*  
26 *January 1, 2010” and inserting “before January 1, 2012”.*

1 **SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COM-**  
2 **PONENT OF CERTAIN PHYSICIAN PATHOLOGY**  
3 **SERVICES.**

4 *Section 542(c) of the Medicare, Medicaid, and SCHIP*  
5 *Benefits Improvement and Protection Act of 2000 (as en-*  
6 *acted into law by section 1(a)(6) of Public Law 106–554),*  
7 *as amended by section 732 of the Medicare Prescription*  
8 *Drug, Improvement, and Modernization Act of 2003 (42*  
9 *U.S.C. 1395w–4 note), section 104 of division B of the Tax*  
10 *Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4*  
11 *note), section 104 of the Medicare, Medicaid, and SCHIP*  
12 *Extension Act of 2007 (Public Law 110–173), and section*  
13 *136 of the Medicare Improvements for Patients and Pro-*  
14 *viders Act of 1008 (Public Law 110–275), is amended by*  
15 *striking “and 2009” and inserting “2009, 2010, and 2011”.*

16 **SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.**

17 (a) *IN GENERAL.*—*Section 1834(l)(13) of the Social*  
18 *Security Act (42 U.S.C. 1395m(l)(13)) is amended—*

19 (1) *in subparagraph (A)—*

20 (A) *in the matter preceding clause (i), by*  
21 *striking “before January 1, 2010” and inserting*  
22 *“before January 1, 2012”; and*

23 (B) *in each of clauses (i) and (ii), by strik-*  
24 *ing “before January 1, 2010” and inserting “be-*  
25 *fore January 1, 2012”.*



1       (b) *AIR AMBULANCE IMPROVEMENTS.*—Section  
2 *146(b)(1) of the Medicare Improvements for Patients and*  
3 *Providers Act of 2008 (Public Law 110–275) is amended*  
4 *by striking “ending on December 31, 2009” and inserting*  
5 *“ending on December 31, 2011”.*

6 **SEC. 1197. ENSURING PROPORTIONAL REPRESENTATION**  
7 **OF INTERESTS OF RURAL AREAS ON MEDPAC.**

8       (a) *IN GENERAL.*—Section 1805(c)(2) of the Social Se-  
9 *curity Act (42 U.S.C. 1395b-6(c)(2)) is amended—*

10           (1) *in subparagraph (A), by inserting “con-*  
11 *sistent with subparagraph (E)” after “rural rep-*  
12 *resentatives”; and*

13           (2) *by adding at the end the following new sub-*  
14 *paragraph:*

15                   “(E) *PROPORTIONAL REPRESENTATION OF*  
16 *INTERESTS OF RURAL AREAS.*—*In order to pro-*  
17 *vide a balance between urban and rural rep-*  
18 *resentatives under subparagraph (A), the propor-*  
19 *tion of members of the Commission who rep-*  
20 *resent the interests of health care providers and*  
21 *Medicare beneficiaries located in rural areas*  
22 *shall be no less than the proportion of the total*  
23 *number of Medicare beneficiaries who reside in*  
24 *rural areas.”.*

1       (b) *EFFECTIVE DATE.*—*The amendments made by sub-*  
 2 *section (a) shall apply to appointments to the Medicare*  
 3 *Payment Advisory Commission made after the date of the*  
 4 *enactment of this Act.*

5                               **TITLE II—MEDICARE**  
 6       **BENEFICIARY IMPROVEMENTS**  
 7       **Subtitle A—Improving and Simpli-**  
 8       **fyng Financial Assistance for**  
 9       **Low Income Medicare Bene-**  
 10       **ficiaries**

11 **SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**  
 12                               **INGS PROGRAM AND LOW-INCOME SUBSIDY**  
 13                               **PROGRAM.**

14       (a) *APPLICATION OF HIGHEST LEVEL PERMITTED*  
 15 *UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.*—

16               (1) *IN GENERAL.*—*Section 1860D–14(a)(1) of the*  
 17 *Social Security Act (42 U.S.C. 1395w–114(a)(1)) is*  
 18 *amended in the matter before subparagraph (A), by*  
 19 *inserting “(or, beginning with 2012, paragraph*  
 20 *(3)(E))” after “paragraph (3)(D)”.*

21               (2) *ANNUAL INCREASE IN LIS RESOURCE*  
 22 *TEST.*—*Section 1860D–14(a)(3)(E)(i) of such Act (42*  
 23 *U.S.C. 1395w–114(a)(3)(E)(i)) is amended—*

24                               (A) *by striking “and” at the end of sub-*  
 25                               *clause (I);*

1           (B) in subclause (II), by inserting “(before  
2           2012)” after “subsequent year”;

3           (C) by striking the period at the end of sub-  
4           clause (II) and inserting a semicolon;

5           (D) by inserting after subclause (II) the fol-  
6           lowing new subclauses:

7                         “(III) for 2012, \$17,000 (or  
8                         \$34,000 in the case of the combined  
9                         value of the individual’s assets or re-  
10                        sources and the assets or resources of  
11                        the individual’s spouse); and

12                       “(IV) for a subsequent year, the  
13                       dollar amounts specified in this sub-  
14                       clause (or subclause (III)) for the pre-  
15                       vious year increased by the annual  
16                       percentage increase in the consumer  
17                       price index (all items; U.S. city aver-  
18                       age) as of September of such previous  
19                       year.”; and

20           (E) in the last sentence, by inserting “or  
21           (IV)” after “subclause (II)”.

22           (3) *APPLICATION OF LIS TEST UNDER MEDICARE*  
23           *SAVINGS PROGRAM.*—Section 1905(p)(1)(C) of such  
24           Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

1 (A) by striking “effective beginning with  
2 January 1, 2010” and inserting “effective for the  
3 period beginning with January 1, 2010, and  
4 ending with December 31, 2011”; and

5 (B) by inserting before the period at the end  
6 the following: “or, effective beginning with Janu-  
7 ary 1, 2012, whose resources (as so determined)  
8 do not exceed the maximum resource level ap-  
9 plied for the year under subparagraph (E) of  
10 section 1860D–14(a)(3) (determined without re-  
11 gard to the life insurance policy exclusion pro-  
12 vided under subparagraph (G) of such section)  
13 applicable to an individual or to the individual  
14 and the individual’s spouse (as the case may  
15 be)”.

16 (b) *EFFECTIVE DATE.*—The amendments made by sub-  
17 section (a) shall apply to eligibility determinations for in-  
18 come-related subsidies and medicare cost-sharing furnished  
19 for periods beginning on or after January 1, 2012.

20 **SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR**  
21 **CERTAIN NONINSTITUTIONALIZED FULL-BEN-**  
22 **EFIT 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–114(a)(1)(D)(i))  
25 is amended—

1           (1) by striking “*INSTITUTIONALIZED INDIVID-*  
2           *UALS.—In*” and inserting “*ELIMINATION OF COST-*  
3           *SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE*  
4           *INDIVIDUALS.—*—

5                           “(I) *INSTITUTIONALIZED INDIVID-*  
6                           *UALS.—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, 1932, or under a waiver under*  
17                          *section 1115) the individual would re-*  
18                          *quire the level of care provided in a*  
19                          *hospital or a nursing facility or inter-*  
20                          *mediate care facility for the mentally*  
21                          *retarded the cost of which could be re-*  
22                          *imbursed under the State plan under*  
23                          *title XIX, the elimination of any bene-*  
24                          *ficiary coinsurance described in section*  
25                          *1860D–2(b)(2) (for all amounts*

1                   *through the total amount of expendi-*  
2                   *tures at which benefits are available*  
3                   *under section 1860D-2(b)(4).”.*

4           **(b) EFFECTIVE DATE.**—*The amendments made by sub-*  
5           *section (a) shall apply to drugs dispensed on or after Janu-*  
6           *ary 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.**—

11                   **(1) IN GENERAL.**—*Clause (iii) of section 1860D-*  
12                   *14(a)(3)(E) of the Social Security Act (42 U.S.C.*  
13                   *1395w-114(a)(3)(E)) is amended to read as follows:*

14                                   **“(iii) CERTIFICATION OF INCOME AND**  
15                                   **RESOURCES.**—*For purposes of applying this*  
16                                   *section—*

17   **“(I) an individual shall be per-**  
18   *mitted to apply on the basis of self-cer-*  
19   *tification of income and resources; and*

20   **“(II) matters attested to in the**  
21   *application shall be subject to appro-*  
22   *prate 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           (2) *EFFECTIVE DATE.*—*The amendment made by*  
4           *paragraph (1) shall apply beginning January 1,*  
5           *2010.*

6           (b) *DISCLOSURES TO FACILITATE IDENTIFICATION OF*  
7           *INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-*  
8           *INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIP-*  
9           *TION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMIN-*  
10          *ISTRATION’S OUTREACH TO ELIGIBLE INDIVIDUALS.*—*For*  
11          *provision authorizing disclosure of return information to*  
12          *facilitate identification of individuals likely to be ineligible*  
13          *for low-income subsidies under Medicare prescription drug*  
14          *program, see section 1801.*

15       **SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIM-**  
16                                    **BURSEMENTS FOR RETROACTIVE LOW IN-**  
17                                    **COME SUBSIDY ENROLLMENT.**

18          (a) *IN GENERAL.*—*In the case of a retroactive LIS en-*  
19          *rollment beneficiary who is enrolled under a prescription*  
20          *drug plan under part D of title XVIII of the Social Security*  
21          *Act (or an MA-PD plan under part C of such title), the*  
22          *beneficiary (or any eligible third party) is entitled to reim-*  
23          *bursement by the plan for covered drug costs incurred by*  
24          *the beneficiary during the retroactive coverage period of the*  
25          *beneficiary in accordance with subsection (b) and in the*

1 *case of such a beneficiary described in subsection*  
2 *(c)(4)(A)(i), such reimbursement shall be made automati-*  
3 *cally by the plan upon receipt of appropriate notice the*  
4 *beneficiary is eligible for assistance described in such sub-*  
5 *section (c)(4)(A)(i) without further information required to*  
6 *be filed with the plan by the beneficiary.*

7 *(b) ADMINISTRATIVE REQUIREMENTS RELATING TO*  
8 *REIMBURSEMENTS.—*

9 *(1) LINE-ITEM DESCRIPTION.—Each reimburse-*  
10 *ment made by a prescription drug plan or MA-PD*  
11 *plan under subsection (a) shall include a line-item*  
12 *description of the items for which the reimbursement*  
13 *is made.*

14 *(2) TIMING OF REIMBURSEMENTS.—A prescrip-*  
15 *tion drug plan or MA-PD plan must make a reim-*  
16 *bursement under subsection (a) to a retroactive LIS*  
17 *enrollment beneficiary, with respect to a claim, not*  
18 *later than 45 days after—*

19 *(A) in the case of a beneficiary described in*  
20 *subsection (c)(4)(A)(i), the date on which the*  
21 *plan receives notice from the Secretary that the*  
22 *beneficiary is eligible for assistance described in*  
23 *such subsection; or*



1           (B) *in the case of a beneficiary described in*  
2           *subsection (c)(4)(A)(ii), the date on which the*  
3           *beneficiary files the claim with the plan.*

4           (3) *REPORTING REQUIREMENT.—For each month*  
5           *beginning with January 2011, each prescription drug*  
6           *plan and each MA-PD plan shall report to the Sec-*  
7           *retary the following:*

8                   (A) *The number of claims the plan has re-*  
9                   *adjudicated during the month due to a bene-*  
10                  *ficiary becoming retroactively eligible for sub-*  
11                  *sidies available under section 1860D-14 of the*  
12                  *Social Security Act.*

13                  (B) *The total value of the readjudicated*  
14                  *claim amount for the month.*

15                  (C) *The Medicare Health Insurance Claims*  
16                  *Number of beneficiaries for whom claims were*  
17                  *readjudicated.*

18                  (D) *For the claims described in subpara-*  
19                  *graphs (A) and (B), an attestation to the Ad-*  
20                  *ministrator of the Centers for Medicare & Med-*  
21                  *icaid Services of the total amount of reimburse-*  
22                  *ment the plan has provided to beneficiaries for*  
23                  *premiums and cost-sharing that the beneficiary*  
24                  *overpaid for which the plan received payment*

1           *from the Centers for Medicare & Medicaid Serv-*  
2           *ices.*

3           (c) *DEFINITIONS.—For purposes of this section:*

4           (1) *COVERED DRUG COSTS.—The term “covered*  
5           *drug costs” means, with respect to a retroactive LIS*  
6           *enrollment beneficiary enrolled under a prescription*  
7           *drug plan under part D of title XVIII of the Social*  
8           *Security Act (or an MA-PD plan under part C of*  
9           *such title), the amount by which—*

10           (A) *the costs incurred by such beneficiary*  
11           *during the retroactive coverage period of the ben-*  
12           *eficiary for covered part D drugs, premiums,*  
13           *and cost-sharing under such title; exceeds*

14           (B) *such costs that would have been in-*  
15           *curring by such beneficiary during such period if*  
16           *the beneficiary had been both enrolled in the*  
17           *plan and recognized by such plan as qualified*  
18           *during such period for the low income subsidy*  
19           *under section 1860D-14 of the Social Security*  
20           *Act to which the individual is entitled.*

21           (2) *ELIGIBLE THIRD PARTY.—The term “eligible*  
22           *third party” means, with respect to a retroactive LIS*  
23           *enrollment beneficiary, an organization or other third*  
24           *party that is owed payment on behalf of such bene-*  
25           *ficiary for covered drug costs incurred by such bene-*

1       *beneficiary during the retroactive coverage period of such*  
2       *beneficiary.*

3               (3) *RETROACTIVE COVERAGE PERIOD.*—*The term*  
4       *“retroactive coverage period” means—*

5               (A) *with respect to a retroactive LIS enroll-*  
6       *ment beneficiary described in paragraph*  
7       *(4)(A)(i), the period—*

8               (i) *beginning on the effective date of*  
9       *the assistance described in such paragraph*  
10       *for which the individual is eligible; and*

11              (ii) *ending on the date the plan effec-*  
12       *tuates the status of such individual as so el-*  
13       *igible; and*

14              (B) *with respect to a retroactive LIS enroll-*  
15       *ment beneficiary described in paragraph*  
16       *(4)(A)(ii), the period—*

17              (i) *beginning on the date the indi-*  
18       *vidual is both entitled to benefits under part*  
19       *A, or enrolled under part B, of title XVIII*  
20       *of the Social Security Act and eligible for*  
21       *medical assistance under a State plan*  
22       *under title XIX of such Act; and*

23              (ii) *ending on the date the plan effec-*  
24       *tuates the status of such individual as a*

1           *full-benefit dual eligible individual (as de-*  
2           *defined in section 1935(c)(6) of such Act).*

3           (4) *RETROACTIVE LIS ENROLLMENT BENE-*  
4           *FICIARY.—*

5           (A) *IN GENERAL.—The term “retroactive*  
6           *LIS enrollment beneficiary” means an indi-*  
7           *vidual who—*

8                   (i) *is enrolled in a prescription drug*  
9                   *plan under part D of title XVIII of the So-*  
10                   *cial Security Act (or an MA-PD plan under*  
11                   *part C of such title) and subsequently be-*  
12                   *comes eligible as a full-benefit dual eligible*  
13                   *individual (as defined in section 1935(c)(6)*  
14                   *of such Act), an individual receiving a low-*  
15                   *income subsidy under section 1860D-14 of*  
16                   *such Act, an individual receiving assistance*  
17                   *under the Medicare Savings Program im-*  
18                   *plemented under clauses (i), (iii), and (iv)*  
19                   *of section 1902(a)(10)(E) of such Act, or an*  
20                   *individual receiving assistance under the*  
21                   *supplemental security income program*  
22                   *under section 1611 of such Act; or*

23                   (ii) *subject to subparagraph (B)(i), is*  
24                   *a full-benefit dual eligible individual (as de-*  
25                   *defined in section 1935(c)(6) of such Act) who*

1            *is automatically enrolled in such a plan*  
2            *under section 1860D-1(b)(1)(C) of such Act.*

3            *(B) EXCEPTION FOR BENEFICIARIES EN-*  
4            *ROLLED IN RFP PLAN.—*

5            *(i) IN GENERAL.—In no case shall an*  
6            *individual described in subparagraph*  
7            *(A)(ii) include an individual who is en-*  
8            *rolled, pursuant to a RFP contract de-*  
9            *scribed in clause (ii), in a prescription drug*  
10           *plan offered by the sponsor of such plan*  
11           *awarded such contract.*

12           *(ii) RFP CONTRACT DESCRIBED.—The*  
13           *RFP contract described in this section is a*  
14           *contract entered into between the Secretary*  
15           *and a sponsor of a prescription drug plan*  
16           *pursuant to the Centers for Medicare &*  
17           *Medicaid Services' request for proposals*  
18           *issued on February 17, 2009, relating to*  
19           *Medicare part D retroactive coverage for*  
20           *certain low income beneficiaries, or a simi-*  
21           *lar subsequent request for proposals.*

22    **SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

23           *(a) IN GENERAL.—Section 1860D-1(b)(1)(C) of the*  
24           *Social Security Act (42 U.S.C. 1395w-101(b)(1)(C)) is*  
25           *amended by adding after “PDP region” the following: “or*

1 *through use of an intelligent assignment process that is de-*  
 2 *signed to maximize the access of such individual to nec-*  
 3 *essary prescription drugs while minimizing costs to such*  
 4 *individual and to the program under this part to the great-*  
 5 *est extent possible. In the case the Secretary enrolls such*  
 6 *individuals through use of an intelligent assignment proc-*  
 7 *ess, such process shall take into account the extent to which*  
 8 *prescription drugs necessary for the individual are covered*  
 9 *in the case of a PDP sponsor of a prescription drug plan*  
 10 *that uses a formulary, the use of prior authorization or*  
 11 *other restrictions on access to coverage of such prescription*  
 12 *drugs by such a sponsor, and the overall quality of a pre-*  
 13 *scription drug plan as measured by quality ratings estab-*  
 14 *lished by the Secretary”*

15       (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
 16 *section (a) shall take effect for contract years beginning*  
 17 *with 2012.*

18 **SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC**  
 19 **ENROLLMENT PROCESS FOR CERTAIN SUB-**  
 20 **SIDY ELIGIBLE INDIVIDUALS.**

21       (a) *SPECIAL ENROLLMENT PERIOD.*—*Section 1860D-*  
 22 *1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w-*  
 23 *101(b)(3)(D)) is amended to read as follows:*

24                       “(D) *SUBSIDY ELIGIBLE INDIVIDUALS.*—*In*  
 25                       *the case of an individual (as determined by the*

1           *Secretary) who is determined under subpara-*  
2           *graph (B) of section 1860D–14(a)(3) to be a sub-*  
3           *sidy eligible individual.”.*

4           **(b) AUTOMATIC ENROLLMENT.**—*Section 1860D–*  
5           *1(b)(1) of the Social Security Act (42 U.S.C. 1395w–*  
6           *101(b)(1)) is amended by adding at the end the following*  
7           *new subparagraph:*

8                         **“(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE**  
9                         **INDIVIDUALS.**—*The process established under*  
10                        *subparagraph (A) shall include, in the case of an*  
11                        *individual described in paragraph (3)(D) who*  
12                        *fails to enroll in a prescription drug plan or an*  
13                        *MA–PD plan during the special enrollment es-*  
14                        *tablished under such section applicable to such*  
15                        *individual, the application of the assignment*  
16                        *process described in subparagraph (C) to such*  
17                        *individual in the same manner as such assign-*  
18                        *ment process applies to a part D eligible indi-*  
19                        *vidual described in such subparagraph (C).*  
20                        *Nothing in the previous sentence shall prevent an*  
21                        *individual described in such sentence from de-*  
22                        *clining enrollment in a plan determined appro-*  
23                        *priate by the Secretary (or in the program under*  
24                        *this part) or from changing such enrollment.”.*

1           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
 2 *section shall apply to subsidy determinations made for*  
 3 *months beginning with January 2011.*

4 **SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO RE-**  
 5 **BATE IN CALCULATION OF LOW INCOME SUB-**  
 6 **SIDY BENCHMARK.**

7           (a) *IN GENERAL.*—*Section 1860D–14(b)(2)(B)(iii) of*  
 8 *the Social Security Act (42 U.S.C. 1395w–*  
 9 *114(b)(2)(B)(iii)) is amended by inserting before the period*  
 10 *the following: “before the application of the monthly rebate*  
 11 *computed under section 1854(b)(1)(C)(i) for that plan and*  
 12 *year involved”.*

13           (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
 14 *section (a) shall apply to subsidy determinations made for*  
 15 *months beginning with January 2011.*

16                           **Subtitle B—Reducing Health**  
 17   **Disparities**

18 **SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN**  
 19 **MEDICARE.**

20           (a) *ENSURING EFFECTIVE COMMUNICATION BY THE*  
 21 *CENTERS FOR MEDICARE & MEDICAID SERVICES.—*

22                           (1) *STUDY ON MEDICARE PAYMENTS FOR LAN-*  
 23 *GUAGE SERVICES.*—*The Secretary of Health and*  
 24 *Human Services shall conduct a study that examines*  
 25 *the extent to which Medicare service providers utilize,*



1       offer, or make available language services for bene-  
2       ficiaries who are limited English proficient and ways  
3       that Medicare should develop payment systems for  
4       language services.

5           (2) ANALYSES.—The study shall include an  
6       analysis of each of the following:

7           (A) How to develop and structure appro-  
8       priate payment systems for language services for  
9       all Medicare service providers.

10          (B) The feasibility of adopting a payment  
11       methodology for on-site interpreters, including  
12       interpreters who work as independent contractors  
13       and interpreters who work for agencies that pro-  
14       vide on-site interpretation, pursuant to which  
15       such interpreters could directly bill Medicare for  
16       services provided in support of physician office  
17       services for an LEP Medicare patient.

18          (C) The feasibility of Medicare contracting  
19       directly with agencies that provide off-site inter-  
20       pretation including telephonic and video inter-  
21       pretation pursuant to which such contractors  
22       could directly bill Medicare for the services pro-  
23       vided in support of physician office services for  
24       an LEP Medicare patient.

1           (D) *The feasibility of modifying the existing*  
2           *Medicare resource-based relative value scale*  
3           *(RBRVS) by using adjustments (such as multi-*  
4           *pliers or add-ons) when a patient is LEP.*

5           (E) *How each of options described in a pre-*  
6           *vious paragraph would be funded and how such*  
7           *funding would affect physician payments, a phy-*  
8           *sician's practice, and beneficiary cost-sharing.*

9           (F) *The extent to which providers under*  
10           *parts A and B of title XVIII of the Social Secu-*  
11           *rity Act, MA organizations offering Medicare*  
12           *Advantage plans under part C of such title and*  
13           *PDP sponsors of a prescription drug plan under*  
14           *part D of such title utilize, offer, or make avail-*  
15           *able language services for beneficiaries with lim-*  
16           *ited English proficiency.*

17           (G) *The nature and type of language serv-*  
18           *ices provided by States under title XIX of the*  
19           *Social Security Act and the extent to which such*  
20           *services could be utilized by beneficiaries and*  
21           *providers under title XVIII of such Act.*

22           (3) *VARIATION IN PAYMENT SYSTEM DE-*  
23           *SCRIBED.—The payment systems described in para-*  
24           *graph (2)(A) may allow variations based upon types*  
25           *of service providers, available delivery methods, and*

1 *costs for providing language services including such*  
2 *factors as—*

3 *(A) the type of language services provided*  
4 *(such as provision of health care or health care*  
5 *related services directly in a non-English lan-*  
6 *guage by a bilingual provider or use of an inter-*  
7 *preter);*

8 *(B) type of interpretation services provided*  
9 *(such as in-person, telephonic, video interpreta-*  
10 *tion);*

11 *(C) the methods and costs of providing lan-*  
12 *guage services (including the costs of providing*  
13 *language services with internal staff or through*  
14 *contract with external independent contractors*  
15 *or agencies, or both);*

16 *(D) providing services for languages not fre-*  
17 *quently encountered in the United States; and*

18 *(E) providing services in rural areas.*

19 *(4) REPORT.—The Secretary shall submit a re-*  
20 *port on the study conducted under subsection (a) to*  
21 *appropriate committees of Congress not later than 12*  
22 *months after the date of the enactment of this Act.*

23 *(5) EXEMPTION FROM PAPERWORK REDUCTION*  
24 *ACT.—Chapter 35 of title 44, United States Code*  
25 *(commonly known as the “Paperwork Reduction Act”*

1       ), shall not apply for purposes of carrying out this  
2       subsection.

3               (6) *AUTHORIZATION OF APPROPRIATIONS.*—  
4       There is authorized to be appropriated to carry out  
5       this subsection such sums as are necessary.

6       (b) *HEALTH PLANS.*—Section 1857(g)(1) of the Social  
7       Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

8               (1) by striking “or” at the end of subparagraph  
9       (F);

10              (2) by adding “or” at the end of subparagraph  
11       (G); and

12              (3) by inserting after subparagraph (G) the fol-  
13       lowing new subparagraph:

14                       “(H) fails substantially to provide language  
15       services to limited English proficient bene-  
16       ficiaries enrolled in the plan that are required  
17       under law;”.

18       **SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR**  
19                       **MEDICARE BENEFICIARIES WITH LIMITED-**  
20                       **ENGLISH PROFICIENCY BY PROVIDING REIM-**  
21                       **BURSEMENT FOR CULTURALLY AND LINGUIS-**  
22                       **TICALLY APPROPRIATE SERVICES.**

23       (a) *IN GENERAL.*—Not later than 6 months after the  
24       date of the completion of the study described in section  
25       1221(a), the Secretary, acting through the Centers for Medi-

1 *care & Medicaid Services and the Center for Medicare and*  
2 *Medicaid Payment Innovation established under section*  
3 *1115A of the Social Security Act (as added by section 1910)*  
4 *and consistent with the applicable provisions of such sec-*  
5 *tion, shall carry out a demonstration program under which*  
6 *the Secretary shall award not fewer than 24 3-year grants*  
7 *to eligible Medicare service providers (as described in sub-*  
8 *section (b)(1)) to improve effective communication between*  
9 *such providers and Medicare beneficiaries who are living*  
10 *in communities where racial and ethnic minorities, includ-*  
11 *ing populations that face language barriers, are under-*  
12 *served with respect to such services. In designing and car-*  
13 *rying out the demonstration the Secretary shall take into*  
14 *consideration the results of the study conducted under sec-*  
15 *tion 1221(a) and adjust, as appropriate, the distribution*  
16 *of grants so as to better target Medicare beneficiaries who*  
17 *are in the greatest need of language services. The Secretary*  
18 *shall not authorize a grant larger than \$500,000 over three*  
19 *years for any grantee.*

20 (b) *ELIGIBILITY; PRIORITY.—*

21 (1) *ELIGIBILITY.—To be eligible to receive a*  
22 *grant under subsection (a) an entity shall—*

23 (A) *be—*

24 (i) *a provider of services under part A*  
25 *of title XVIII of the Social Security Act;*

1                   (ii) a service provider under part B of  
2 such title;

3                   (iii) a part C organization offering a  
4 Medicare part C plan under part C of such  
5 title; or

6                   (iv) a PDP sponsor of a prescription  
7 drug plan under part D of such title; and

8                   (B) prepare and submit to the Secretary an  
9 application, at such time, in such manner, and  
10 accompanied by such additional information as  
11 the Secretary may require.

12                   (2) *PRIORITY.*—

13                   (A) *DISTRIBUTION.*—To the extent feasible,  
14 in awarding grants under this section, the Sec-  
15 retary shall award—

16                   (i) at least 6 grants to providers of  
17 services described in paragraph (1)(A)(i);

18                   (ii) at least 6 grants to service pro-  
19 viders described in paragraph (1)(A)(ii);

20                   (iii) at least 6 grants to organizations  
21 described in paragraph (1)(A)(iii); and

22                   (iv) at least 6 grants to sponsors de-  
23 scribed in paragraph (1)(A)(iv).

24                   (B) *FOR COMMUNITY ORGANIZATIONS.*—The  
25 Secretary shall give priority to applicants that

1           *have developed partnerships with community or-*  
2           *ganizations or with agencies with experience in*  
3           *language access.*

4           (C) *VARIATION IN GRANTEES.*—*The Sec-*  
5           *retary shall also ensure that the grantees under*  
6           *this section represent, among other factors, vari-*  
7           *ations in—*

8                   (i) *different types of language services*  
9                   *provided and of service providers and orga-*  
10                  *nizations under parts A through D of title*  
11                  *XVIII of the Social Security Act;*

12                  (ii) *languages needed and their fre-*  
13                  *quency of use;*

14                  (iii) *urban and rural settings;*

15                  (iv) *at least two geographic regions, as*  
16                  *defined by the Secretary; and*

17                  (v) *at least two large metropolitan sta-*  
18                  *tistical areas with diverse populations.*

19           (c) *USE OF FUNDS.*—

20                   (1) *IN GENERAL.*—*A grantee shall use grant*  
21                   *funds received under this section to pay for the provi-*  
22                   *sion of competent language services to Medicare bene-*  
23                   *ficiaries who are limited-English proficient. Com-*  
24                   *petent interpreter services may be provided through*  
25                   *on-site interpretation, telephonic interpretation, or*

1 *video interpretation or direct provision of health care*  
2 *or health care related services by a bilingual health*  
3 *care provider. A grantee may use bilingual providers,*  
4 *staff, or contract interpreters. A grantee may use*  
5 *grant funds to pay for competent translation services.*  
6 *A grantee may use up to 10 percent of the grant*  
7 *funds to pay for administrative costs associated with*  
8 *the provision of competent language services and for*  
9 *reporting required under subsection (e).*

10 (2) *ORGANIZATIONS.—Grantees that are part C*  
11 *organizations or PDP sponsors must ensure that their*  
12 *network providers receive at least 50 percent of the*  
13 *grant funds to pay for the provision of competent lan-*  
14 *guage services to Medicare beneficiaries who are lim-*  
15 *ited-English proficient, including physicians and*  
16 *pharmacies.*

17 (3) *DETERMINATION OF PAYMENTS FOR LAN-*  
18 *GUAGE SERVICES.—Payments to grantees shall be cal-*  
19 *culated based on the estimated numbers of limited-*  
20 *English proficient Medicare beneficiaries in a grant-*  
21 *ee’s service area utilizing—*

22 (A) *data on the numbers of limited-English*  
23 *proficient individuals who speak English less*  
24 *than “very well” from the most recently avail-*  
25 *able data from the Bureau of the Census or other*



1           *State-based study the Secretary determines likely*  
2           *to yield accurate data regarding the number of*  
3           *such individuals served by the grantee; or*

4           *(B) the grantee's own data if the grantee*  
5           *routinely collects data on Medicare beneficiaries'*  
6           *primary language in a manner determined by*  
7           *the Secretary to yield accurate data and such*  
8           *data shows greater numbers of limited-English*  
9           *proficient individuals than the data listed in*  
10          *subparagraph (A).*

11          (4) *LIMITATIONS.—*

12           *(A) REPORTING.—Payments shall only be*  
13           *provided under this section to grantees that re-*  
14           *port their costs of providing language services as*  
15           *required under subsection (e) and may be modi-*  
16           *fied annually at the discretion of the Secretary.*  
17           *If a grantee fails to provide the reports under*  
18           *such section for the first year of a grant, the Sec-*  
19           *retary may terminate the grant and solicit ap-*  
20           *plications from new grantees to participate in*  
21           *the subsequent two years of the demonstration*  
22           *program.*

23           *(B) TYPE OF SERVICES.—*

24           *(i) IN GENERAL.—Subject to clause*  
25           *(ii), payments shall be provided under this*

1            *section only to grantees that utilize com-*  
2            *petent bilingual staff or competent inter-*  
3            *preter or translation services which—*

4                    *(I) if the grantee operates in a*  
5                    *State that has statewide health care in-*  
6                    *terpreter standards, meet the State*  
7                    *standards currently in effect; or*

8                    *(II) if the grantee operates in a*  
9                    *State that does not have statewide*  
10                   *health care interpreter standards, uti-*  
11                   *lizes competent interpreters who follow*  
12                   *the National Council on Interpreting*  
13                   *in Health Care’s Code of Ethics and*  
14                   *Standards of Practice.*

15                   *(ii) EXEMPTIONS.—The requirements*  
16                   *of clause (i) shall not apply—*

17                   *(I) in the case of a Medicare bene-*  
18                   *ficiary who is limited-English pro-*  
19                   *ficient (who has been informed in the*  
20                   *beneficiary’s primary language of the*  
21                   *availability of free interpreter and*  
22                   *translation services) and who requests*  
23                   *the use of family, friends, or other per-*  
24                   *sons untrained in interpretation or*  
25                   *translation and the grantee documents*

1                    *the request in the beneficiary's record;*  
2                    *and*

3                    *(II) in the case of a medical emer-*  
4                    *gency where the delay directly associ-*  
5                    *ated with obtaining a competent inter-*  
6                    *preter or translation services would*  
7                    *jeopardize the health of the patient.*

8                    *Nothing in clause (ii)(II) shall be construed*  
9                    *to exempt emergency rooms or similar enti-*  
10                    *ties that regularly provide health care serv-*  
11                    *ices in medical emergencies from having in*  
12                    *place systems to provide competent inter-*  
13                    *preter and translation services without*  
14                    *undue delay.*

15                    *(d) ASSURANCES.—Grantees under this section shall—*

16                    *(1) ensure that appropriate clinical and support*  
17                    *staff receive ongoing education and training in lin-*  
18                    *guistically appropriate service delivery;*

19                    *(2) ensure the linguistic competence of bilingual*  
20                    *providers;*

21                    *(3) offer and provide appropriate language serv-*  
22                    *ices at no additional charge to each patient with lim-*  
23                    *ited-English proficiency at all points of contact, in a*  
24                    *timely manner during all hours of operation;*

1           (4) *notify Medicare beneficiaries of their right to*  
2           *receive language services in their primary language;*

3           (5) *post signage in the languages of the com-*  
4           *monly encountered group or groups present in the*  
5           *service area of the organization; and*

6           (6) *ensure that—*

7                 (A) *primary language data are collected for*  
8                 *recipients of language services; and*

9                 (B) *consistent with the privacy protections*  
10                *provided under the regulations promulgated pur-*  
11                *suant to section 264(c) of the Health Insurance*  
12                *Portability and Accountability Act of 1996 (42*  
13                *U.S.C. 1320d–2 note), if the recipient of lan-*  
14                *guage services is a minor or is incapacitated, the*  
15                *primary language of the parent or legal guard-*  
16                *ian is collected and utilized.*

17           (e) *REPORTING REQUIREMENTS.—Grantees under this*  
18           *section shall provide the Secretary with reports at the con-*  
19           *clusion of the each year of a grant under this section. Each*  
20           *report shall include at least the following information:*

21                 (1) *The number of Medicare beneficiaries to*  
22                 *whom language services are provided.*

23                 (2) *The languages of those Medicare beneficiaries.*

24                 (3) *The types of language services provided (such*  
25                 *as provision of services directly in non-English lan-*

1        *guage by a bilingual health care provider or use of an*  
2        *interpreter).*

3            (4) *Type of interpretation (such as in-person,*  
4        *telephonic, or video interpretation).*

5            (5) *The methods of providing language services*  
6        *(such as staff or contract with external independent*  
7        *contractors or agencies).*

8            (6) *The length of time for each interpretation en-*  
9        *counter.*

10           (7) *The costs of providing language services*  
11        *(which may be actual or estimated, as determined by*  
12        *the Secretary).*

13        (f) *NO COST SHARING.—Limited-English proficient*  
14        *Medicare beneficiaries shall not have to pay cost-sharing*  
15        *or co-pays for language services provided through this dem-*  
16        *onstration program.*

17        (g) *EVALUATION AND REPORT.—The Secretary shall*  
18        *conduct an evaluation of the demonstration program under*  
19        *this section and shall submit to the appropriate committees*  
20        *of Congress a report not later than 1 year after the comple-*  
21        *tion of the program. The report shall include the following:*

22            (1) *An analysis of the patient outcomes and costs*  
23        *of furnishing care to the limited-English proficient*  
24        *Medicare beneficiaries participating in the project as*  
25        *compared to such outcomes and costs for limited-*

1       *English proficient Medicare beneficiaries not partici-*  
2       *parting.*

3           (2) *The effect of delivering culturally and lin-*  
4       *guistically appropriate services on beneficiary access*  
5       *to care, utilization of services, efficiency and cost-ef-*  
6       *fectiveness of health care delivery, patient satisfaction,*  
7       *and select health outcomes.*

8           (3) *Recommendations, if any, regarding the ex-*  
9       *tension of such project to the entire Medicare pro-*  
10       *gram.*

11       (h) *GENERAL PROVISIONS.—Nothing in this section*  
12       *shall be construed to limit otherwise existing obligations of*  
13       *recipients of Federal financial assistance under title VI of*  
14       *the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.)*  
15       *or any other statute.*

16       (i) *AUTHORIZATION OF APPROPRIATIONS.—There are*  
17       *authorized to be appropriated to carry out this section*  
18       *\$16,000,000 for each fiscal year of the demonstration pro-*  
19       *gram.*

20       **SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**  
21               **SERVICES.**

22       (a) *IN GENERAL.—The Secretary of Health and*  
23       *Human Services shall enter into an arrangement with the*  
24       *Institute of Medicine under which the Institute will prepare*  
25       *and publish, not later than 3 years after the date of the*

1 *enactment of this Act, a report on the impact of language*  
2 *access services on the health and health care of limited-*  
3 *English proficient populations.*

4 *(b) CONTENTS.—Such report shall include—*

5 *(1) recommendations on the development and*  
6 *implementation of policies and practices by health*  
7 *care organizations and providers for limited-English*  
8 *proficient patient populations;*

9 *(2) a description of the effect of providing lan-*  
10 *guage access services on quality of health care and ac-*  
11 *cess to care and reduced medical error; and*

12 *(3) a description of the costs associated with or*  
13 *savings related to provision of language access serv-*  
14 *ices.*

15 **SEC. 1224. DEFINITIONS.**

16 *In this subtitle:*

17 *(1) BILINGUAL.—The term “bilingual” with re-*  
18 *spect to an individual means a person who has suffi-*  
19 *cient degree of proficiency in two languages and can*  
20 *ensure effective communication can occur in both lan-*  
21 *guages.*

22 *(2) COMPETENT INTERPRETER SERVICES.—The*  
23 *term “competent interpreter services” means a trans-*  
24 *language rendition of a spoken message in which the*  
25 *interpreter comprehends the source language and can*

1 *speak comprehensively in the target language to con-*  
2 *vey the meaning intended in the source language. The*  
3 *interpreter knows health and health-related termi-*  
4 *nology and provides accurate interpretations by*  
5 *choosing equivalent expressions that convey the best*  
6 *matching and meaning to the source language and*  
7 *captures, to the greatest possible extent, all nuances*  
8 *intended in the source message.*

9 (3) *COMPETENT TRANSLATION SERVICES.—The*  
10 *term “competent translation services” means a trans-*  
11 *language rendition of a written document in which*  
12 *the translator comprehends the source language and*  
13 *can write comprehensively in the target language to*  
14 *convey the meaning intended in the source language.*  
15 *The translator knows health and health-related termi-*  
16 *nology and provides accurate translations by choosing*  
17 *equivalent expressions that convey the best matching*  
18 *and meaning to the source language and captures, to*  
19 *the greatest possible extent, all nuances intended in*  
20 *the source document.*

21 (4) *EFFECTIVE COMMUNICATION.—The term “ef-*  
22 *fective communication” means an exchange of infor-*  
23 *mation between the provider of health care or health*  
24 *care-related services and the limited-English pro-*  
25 *ficient recipient of such services that enables limited-*



1     *English proficient individuals to access, understand,*  
2     *and benefit from health care or health care-related*  
3     *services.*

4             (5) *INTERPRETING/INTERPRETATION.*—*The terms*  
5     *“interpreting” and “interpretation” mean the trans-*  
6     *mission of a spoken message from one language into*  
7     *another, faithfully, accurately, and objectively.*

8             (6) *HEALTH CARE SERVICES.*—*The term “health*  
9     *care services” means services that address physical as*  
10    *well as mental health conditions in all care settings.*

11            (7) *HEALTH CARE-RELATED SERVICES.*—*The*  
12    *term “health care-related services” means human or*  
13    *social services programs or activities that provide ac-*  
14    *cess, referrals or links to health care.*

15            (8) *LANGUAGE ACCESS.*—*The term “language ac-*  
16    *cess” means the provision of language services to an*  
17    *LEP individual designed to enhance that individual’s*  
18    *access to, understanding of or benefit from health care*  
19    *or health care-related services.*

20            (9) *LANGUAGE SERVICES.*—*The term “language*  
21    *services” means provision of health care services di-*  
22    *rectly in a non-English language, interpretation,*  
23    *translation, and non-English signage.*

24            (10) *LIMITED-ENGLISH PROFICIENT.*—*The term*  
25    *“limited-English proficient” or “LEP” with respect*

1 *to an individual means an individual who speaks a*  
2 *primary language other than English and who cannot*  
3 *speak, read, write or understand the English language*  
4 *at a level that permits the individual to effectively*  
5 *communicate with clinical or nonclinical staff at an*  
6 *entity providing health care or health care related*  
7 *services.*

8 (11) *MEDICARE BENEFICIARY.*—*The term “Medi-*  
9 *care beneficiary” means an individual entitled to*  
10 *benefits under part A of title XVIII of the Social Se-*  
11 *curity Act or enrolled under part B of such title.*

12 (12) *MEDICARE PROGRAM.*—*The term “Medicare*  
13 *program” means the programs under parts A through*  
14 *D of title XVIII of the Social Security Act.*

15 (13) *SERVICE PROVIDER.*—*The term “service*  
16 *provider” includes all suppliers, providers of services,*  
17 *or entities under contract to provide coverage, items*  
18 *or services under any part of title XVIII of the Social*  
19 *Security Act.*

## 20 ***Subtitle C—Miscellaneous***

### 21 ***Improvements***

#### 22 ***SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS***

#### 23 ***PROCESS.***

24 *Section 1833(g)(5) of the Social Security Act (42*  
25 *U.S.C. 1395l(g)(5)), as amended by section 141 of the Medi-*

1 *care Improvements for Patients and Providers Act of 2008*  
2 *(Public Law 110–275), is amended by striking “December*  
3 *31, 2009” and inserting “December 31, 2011”.*

4 **SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNO-**  
5 **SUPPRESSIVE DRUGS FOR KIDNEY TRANS-**  
6 **PLANT PATIENTS AND OTHER RENAL DIALY-**  
7 **SIS PROVISIONS.**

8 *(a) PROVISION OF APPROPRIATE COVERAGE OF IM-*  
9 *MUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PRO-*  
10 *GRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—*

11 *(1) CONTINUED ENTITLEMENT TO IMMUNO-*  
12 *SUPPRESSIVE DRUGS.—*

13 *(A) KIDNEY TRANSPLANT RECIPIENTS.—*  
14 *Section 226A(b)(2) of the Social Security Act*  
15 *(42 U.S.C. 426–1(b)(2)) is amended by inserting*  
16 *“(except for coverage of immunosuppressive*  
17 *drugs under section 1861(s)(2)(J))” before “,*  
18 *with the thirty-sixth month”.*

19 *(B) APPLICATION.—Section 1836 of such*  
20 *Act (42 U.S.C. 1395o) is amended—*

21 *(i) by striking “Every individual who”*  
22 *and inserting “(a) IN GENERAL.—Every*  
23 *individual who”; and*

24 *(ii) by adding at the end the following*  
25 *new subsection:*

1       “(b) *SPECIAL RULES APPLICABLE TO INDIVIDUALS*  
2 *ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE*  
3 *DRUGS.*—

4               “(1) *IN GENERAL.*—*In the case of an individual*  
5 *whose eligibility for benefits under this title has ended*  
6 *on or after January 1, 2012, except for the coverage*  
7 *of immunosuppressive drugs by reason of section*  
8 *226A(b)(2), the following rules shall apply:*

9               “(A) *The individual shall be deemed to be*  
10 *enrolled under this part for purposes of receiving*  
11 *coverage of such drugs.*

12               “(B) *The individual shall be responsible for*  
13 *providing for payment of the portion of the pre-*  
14 *mium under section 1839 which is not covered*  
15 *under the Medicare savings program (as defined*  
16 *in section 1144(c)(7)) in order to receive such*  
17 *coverage.*

18               “(C) *The provision of such drugs shall be*  
19 *subject to the application of—*

20                       “(i) *the deductible under section*  
21 *1833(b); and*

22                       “(ii) *the coinsurance amount applica-*  
23 *ble for such drugs (as determined under this*  
24 *part).*

1           “(D) *If the individual is an inpatient of a*  
2           *hospital or other entity, the individual is entitled*  
3           *to receive coverage of such drugs under this part.*

4           “(2) *ESTABLISHMENT OF PROCEDURES IN*  
5           *ORDER TO IMPLEMENT COVERAGE.—The Secretary*  
6           *shall establish procedures for—*

7           “(A) *identifying individuals that are enti-*  
8           *tled to coverage of immunosuppressive drugs by*  
9           *reason of section 226A(b)(2); and*

10           “(B) *distinguishing such individuals from*  
11           *individuals that are enrolled under this part for*  
12           *the complete package of benefits under this*  
13           *part.”.*

14           “(C) *TECHNICAL AMENDMENT TO CORRECT*  
15           *DUPLICATE SUBSECTION DESIGNATION.—Sub-*  
16           *section (c) of section 226A of such Act (42 U.S.C.*  
17           *426–1), as added by section 201(a)(3)(D)(ii) of*  
18           *the Social Security Independence and Program*  
19           *Improvements Act of 1994 (Public Law 103–296;*  
20           *108 Stat. 1497), is redesignated as subsection*  
21           *(d).*

22           “(2) *EXTENSION OF SECONDARY PAYER REQUIRE-*  
23           *MENTS FOR ESRD BENEFICIARIES.—Section*  
24           *1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C))*  
25           *is amended by adding at the end the following new*

1       *sentence: “With regard to immunosuppressive drugs*  
2       *furnished on or after the date of the enactment of the*  
3       *America’s Affordable Health Choices Act of 2009, this*  
4       *subparagraph shall be applied without regard to any*  
5       *time limitation.”.*

6       ***(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—***

7       *Section 1881 of such Act is further amended—*

8               *(1) in subsection (b)(14)(B)(iii), by inserting “,*  
9               *including oral drugs that are not the oral equivalent*  
10              *of an intravenous drug (such as oral phosphate bind-*  
11              *ers and calcimimetics),” after “other drugs and*  
12              *biologicals”;*

13              *(2) in subsection (b)(14)(E)(ii)—*

14                      *(A) in the first sentence—*

15                              *(i) by striking “a one-time election to*  
16                              *be excluded from the phase-in” and insert-*  
17                              *ing “an election, with respect to 2011, 2012,*  
18                              *or 2013, to be excluded from the phase-in*  
19                              *(or the remainder of the phase-in)”;* and

20                                      *(ii) by adding before the period at the*  
21                                      *end the following: “for such year and for*  
22                                      *each subsequent year during the phase-in*  
23                                      *described in clause (i)”;* and

24                              *(B) in the second sentence—*

1                   (i) by striking “January 1, 2011” and  
2                   inserting “the first date of such year”; and  
3                   (ii) by inserting “and at a time” after  
4                   “form and manner”; and  
5                   (3) in subsection (h)(4)(E), by striking “lesser”  
6                   and inserting “greater”.

7 **SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.**

8                   (a) *MEDICARE*.—

9                   (1) *IN GENERAL*.—Section 1861 of the Social Se-  
10                   curity Act (42 U.S.C. 1395x) is amended—

11                   (A) in subsection (s)(2)—

12                   (i) by striking “and” at the end of sub-  
13                   paragraph (DD);

14                   (ii) by adding “and” at the end of sub-  
15                   paragraph (EE); and

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

18                   “(FF) advance care planning consultation (as  
19                   defined in subsection (hhh)(1));”; and

20                   (B) by adding at the end the following new  
21                   subsection:

22                   “Advance Care Planning Consultation

23                   “(hhh)(1) Subject to paragraphs (3) and (4), the term  
24                   ‘advance care planning consultation’ means a consultation  
25                   between the individual and a practitioner described in

1 *paragraph (2) regarding advance care planning, if, subject*  
2 *to paragraph (3), the individual involved has not had such*  
3 *a consultation within the last 5 years. Such consultation*  
4 *shall include the following:*

5           “(A) *An explanation by the practitioner of ad-*  
6 *vance care planning, including key questions and*  
7 *considerations, important steps, and suggested people*  
8 *to talk to.*

9           “(B) *An explanation by the practitioner of ad-*  
10 *vance directives, including living wills and durable*  
11 *powers of attorney, and their uses.*

12           “(C) *An explanation by the practitioner of the*  
13 *role and responsibilities of a health care proxy.*

14           “(D) *The provision by the practitioner of a list*  
15 *of national and State-specific resources to assist con-*  
16 *sumers and their families with advance care plan-*  
17 *ning, including the national toll-free hotline, the ad-*  
18 *vance care planning clearinghouses, and State legal*  
19 *service organizations (including those funded through*  
20 *the Older Americans Act of 1965).*

21           “(E) *An explanation by the practitioner of the*  
22 *continuum of end-of-life services and supports avail-*  
23 *able, including palliative care and hospice, and bene-*  
24 *fits for such services and supports that are available*  
25 *under this title.*



1           “(F)(i) Subject to clause (ii), an explanation of  
2 orders regarding life sustaining treatment or similar  
3 orders, which shall include—

4           “(I) the reasons why the development of  
5 such an order is beneficial to the individual and  
6 the individual’s family and the reasons why such  
7 an order should be updated periodically as the  
8 health of the individual changes;

9           “(II) the information needed for an indi-  
10 vidual or legal surrogate to make informed deci-  
11 sions regarding the completion of such an order;  
12 and

13           “(III) the identification of resources that an  
14 individual may use to determine the require-  
15 ments of the State in which such individual re-  
16 sides so that the treatment wishes of that indi-  
17 vidual will be carried out if the individual is  
18 unable to communicate those wishes, including  
19 requirements regarding the designation of a sur-  
20 rogate decisionmaker (also known as a health  
21 care proxy).

22           “(ii) The Secretary shall limit the requirement  
23 for explanations under clause (i) to consultations fur-  
24 nished in a State—

1           “(I) in which all legal barriers have been  
2 addressed for enabling orders for life sustaining  
3 treatment to constitute a set of medical orders re-  
4 spected across all care settings; and

5           “(II) that has in effect a program for orders  
6 for life sustaining treatment described in clause  
7 (iii).

8           “(iii) A program for orders for life sustaining  
9 treatment for a States described in this clause is a  
10 program that—

11           “(I) ensures such orders are standardized  
12 and uniquely identifiable throughout the State;

13           “(II) distributes or makes accessible such or-  
14 ders to physicians and other health professionals  
15 that (acting within the scope of the professional’s  
16 authority under State law) may sign orders for  
17 life sustaining treatment;

18           “(III) provides training for health care pro-  
19 fessionals across the continuum of care about the  
20 goals and use of orders for life sustaining treat-  
21 ment; and

22           “(IV) is guided by a coalition of stake-  
23 holders includes representatives from emergency  
24 medical services, emergency department physi-  
25 cians or nurses, state long-term care association,

1           *state medical association, state surveyors, agency*  
2           *responsible for senior services, state department*  
3           *of health, state hospital association, home health*  
4           *association, state bar association, and state hos-*  
5           *pice association.*

6           “(2) *A practitioner described in this paragraph is—*

7                 “(A) *a physician (as defined in subsection*  
8                 *(r)(1)); and*

9                 “(B) *a nurse practitioner or physician assistant*  
10                 *who has the authority under State law to sign orders*  
11                 *for life sustaining treatments.*

12           “(3)(A) *An initial preventive physical examination*  
13           *under subsection (WW), including any related discussion*  
14           *during such examination, shall not be considered an ad-*  
15           *vance care planning consultation for purposes of applying*  
16           *the 5-year limitation under paragraph (1).*

17           “(B) *An advance care planning consultation with re-*  
18           *spect to an individual may be conducted more frequently*  
19           *than provided under paragraph (1) if there is a significant*  
20           *change in the health condition of the individual, including*  
21           *diagnosis of a chronic, progressive, life-limiting disease, a*  
22           *life-threatening or terminal diagnosis or life-threatening in-*  
23           *jury, or upon admission to a skilled nursing facility, a*  
24           *long-term care facility (as defined by the Secretary), or a*  
25           *hospice program.*

1       “(4) *A consultation under this subsection may include*  
2 *the formulation of an order regarding life sustaining treat-*  
3 *ment or a similar order.*

4       “(5)(A) *For purposes of this section, the term ‘order*  
5 *regarding life sustaining treatment’ means, with respect to*  
6 *an individual, an actionable medical order relating to the*  
7 *treatment of that individual that—*

8               “(i) *is signed and dated by a physician (as de-*  
9 *fin ed in subsection (r)(1)) or another health care pro-*  
10 *fessional (as specified by the Secretary and who is*  
11 *acting within the scope of the professional’s authority*  
12 *under State law in signing such an order, including*  
13 *a nurse practitioner or physician assistant) and is in*  
14 *a form that permits it to stay with the individual*  
15 *and be followed by health care professionals and pro-*  
16 *viders across the continuum of care;*

17               “(ii) *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               “(iii) *is uniquely identifiable and standardized*  
22 *within a given locality, region, or State (as identified*  
23 *by the Secretary); and*

1           “(iv) may incorporate any advance directive (as  
2           defined in section 1866(f)(3)) if executed by the indi-  
3           vidual.

4           “(B) The level of treatment indicated under subpara-  
5           graph (A)(ii) may range from an indication for full treat-  
6           ment to an indication to limit some or all or specified inter-  
7           ventions. Such indicated levels of treatment may include  
8           indications respecting, among other items—

9           “(i) the intensity of medical intervention if the  
10          patient is pulse less, apneic, or has serious cardiac or  
11          pulmonary problems;

12          “(ii) the individual’s desire regarding transfer to  
13          a hospital or remaining at the current care setting;

14          “(iii) the use of antibiotics; and

15          “(iv) the use of artificially administered nutri-  
16          tion and hydration.”.

17          (2) *PAYMENT*.—Section 1848(j)(3) of such Act  
18          (42 U.S.C. 1395w-4(j)(3)) is amended by inserting  
19          “(2)(FF),” after “(2)(EE),”.

20          (3) *FREQUENCY LIMITATION*.—Section 1862(a) of  
21          such Act (42 U.S.C. 1395y(a)) is amended—

22                  (A) in paragraph (1)—

23                          (i) in subparagraph (N), by striking  
24                          “and” at the end;

1                   (ii) in subparagraph (O) by striking  
2                   the semicolon at the end and inserting “,  
3                   and”; and

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

6                   “(P) in the case of advance care planning  
7                   consultations (as defined in section  
8                   1861(hhh)(1)), which are performed more fre-  
9                   quently than is covered under such section;” and  
10                  (B) in paragraph (7), by striking “or (K)”  
11                  and inserting “(K), or (P)”.

12                  (4) *EFFECTIVE DATE.*—The amendments made  
13                  by this subsection shall apply to consultations fur-  
14                  nished on or after January 1, 2011.

15                  (b) *EXPANSION OF PHYSICIAN QUALITY REPORTING*  
16                  *INITIATIVE FOR END OF LIFE CARE.*—

17                   (1) *PHYSICIAN’S QUALITY REPORTING INITIA-*  
18                   *TIVE.*—Section 1848(k)(2) of the Social Security Act  
19                   (42 U.S.C. 1395w–4(k)(2)) is amended by adding at  
20                   the end the following new subparagraph:

21                   “(E) *PHYSICIAN’S QUALITY REPORTING INI-*  
22                   *TIATIVE.*—

23                   “(i) *IN GENERAL.*—For purposes of re-  
24                   porting data on quality measures for cov-  
25                   ered professional services furnished during

1           2011 and any subsequent year, to the extent  
2           that measures are available, the Secretary  
3           shall include quality measures on end of life  
4           care and advanced care planning that have  
5           been adopted or endorsed by a consensus-  
6           based organization, if appropriate. Such  
7           measures shall measure both the creation of  
8           and adherence to orders for life-sustaining  
9           treatment.

10           “(i) *PROPOSED SET OF MEASURES.*—  
11           The Secretary shall publish in the Federal  
12           Register proposed quality measures on end  
13           of life care and advanced care planning  
14           that the Secretary determines are described  
15           in subparagraph (A) and would be appro-  
16           priate for eligible professionals to use to  
17           submit data to the Secretary. The Secretary  
18           shall provide for a period of public com-  
19           ment on such set of measures before final-  
20           izing such proposed measures.”.

21           (c) *INCLUSION OF INFORMATION IN MEDICARE & YOU*  
22           *HANDBOOK.*—

23           (1) *MEDICARE & YOU HANDBOOK.*—

24           (A) *IN GENERAL.*—Not later than 1 year  
25           after the date of the enactment of this Act, the

1            *Secretary of Health and Human Services shall*  
2            *update the online version of the Medicare & You*  
3            *Handbook to include the following:*

4                    *(i) An explanation of advance care*  
5                    *planning and advance directives, includ-*  
6                    *ing—*

7                                    *(I) living wills;*

8                                    *(II) durable power of attorney;*

9                                    *(III) orders of life-sustaining*  
10                    *treatment; and*

11                                    *(IV) health care proxies.*

12                    *(ii) A description of Federal and State*  
13                    *resources available to assist individuals and*  
14                    *their families with advance care planning*  
15                    *and advance directives, including—*

16                                    *(I) available State legal service*  
17                                    *organizations to assist individuals*  
18                                    *with advance care planning, including*  
19                                    *those organizations that receive fund-*  
20                                    *ing pursuant to the Older Americans*  
21                                    *Act of 1965 (42 U.S.C. 93001 et seq.);*

22                                    *(II) website links or addresses for*  
23                                    *State-specific advance directive forms;*  
24                                    *and*



1                   (III) any additional information,  
2                   as determined by the Secretary.

3                   (B) *UPDATE OF PAPER AND SUBSEQUENT*  
4                   *VERSIONS.*—The Secretary shall include the in-  
5                   formation described in subparagraph (A) in all  
6                   paper and electronic versions of the Medicare &  
7                   You Handbook that are published on or after the  
8                   date that is 1 year after the date of the enact-  
9                   ment of this Act.

10 **SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND**  
11                   **WAIVER OF LIMITED ENROLLMENT PENALTY**  
12                   **FOR TRICARE BENEFICIARIES.**

13                   (a) *PART B SPECIAL ENROLLMENT PERIOD.*—

14                   (1) *IN GENERAL.*—Section 1837 of the Social Se-  
15                   curity Act (42 U.S.C. 1395p) is amended by adding  
16                   at the end the following new subsection:

17                   “(l)(1) In the case of any individual who is a covered  
18                   beneficiary (as defined in section 1072(5) of title 10, United  
19                   States Code) at the time the individual is entitled to hos-  
20                   pital insurance benefits under part A under section 226(b)  
21                   or section 226A and who is eligible to enroll but who has  
22                   elected not to enroll (or to be deemed enrolled) during the  
23                   individual’s initial enrollment period, there shall be a spe-  
24                   cial enrollment period described in paragraph (2).

1       “(2) *The special enrollment period described in this*  
2 *paragraph, with respect to an individual, is the 12-month*  
3 *period beginning on the day after the last day of the initial*  
4 *enrollment period of the individual or, if later, the 12-*  
5 *month period beginning with the month the individual is*  
6 *notified of enrollment under this section.*

7       “(3) *In the case of an individual who enrolls during*  
8 *the special enrollment period provided under paragraph*  
9 *(1), the coverage period under this part shall begin on the*  
10 *first day of the month in which the individual enrolls or,*  
11 *at the option of the individual, on the first day of the second*  
12 *month following the last month of the individual’s initial*  
13 *enrollment period.*

14       “(4) *The Secretary of Defense shall establish a method*  
15 *for identifying individuals described in paragraph (1) and*  
16 *providing notice to them of their eligibility for enrollment*  
17 *during the special enrollment period described in para-*  
18 *graph (2).”.*

19               (2) *EFFECTIVE DATE.—The amendment made by*  
20 *paragraph (1) shall apply to elections made on or*  
21 *after the date of the enactment of this Act.*

22               (b) *WAIVER OF INCREASE OF PREMIUM.—*

23                       (1) *IN GENERAL.—Section 1839(b) of the Social*  
24 *Security Act (42 U.S.C. 1395r(b)) is amended by*

1        *striking “section 1837(i)(4)” and inserting “sub-*  
2        *section (i)(4) or (l) of section 1837”.*

3            (2) *EFFECTIVE DATE.—*

4            (A) *IN GENERAL.—The amendment made*  
5        *by paragraph (1) shall apply with respect to*  
6        *elections made on or after the date of the enact-*  
7        *ment of this Act.*

8            (B) *REBATES FOR CERTAIN DISABLED AND*  
9        *ESRD BENEFICIARIES.—*

10           (i) *IN GENERAL.—With respect to pre-*  
11        *miums for months on or after January*  
12        *2005 and before the month of the enactment*  
13        *of this Act, no increase in the premium*  
14        *shall be effected for a month in the case of*  
15        *any individual who is a covered beneficiary*  
16        *(as defined in section 1072(5) of title 10,*  
17        *United States Code) at the time the indi-*  
18        *vidual is entitled to hospital insurance ben-*  
19        *efits under part A of title XVIII of the So-*  
20        *cial Security Act under section 226(b) or*  
21        *226A of such Act, and who is eligible to en-*  
22        *roll, but who has elected not to enroll (or to*  
23        *be deemed enrolled), during the individual’s*  
24        *initial enrollment period, and who enrolls*  
25        *under this part within the 12-month period*

1           that begins on the first day of the month  
2           after the month of notification of entitle-  
3           ment under this part.

4                   (ii) *CONSULTATION WITH DEPARTMENT*  
5                   *OF DEFENSE.*—The Secretary of Health and  
6                   Human Services shall consult with the Sec-  
7                   retary of Defense in identifying individuals  
8                   described in this paragraph.

9                   (iii) *REBATES.*—The Secretary of  
10                  Health and Human Services shall establish  
11                  a method for providing rebates of premium  
12                  increases paid for months on or after Janu-  
13                  ary 1, 2005, and before the month of the en-  
14                  actment of this Act for which a penalty was  
15                  applied and collected.

16 **SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX**  
17 **YEAR IN CASE OF GAINS FROM SALE OF PRI-**  
18 **MARY RESIDENCE IN COMPUTING PART B IN-**  
19 **COME-RELATED PREMIUM.**

20           (a) *IN GENERAL.*—Section 1839(i)(4)(C)(ii)(II) of the  
21 *Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II))* is  
22 amended by inserting “sale of primary residence,” after  
23 “divorce of such individual.”

1       (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
2 *section (a) shall apply to premiums and payments for years*  
3 *beginning with 2011.*

4 **SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT**  
5 **DECISIONS AIDS.**

6       (a) *IN GENERAL.*—*The Secretary of Health and*  
7 *Human Services, acting through the Center for Medicare*  
8 *and Medicaid Payment Innovation established under sec-*  
9 *tion 1115A of the Social Security Act (as added by section*  
10 *1910) and consistent with the applicable provisions of such*  
11 *section, shall establish a shared decision making demonstra-*  
12 *tion program (in this subsection referred to as the “pro-*  
13 *gram”)* *under the Medicare program using patient decision*  
14 *aids to meet the objective of improving the understanding*  
15 *by Medicare beneficiaries of their medical treatment op-*  
16 *tions, as compared to comparable Medicare beneficiaries*  
17 *who do not participate in a shared decision making process*  
18 *using patient decision aids.*

19       (b) *SITES.*—

20               (1) *ENROLLMENT.*—*The Secretary shall enroll in*  
21 *the program not more than 30 eligible providers who*  
22 *have experience in implementing, and have invested*  
23 *in the necessary infrastructure to implement, shared*  
24 *decision making using patient decision aids.*

1           (2) *APPLICATION.*—*An eligible provider seeking*  
2 *to participate in the program shall submit to the Sec-*  
3 *retary an application at such time and containing*  
4 *such information as the Secretary may require.*

5           (3) *PREFERENCE.*—*In enrolling eligible pro-*  
6 *viders in the program, the Secretary shall give pref-*  
7 *erence to eligible providers that—*

8                   (A) *have documented experience in using*  
9 *patient decision aids for the conditions identified*  
10 *by the Secretary and in using shared decision*  
11 *making;*

12                   (B) *have the necessary information tech-*  
13 *nology infrastructure to collect the information*  
14 *required by the Secretary for reporting purposes;*  
15 *and*

16                   (C) *are trained in how to use patient deci-*  
17 *sion aids and shared decision making.*

18           (c) *FOLLOW-UP COUNSELING VISIT.*—

19                   (1) *IN GENERAL.*—*An eligible provider partici-*  
20 *ating in the program shall routinely schedule Medi-*  
21 *care beneficiaries for a counseling visit after the view-*  
22 *ing of such a patient decision aid to answer any*  
23 *questions the beneficiary may have with respect to the*  
24 *medical care of the condition involved and to assist*

1        *the beneficiary in thinking through how their pref-*  
2        *erences and concerns relate to their medical care.*

3            (2) *PAYMENT FOR FOLLOW-UP COUNSELING*  
4        *VISIT.—The Secretary shall establish procedures for*  
5        *making payments for such counseling visits provided*  
6        *to Medicare beneficiaries under the program. Such*  
7        *procedures shall provide for the establishment—*

8            (A) *of a code (or codes) to represent such*  
9            *services; and*

10          (B) *of a single payment amount for such*  
11        *service that includes the professional time of the*  
12        *health care provider and a portion of the reason-*  
13        *able costs of the infrastructure of the eligible pro-*  
14        *vider such as would be made under the applica-*  
15        *ble payment systems to that provider for similar*  
16        *covered services.*

17        (d) *COSTS OF AIDS.—An eligible provider partici-*  
18        *pating in the program shall be responsible for the costs of*  
19        *selecting, purchasing, and incorporating such patient deci-*  
20        *sion aids into the provider’s practice, and reporting data*  
21        *on quality and outcome measures under the program.*

22        (e) *FUNDING.—The Secretary shall provide for the*  
23        *transfer from the Federal Supplementary Medical Insur-*  
24        *ance Trust Fund established under section 1841 of the So-*

1 *cial Security Act (42 U.S.C. 1395t) of such funds as are*  
2 *necessary for the costs of carrying out the program.*

3 (f) *WAIVER AUTHORITY.—The Secretary may waive*  
4 *such requirements of titles XI and XVIII of the Social Secu-*  
5 *rity Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may*  
6 *be necessary for the purpose of carrying out the program.*

7 (g) *REPORT.—Not later than 12 months after the date*  
8 *of completion of the program, the Secretary shall submit*  
9 *to Congress a report on such program, together with rec-*  
10 *ommendations for such legislation and administrative ac-*  
11 *tion as the Secretary determines to be appropriate. The*  
12 *final report shall include an evaluation of the impact of*  
13 *the use of the program on health quality, utilization of*  
14 *health care services, and on improving the quality of life*  
15 *of such beneficiaries.*

16 (h) *DEFINITIONS.—In this section:*

17 (1) *ELIGIBLE PROVIDER.—The term “eligible*  
18 *provider” means the following:*

19 (A) *A primary care practice.*

20 (B) *A specialty practice.*

21 (C) *A multispecialty group practice.*

22 (D) *A hospital.*

23 (E) *A rural health clinic.*



1           (F) A Federally qualified health center (as  
2           defined in section 1861(aa)(4) of the Social Se-  
3           curity Act (42 U.S.C. 1395x(aa)(4)).

4           (G) An integrated delivery system.

5           (H) A State cooperative entity that includes  
6           the State government and at least one other  
7           health care provider which is set up for the pur-  
8           pose of testing shared decision making and pa-  
9           tient decision aids.

10          (2) *PATIENT DECISION AID.*—The term “patient  
11          decision aid” means an educational tool (such as the  
12          Internet, a video, or a pamphlet) that helps patients  
13          (or, if appropriate, the family caregiver of the pa-  
14          tient) understand and communicate their beliefs and  
15          preferences related to their treatment options, and to  
16          decide with their health care provider what treat-  
17          ments are best for them based on their treatment op-  
18          tions, scientific evidence, circumstances, beliefs, and  
19          preferences.

20          (3) *SHARED DECISION MAKING.*—The term  
21          “shared decision making” means a collaborative proc-  
22          ess between patient and clinician that engages the pa-  
23          tient in decision making, provides patients with in-  
24          formation about trade-offs among treatment options,

1       *and facilitates the incorporation of patient pref-*  
2       *erences and values into the medical plan.*

3       ***TITLE III—PROMOTING PRIMARY***  
4       ***CARE, MENTAL HEALTH SERV-***  
5       ***ICES, AND COORDINATED***  
6       ***CARE***

7       ***SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT PRO-***  
8       ***GRAM.***

9       *Title XVIII of the Social Security Act is amended by*  
10      *inserting after section 1866D, as added by section 1152(f)*  
11      *of this Act, the following new section:*

12      “*ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM*

13      “*SEC. 1866E. (a) ESTABLISHMENT.—*

14             “*(1) IN GENERAL.—The Secretary shall conduct*  
15      *a pilot program (in this section referred to as the*  
16      *‘pilot program’) to test different payment incentive*  
17      *models, including (to the extent practicable) the spe-*  
18      *cific payment incentive models described in subsection*  
19      *(c), designed to reduce the growth of expenditures and*  
20      *improve health outcomes in the provision of items and*  
21      *services under this title to applicable beneficiaries (as*  
22      *defined in subsection (d)) by qualifying accountable*  
23      *care organizations (as defined in subsection (b)(1)) in*  
24      *order to—*

1           “(A) promote accountability for a patient  
2           population and coordinate items and services  
3           under parts A and B;

4           “(B) encourage investment in infrastructure  
5           and redesigned care processes for high quality  
6           and efficient service delivery; and

7           “(C) reward physician practices and other  
8           physician organizational models for the provi-  
9           sion of high quality and efficient health care  
10          services.

11          “(2) SCOPE.—The Secretary shall set specific  
12          goals for the number of accountable care organiza-  
13          tions, participating practitioners, and patients served  
14          in the initial tests under the pilot program to ensure  
15          that the pilot program is of sufficient size and scope  
16          to—

17                 “(A) test the approach involved in a variety  
18                 of settings, including urban, rural, and under-  
19                 served areas; and

20                 “(B) subject to subsection (f)(1), disseminate  
21                 such approach rapidly on a national basis.

22          To the extent that the Secretary finds a qualifying ac-  
23          countable care organization model to be successful in  
24          improving quality and reducing costs, the Secretary  
25          shall attempt to attract at least 10 percent of all eligi-

1        *ble providers to act as accountable care organizations*  
2        *and implement such mechanisms and reforms within*  
3        *5 years after the date of the enactment of this section.*  
4        *If the Secretary further finds such accountable care*  
5        *organization models to be successful, the Secretary*  
6        *shall seek to implement such mechanisms and reforms*  
7        *on as large a geographic scale as practical and eco-*  
8        *nomical.*

9        “(b) *QUALIFYING ACCOUNTABLE CARE ORGANIZA-*  
10       *TIONS (ACOs).*—

11                “(1) *QUALIFYING ACO DEFINED.*—*In this section:*

12                        “(A) *IN GENERAL.*—*The terms ‘qualifying*  
13                        *accountable care organization’ and ‘qualifying*  
14                        *ACO’ mean a group of physicians or other phy-*  
15                        *sician organizational model (as defined in sub-*  
16                        *paragraph (D)) that—*

17                                “(i) *is organized at least in part for*  
18                                *the purpose of providing physicians’ serv-*  
19                                *ices; and*

20                                “(ii) *meets such criteria as the Sec-*  
21                                *retary determines to be appropriate to par-*  
22                                *ticipate in the pilot program, including the*  
23                                *criteria specified in paragraph (2).*

24                        “(B) *INCLUSION OF OTHER PROVIDERS.*—

25                        *Nothing in this subsection shall be construed as*

1        *preventing a qualifying ACO from including a*  
2        *hospital or any other provider of services or sup-*  
3        *plier furnishing items or services for which pay-*  
4        *ment may be made under this title that is affili-*  
5        *ated with the ACO under an arrangement struc-*  
6        *tured so that such provider or supplier partici-*  
7        *pates in the pilot program and shares in any in-*  
8        *centive payments under the pilot program.*

9            *“(C) PHYSICIAN.—The term ‘physician’ in-*  
10        *cludes, except as the Secretary may otherwise*  
11        *provide, any individual who furnishes services*  
12        *for which payment may be made as physicians’*  
13        *services.*

14            *“(D) OTHER PHYSICIAN ORGANIZATIONAL*  
15        *MODEL.—The term ‘other physician organization*  
16        *model’ means, with respect to a qualifying ACO*  
17        *any model of organization under which physi-*  
18        *cians enter into agreements with other providers*  
19        *for the purposes of participation in the pilot*  
20        *program in order to provide high quality and ef-*  
21        *ficent health care services and share in any in-*  
22        *centive payments under such program*

23            *“(E) OTHER SERVICES.—Nothing in this*  
24        *paragraph shall be construed as preventing a*  
25        *qualifying ACO from furnishing items or serv-*

1           ices, for which payment may not be made under  
2           this title, for purposes of achieving performance  
3           goals under the pilot program.

4           “(2) *QUALIFYING CRITERIA.*—The following are  
5           criteria described in this paragraph for an organized  
6           group of physicians to be a qualifying ACO:

7                   “(A) *The group has a legal structure that*  
8                   *would allow the group to receive and distribute*  
9                   *incentive payments under this section.*

10                   “(B) *The group includes a sufficient num-*  
11                   *ber of primary care physicians (regardless of*  
12                   *specialty) for the applicable beneficiaries for*  
13                   *whose care the group is accountable (as deter-*  
14                   *mined by the Secretary).*

15                   “(C) *The group reports on quality measures*  
16                   *in such form, manner, and frequency as specified*  
17                   *by the Secretary (which may be for the group,*  
18                   *for providers of services and suppliers, or both).*

19                   “(D) *The group reports to the Secretary (in*  
20                   *a form, manner and frequency as specified by*  
21                   *the Secretary) such data as the Secretary deter-*  
22                   *mines appropriate to monitor and evaluate the*  
23                   *pilot program.*

1           “(E) *The group provides notice to applica-*  
2           *ble beneficiaries regarding the pilot program (as*  
3           *determined appropriate by the Secretary).*

4           “(F) *The group contributes to a best prac-*  
5           *tices network or website, that shall be main-*  
6           *tained by the Secretary for the purpose of shar-*  
7           *ing strategies on quality improvement, care co-*  
8           *ordination, and efficiency that the groups believe*  
9           *are effective.*

10          “(G) *The group utilizes patient-centered*  
11          *processes of care, including those that emphasize*  
12          *patient and caregiver involvement in planning*  
13          *and monitoring of ongoing care management*  
14          *plan.*

15          “(H) *The group meets other criteria deter-*  
16          *mined to be appropriate by the Secretary.*

17          “(c) *SPECIFIC PAYMENT INCENTIVE MODELS.—The*  
18          *specific payment incentive models described in this sub-*  
19          *section are the following:*

20                 “(1) *PERFORMANCE TARGET MODEL.—Under the*  
21                 *performance target model under this paragraph (in*  
22                 *this paragraph referred to as the ‘performance target*  
23                 *model’):*

24                         “(A) *IN GENERAL.—A qualifying ACO*  
25                         *qualifies to receive an incentive payment if ex-*

1           *penditures for applicable beneficiaries are less*  
2           *than a target spending level or a target rate of*  
3           *growth. The incentive payment shall be made*  
4           *only if savings are greater than would result*  
5           *from normal variation in expenditures for items*  
6           *and services covered under parts A and B.*

7           “(B) *COMPUTATION OF PERFORMANCE TAR-*  
8           *GET.—*

9                   “(i) *IN GENERAL.—The Secretary shall*  
10           *establish a performance target for each*  
11           *qualifying ACO comprised of a base amount*  
12           *(described in clause (ii)) increased to the*  
13           *current year by an adjustment factor (de-*  
14           *scribed in clause (iii)). Such a target may*  
15           *be established on a per capita basis, as the*  
16           *Secretary determines to be appropriate.*

17                   “(ii) *BASE AMOUNT.—For purposes of*  
18           *clause (i), the base amount in this subpara-*  
19           *graph is equal to the average total pay-*  
20           *ments (or allowed charges) under parts A*  
21           *and B (and may include part D, if the Sec-*  
22           *retary determines appropriate) for applica-*  
23           *ble beneficiaries for whom the qualifying*  
24           *ACO furnishes items and services in a base*  
25           *period determined by the Secretary. Such*



1           *base amount may be determined on a per*  
2           *capita basis.*

3           “(iii) *ADJUSTMENT FACTOR.*—*For*  
4           *purposes of clause (i), the adjustment factor*  
5           *in this clause may equal an annual per*  
6           *capita amount that reflects changes in ex-*  
7           *penditures from the period of the base*  
8           *amount to the current year that would rep-*  
9           *resent an appropriate performance target*  
10           *for applicable beneficiaries (as determined*  
11           *by the Secretary). Such adjustment factor*  
12           *may be determined as an amount or rate,*  
13           *may be determined on a national, regional,*  
14           *local, or organization-specific basis, and*  
15           *may be determined on a per capita basis.*  
16           *Such adjustment factor also may be ad-*  
17           *justed for risk as determined appropriate by*  
18           *the Secretary.*

19           “(iv) *REBASING.*—*Under this model*  
20           *the Secretary shall periodically rebase the*  
21           *base expenditure amount described in clause*  
22           *(ii).*

23           “(C) *MEETING TARGET.*—

24           “(i) *IN GENERAL.*—*Subject to clause*  
25           *(ii), a qualifying ACO that meet or exceeds*

1           *annual quality and performance targets for*  
2           *a year shall receive an incentive payment*  
3           *for such year equal to a portion (as deter-*  
4           *mined appropriate by the Secretary) of the*  
5           *amount by which payments under this title*  
6           *for such year relative are estimated to be*  
7           *below the performance target for such year,*  
8           *as determined by the Secretary. The Sec-*  
9           *retary may establish a cap on incentive*  
10          *payments for a year for a qualifying ACO.*

11           “(ii) *LIMITATION.*—*The Secretary shall*  
12          *limit incentive payments to each qualifying*  
13          *ACO under this paragraph as necessary to*  
14          *ensure that the aggregate expenditures with*  
15          *respect to applicable beneficiaries for such*  
16          *ACOs under this title (inclusive of incentive*  
17          *payments described in this subparagraph)*  
18          *do not exceed the amount that the Secretary*  
19          *estimates would be expended for such ACO*  
20          *for such beneficiaries if the pilot program*  
21          *under this section were not implemented.*

22           “(D) *REPORTING AND OTHER REQUIRE-*  
23          *MENTS.*—*In carrying out such model, the Sec-*  
24          *retary may (as the Secretary determines to be*  
25          *appropriate) incorporate reporting requirements,*

1           *incentive payments, and penalties related to the*  
2           *physician quality reporting initiative (PQRI),*  
3           *electronic prescribing, electronic health records,*  
4           *and other similar initiatives under section 1848,*  
5           *and may use alternative criteria than would oth-*  
6           *erwise apply under such section for determining*  
7           *whether to make such payments. The incentive*  
8           *payments described in this subparagraph shall*  
9           *not be included in the limit described in sub-*  
10          *paragraph (C)(ii) or in the performance target*  
11          *model described in this paragraph.*

12          “(2) *PARTIAL CAPITATION MODEL.—*

13                 “(A) *IN GENERAL.—Subject to subpara-*  
14                 *graph (B), a partial capitation model described*  
15                 *in this paragraph (in this paragraph referred to*  
16                 *as a ‘partial capitation model’) is a model in*  
17                 *which a qualifying ACO would be at financial*  
18                 *risk for some, but not all, of the items and serv-*  
19                 *ices covered under parts A and B, such as at risk*  
20                 *for some or all physicians’ services or all items*  
21                 *and services under part B. The Secretary may*  
22                 *limit a partial capitation model to ACOs that*  
23                 *are highly integrated systems of care and to*  
24                 *ACOs capable of bearing risk, as determined to*  
25                 *be appropriate by the Secretary.*

1           “(B) *NO ADDITIONAL PROGRAM EXPENDI-*  
2           *TURES.—Payments to a qualifying ACO for ap-*  
3           *plicable beneficiaries for a year under the partial*  
4           *capitation model shall be established in a man-*  
5           *ner that does not result in spending more for*  
6           *such ACO for such beneficiaries than would oth-*  
7           *erwise be expended for such ACO for such bene-*  
8           *ficiaries for such year if the pilot program were*  
9           *not implemented, as estimated by the Secretary.*

10          “(3) *OTHER PAYMENT MODELS.—*

11           “(A) *IN GENERAL.—Subject to subpara-*  
12           *graph (B), the Secretary may develop other pay-*  
13           *ment models that meet the goals of this pilot pro-*  
14           *gram to improve quality and efficiency.*

15           “(B) *NO ADDITIONAL PROGRAM EXPENDI-*  
16           *TURES.—Subparagraph (B) of paragraph (2)*  
17           *shall apply to a payment model under subpara-*  
18           *graph (A) in a similar manner as such subpara-*  
19           *graph (B) applies to the payment model under*  
20           *paragraph (2).*

21          “(d) *APPLICABLE BENEFICIARIES.—*

22           “(1) *IN GENERAL.—In this section, the term ‘ap-*  
23           *plicable beneficiary’ means, with respect to a quali-*  
24           *fying ACO, an individual who—*

1           “(A) is enrolled under part B and entitled  
2           to benefits under part A;

3           “(B) is not enrolled in a Medicare Advan-  
4           tage plan under part C or a PACE program  
5           under section 1894; and

6           “(C) meets such other criteria as the Sec-  
7           retary determines appropriate, which may in-  
8           clude criteria relating to frequency of contact  
9           with physicians in the ACO

10          “(2) *FOLLOWING APPLICABLE BENEFICIARIES.*—  
11          *The Secretary may monitor data on expenditures and*  
12          *quality of services under this title after an applicable*  
13          *beneficiary discontinues receiving services under this*  
14          *title through a qualifying ACO.*

15          “(e) *IMPLEMENTATION.*—

16          “(1) *STARTING DATE.*—*The pilot program shall*  
17          *begin no later than January 1, 2012. An agreement*  
18          *with a qualifying ACO under the pilot program may*  
19          *cover a multi-year period of between 3 and 5 years.*

20          “(2) *WAIVER.*—*The Secretary may waive such*  
21          *provisions of this title (including section 1877) and*  
22          *title XI in the manner the Secretary determines nec-*  
23          *essary in order implement the pilot program.*

24          “(3) *PERFORMANCE RESULTS REPORTS.*—*The*  
25          *Secretary shall report performance results to quali-*

1 *fyling ACOs under the pilot program at least annu-*  
2 *ally.*

3 “(4) *LIMITATIONS ON REVIEW.*—*There shall be*  
4 *no administrative or judicial review under section*  
5 *1869, section 1878, or otherwise of—*

6 “(A) *the elements, parameters, scope, and*  
7 *duration of the pilot program;*

8 “(B) *the selection of qualifying ACOs for*  
9 *the pilot program;*

10 “(C) *the establishment of targets, measure-*  
11 *ment of performance, determinations with re-*  
12 *spect to whether savings have been achieved and*  
13 *the amount of savings;*

14 “(D) *determinations regarding whether, to*  
15 *whom, and in what amounts incentive payments*  
16 *are paid; and*

17 “(E) *decisions about the extension of the*  
18 *program under subsection (g), expansion of the*  
19 *program under subsection (h) or extensions*  
20 *under subsection (i).*

21 “(5) *ADMINISTRATION.*—*Chapter 35 of title 44,*  
22 *United States Code shall not apply to this section.*

23 “(f) *EVALUATION; MONITORING.*—

24 “(1) *IN GENERAL.*—*The Secretary shall evaluate*  
25 *the payment incentive model for each qualifying ACO*

1        *under the pilot program to assess impacts on bene-*  
2        *ficiaries, providers of services, suppliers and the pro-*  
3        *gram under this title. The Secretary shall make such*  
4        *evaluation publicly available within 60 days of the*  
5        *date of completion of such report.*

6                *“(2) MONITORING.—The Inspector General of the*  
7        *Department of Health and Human Services shall pro-*  
8        *vide for monitoring of the operation of ACOs under*  
9        *the pilot program with regard to violations of section*  
10        *1877 (popularly known as the ‘Stark law’).*

11                *“(g) EXTENSION OF PILOT AGREEMENT WITH SUC-*  
12        *CESSFUL ORGANIZATIONS.—*

13                *“(1) REPORTS TO CONGRESS.—Not later than 2*  
14        *years after the date the first agreement is entered into*  
15        *under this section, and biennially thereafter for six*  
16        *years, the Secretary shall submit to Congress and*  
17        *make publicly available a report on the use of au-*  
18        *thorities under the pilot program. Each report shall*  
19        *address the impact of the use of those authorities on*  
20        *expenditures, access, and quality under this title.*

21                *“(2) EXTENSION.—Subject to the report provided*  
22        *under paragraph (1), with respect to a qualifying*  
23        *ACO, the Secretary may extend the duration of the*  
24        *agreement for such ACO under the pilot program as*  
25        *the Secretary determines appropriate if—*

1           “(A) *the ACO receives incentive payments*  
2           *with respect to any of the first 4 years of the*  
3           *pilot agreement and is consistently meeting qual-*  
4           *ity standards or*

5           “(B) *the ACO is consistently exceeding*  
6           *quality standards and is not increasing spend-*  
7           *ing under the program.*

8           “(3) *TERMINATION.—The Secretary may termi-*  
9           *nate an agreement with a qualifying ACO under the*  
10          *pilot program if such ACO did not receive incentive*  
11          *payments or consistently failed to meet quality stand-*  
12          *ards in any of the first 3 years under the program.*

13          “(h) *EXPANSION TO ADDITIONAL ACOs.—*

14                 “(1) *TESTING AND REFINEMENT OF PAYMENT IN-*  
15                 *CENTIVE MODELS.—Subject to the evaluation de-*  
16                 *scribed in subsection (f), the Secretary may enter into*  
17                 *agreements under the pilot program with additional*  
18                 *qualifying ACOs to further test and refine payment*  
19                 *incentive models with respect to qualifying 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, 1 or more*  
25                         *models if, and to the extent that, such models are*



1           *beneficial to the program under this title, as de-*  
2           *termined by the Secretary.*

3           “(B) *CERTIFICATION.*—*The Chief Actuary*  
4           *of the Centers for Medicare & Medicaid Services*  
5           *shall certify that 1 or more of such models de-*  
6           *scribed in subparagraph (A) would result in esti-*  
7           *mated spending that would be less than what*  
8           *spending would otherwise be estimated to be in*  
9           *the absence of such expansion.*

10          “(i) *TREATMENT OF PHYSICIAN GROUP PRACTICE*  
11          *DEMONSTRATION.*—

12                 “(1) *EXTENSION.*—*The Secretary may enter in*  
13                 *to an agreement with a qualifying ACO under the*  
14                 *demonstration under section 1866A, subject to re-*  
15                 *basing and other modifications deemed appropriate*  
16                 *by the Secretary, until the pilot program under this*  
17                 *section is operational.*

18                 “(2) *TRANSITION.*—*For purposes of extension of*  
19                 *an agreement with a qualifying ACO under sub-*  
20                 *section (g)(2), the Secretary shall treat receipt of an*  
21                 *incentive payment for a year by an organization*  
22                 *under the physician group practice demonstration*  
23                 *pursuant to section 1866A as a year for which an in-*  
24                 *centive 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 AR-*  
5 *RANGEMENTS.—The Secretary may create separate*  
6 *incentive arrangements (including using multiple*  
7 *years of data, varying thresholds, varying shared sav-*  
8 *ings amounts, and varying shared savings limits) for*  
9 *different categories of qualifying ACOs to reflect nat-*  
10 *ural variations in data availability, variation in av-*  
11 *erage annual attributable expenditures, program in-*  
12 *tegrity, and other matters the Secretary deems appro-*  
13 *priate.*

14 “(2) *ENCOURAGEMENT OF PARTICIPATION OF*  
15 *SMALLER ORGANIZATIONS.—In order to encourage the*  
16 *participation of smaller accountable care organiza-*  
17 *tions 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) *TREATMENT OF HIGH-COST BENEFICIARIES*  
21 *WITH CHRONIC DISEASES.—Nothing in this section*  
22 *shall be construed as preventing a qualifying ACO*  
23 *from entering into an arrangement with an Inde-*  
24 *pendence at Home Medical Practice or from pro-*

1        *viding home based services for the treatment of bene-*  
2        *ficiaries who are eligible for that program.*

3                *“(4) INVOLVEMENT IN PRIVATE PAYER ARRANGE-*  
4        *MENTS.—Nothing in this section shall be construed as*  
5        *preventing qualifying ACOs participating in the pilot*  
6        *program from negotiating similar contracts with pri-*  
7        *vate payers.*

8                *“(5) ANTIDISCRIMINATION LIMITATION.—The*  
9        *Secretary shall not enter into an agreement with an*  
10        *entity to provide health care items or services under*  
11        *the pilot program, or with an entity to administer the*  
12        *program, unless such entity guarantees that it will*  
13        *not deny, limit, or condition the coverage or provision*  
14        *of benefits under the program, for individuals eligible*  
15        *to be enrolled under such program, based on any*  
16        *health status-related factor described in section*  
17        *2702(a)(1) of the Public Health Service Act.*

18                *“(6) CONSTRUCTION.—Nothing in this section*  
19        *shall be construed to compel or require an organiza-*  
20        *tion to use an organization-specific target growth rate*  
21        *for an accountable care organization under this sec-*  
22        *tion for purposes of section 1848.*

23                *“(7) FUNDING.—For purposes of administering*  
24        *and carrying out the pilot program, other than for*  
25        *payments for items and services furnished under this*

1 *title and incentive payments under subsection (c)(1),*  
2 *in addition to funds otherwise appropriated, there are*  
3 *appropriated to the Secretary for the Center for Medi-*  
4 *care & Medicaid Services Program Management Ac-*  
5 *count \$25,000,000 for each of fiscal years 2010*  
6 *through 2014 and \$20,000,000 for fiscal year 2015.*  
7 *Amounts appropriated under this paragraph for a*  
8 *fiscal year shall be available until expended.”.*

9 **SEC. 1302. MEDICAL HOME PILOT PROGRAM.**

10 *(a) IN GENERAL.—Title XVIII of the Social Security*  
11 *Act is amended by inserting after section 1866E, as inserted*  
12 *by section 1301, the following new section:*

13 *“MEDICAL HOME PILOT PROGRAM*

14 *“SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL*  
15 *HOME MODELS.—*

16 *“(1) ESTABLISHMENT OF PILOT PROGRAM.—The*  
17 *Secretary shall establish a medical home pilot pro-*  
18 *gram (in this section referred to as the ‘pilot pro-*  
19 *gram’) for the purpose of evaluating the feasibility*  
20 *and advisability of reimbursing qualified patient-cen-*  
21 *tered medical homes for furnishing medical home*  
22 *services (as defined under subsection (b)(1)) to high*  
23 *need beneficiaries (as defined in subsection (d)(1)(C))*  
24 *and to targeted high need beneficiaries (as defined in*  
25 *subsection (c)(1)(C)).*

1           “(2) *SCOPE.*—Subject to subsection (g), the Sec-  
2           retary shall set specific goals for the number of prac-  
3           tices and communities, and the number of patients  
4           served, under the pilot program in the initial tests to  
5           ensure that the pilot program is of sufficient size and  
6           scope to—

7                   “(A) test the approach involved in a variety  
8                   of settings, including urban, rural, and under-  
9                   served areas; and

10                   “(B) subject to subsection (e)(1), dissemi-  
11                   nate such approach rapidly on a national basis.  
12           To the extent that the Secretary finds a medical home  
13           model to be successful in improving quality and re-  
14           ducing costs, the Secretary shall implement such  
15           mechanisms and reforms on as large a geographic  
16           scale as practical and economical.

17           “(3) *MODELS OF MEDICAL HOMES IN THE PILOT*  
18           *PROGRAM.*—The pilot program shall evaluate each of  
19           the following medical home models:

20                   “(A) *INDEPENDENT PATIENT-CENTERED*  
21                   *MEDICAL HOME MODEL.*—Independent patient-  
22                   centered medical home model under subsection  
23                   (c).

1                   “(B) *COMMUNITY-BASED MEDICAL HOME*  
2                   *MODEL.—Community-based medical home model*  
3                   *under subsection (d).*

4                   “(4) *PARTICIPATION OF NURSE PRACTITIONERS*  
5                   *AND PHYSICIAN ASSISTANTS.—*

6                   “(A) *Nothing in this section shall be con-*  
7                   *strued as preventing a nurse practitioner from*  
8                   *leading a patient centered medical home so long*  
9                   *as—*

10                   “(i) *all the requirements of this section*  
11                   *are met; and*

12                   “(ii) *the nurse practitioner is acting*  
13                   *consistently with State law.*

14                   “(B) *Nothing in this section shall be con-*  
15                   *strued as preventing a physician assistant from*  
16                   *participating in a patient centered medical*  
17                   *home so long as—*

18                   “(i) *all the requirements of this section*  
19                   *are met; and*

20                   “(ii) *the physician assistant is acting*  
21                   *consistently with State law.*

22                   “(b) *DEFINITIONS.—For purposes of this section:*

23                   “(1) *PATIENT-CENTERED MEDICAL HOME SERV-*  
24                   *ICES.—The term ‘patient-centered medical home serv-*  
25                   *ices’ means services that—*

1           “(A) provide beneficiaries with direct and  
2 ongoing access to a primary care or principal  
3 care by a physician or nurse practitioner who  
4 accepts responsibility for providing first contact,  
5 continuous and comprehensive care to such bene-  
6 ficiary;

7           “(B) coordinate the care provided to a bene-  
8 ficiary by a team of individuals at the practice  
9 level across office, institutional and home set-  
10 tings led by a primary care or principal care  
11 physician or nurse practitioner, as needed and  
12 appropriate;

13           “(C) provide for all the patient’s health care  
14 needs or take responsibility for appropriately ar-  
15 ranging care with other qualified providers for  
16 all stages of life;

17           “(D) provide continuous access to care and  
18 communication with participating beneficiaries;

19           “(E) provide support for patient self-man-  
20 agement, proactive and regular patient moni-  
21 toring, support for family caregivers, use pa-  
22 tient-centered processes, and coordination with  
23 community resources;

24           “(F) integrate readily accessible, clinically  
25 useful information on participating patients

1           *that enables the practice to treat such patients*  
2           *comprehensively and systematically; and*

3           “(G) *implement evidence-based guidelines*  
4           *and apply such guidelines to the identified needs*  
5           *of beneficiaries over time and with the intensity*  
6           *needed by such beneficiaries.*

7           “(2) *PRIMARY CARE.*—*The term ‘primary care’*  
8           *means health care that is provided by a physician,*  
9           *nurse practitioner, or physician assistant who prac-*  
10          *tices in the field of family medicine, general internal*  
11          *medicine, geriatric 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)) pur-  
3           suant to paragraph (3)(B) for a targeted high  
4           need beneficiaries (as defined in subparagraph  
5           (C)).

6           “(B) *INDEPENDENT PATIENT-CENTERED*  
7           *MEDICAL HOME DEFINED.*—In this section, the  
8           term ‘independent patient-centered medical  
9           home’ means a physician-directed or nurse-prac-  
10          titioner-directed practice that is qualified under  
11          paragraph (2) as—

12                 “(i) providing beneficiaries with pa-  
13                 tient-centered medical home services; and

14                 “(ii) meets such other requirements as  
15                 the Secretary may specify.

16          “(C) *TARGETED HIGH NEED BENEFICIARY*  
17          *DEFINED.*—For purposes of this subsection, the  
18          term ‘targeted high need beneficiary’ means a  
19          high need beneficiary who, based on a risk score  
20          as specified by the Secretary, is generally within  
21          the upper 50th percentile of Medicare bene-  
22          ficiaries.

23          “(D) *BENEFICIARY ELECTION TO PARTICI-*  
24          *PATE.*—The Secretary shall determine an appro-

1            *priate method of ensuring that beneficiaries have*  
2            *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 of*  
6            *this section.*

7            “(2) *STANDARD SETTING AND QUALIFICATION*  
8            *PROCESS FOR PATIENT-CENTERED MEDICAL*  
9            *HOMES.*—*The Secretary shall review alternative mod-*  
10           *els for standard setting and qualification, and shall*  
11           *establish a process—*

12                    “(A) *to establish standards to enable med-*  
13                    *ical practices to qualify as patient-centered med-*  
14                    *ical homes; and*

15                    “(B) *to initially provide for the review and*  
16                    *certification of medical practices as meeting such*  
17                    *standards.*

18            “(3) *PAYMENT.*—

19                    “(A) *ESTABLISHMENT OF METHODOLOGY.*—  
20                    *The Secretary shall establish a methodology for*  
21                    *the payment for medical home services furnished*  
22                    *by independent patient-centered medical homes.*  
23                    *Under such methodology, the Secretary shall ad-*  
24                    *just payments to medical homes based on bene-*

1        *ficiary risk scores to ensure that higher pay-*  
2        *ments are made for higher risk beneficiaries.*

3            *“(B) PER BENEFICIARY PER MONTH PAY-*  
4        *MENTS.—Under such payment methodology, the*  
5        *Secretary shall pay independent patient-centered*  
6        *medical homes a monthly fee for each targeted*  
7        *high need beneficiary who consents to receive*  
8        *medical home services through such medical*  
9        *home.*

10           *“(C) PROSPECTIVE PAYMENT.—The fee*  
11        *under subparagraph (B) shall be paid on a pro-*  
12        *spective basis.*

13           *“(D) AMOUNT OF PAYMENT.—In deter-*  
14        *mining the amount of such fee, the Secretary*  
15        *shall consider the following:*

16           *“(i) The clinical work and practice ex-*  
17        *penses involved in providing the medical*  
18        *home services provided by the independent*  
19        *patient-centered medical home (such as pro-*  
20        *viding increased access, care coordination,*  
21        *population disease management, and teach-*  
22        *ing self-care skills for managing chronic ill-*  
23        *nesses) for which payment is not made*  
24        *under this title as of the date of the enact-*  
25        *ment of this section.*

1           “(ii) Allow for differential payments  
2           based on capabilities of the independent pa-  
3           tient-centered medical home.

4           “(iii) Use appropriate risk-adjustment  
5           in determining the amount of the per bene-  
6           ficiary per month payment under this  
7           paragraph in a manner that ensures that  
8           higher payments are made for higher risk  
9           beneficiaries.

10           “(4) ENCOURAGING PARTICIPATION OF VARIETY  
11           OF PRACTICES.—The pilot program under this sub-  
12           section shall be designed to include the participation  
13           of physicians in practices with fewer than 10 full-  
14           time equivalent physicians, as well as physicians in  
15           larger practices, particularly in underserved and  
16           rural areas, as well as federally qualified community  
17           health centers, and rural health centers.

18           “(5) NO DUPLICATION IN PILOT PARTICIPA-  
19           TION.—A physician in a group practice that partici-  
20           pates in the accountable care organization pilot pro-  
21           gram under section 1866D shall not be eligible to par-  
22           ticipate in the pilot program under this subsection,  
23           unless the pilot program under this section has been  
24           implemented on a permanent basis under subsection  
25           (e)(3).

1       “(d) *COMMUNITY-BASED MEDICAL HOME MODEL.*—

2               “(1) *IN GENERAL.*—

3                       “(A) *AUTHORITY FOR PAYMENTS.*—*Under*  
4                       *the community-based medical home model under*  
5                       *this subsection (in this section referred to as the*  
6                       *‘CBMH model’), the Secretary shall make pay-*  
7                       *ments for the furnishing of medical home services*  
8                       *by a community-based medical home (as defined*  
9                       *in subparagraph (B)) pursuant to paragraph*  
10                      *(5)(B) for high need beneficiaries.*

11                      “(B) *COMMUNITY-BASED MEDICAL HOME*  
12                      *DEFINED.*—*In this section, the term ‘community-*  
13                      *based medical home’ means a nonprofit commu-*  
14                      *nity-based or State-based organization that is*  
15                      *certified under paragraph (2) as meeting the fol-*  
16                      *lowing requirements:*

17                               “(i) *The organization provides bene-*  
18                               *ficiaries with medical home services.*

19                               “(ii) *The organization provides med-*  
20                               *ical home services under the supervision of*  
21                               *and in close collaboration with the primary*  
22                               *care or principal care physician, nurse*  
23                               *practitioner, or physician assistant des-*  
24                               *ignated by the beneficiary as his or her*  
25                               *community-based medical home provider.*

1           “(iii) *The organization employs com-*  
2           *munity health workers, including nurses or*  
3           *other non-physician practitioners, lay*  
4           *health workers, or other persons as deter-*  
5           *mined appropriate by the Secretary, that*  
6           *assist the primary or principal care physi-*  
7           *cian, nurse practitioner, or physician as-*  
8           *stant in chronic care management activi-*  
9           *ties such as teaching self-care skills for*  
10           *managing chronic illnesses, transitional*  
11           *care services, care plan setting, medication*  
12           *therapy management services for patients*  
13           *with multiple chronic diseases, or help bene-*  
14           *ficiaries access the health care and commu-*  
15           *nity-based resources in their local geo-*  
16           *graphic area.*

17           “(iv) *The organization meets such*  
18           *other requirements as the Secretary may*  
19           *specify.*

20           “(C) *HIGH NEED BENEFICIARY.—In this*  
21           *section, the term ‘high need beneficiary’ means*  
22           *an individual who requires regular medical*  
23           *monitoring, advising, or treatment, including*  
24           *such an individual with cognitive impairment*  
25           *that leads to functional impairment.*

1           “(2) *QUALIFICATION PROCESS FOR COMMUNITY-*  
2           *BASED MEDICAL HOMES.*—*The Secretary shall estab-*  
3           *lish a process—*

4                     “(A) *for the initial qualification of commu-*  
5                     *nity-based or State-based organizations as com-*  
6                     *munity-based medical homes; and*

7                     “(B) *to provide for the review and quali-*  
8                     *fication of such community-based and State-*  
9                     *based organizations pursuant to criteria estab-*  
10                    *lished by the Secretary.*

11           “(3) *DURATION.*—*The pilot program for commu-*  
12           *nity-based medical homes under this subsection shall*  
13           *start no later than 2 years after the date of the enact-*  
14           *ment of this section. Each demonstration site under*  
15           *the pilot program shall operate for a period of up to*  
16           *5 years after the initial implementation phase, with-*  
17           *out regard to the receipt of a initial implementation*  
18           *funding under subsection (i).*

19           “(4) *PREFERENCE.*—*In selecting sites for the*  
20           *CBMH model, the Secretary shall seek to eliminate*  
21           *racial, ethnic, gender, and geographic health dispari-*  
22           *ties and may give preference to—*

23                     “(A) *applications from geographic areas*  
24                     *that propose to coordinate health care services for*  
25                     *chronically ill beneficiaries across a variety of*

1           *health care settings, such as primary care physi-*  
2           *cian practices with fewer than 10 physicians,*  
3           *specialty physicians, nurse practitioner prac-*  
4           *tices, Federally qualified health centers, rural*  
5           *health clinics, and other settings;*

6           “(B) *applications that include other payors*  
7           *that furnish medical home services for chron-*  
8           *ically ill patients covered by such payors; and*

9           “(C) *applications from States that propose*  
10           *to use the medical home model to coordinate*  
11           *health care services for individuals enrolled*  
12           *under this title, individuals enrolled under title*  
13           *XIX, and full-benefit dual eligible individuals*  
14           *(as defined in section 1935(c)(6)) with chronic*  
15           *diseases across a variety of health care settings.*

16           “(5) *PAYMENTS.—*

17           “(A) *ESTABLISHMENT OF METHODOLOGY.—*  
18           *The Secretary shall establish a methodology for*  
19           *the payment for medical home services furnished*  
20           *under the CBMH model.*

21           “(B) *PER BENEFICIARY PER MONTH PAY-*  
22           *MENTS.—Under such payment methodology, the*  
23           *Secretary shall make two separate monthly pay-*  
24           *ments for each high need beneficiary who con-*



1           *sents to receive medical home services through*  
2           *such medical home, as follows:*

3                   “(i) *PAYMENT TO COMMUNITY-BASED*  
4                   *ORGANIZATION.—One monthly payment to*  
5                   *a community-based or State-based organiza-*  
6                   *tion.*

7                   “(ii) *PAYMENT TO PRIMARY OR PRIN-*  
8                   *CIPAL CARE PRACTICE.—One monthly pay-*  
9                   *ment to the primary or principal care prac-*  
10                   *tice for such beneficiary.*

11                   “(C) *PROSPECTIVE PAYMENT.—The pay-*  
12                   *ments under subparagraph (B) shall be paid on*  
13                   *a prospective basis.*

14                   “(D) *AMOUNT OF PAYMENT.—In deter-*  
15                   *mining the amount of such payment, the Sec-*  
16                   *retary shall consider the following:*

17                           “(i) *The clinical work and practice ex-*  
18                           *penses involved in providing the medical*  
19                           *home services provided by the community-*  
20                           *based medical home (such as providing in-*  
21                           *creased access, care coordination, care plan*  
22                           *setting, population disease management,*  
23                           *and teaching self-care skills for managing*  
24                           *chronic illnesses) for which payment is not*

1           *made under this title as of the date of the*  
2           *enactment of this section.*

3           “(ii) *Use appropriate risk-adjustment*  
4           *in determining the amount of the per bene-*  
5           *ficiary per month payment under this*  
6           *paragraph.*

7           “(6) *INITIAL IMPLEMENTATION FUNDING.—The*  
8           *Secretary may make available initial implementation*  
9           *funding to a community based or State-based organi-*  
10          *zation or a State that is participating in the pilot*  
11          *program under this subsection. Such organization*  
12          *shall provide the Secretary with a detailed implemen-*  
13          *tation plan that includes how such funds will be used.*  
14          *The Secretary shall select a territory of the United*  
15          *States as one of the locations in which to implement*  
16          *the pilot program under this subsection.*

17          “(e) *EXPANSION OF PROGRAM.—*

18                 “(1) *EVALUATION OF COST AND QUALITY.—The*  
19                 *Secretary shall evaluate the pilot program to deter-*  
20                 *mine—*

21                         “(A) *the extent to which medical homes re-*  
22                         *sult in—*

23                                 “(i) *improvement in the quality and*  
24                                 *coordination of health care services, particu-*

1                    *larly with regard to the care of complex pa-*  
2                    *tients;*

3                    *“(ii) improvement in reducing health*  
4                    *disparities;*

5                    *“(iii) reductions in preventable hos-*  
6                    *pitalizations;*

7                    *“(iv) prevention of readmissions;*

8                    *“(v) reductions in emergency room vis-*  
9                    *its;*

10                   *“(vi) improvement in health outcomes,*  
11                   *including patient functional status where*  
12                   *applicable;*

13                   *“(vii) improvement in patient satisfac-*  
14                   *tion;*

15                   *“(viii) improved efficiency of care such*  
16                   *as reducing duplicative diagnostic tests and*  
17                   *laboratory tests; and*

18                   *“(ix) reductions in health care expend-*  
19                   *itures; and*

20                   *“(B) the feasibility and advisability of re-*  
21                   *imbursing medical homes for medical home serv-*  
22                   *ices under this title on a permanent basis.*

23                   *“(2) REPORT.—Not later than 60 days after the*  
24                   *date of completion of the evaluation under paragraph*  
25                   *(1), the Secretary shall submit to Congress and make*

1 available to the public a report on the findings of the  
2 evaluation under paragraph (1).

3 “(3) *EXPANSION OF PROGRAM.*—

4 “(A) *IN GENERAL.*—Subject to the results of  
5 the evaluation under paragraph (1) and sub-  
6 paragraph (B), the Secretary may issue regula-  
7 tions to implement, on a permanent basis, one or  
8 more models, if, and to the extent that such  
9 model or models, are beneficial to the program  
10 under this title, including that such implementa-  
11 tion will improve quality of care, as determined  
12 by the Secretary.

13 “(B) *CERTIFICATION REQUIREMENT.*—The  
14 Secretary may not issue such regulations unless  
15 the Chief Actuary of the Centers for Medicare &  
16 Medicaid Services certifies that the expansion of  
17 the components of the pilot program described in  
18 subparagraph (A) would result in estimated  
19 spending under this title that would be no more  
20 than the level of spending that the Secretary esti-  
21 mates would otherwise be spent under this title  
22 in the absence of such expansion.

23 “(f) *ADMINISTRATIVE PROVISIONS.*—

24 “(1) *NO DUPLICATION IN PAYMENTS.*—During  
25 any month, the Secretary may not make payments

1       *under this section under more than one model or*  
2       *through more than one medical home under any*  
3       *model for the furnishing of medical home services to*  
4       *an individual.*

5               “(2) *NO EFFECT ON PAYMENT FOR EVALUATION*  
6       *AND MANAGEMENT SERVICES.—Payments made under*  
7       *this section are in addition to, and have no effect on*  
8       *the amount of, payment for evaluation and manage-*  
9       *ment services made under this title*

10              “(3) *ADMINISTRATION.—Chapter 35 of title 44,*  
11       *United States Code shall not apply to this section.*

12              “(g) *FUNDING.—*

13              “(1) *OPERATIONAL COSTS.—For purposes of ad-*  
14       *ministering and carrying out the pilot program (in-*  
15       *cluding the design, implementation, technical assist-*  
16       *ance for and evaluation of such program), in addition*  
17       *to funds otherwise available, there shall be transferred*  
18       *from the Federal Supplementary Medical Insurance*  
19       *Trust Fund under section 1841 to the Secretary for*  
20       *the Centers for Medicare & Medicaid Services Pro-*  
21       *gram Management Account \$6,000,000 for each of fis-*  
22       *cal years 2010 through 2014. Amounts appropriated*  
23       *under this paragraph for a fiscal year shall be avail-*  
24       *able until expended.*

1           “(2) *PATIENT-CENTERED MEDICAL HOME SERV-*  
2           *ICES.—In addition to funds otherwise available, there*  
3           *shall be available to the Secretary for the Centers for*  
4           *Medicare & Medicaid Services, from the Federal Sup-*  
5           *plementary Medical Insurance Trust Fund under sec-*  
6           *tion 1841—*

7                   “(A) \$200,000,000 for each of fiscal years  
8                   2010 through 2014 for payments for medical  
9                   home services under subsection (c)(3); and

10                   “(B) \$125,000,000 for each of fiscal years  
11                   2012 through 2016, for payments under sub-  
12                   section (d)(5).

13           *Amounts available under this paragraph for a fiscal*  
14           *year shall be available until expended.*

15           “(3) *INITIAL IMPLEMENTATION.—In addition to*  
16           *funds otherwise available, there shall be available to*  
17           *the Secretary for the Centers for Medicare & Medicaid*  
18           *Services, from the Federal Supplementary Medical*  
19           *Insurance Trust Fund under section 1841, \$2,500,000*  
20           *for each of fiscal years 2010 through 2012, under sub-*  
21           *section (d)(6). Amounts available under this para-*  
22           *graph for a fiscal year shall be available until ex-*  
23           *pended.*

24           “(h) *TREATMENT OF TRHCA MEDICARE MEDICAL*  
25           *HOME DEMONSTRATION FUNDING.—*

1           “(1) *In addition to funds otherwise available for*  
2           *payment of medical home services under subsection*  
3           *(c)(3), there shall also be available the amount pro-*  
4           *vided in subsection (g) of section 204 of division B*  
5           *of the Tax Relief and Health Care Act of 2006 (42*  
6           *U.S.C. 1395b–1 note).*

7           “(2) *Notwithstanding section 1302(c) of the*  
8           *America’s Affordable Health Choices Act of 2009, in*  
9           *addition to funds provided in paragraph (1) and sub-*  
10           *section (g)(2)(A), the funding for medical home serv-*  
11           *ices that would otherwise have been available if such*  
12           *section 204 medical home demonstration had been im-*  
13           *plemented (without regard to subsection (g) of such*  
14           *section) shall be available to the independent patient-*  
15           *centered medical home model described in subsection*  
16           *(c).”.*

17           **(b) EFFECTIVE DATE.**—*The amendment made by this*  
18           *section shall apply to services furnished on or after the date*  
19           *of the enactment of this Act.*

20           **(c) CONFORMING REPEAL.**—*Section 204 of division B*  
21           *of the Tax Relief and Health Care Act of 2006 (42 U.S.C.*  
22           *1395b–1 note), as amended by section 133(a)(2) of the*  
23           *Medicare Improvements for Patients and Providers Act of*  
24           *2008 (Public Law 110–275), is repealed.*

1 **SEC. 1303. INDEPENDENCE AT HOME PILOT PROGRAM.**

2 *Title XVIII of the Social Security Act is amended by*  
3 *inserting after section 1866F, as inserted by section 1302,*  
4 *the following new section:*

5 *“INDEPENDENCE AT HOME MEDICAL PRACTICE PILOT*  
6 *PROGRAM*

7 *“SEC. 1866G. (a) IN GENERAL.—The Secretary shall*  
8 *conduct a pilot program (in this section referred to as the*  
9 *‘pilot program’) to test a payment incentive and service de-*  
10 *livery model that utilizes physician and nurse practitioner*  
11 *directed home-based primary care teams designed to reduce*  
12 *expenditures and improve health outcomes in the provision*  
13 *of items and services under this title to applicable bene-*  
14 *ficiaries (as defined in subsection (d)). The pilot program*  
15 *tests whether such a model, which is accountable for pro-*  
16 *viding comprehensive, coordinated, continuous, and acces-*  
17 *sible care to high-need populations at home and coordi-*  
18 *nating health care across all treatment settings, results in—*

19 *“(1) reducing preventable hospitalizations;*

20 *“(2) preventing hospital readmissions;*

21 *“(3) reducing emergency room visits;*

22 *“(4) improving health outcomes;*

23 *“(5) improving the efficiency of care, such as by*  
24 *reducing duplicative diagnostic and laboratory tests;*

25 *“(6) reducing the cost of health care services cov-*  
26 *ered under this title; and*



1           “(7) *achieving beneficiary and family caregiver*  
2           *satisfaction.*

3           “(b) *QUALIFYING INDEPENDENCE AT HOME MEDICAL*  
4           *PRACTICE.—*

5           “(1) *DEFINITION.—In this section, the term*  
6           *‘qualifying independence at home medical practice’*  
7           *means a legal entity comprised of an individual phy-*  
8           *sician or nurse practitioner or group of physicians*  
9           *and nurse practitioners who are certified or have ex-*  
10           *perience and training in providing home-based pri-*  
11           *mary care services to high cost chronically ill bene-*  
12           *ficiaries as determined appropriate by the Secretary*  
13           *and which has entered into an agreement with the*  
14           *Secretary. Care is provided by a team, including phy-*  
15           *sicians, nurses, physician assistants, pharmacists,*  
16           *and other health and social services staff as appro-*  
17           *priate who are certified or have experience providing*  
18           *home-based primary care to applicable beneficiaries,*  
19           *make in-home visits and carry out plans of care that*  
20           *are tailored to the individual beneficiary’s chronic*  
21           *conditions and designed to achieve the results in sub-*  
22           *section (a) and report the clinical and quality of care*  
23           *outcomes as determined by the Secretary. The pilot*  
24           *program shall be designed to include the participa-*  
25           *tion of physician and nurse practitioner practices*

1 *with fewer than 10 full-time equivalent physicians, as*  
2 *well as physicians in larger practices, particularly in*  
3 *underserved rural areas.*

4 “(2) *PARTICIPATION OF NURSE PRACTITIONERS*  
5 *AND PHYSICIAN ASSISTANTS.—Nothing in this section*  
6 *shall be construed to prevent a nurse practitioner or*  
7 *physician assistant from leading a home-based pri-*  
8 *mary care team as part of an Independence at Home*  
9 *Medical Practice if—*

10 “(A) *all the requirements of this section are*  
11 *met; and*

12 “(B) *the nurse practitioner or physician as-*  
13 *stant, as the case may be, is acting consistently*  
14 *with State law.*

15 “(3) *INCLUSION OF PROVIDERS AND PRACTI-*  
16 *TIONERS.—Nothing in this subsection shall be con-*  
17 *strued as preventing a qualifying Independence at*  
18 *Home Medical Practice from including a provider or*  
19 *participating practitioner that is affiliated with the*  
20 *medical practice under an arrangement structured so*  
21 *that such provider or practitioner participates in the*  
22 *pilot program and shares in any savings under the*  
23 *pilot program.*

24 “(c) *PAYMENT.—*

1           “(1) *SHARED SAVINGS.*—A qualifying *Independ-*  
2           *ence at Home Medical Practice* may receive 80 per-  
3           *cent of savings in excess of 5 percent if expenditures*  
4           *under this title for applicable beneficiaries partici-*  
5           *parting in the pilot program are at least 5 percent less*  
6           *than a target spending level or a target rate of*  
7           *growth. The shared savings payment shall be made*  
8           *only if savings are at a minimum 5 percent greater*  
9           *than would result from normal variation in expendi-*  
10           *tures for items and services covered under parts A*  
11           *and B (and part D to the extent the Secretary decides*  
12           *to include such costs).*

13           “(2) *ESTABLISHMENT OF LEVELS, THRESHOLDS,*  
14           *AND LIMITS.*—The Secretary may establish target  
15           *spending levels, savings thresholds, and limits on*  
16           *shared savings amounts for each participating Inde-*  
17           *pendence at Home Medical Practice based upon the*  
18           *size of the practice, characteristics of the enrolled in-*  
19           *dividuals, and such other factors as the Secretary de-*  
20           *termines appropriate.*

21           “(3) *INTERIM PAYMENTS.*—A qualifying *Inde-*  
22           *pendence at Home Medical Practice* may receive pay-  
23           *ments for geriatric assessments and monthly care co-*  
24           *ordination services as determined by the Secretary*  
25           *but in the event that an Independence at Home Med-*

1        *ical Practice does not achieve the required savings in*  
2        *this subsection, those payments or a fraction of them,*  
3        *as appropriate, are at risk of being recouped by the*  
4        *Secretary to ensure that no Independence at Home*  
5        *Medical Practice receives Medicare payments in ex-*  
6        *cess of what Medicare otherwise would have paid for*  
7        *the services provided to the beneficiaries receiving*  
8        *medical care from the Independence at Home Medical*  
9        *Practice in the absence of the pilot program.*

10            *“(4) ASSURANCE OF FINANCIAL SOLVENCY.—In*  
11        *order to receive payments under paragraph (3), a*  
12        *qualifying Independence at Home Medical Practice*  
13        *shall demonstrate to the satisfaction of the Secretary*  
14        *that the organization is able to assume financial risk*  
15        *for the 5 percent savings requirements through avail-*  
16        *able reserves, reinsurance, or withholding of funding*  
17        *provided under this title, or such other means as the*  
18        *Secretary determines appropriate.*

19            *“(5) NO ADDITIONAL PROGRAM EXPENDI-*  
20        *TURES.—The Secretary shall limit shared savings*  
21        *payments to each qualifying Independence at Home*  
22        *Medical Practice under this subsection as necessary to*  
23        *ensure that the aggregate expenditures with respect to*  
24        *applicable beneficiaries for such Independence at*  
25        *Home Medical Practice under this title (inclusive of*

1 *shared savings payments described in this paragraph)*  
2 *do not exceed the amount that the Secretary estimates*  
3 *would be expended for such Independence at Home*  
4 *Medical Practice for such beneficiaries if the pilot*  
5 *program under this section were not implemented.*

6 *“(d) APPLICABLE BENEFICIARIES.—*

7 *“(1) DEFINITION.—In this section, the term ‘ap-*  
8 *plicable beneficiary’ means, with respect to a quali-*  
9 *fying Independence at Home Medical Practice, an in-*  
10 *dividual who—*

11 *“(A) is enrolled under part B and entitled*  
12 *to benefits under part A;*

13 *“(B) is not enrolled in a Medicare Advan-*  
14 *tage plan under part C or a PACE program*  
15 *under section 1894;*

16 *“(C) is in the top 20 percent of Medicare*  
17 *patient risk scores;*

18 *“(D) has two or more chronic illnesses, in-*  
19 *cluding congestive heart failure, diabetes, chronic*  
20 *obstructive pulmonary disease, ischemic heart*  
21 *disease, stroke, Alzheimer’s Disease and other de-*  
22 *mentias designated by the Secretary, pressure ul-*  
23 *cers, hypertension, neurodegenerative diseases*  
24 *designated by the Secretary which result in high*  
25 *costs under this title including amyotrophic lat-*

1           *eral sclerosis (ALS), multiple sclerosis, and Par-*  
2           *kinson's disease, and other chronic conditions*  
3           *identified by the Secretary that result in high*  
4           *costs when in combination with one or more of*  
5           *the diseases listed in this subparagraph;*

6           *“(E) had a nonelective hospital admission*  
7           *within the past 12 months;*

8           *“(F) has received acute or subacute rehabili-*  
9           *tation services;*

10           *“(G) continues to have two or more func-*  
11           *tional dependencies requiring the assistance of*  
12           *another person (for example, bathing, dressing,*  
13           *toileting, walking, or feeding); and*

14           *“(H) fulfills such other criteria as the Sec-*  
15           *retary determines appropriate.*

16           *“(2) PUBLICATION OF REQUIREMENTS.—The*  
17           *Secretary shall publish eligibility requirements for*  
18           *beneficiaries that are sufficiently clear to be under-*  
19           *stood by beneficiaries and the individuals providing*  
20           *services to them as part of the pilot program.*

21           *“(3) PATIENT ELECTION TO PARTICIPATE.—The*  
22           *Secretary shall determine an appropriate method of*  
23           *ensuring that applicable beneficiaries have agreed to*  
24           *participate in an Independence at Home Medical*  
25           *Practice. Participation shall be entirely voluntary.*

1           “(4) *BENEFICIARY ACCESS TO SERVICES.*—*Ex-*  
2           *cept as provided in subsection (e)(2), nothing in this*  
3           *section shall be construed as encouraging physicians*  
4           *or nurse practitioners to limit beneficiary access to*  
5           *services covered under title XVIII and beneficiaries*  
6           *shall not be required to relinquish access to any ben-*  
7           *efit under this title as a condition of receiving serv-*  
8           *ices from an Independence at Home Medical Practice.*

9           “(e) *IMPLEMENTATION.*—

10           “(1) *STARTING DATE.*—*The pilot program shall*  
11           *begin not later than January 1, 2012. An agreement*  
12           *with a qualifying Independence at Home Medical*  
13           *Practice under the pilot program may cover a 3 year*  
14           *period.*

15           “(2) *NO DUPLICATION IN PILOT PARTICIPA-*  
16           *TION.*—*A physician or nurse practitioner who par-*  
17           *ticipates in the accountable care organization pilot*  
18           *program under section 1866D or the medical home*  
19           *pilot program under section 1866E shall not be eligi-*  
20           *ble to participate in the pilot program under this*  
21           *subsection.*

22           “(3) *PREFERENCE.*—*In approving an Independ-*  
23           *ence at Home Medical Practice, the Secretary shall*  
24           *give preference to medical practices that are—*

1           “(A) *located in high cost areas of the coun-*  
2           *try;*

3           “(B) *have experience in furnishing health*  
4           *care services to applicable beneficiaries in the*  
5           *home; and*

6           “(C) *use electronic medical records, health*  
7           *information technology, and individualized*  
8           *plans of care.*

9           “(4) *WAIVER.—The Secretary may waive such*  
10          *provisions of this title (including section 1877) and*  
11          *title XI in the manner the Secretary determines nec-*  
12          *essary in order implement the pilot program.*

13          “(5) *ADMINISTRATION.—Chapter 35 of title 44,*  
14          *United States Code shall not apply to this section.*

15          “(f) *MINIMUM NUMBER OF SITES.—To the extent*  
16          *practicable, at least two unaffiliated Independence at Home*  
17          *Medical Practices will be established in the 13 highest cost*  
18          *States and the District of Columbia and in 13 additional*  
19          *States that are representative of other regions of the United*  
20          *States and include medically underserved rural and urban*  
21          *areas as determined by the Secretary.*

22          “(g) *EVALUATION AND MONITORING.—The Secretary*  
23          *shall annually evaluate each qualifying Independence at*  
24          *Home Medical Practice under the pilot program to assess*  
25          *whether it achieved the minimum savings of 5 percent and*



1 *the results described in subsection (a). The Secretary shall*  
2 *have the discretion to terminate an agreement with an Inde-*  
3 *pendence at Home Medical Practice that fails to achieve*  
4 *a preponderance of those results. The Secretary shall make*  
5 *evaluations publicly available within 60 days of the date*  
6 *of completion of such report.*

7       “(h) *REPORTS TO CONGRESS.*—*Not later than 2 years*  
8 *after the date the first agreement is entered into under this*  
9 *section, and biennially thereafter until the pilot is com-*  
10 *pleted, the Secretary shall submit to Congress and make*  
11 *publicly available a report on best practices under the pilot*  
12 *program. Each report shall address the impact of such best*  
13 *practices on expenditures, access, and quality under this*  
14 *title.*

15       “(i) *EXPANSION TO PROGRAM IMPLEMENTATIONS.*—

16               “(1) *TESTING AND REFINEMENT OF PAYMENT IN-*  
17 *CENTIVE AND SERVICE DELIVERY MODELS.*—*Subject*  
18 *to the evaluation described in subsection (f), the Sec-*  
19 *retary may enter into agreements under the pilot pro-*  
20 *gram with additional qualifying Independence at*  
21 *Home Medical Practices to further test and refine*  
22 *models with respect to qualifying Independence at*  
23 *Home Medical Practices.*

24               “(2) *EXPANDING USE OF SUCCESSFUL MODELS*  
25 *TO PROGRAM IMPLEMENTATION.*—

1           “(A) *IN GENERAL.*—Subject to subpara-  
2 graph (B), the Secretary may issue regulations  
3 to implement, on a permanent basis, the Inde-  
4 pendence at Home Medical Practice Model if,  
5 and to the extent that, such models are beneficial  
6 to the program under this title, as determined by  
7 the Secretary.

8           “(B) *CERTIFICATION.*—The Chief Actuary  
9 of the Centers for Medicare and Medicaid Serv-  
10 ices shall certify that the Independence at Home  
11 Medical Model described in subparagraph (A)  
12 would result in estimated spending that would be  
13 less than what spending would otherwise be esti-  
14 mated to be in the absence of such expansion.

15           “(j) *FUNDING.*—For purposes of administering and  
16 carrying out the pilot program, other than for payments  
17 for items and services furnished under this title, shared sav-  
18 ings and monthly fees, or other payments under subsection  
19 (c), in addition to funds otherwise appropriated, there are  
20 appropriated to the Secretary for the Center for Medicare  
21 and Medicaid Services Program Management Account  
22 \$5,000,000 for each of fiscal years 2010 through 2014.  
23 Amounts appropriated under this paragraph for a fiscal  
24 year shall be available until expended.”.

1 **SEC. 1304. PAYMENT INCENTIVE FOR SELECTED PRIMARY**  
2 **CARE SERVICES.**

3 (a) *IN GENERAL.*—Section 1833 of the Social Security  
4 Act is amended by inserting after subsection (o) the fol-  
5 lowing new subsection:

6 “(p) *PRIMARY CARE PAYMENT INCENTIVES.*—

7 “(1) *IN GENERAL.*—In the case of primary care  
8 services (as defined in paragraph (2)) furnished on or  
9 after January 1, 2011, by a primary care practi-  
10 tioner (as defined in paragraph (3)) for which  
11 amounts are payable under section 1848, in addition  
12 to the amount otherwise paid under this part there  
13 shall also be paid to the practitioner (or to an em-  
14 ployer or facility in the cases described in clause (A)  
15 of section 1842(b)(6)) (on a monthly or quarterly  
16 basis) from the Federal Supplementary Medical In-  
17 surance Trust Fund an amount equal 5 percent (or  
18 10 percent if the practitioner predominately furnishes  
19 such services in an area that is designated (under sec-  
20 tion 332(a)(1)(A) of the Public Health Service Act) as  
21 a primary care health professional shortage area.

22 “(2) *PRIMARY CARE SERVICES DEFINED.*—In  
23 this subsection, the term ‘primary care services’—

24 “(A) means services which are evaluation  
25 and management services as defined in section  
26 1848(j)(5)(A); and

1           “(B) includes services furnished by another  
2           health care professional that would be described  
3           in subparagraph (A) if furnished by a physician.

4           “(3) PRIMARY CARE PRACTITIONER DEFINED.—  
5           In this subsection, the term ‘primary care practi-  
6           tioner’—

7           “(A) means a physician or other health care  
8           practitioner (including a nurse practitioner)  
9           who—

10           “(i) specializes in family medicine,  
11           general internal medicine, general pediat-  
12           rics, geriatrics, or obstetrics and gynecology;  
13           and

14           “(ii) has allowed charges for primary  
15           care services that account for at least 50  
16           percent of the physician’s or practitioner’s  
17           total allowed charges under section 1848, as  
18           determined by the Secretary for the most re-  
19           cent period for which data are available;  
20           and

21           “(B) includes a physician assistant who is  
22           under the supervision of a physician described in  
23           subparagraph (A).

1           “(4) *LIMITATION ON REVIEW.*—*There shall be no*  
2 *administrative or judicial review under section 1869,*  
3 *section 1878, or otherwise, respecting—*

4                   “(A) *any determination or designation*  
5 *under this subsection;*

6                   “(B) *the identification of services as pri-*  
7 *mary care services under this subsection; and*

8                   “(C) *the identification of a practitioner as*  
9 *a primary care practitioner under this sub-*  
10 *section.*

11           “(5) *COORDINATION WITH OTHER PAYMENTS.*—

12                   “(A) *WITH OTHER PRIMARY CARE INCEN-*  
13 *TIVES.*—*The provisions of this subsection shall*  
14 *not be taken into account in applying sub-*  
15 *sections (m) and (u) and any payment under*  
16 *such subsections shall not be taken into account*  
17 *in computing payments under this subsection.*

18                   “(B) *WITH QUALITY INCENTIVES.*—*Pay-*  
19 *ments under this subsection shall not be taken*  
20 *into account in determining the amounts that*  
21 *would otherwise be paid under this part for pur-*  
22 *poses of section 1834(g)(2)(B).”.*

23           “(b) *CONFORMING AMENDMENTS.*—

24                   “(1) *Section 1833(m) of such Act (42 U.S.C.*  
25 *1395l(m)) is amended by redesignating paragraph (4)*

1 as paragraph (5) and by inserting after paragraph  
2 (3) the following new paragraph:

3 “(4) The provisions of this subsection shall not be taken  
4 into account in applying subsections (m) or (u) and any  
5 payment under such subsections shall not be taken into ac-  
6 count in computing payments under this subsection.”.

7 (2) Section 1848(m)(5)(B) of such Act (42  
8 U.S.C. 1395w-4(m)(5)(B)) is amended by inserting “,  
9 (p),” after “(m)”.

10 (3) Section 1848(o)(1)(B)(iv) of such Act (42  
11 U.S.C. 1395w-4(o)(1)(B)(iv)) is amended by insert-  
12 ing “primary care” before “health professional short-  
13 age area”.

14 **SEC. 1305. INCREASED REIMBURSEMENT RATE FOR CER-**  
15 **TIFIED NURSE-MIDWIVES.**

16 (a) *IN GENERAL.*—Section 1833(a)(1)(K) of the Social  
17 Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by  
18 striking “(but in no event” and all that follows through  
19 “performed by a physician)”.

20 (b) *EFFECTIVE DATE.*—The amendment made by sub-  
21 section (a) shall apply to services furnished on or after Jan-  
22 uary 1, 2011.

1 **SEC. 1306. COVERAGE AND WAIVER OF COST-SHARING FOR**  
2 **PREVENTIVE SERVICES.**

3 (a) *MEDICARE COVERED PREVENTIVE SERVICES DE-*  
4 *FINED.*—Section 1861 of the Social Security Act (42 U.S.C.  
5 1395x), as amended by section 1233(a), is amended by add-  
6 ing at the end the following new subsection:

7 “Medicare Covered Preventive Services

8 “(iii)(1) Subject to the succeeding provisions of this  
9 subsection, the term ‘Medicare covered preventive services’  
10 means the following:

11 “(A) Prostate cancer screening tests (as defined  
12 in subsection (oo)).

13 “(B) Colorectal cancer screening tests (as defined  
14 in subsection (pp) and when applicable as described  
15 in section 1305).

16 “(C) Diabetes outpatient self-management train-  
17 ing services (as defined in subsection (qq)).

18 “(D) Screening for glaucoma for certain individ-  
19 uals (as described in subsection (s)(2)(U)).

20 “(E) Medical nutrition therapy services for cer-  
21 tain individuals (as described in subsection  
22 (s)(2)(V)).

23 “(F) An initial preventive physical examination  
24 (as defined in subsection (ww)).

25 “(G) Cardiovascular screening blood tests (as de-  
26 fined in subsection (xx)(1)).

1           “(H) Diabetes screening tests (as defined in sub-  
2           section (yy)).

3           “(I) Ultrasound screening for abdominal aortic  
4           aneurysm for certain individuals (as described in de-  
5           scribed in subsection (s)(2)(AA)).

6           “(J) Pneumococcal and influenza vaccines and  
7           their administration (as described in subsection  
8           (s)(10)(A)) and hepatitis B vaccine and its adminis-  
9           tration for certain individuals (as described in sub-  
10          section (s)(10)(B)).

11          “(K) Screening mammography (as defined in  
12          subsection (jj)).

13          “(L) Screening pap smear and screening pelvic  
14          exam (as defined in subsection (nn)).

15          “(M) Bone mass measurement (as defined in  
16          subsection (rr)).

17          “(N) Kidney disease education services (as de-  
18          fined in subsection (ggg)).

19          “(O) Additional preventive services (as defined  
20          in subsection (ddd)).

21          “(2) With respect to specific Medicare covered preven-  
22          tive services, the limitations and conditions described in the  
23          provisions referenced in paragraph (1) with respect to such  
24          services shall apply.”.

25          (b) PAYMENT AND ELIMINATION OF COST-SHARING.—



1           (1) *IN GENERAL.*—

2                   (A) *IN GENERAL.*—Section 1833(a) of the  
3           *Social Security Act (42 U.S.C. 1395l(a))* is  
4           amended by adding after and below paragraph  
5           (9) the following:

6           “*With respect to Medicare covered preventive services, in*  
7           *any case in which the payment rate otherwise provided*  
8           *under this part is computed as a percent of less than 100*  
9           *percent of an actual charge, fee schedule rate, or other rate,*  
10          *such percentage shall be increased to 100 percent.*”

11                   (B) *APPLICATION TO SIGMOIDOSCOPIES AND*  
12          *COLONOSCOPIES.*—Section 1834(d) of such Act  
13          (42 U.S.C. 1395m(d)) is amended—

14                   (i) in paragraph (2)(C), by amending  
15          clause (i) to read as follows:

16                   “*(i) NO COINSURANCE.*—*In the case of*  
17                   *a beneficiary who receives services described*  
18                   *in clause (i), there shall be no coinsurance*  
19                   *applied.*”; and

20                   (ii) in paragraph (3)(C), by amending  
21          clause (i) to read as follows:

22                   “*(i) NO COINSURANCE.*—*In the case of*  
23                   *a beneficiary who receives services described*  
24                   *in clause (i), there shall be no coinsurance*  
25                   *applied.*”

1           (2) *ELIMINATION OF COINSURANCE IN OUT-*  
2           *PATIENT HOSPITAL SETTINGS.—*

3           (A) *EXCLUSION FROM OPD FEE SCHED-*  
4           *ULE.—Section 1833(t)(1)(B)(iv) of the Social*  
5           *Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is*  
6           *amended by striking “screening mammography*  
7           *(as defined in section 1861(jj)) and diagnostic*  
8           *mammography” and inserting “diagnostic mam-*  
9           *mograms and Medicare covered preventive serv-*  
10           *ices (as defined in section 1861(iii)(1))”.*

11           (B) *CONFORMING AMENDMENTS.—Section*  
12           *1833(a)(2) of the Social Security Act (42 U.S.C.*  
13           *1395l(a)(2)) is amended—*

14           (i) *in subparagraph (F), by striking*  
15           *“and” after the semicolon at the end;*

16           (ii) *in subparagraph (G), by adding*  
17           *“and” at the end; and*

18           (iii) *by adding at the end the following*  
19           *new subparagraph:*

20           *“(H) with respect to additional preventive*  
21           *services (as defined in section 1861(ddd)) fur-*  
22           *nished by an outpatient department of a hos-*  
23           *pital, the amount determined under paragraph*  
24           *(1)(W);”.*

1           (3) *WAIVER OF APPLICATION OF DEDUCTIBLE*  
2           *FOR ALL PREVENTIVE SERVICES.*—*The first sentence*  
3           *of section 1833(b) of the Social Security Act (42*  
4           *U.S.C. 1395l(b)) is amended—*

5                     *(A) in clause (1), by striking “items and*  
6                     *services described in section 1861(s)(10)(A)” and*  
7                     *inserting “Medicare covered preventive services*  
8                     *(as defined in section 1861(iii))”; and*

9                     *(B) by striking clause (5) and all that fol-*  
10                    *lows through “(9)” and inserting “and (5)”.*

11           (4) *APPLICATION TO PROVIDERS OF SERVICES.*—  
12           *Section 1866(a)(2)(A)(ii) of such Act (42 U.S.C.*  
13           *1395cc(a)(2)(A)(ii)) is amended by inserting “other*  
14           *than for Medicare covered preventive services and”*  
15           *after “for such items and services (“.*

16           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
17           *section shall apply to services furnished on or after January*  
18           *1, 2011.*

19           (d) *REPORT TO CONGRESS ON BARRIERS TO PREVEN-*  
20           *TIVE SERVICES.*—*Not later than 12 months after the date*  
21           *of the enactment of this Act, the Secretary of Health and*  
22           *Human Services shall report to Congress on Medicare bene-*  
23           *ficiary barriers, such as physician referral requirements or*  
24           *being a part of the Welcome to Medicare Physical Exam,*  
25           *to abdominal aortic aneurysm screening and other prevent-*

1 *ative services as approved by the U.S. Preventive Services*  
2 *Task Force. Furthermore, using existing educational re-*  
3 *sources, the Secretary shall make educating patients and*  
4 *physicians regarding the risk factors for an abdominal aor-*  
5 *tic aneurysm and when beneficiaries should be screened, a*  
6 *priority.*

7 **SEC. 1307. WAIVER OF DEDUCTIBLE FOR COLORECTAL CAN-**  
8 **CER SCREENING TESTS REGARDLESS OF**  
9 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**  
10 **LARY TISSUE REMOVAL.**

11 *(a) IN GENERAL.—Section 1833(b) of the Social Secu-*  
12 *rity Act (42 U.S.C. 1395l(b)), as amended by section*  
13 *1306(b)(3), is amended by adding at the end the following*  
14 *new sentence: “Clause (1) of the first sentence of this sub-*  
15 *section shall apply with respect to a colorectal cancer*  
16 *screening test regardless of the code that is billed for the*  
17 *establishment of a diagnosis as a result of the test, or for*  
18 *the removal of tissue or other matter or other procedure that*  
19 *is furnished in connection with, as a result of, and in the*  
20 *same clinical encounter as, the screening test.”.*

21 *(b) EFFECTIVE DATE.—The amendment made by sub-*  
22 *section (a) shall apply to items and services furnished on*  
23 *or after January 1, 2011.*

1 **SEC. 1308. EXCLUDING CLINICAL SOCIAL WORKER SERV-**  
2 **ICES FROM COVERAGE UNDER THE MEDI-**  
3 **CARE SKILLED NURSING FACILITY PROSPEC-**  
4 **TIVE PAYMENT SYSTEM AND CONSOLIDATED**  
5 **PAYMENT.**

6 (a) *IN GENERAL.*—Section 1888(e)(2)(A)(ii) of the So-  
7 cial Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amend-  
8 ed by inserting “clinical social worker services,” after  
9 “qualified psychologist services.”

10 (b) *CONFORMING AMENDMENT.*—Section 1861(hh)(2)  
11 of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is  
12 amended by striking “and other than services furnished to  
13 an inpatient of a skilled nursing facility which the facility  
14 is required to provide as a requirement for participation”.

15 (c) *EFFECTIVE DATE.*—The amendments made by this  
16 section shall apply to items and services furnished on or  
17 after July 1, 2010.

18 **SEC. 1309. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
19 **PIST SERVICES AND MENTAL HEALTH COUN-**  
20 **SELOR SERVICES.**

21 (a) *COVERAGE OF MARRIAGE AND FAMILY THERAPIST*  
22 *SERVICES.*—

23 (1) *COVERAGE OF SERVICES.*—Section 1861(s)(2)  
24 of the Social Security Act (42 U.S.C. 1395x(s)(2)), as  
25 amended by section 1233, is amended—

1           (A) in subparagraph (EE), by striking  
2           “and” at the end;

3           (B) in subparagraph (FF), by adding  
4           “and” at the end; and

5           (C) by adding at the end the following new  
6           subparagraph:

7           “(GG) marriage and family therapist services  
8           (as defined in subsection (jjj));”.

9           (2) *DEFINITION.*—Section 1861 of the Social Se-  
10          curity Act (42 U.S.C. 1395x), as amended by sections  
11          1233 and 1306, is amended by adding at the end the  
12          following new subsection:

13           “*Marriage and Family Therapist Services*  
14           “(jjj)(1) The term ‘marriage and family therap-  
15          ists’ means services performed by a marriage and family  
16          therapist (as defined in paragraph (2)) for the diagnosis  
17          and treatment of mental illnesses, which the marriage and  
18          family therapist is legally authorized to perform under  
19          State law (or the State regulatory mechanism provided by  
20          State law) of the State in which such services are performed,  
21          as would otherwise be covered if furnished by a physician  
22          or as incident to a physician’s professional service, but only  
23          if no facility or other provider charges or is paid any  
24          amounts with respect to the furnishing of such services.

1       “(2) *The term ‘marriage and family therapist’ means*  
2 *an individual who—*

3               “(A) *possesses a master’s or doctoral degree*  
4 *which qualifies for licensure or certification as a mar-*  
5 *riage and family therapist pursuant to State law;*

6               “(B) *after obtaining such degree has performed*  
7 *at least 2 years of clinical supervised experience in*  
8 *marriage and family therapy; and*

9               “(C) *is licensed or certified as a marriage and*  
10 *family therapist in the State in which marriage and*  
11 *family therapist services are performed.”.*

12               (3) *PROVISION FOR PAYMENT UNDER PART B.—*  
13 *Section 1832(a)(2)(B) of the Social Security Act (42*  
14 *U.S.C. 1395k(a)(2)(B)) is amended by adding at the*  
15 *end the following new clause:*

16                       “(v) *marriage and family therapist*  
17 *services;”.*

18               (4) *AMOUNT OF PAYMENT.—*

19                       (A) *IN GENERAL.—Section 1833(a)(1) of the*  
20 *Social Security Act (42 U.S.C. 1395l(a)(1)) is*  
21 *amended—*

22                               (i) *by striking “and” before “(W)”;*

23                               *and*

24                               (ii) *by inserting before the semicolon at*  
25 *the end the following: “, and (X) with re-*

1           *spect to marriage and family therapist serv-*  
2           *ices under section 1861(s)(2)(GG), the*  
3           *amounts paid shall be 80 percent of the less-*  
4           *er of the actual charge for the services or 75*  
5           *percent of the amount determined for pay-*  
6           *ment of a psychologist under clause (L)”.*

7           *(B) DEVELOPMENT OF CRITERIA WITH RE-*  
8           *SPECT TO CONSULTATION WITH A HEALTH CARE*  
9           *PROFESSIONAL.—The Secretary of Health and*  
10          *Human Services shall, taking into consideration*  
11          *concerns for patient confidentiality, develop cri-*  
12          *teria with respect to payment for marriage and*  
13          *family therapist services for which payment may*  
14          *be made directly to the marriage and family*  
15          *therapist under part B of title XVIII of the So-*  
16          *cial Security Act (42 U.S.C. 1395j et seq.) under*  
17          *which such a therapist must agree to consult*  
18          *with a patient’s attending or primary care phy-*  
19          *sician or nurse practitioner in accordance with*  
20          *such criteria.*

21          *(5) EXCLUSION OF MARRIAGE AND FAMILY THER-*  
22          *APIST SERVICES FROM SKILLED NURSING FACILITY*  
23          *PROSPECTIVE PAYMENT SYSTEM.—Section*  
24          *1888(e)(2)(A)(ii) of the Social Security Act (42*  
25          *U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section*



1 1308(a), is amended by inserting “marriage and fam-  
2 ily therapist services (as defined in subsection  
3 (jjj)(1)),” after “clinical social worker services,”.

4 (6) *COVERAGE OF MARRIAGE AND FAMILY THER-*  
5 *APIST SERVICES PROVIDED IN RURAL HEALTH CLIN-*  
6 *ICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—*  
7 *Section 1861(aa)(1)(B) of the Social Security Act (42*  
8 *U.S.C. 1395x(aa)(1)(B)) is amended by striking “or*  
9 *by a clinical social worker (as defined in subsection*  
10 *(hh)(1)),” and inserting “, by a clinical social worker*  
11 *(as defined in subsection (hh)(1)), or by a marriage*  
12 *and family therapist (as defined in subsection*  
13 *(jjj)(2)),”.*

14 (7) *INCLUSION OF MARRIAGE AND FAMILY*  
15 *THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF*  
16 *CLAIMS.—Section 1842(b)(18)(C) of the Social Secu-*  
17 *rity Act (42 U.S.C. 1395u(b)(18)(C)) is amended by*  
18 *adding at the end the following new clause:*

19 “(vii) A marriage and family therapist (as de-  
20 fined in section 1861(jjj)(2)).”.

21 (b) *COVERAGE OF MENTAL HEALTH COUNSELOR*  
22 *SERVICES.—*

23 (1) *COVERAGE OF SERVICES.—Section 1861(s)(2)*  
24 *of the Social Security Act (42 U.S.C. 1395x(s)(2)), as*  
25 *previously amended, is further amended—*

1           (A) in subparagraph (FF), by striking  
2           “and” at the end;

3           (B) in subparagraph (GG), by inserting  
4           “and” at the end; and

5           (C) by adding at the end the following new  
6           subparagraph:

7           “(HH) mental health counselor services (as de-  
8           fined in subsection (kkk)(1));”.

9           (2) *DEFINITION.*—Section 1861 of the Social Se-  
10          curity Act (42 U.S.C. 1395x), as previously amended,  
11          is amended by adding at the end the following new  
12          subsection:

13                   *“Mental Health Counselor Services*

14           “(kkk)(1) The term ‘mental health counselor services’  
15          means services performed by a mental health counselor (as  
16          defined in paragraph (2)) for the diagnosis and treatment  
17          of mental illnesses which the mental health counselor is le-  
18          gally authorized to perform under State law (or the State  
19          regulatory mechanism provided by the State law) of the  
20          State in which such services are performed, as would other-  
21          wise be covered if furnished by a physician or as incident  
22          to a physician’s professional service, but only if no facility  
23          or other provider charges or is paid any amounts with re-  
24          spect to the furnishing of such services.

1       “(2) *The term ‘mental health counselor’ means an in-*  
2 *dividual who—*

3               “(A) *possesses a master’s or doctor’s degree which*  
4 *qualifies the individual for licensure or certification*  
5 *for the practice of mental health counseling in the*  
6 *State in which the services are performed;*

7               “(B) *after obtaining such a degree has performed*  
8 *at least 2 years of supervised mental health counselor*  
9 *practice; and*

10              “(C) *is licensed or certified as a mental health*  
11 *counselor or professional counselor by the State in*  
12 *which the services are performed.”.*

13              (3) *PROVISION FOR PAYMENT UNDER PART B.—*  
14 *Section 1832(a)(2)(B) of the Social Security Act (42*  
15 *U.S.C. 1395k(a)(2)(B)), as amended by subsection*  
16 *(a)(3), is further amended—*

17                      (A) *by striking “and” at the end of clause*  
18 *(iv);*

19                      (B) *by adding “and” at the end of clause*  
20 *(v); and*

21                      (C) *by adding at the end the following new*  
22 *clause:*

23                                      “(vi) *mental health counselor services;*  
24 *and”.*

25              (4) *AMOUNT OF PAYMENT.—*

1           (A) *IN GENERAL.*—Section 1833(a)(1) of the  
2           *Social Security Act (42 U.S.C. 1395l(a)(1))*, as  
3           *amended by subsection (a)*, is further amended—

4                     (i) by striking “and” before “(X)”; and

5                     (ii) by inserting before the semicolon at  
6           the end the following: “, and (Y) with re-  
7           spect to mental health counselor services  
8           under section 1861(s)(2)(HH), the amounts  
9           paid shall be 80 percent of the lesser of the  
10          actual charge for the services or 75 percent  
11          of the amount determined for payment of a  
12          psychologist under clause (L)”.

13          (B) *DEVELOPMENT OF CRITERIA WITH RE-*  
14          *SPECT TO CONSULTATION WITH A PHYSICIAN.*—

15          *The Secretary of Health and Human Services*  
16          *shall, taking into consideration concerns for pa-*  
17          *tient confidentiality, develop criteria with re-*  
18          *spect to payment for mental health counselor*  
19          *services for which payment may be made directly*  
20          *to the mental health counselor under part B of*  
21          *title XVIII of the Social Security Act (42 U.S.C.*  
22          *1395j et seq.) under which such a counselor must*  
23          *agree to consult with a patient’s attending or*  
24          *primary care physician in accordance with such*  
25          *criteria.*

1           (5) *EXCLUSION OF MENTAL HEALTH COUNSELOR*  
2           *SERVICES FROM SKILLED NURSING FACILITY PRO-*  
3           *SPECTIVE PAYMENT SYSTEM.*—Section  
4           1888(e)(2)(A)(ii) of the Social Security Act (42  
5           U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section  
6           1308(a) and subsection (a), is amended by inserting  
7           “mental health counselor services (as defined in sec-  
8           tion 1861(kkk)(1)),” after “marriage and family ther-  
9           apist services (as defined in subsection (jjj)(1)),”.

10           (6) *COVERAGE OF MENTAL HEALTH COUNSELOR*  
11           *SERVICES PROVIDED IN RURAL HEALTH CLINICS AND*  
12           *FEDERALLY QUALIFIED HEALTH CENTERS.*—Section  
13           1861(aa)(1)(B) of the Social Security Act (42 U.S.C.  
14           1395x(aa)(1)(B)), as amended by subsection (a), is  
15           amended by striking “or by a marriage and family  
16           therapist (as defined in subsection (jjj)(2)),” and in-  
17           serting “by a marriage and family therapist (as de-  
18           fined in subsection (jjj)(2)), or a mental health coun-  
19           selor (as defined in subsection (kkk)(2)),”.

20           (7) *INCLUSION OF MENTAL HEALTH COUNSELORS*  
21           *AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.*—  
22           Section 1842(b)(18)(C) of the Social Security Act (42  
23           U.S.C. 1395u(b)(18)(C)), as amended by subsection  
24           (a)(7), is amended by adding at the end the following  
25           new clause:

1           “(viii) A mental health counselor (as defined in  
2           section 1861(kkk)(2)).”.

3           (c) *EFFECTIVE DATE.*—The amendments made by this  
4 section shall apply to items and services furnished on or  
5 after January 1, 2011.

6 **SEC. 1310. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**  
7 **TAL HEALTH ADD-ON.**

8           Section 138(a)(1) of the Medicare Improvements for  
9 Patients and Providers Act of 2008 (Public Law 110–275)  
10 is amended by striking “December 31, 2009” and inserting  
11 “December 31, 2011”.

12 **SEC. 1311. EXPANDING ACCESS TO VACCINES.**

13           (a) *IN GENERAL.*—Paragraph (10) of section 1861(s)  
14 of the Social Security Act (42 U.S.C. 1395w(s)) is amended  
15 to read as follows:

16           “(10) *federally recommended vaccines (as defined*  
17 *in subsection (ll)) and their respective administra-*  
18 *tion;*”.

19           (b) *FEDERALLY RECOMMENDED VACCINES DE-*  
20 *FINED.*—Section 1861 of such Act, as previously amended,  
21 is further amended by adding at the end the following new  
22 subsection:

23           “*Federally Recommended Vaccines*

24           “(ll) The term ‘federally recommended vaccine’ means  
25 an approved vaccine recommended by the Advisory Com-

1 *mittee on Immunization Practices (an advisory committee*  
2 *established by the Secretary, acting through the Director of*  
3 *the Centers for Disease Control and Prevention).”.*

4 *(c) CONFORMING AMENDMENTS.—*

5 *(1) Section 1833 of such Act (42 U.S.C. 1395l)*  
6 *is amended, in each of subsections (a)(1)(B),*  
7 *(a)(2)(G), (a)(3)(A), by striking “1861(s)(10)(A)”*  
8 *and inserting “1861(s)(10)” each place it appears.*

9 *(2) Section 1842(o)(1)(A)(iv) of such Act (42*  
10 *U.S.C. 1395u(o)(1)(A)(iv)) is amended—*

11 *(A) by striking “subparagraph (A) or (B)*  
12 *of”; and*

13 *(B) by inserting before the period the fol-*  
14 *lowing: “and before January 1, 2011, and influ-*  
15 *enza vaccines furnished on or after January 1,*  
16 *2011”.*

17 *(3) Section 1847A(c)(6) of such Act (42 U.S.C.*  
18 *1395w-3a(c)(6)) is amended by striking subpara-*  
19 *graph (G) and inserting the following:*

20 *“(G) IMPLEMENTATION.—Chapter 35 of*  
21 *title 44, United States Code shall not apply to*  
22 *manufacturer provision of information pursuant*  
23 *to section 1927(b)(3)(A)(iii) for purposes of im-*  
24 *plementation of this section.”.*

1           (4) *Section 1860D–2(e)(1) of such Act (42 U.S.C.*  
2 *1395w–102(e)(1)) is amended by striking “such term*  
3 *includes a vaccine” and all that follows through “its*  
4 *administration) and”.*

5           (5) *Section 1861(ww)(2)(A) of such Act (42*  
6 *U.S.C. 1395x(ww)(2)(A)) is amended by striking*  
7 *“Pneumococcal, influenza, and hepatitis B vaccine*  
8 *and administration” and inserting “Federally rec-*  
9 *ommended vaccines (as defined in subsection (ll))*  
10 *and their respective administration”.*

11           (6) *Section 1861(iii)(1) of such Act, as added by*  
12 *section 1306(a), is amended by amending subpara-*  
13 *graph (J) to read as follows:*

14           *“(J) Federally recommended vaccines (as defined*  
15 *in subsection (ll)) and their respective administra-*  
16 *tion.”.*

17           (7) *Section 1927(b)(3)(A)(iii) of such Act (42*  
18 *U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the mat-*  
19 *ter following subclause (III), by inserting “(A)(iv)*  
20 *(including influenza vaccines furnished on or after*  
21 *January 1, 2011),” after “described in subpara-*  
22 *graph”*

23           (d) *EFFECTIVE DATES.—The amendments made by—*



1           (1) *this section (other than by subsection (c)(7))*  
2           *shall apply to vaccines administered on or after Jan-*  
3           *uary 1, 2011; and*

4           (2) *by subsection (c)(7) shall apply to calendar*  
5           *quarters beginning on or after January 1, 2010.*

6 **SEC. 1312. RECOGNITION OF CERTIFIED DIABETES EDU-**  
7           **CATORS AS CERTIFIED PROVIDERS FOR PUR-**  
8           **POSES OF MEDICARE DIABETES OUTPATIENT**  
9           **SELF-MANAGEMENT TRAINING SERVICES.**

10          (a) *IN GENERAL.*—*Section 1861(qq) of the Social Se-*  
11          *curity Act (42 U.S.C. 1395x(qq)) is amended—*

12               (1) *in paragraph (1), by inserting “or by a cer-*  
13               *tified diabetes educator (as defined in paragraph*  
14               *(3))” after “paragraph (2)(B)”;* and

15               (2) *by adding at the end the following new para-*  
16               *graphs:*

17                       “(3) *For purposes of paragraph (1), the term*  
18                       *‘certified diabetes educator’ means an individual*  
19                       *who—*

20                               “(A) *is licensed or registered by the State in*  
21                               *which the services are performed as a health care*  
22                               *professional;*

23                               “(B) *specializes in teaching individuals*  
24                               *with diabetes to develop the necessary skills and*

1           *knowledge to manage the individual’s diabetic*  
2           *condition; and*

3           “(C) *is certified as a diabetes educator by*  
4           *a recognized certifying body (as defined in para-*  
5           *graph (4)).*

6           “(4)(A) *For purposes of paragraph (3)(C), the*  
7           *term ‘recognized certifying body’ means—*

8           “(i) *the National Certification Board for*  
9           *Diabetes Educators, or*

10           “(ii) *a certifying body for diabetes edu-*  
11           *cators, which is recognized by the Secretary as*  
12           *authorized to grant certification of diabetes edu-*  
13           *cators for purposes of this subsection pursuant to*  
14           *standards established by the Secretary, if the*  
15           *Secretary determines such Board or body, respec-*  
16           *tively, meets the requirement of subparagraph*  
17           *(B).*

18           “(B) *The National Certification Board for Dia-*  
19           *betes Educators or a certifying body for diabetes edu-*  
20           *cators meets the requirement of this subparagraph,*  
21           *with respect to the certification of an individual, if*  
22           *the Board or body, respectively, is incorporated and*  
23           *registered to do business in the United States and re-*  
24           *quires as a condition of such certification each of the*  
25           *following:*

1           “(i) *The individual has a qualifying creden-*  
2           *tial in a specified health care profession.*”

3           “(ii) *The individual has professional prac-*  
4           *tice experience in diabetes self-management*  
5           *training that includes a minimum number of*  
6           *hours and years of experience in such training.*”

7           “(iii) *The individual has successfully com-*  
8           *pleted a national certification examination of-*  
9           *fered by such entity.*”

10           “(iv) *The individual periodically renews*  
11           *certification status following initial certifi-*  
12           *cation.*”.

13           **(b) EFFECTIVE DATE.**—*The amendments made by sub-*  
14           *section (a) shall apply to diabetes outpatient self-manage-*  
15           *ment training services furnished on or after the first day*  
16           *of the first calendar year that is at least 6 months after*  
17           *the date of the enactment of this Act.*

18                           **TITLE IV—QUALITY**  
19                           **Subtitle A—Comparative**  
20                           **Effectiveness Research**

21           **SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.**

22           **(a) IN GENERAL.**—*Title XI of the Social Security Act*  
23           *is amended by adding at the end the following new part:*

1     “PART D—COMPARATIVE EFFECTIVENESS RESEARCH

2             “COMPARATIVE EFFECTIVENESS RESEARCH

3             “SEC. 1181. (a) CENTER FOR COMPARATIVE EFFEC-  
4     TIVENESS RESEARCH ESTABLISHED.—

5             “(1) IN GENERAL.—The Secretary shall establish  
6     within the Agency for Healthcare Research and Qual-  
7     ity a Center for Comparative Effectiveness Research  
8     (in this section referred to as the ‘Center’) to conduct,  
9     support, and synthesize research (including research  
10    conducted or supported under section 1013 of the  
11    Medicare Prescription Drug, Improvement, and Mod-  
12    ernization Act of 2003) with respect to the outcomes,  
13    effectiveness, and appropriateness of health care serv-  
14    ices and procedures in order to identify the manner  
15    in which diseases, disorders, and other health condi-  
16    tions can most effectively and appropriately be pre-  
17    vented, diagnosed, treated, and managed clinically.

18             “(2) DUTIES.—The Center shall—

19             “(A) conduct, support, and synthesize re-  
20     search relevant to the comparative effectiveness of  
21     the full spectrum of health care items, services  
22     and systems, including pharmaceuticals, medical  
23     devices, medical and surgical procedures, and  
24     other medical interventions;

1           “(B) conduct and support systematic re-  
2 views of clinical research, including original re-  
3 search conducted subsequent to the date of the en-  
4 actment of this section;

5           “(C) continuously develop rigorous scientific  
6 methodologies for conducting comparative effec-  
7 tiveness studies, and use such methodologies ap-  
8 propriately;

9           “(D) submit to the Comparative Effective-  
10 ness Research Commission, the Secretary, and  
11 Congress appropriate relevant reports described  
12 in subsection (d)(2); and

13           “(E) encourage, as appropriate, the develop-  
14 ment and use of clinical registries and the devel-  
15 opment of clinical effectiveness research data net-  
16 works from electronic health records, post mar-  
17 keting drug and medical device surveillance ef-  
18 forts, and other forms of electronic health data.

19           “(3) POWERS.—

20           “(A) OBTAINING OFFICIAL DATA.—The Cen-  
21 ter may secure directly from any department or  
22 agency of the United States information nec-  
23 essary to enable it to carry out this section.  
24           Upon request of the Center, the head of that de-

1            *partment or agency shall furnish that informa-*  
2            *tion to the Center on an agreed upon schedule.*

3            *“(B) DATA COLLECTION.—In order to carry*  
4            *out its functions, the Center shall—*

5                    *“(i) utilize existing information, both*  
6                    *published and unpublished, where possible,*  
7                    *collected and assessed either by its own staff*  
8                    *or under other arrangements made in ac-*  
9                    *cordance with this section,*

10                   *“(ii) carry out, or award grants or*  
11                   *contracts for, original research and experi-*  
12                   *mentation, where existing information is*  
13                   *inadequate, and*

14                   *“(iii) adopt procedures allowing any*  
15                   *interested party to submit information for*  
16                   *the use by the Center and Commission*  
17                   *under subsection (b) in making reports and*  
18                   *recommendations.*

19            *“(C) ACCESS OF GAO TO INFORMATION.—*  
20            *The Comptroller General shall have unrestricted*  
21            *access to all deliberations, records, and non-*  
22            *proprietary data of the Center and Commission*  
23            *under subsection (b), immediately upon request.*

1                   “(D) *PERIODIC AUDIT.*—*The Center and*  
2                   *Commission under subsection (b) shall be subject*  
3                   *to periodic audit by the Comptroller General.*

4                   “(b) *OVERSIGHT BY COMPARATIVE EFFECTIVENESS*  
5 *RESEARCH COMMISSION.*—

6                   “(1) *IN GENERAL.*—*The Secretary shall establish*  
7                   *an independent Comparative Effectiveness Research*  
8                   *Commission (in this section referred to as the ‘Com-*  
9                   *mission’) to oversee and evaluate the activities carried*  
10                   *out by the Center under subsection (a), subject to the*  
11                   *authority of the Secretary, to ensure such activities*  
12                   *result in highly credible research and information re-*  
13                   *sulting from such research.*

14                   “(2) *DUTIES.*—*The Commission shall—*

15                   “(A) *determine national priorities for re-*  
16                   *search described in subsection (a) and in making*  
17                   *such determinations consult with a broad array*  
18                   *of public and private stakeholders, including pa-*  
19                   *tients and health care providers and payers;*

20                   “(B) *monitor the appropriateness of use of*  
21                   *the CERTF described in subsection (g) with re-*  
22                   *spect to the timely production of comparative ef-*  
23                   *fectiveness research determined to be a national*  
24                   *priority under subparagraph (A);*

1           “(C) identify highly credible research meth-  
2           ods and standards of evidence for such research  
3           to be considered by the Center;

4           “(D) review the methodologies developed by  
5           the center under subsection (a)(2)(C);

6           “(E) not later than one year after the date  
7           of the enactment of this section, enter into an ar-  
8           rangement under which the Institute of Medicine  
9           of the National Academy of Sciences shall con-  
10          duct an evaluation and report on standards of  
11          evidence for such research;

12          “(F) support forums to increase stakeholder  
13          awareness and permit stakeholder feedback on  
14          the efforts of the Center to advance methods and  
15          standards that promote highly credible research;

16          “(G) make recommendations for policies  
17          that would allow for public access of data pro-  
18          duced under this section, in accordance with ap-  
19          propriate privacy and proprietary practices,  
20          while ensuring that the information produced  
21          through such data is timely and credible;

22          “(H) appoint a clinical perspective advi-  
23          sory panel for each research priority determined  
24          under subparagraph (A), which shall consult  
25          with patients and advise the Center on research



1           *questions, methods, and evidence gaps in terms*  
2           *of clinical outcomes for the specific research in-*  
3           *quiry to be examined with respect to such pri-*  
4           *ority to ensure that the information produced*  
5           *from such research is clinically relevant to deci-*  
6           *sions made by clinicians and patients at the*  
7           *point of care;*

8           *“(I) make recommendations for the priority*  
9           *for periodic reviews of previous comparative ef-*  
10           *fectiveness research and studies conducted by the*  
11           *Center under subsection (a);*

12           *“(J) routinely review processes of the Center*  
13           *with respect to such research to confirm that the*  
14           *information produced by such research is objec-*  
15           *tive, credible, consistent with standards of evi-*  
16           *dence established under this section, and devel-*  
17           *oped through a transparent process that includes*  
18           *consultations with appropriate stakeholders; and*

19           *“(K) make recommendations to the center*  
20           *for the broad dissemination of the findings of re-*  
21           *search conducted and supported under this sec-*  
22           *tion that enables clinicians, patients, consumers,*  
23           *and payers to make more informed health care*  
24           *decisions that improve quality and value.*

25           *“(3) COMPOSITION OF COMMISSION.—*

1           “(A) *IN GENERAL.*—*The members of the*  
2           *Commission shall consist of—*

3                     “(i) *the Director of the Agency for*  
4                     *Healthcare Research and Quality;*

5                     “(ii) *the Chief Medical Officer of the*  
6                     *Centers for Medicare & Medicaid Services;*  
7                     *and*

8                     “(iii) *15 additional members who shall*  
9                     *represent broad constituencies of stake-*  
10                    *holders including clinicians, patients, re-*  
11                    *searchers, third-party payers, consumers of*  
12                    *Federal and State beneficiary programs.*

13           *Of such members, at least 9 shall be practicing*  
14           *physicians, health care practitioners, consumers,*  
15           *or patients.*

16           “(B) *QUALIFICATIONS.*—

17                     “(i) *DIVERSE REPRESENTATION OF*  
18                     *PERSPECTIVES.*—*The members of the Com-*  
19                     *mission shall represent a broad range of*  
20                     *perspectives and shall collectively have expe-*  
21                     *rience in the following areas:*

22                             “(I) *Epidemiology.*

23                             “(II) *Health services research.*

24                             “(III) *Bioethics.*

25                             “(IV) *Decision sciences.*

1 “(V) *Health disparities.*

2 “(VI) *Economics.*

3 “(ii) *DIVERSE REPRESENTATION OF*  
4 *HEALTH CARE COMMUNITY.—At least one*  
5 *member shall represent each of the following*  
6 *health care communities:*

7 “(I) *Patients.*

8 “(II) *Health care consumers.*

9 “(III) *Practicing Physicians, in-*  
10 *cluding surgeons.*

11 “(IV) *Other health care practi-*  
12 *tioners engaged in clinical care.*

13 “(V) *Employers.*

14 “(VI) *Public payers.*

15 “(VII) *Insurance plans.*

16 “(VIII) *Clinical researchers who*  
17 *conduct research on behalf of pharma-*  
18 *ceutical or device manufacturers.*

19 “(C) *LIMITATION.—No more than 3 of the*  
20 *Members of the Commission may be representa-*  
21 *tives of pharmaceutical or device manufacturers*  
22 *and such representatives shall be clinical re-*  
23 *searchers described under subparagraph*  
24 *(B)(ii)(VIII).*

25 “(4) *APPOINTMENT.—*

1           “(A) *IN GENERAL.*—*The Secretary shall ap-*  
2           *point the members of the Commission.*

3           “(B) *CONSULTATION.*—*In considering can-*  
4           *didates for appointment to the Commission, the*  
5           *Secretary may consult with the Government Ac-*  
6           *countability Office and the Institute of Medicine*  
7           *of the National Academy of Sciences.*

8           “(5) *CHAIRMAN; VICE CHAIRMAN.*—*The Secretary*  
9           *shall designate a member of the Commission, at the*  
10          *time of appointment of the member, as Chairman and*  
11          *a member as Vice Chairman for that term of appoint-*  
12          *ment, except that in the case of vacancy of the Chair-*  
13          *manship or Vice Chairmanship, the Secretary may*  
14          *designate another member for the remainder of that*  
15          *member’s term. The Chairman shall serve as an ex*  
16          *officio member of the National Advisory Council of*  
17          *the Agency for Health Care Research and Quality*  
18          *under section 931(c)(3)(B) of the Public Health Serv-*  
19          *ice Act.*

20          “(6) *TERMS.*—

21                 “(A) *IN GENERAL.*—*Except as provided in*  
22                 *subparagraph (B), each member of the Commis-*  
23                 *sion shall be appointed for a term of 4 years.*

24                 “(B) *TERMS OF INITIAL APPOINTEES.*—*Of*  
25                 *the members first appointed—*

1                   “(i) 8 shall be appointed for a term of  
2                   4 years; and

3                   “(ii) 7 shall be appointed for a term of  
4                   3 years.

5                   “(7) *COORDINATION.*—To enhance effectiveness  
6                   and coordination, the Secretary is encouraged, to the  
7                   greatest extent possible, to seek coordination between  
8                   the Commission and the National Advisory Council of  
9                   the Agency for Healthcare Research and Quality.

10                  “(8) *CONFLICTS OF INTEREST.*—

11                  “(A) *IN GENERAL.*—In appointing the  
12                  members of the Commission or a clinical per-  
13                  spective advisory panel described in paragraph  
14                  (2)(H), the Secretary or the Commission, respec-  
15                  tively, shall take into consideration any finan-  
16                  cial interest (as defined in subparagraph (D)),  
17                  consistent with this paragraph, and develop a  
18                  plan for managing any identified conflicts.

19                  “(B) *EVALUATION AND CRITERIA.*—When  
20                  considering an appointment to the Commission  
21                  or a clinical perspective advisory panel described  
22                  paragraph (2)(H) the Secretary or the Commis-  
23                  sion shall review the expertise of the individual  
24                  and the financial disclosure report filed by the  
25                  individual pursuant to the Ethics in Govern-

1           *ment Act of 1978 for each individual under con-*  
2           *sideration for the appointment, so as to reduce*  
3           *the likelihood that an appointed individual will*  
4           *later require a written determination as referred*  
5           *to in section 208(b)(1) of title 18, United States*  
6           *Code, a written certification as referred to in sec-*  
7           *tion 208(b)(3) of title 18, United States Code, or*  
8           *a waiver as referred to in subparagraph (D)(iii)*  
9           *for service on the Commission at a meeting of*  
10          *the Commission.*

11                   “(C) *DISCLOSURES; PROHIBITIONS ON PAR-*  
12                   *TICIPATION; WAIVERS.—*

13                           “(i) *DISCLOSURE OF FINANCIAL INTER-*  
14                           *EST.—Prior to a meeting of the Commis-*  
15                           *sion or a clinical perspective advisory panel*  
16                           *described in paragraph (2)(H) regarding a*  
17                           *‘particular matter’ (as that term is used in*  
18                           *section 208 of title 18, United States Code),*  
19                           *each member of the Commission or the clin-*  
20                           *ical perspective advisory panel who is a*  
21                           *full-time Government employee or special*  
22                           *Government employee shall disclose to the*  
23                           *Secretary financial interests in accordance*  
24                           *with subsection (b) of such section 208.*

1                   “(ii) *PROHIBITIONS ON PARTICIPA-*  
2                   *TION.—Except as provided under clause*  
3                   *(iii), a member of the Commission or a*  
4                   *clinical perspective advisory panel described*  
5                   *in paragraph (2)(H) may not participate*  
6                   *with respect to a particular matter consid-*  
7                   *ered in meeting of the Commission or the*  
8                   *clinical perspective advisory panel if such*  
9                   *member (or an immediate family member of*  
10                   *such member) has a financial interest that*  
11                   *could be affected by the advice given to the*  
12                   *Secretary with respect to such matter, ex-*  
13                   *cluding interests exempted in regulations*  
14                   *issued by the Director of the Office of Gov-*  
15                   *ernment Ethics as too remote or incon-*  
16                   *sequential to affect the integrity of the serv-*  
17                   *ices of the Government officers or employees*  
18                   *to which such regulations apply.*

19                   “(iii) *WAIVER.—If the Secretary deter-*  
20                   *mines it necessary to afford the Commission*  
21                   *or a clinical perspective advisory panel de-*  
22                   *scribed in paragraph 2(H) essential exper-*  
23                   *tise, the Secretary may grant a waiver of*  
24                   *the prohibition in clause (ii) to permit a*

1 member described in such subparagraph  
2 to—

3 “(I) participate as a non-voting  
4 member with respect to a particular  
5 matter considered in a Commission or  
6 a clinical perspective advisory panel  
7 meeting; or

8 “(II) participate as a voting  
9 member with respect to a particular  
10 matter considered in a Commission or  
11 a clinical perspective advisory panel  
12 meeting.

13 “(iv) *LIMITATION ON WAIVERS AND*  
14 *OTHER EXCEPTIONS.—*

15 “(I) *DETERMINATION OF ALLOW-*  
16 *ABLE EXCEPTIONS FOR THE COMMIS-*  
17 *SION.—The number of waivers granted*  
18 *to members of the Commission cannot*  
19 *exceed one-half of the total number of*  
20 *members for the Commission.*

21 “(II) *PROHIBITION ON VOTING*  
22 *STATUS ON CLINICAL PERSPECTIVE AD-*  
23 *VISORY PANELS.—No voting member of*  
24 *any clinical perspective advisory panel*  
25 *shall be in receipt of a waiver. No*



1                    *more than two nonvoting members of*  
2                    *any clinical perspective advisory panel*  
3                    *shall receive a waiver.*

4                    “(D) *FINANCIAL INTEREST DEFINED.*—*For*  
5                    *purposes of this paragraph, the term ‘financial*  
6                    *interest’ means a financial interest under section*  
7                    *208(a) of title 18, United States Code.*

8                    “(9) *COMPENSATION.*—*While serving on the busi-*  
9                    *ness of the Commission (including travel time), a*  
10                    *member of the Commission shall be entitled to com-*  
11                    *penetration at the per diem equivalent of the rate pro-*  
12                    *vided for level IV of the Executive Schedule under sec-*  
13                    *tion 5315 of title 5, United States Code; and while so*  
14                    *servicing away from home and the member’s regular*  
15                    *place of business, a member may be allowed travel ex-*  
16                    *penses, as authorized by the Director of the Commis-*  
17                    *sion.*

18                    “(10) *AVAILABILITY OF REPORTS.*—*The Commis-*  
19                    *sion shall transmit to the Secretary a copy of each re-*  
20                    *port submitted under this subsection and shall make*  
21                    *such reports available to the public.*

22                    “(11) *DIRECTOR AND STAFF; EXPERTS AND CON-*  
23                    *SULTANTS.*—*Subject to such review as the Secretary*  
24                    *deems necessary to assure the efficient administration*  
25                    *of the Commission, the Commission may—*

1           “(A) appoint an *Executive Director* (subject  
2           to the approval of the Secretary) and such other  
3           personnel as *Federal employees* under section  
4           2105 of title 5, *United States Code*, as may be  
5           necessary to carry out its duties (without regard  
6           to the provisions of title 5, *United States Code*,  
7           governing appointments in the competitive serv-  
8           ice);

9           “(B) seek such assistance and support as  
10          may be required in the performance of its duties  
11          from appropriate *Federal departments and agen-*  
12          cies;

13          “(C) enter into contracts or make other ar-  
14          rangements, as may be necessary for the conduct  
15          of the work of the Commission (without regard  
16          to section 3709 of the *Revised Statutes* (41  
17          U.S.C. 5));

18          “(D) make advance, progress, and other  
19          payments which relate to the work of the Com-  
20          mission;

21          “(E) provide transportation and subsistence  
22          for persons serving without compensation; and

23          “(F) prescribe such rules and regulations as  
24          it deems necessary with respect to the internal  
25          organization and operation of the Commission.

1       “(c) *RESEARCH REQUIREMENTS.*—Any research con-  
2 ducted, supported, or synthesized under this section shall  
3 meet the following requirements:

4               “(1) *ENSURING TRANSPARENCY, CREDIBILITY,*  
5 *AND ACCESS.*—

6                       “(A) *The establishment of the agenda and*  
7 *conduct of the research shall be insulated from*  
8 *inappropriate political or stakeholder influence.*

9                       “(B) *Methods of conducting such research*  
10 *shall be scientifically based.*

11                      “(C) *All aspects of the prioritization of re-*  
12 *search, conduct of the research, and development*  
13 *of conclusions based on the research shall be*  
14 *transparent to all stakeholders.*

15                      “(D) *The process and methods for con-*  
16 *ducting such research shall be publicly docu-*  
17 *mented and available to all stakeholders.*

18                      “(E) *Throughout the process of such re-*  
19 *search, the Center shall provide opportunities for*  
20 *all stakeholders involved to review and provide*  
21 *public comment on the methods and findings of*  
22 *such research.*

23               “(2) *USE OF CLINICAL PERSPECTIVE ADVISORY*  
24 *PANELS.*—*The research shall meet a national research*  
25 *priority determined under subsection (b)(2)(A) and*

1       *shall consider advice given to the Center by the clinical perspective advisory panel for the national research priority.*

4           “(3) *STAKEHOLDER INPUT.—*

5               “(A) *IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission.*

11              “(B) *SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—*

14                   “(i) *recommending research priorities and questions;*

16                   “(ii) *recommending research methodologies; and*

18                   “(iii) *advising on and assisting with efforts to disseminate research findings.*

20              “(C) *OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—*

23                   “(i) *serve as an available point of contact for any patients with an interest in*

1           *proposed comparative effectiveness studies*  
2           *by the Center; and*

3                   “(ii) *ensure that any comments from*  
4                   *patients regarding proposed comparative ef-*  
5                   *fectiveness studies are reviewed by the Com-*  
6                   *mission.*

7           “(4) *TAKING INTO ACCOUNT POTENTIAL DIF-*  
8           *FERENCES.—Research shall—*

9                   “(A) *be designed, as appropriate, to take*  
10                   *into account the potential for differences in the*  
11                   *effectiveness of health care items and services*  
12                   *used with various subpopulations such as racial*  
13                   *and ethnic minorities, women, different age*  
14                   *groups (including children, adolescents, adults,*  
15                   *and seniors), and individuals with different*  
16                   *comorbidities; and—*

17                   “(B) *seek, as feasible and appropriate, to*  
18                   *include members of such subpopulations as sub-*  
19                   *jects in the research.*

20           “(d) *PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-*  
21           *NESS INFORMATION.—*

22                   “(1) *IN GENERAL.—Not later than 90 days after*  
23                   *receipt by the Center or Commission, as applicable, of*  
24                   *a relevant report described in paragraph (2) made by*  
25                   *the Center, Commission, or clinical perspective advi-*

1        *sory panel under this section, appropriate informa-*  
2        *tion contained in such report shall be posted on the*  
3        *official public Internet site of the Center and of the*  
4        *Commission, as applicable.*

5                *“(2) RELEVANT REPORTS DESCRIBED.—For pur-*  
6        *poses of this section, a relevant report is each of the*  
7        *following submitted by the Center or a grantee or con-*  
8        *tractor of the Center:*

9                        *“(A) Any interim or progress reports as*  
10                      *deemed appropriate by the Secretary.*

11                      *“(B) Stakeholder comments.*

12                      *“(C) A final report.*

13                *“(e) DISSEMINATION AND INCORPORATION OF COM-*  
14        *PARATIVE EFFECTIVENESS INFORMATION.—*

15                      *“(1) DISSEMINATION.—The Center shall provide*  
16        *for the dissemination of appropriate findings pro-*  
17        *duced by research supported, conducted, or syn-*  
18        *thesized under this section to health care providers,*  
19        *patients, vendors of health information technology fo-*  
20        *ocused on clinical decision support, appropriate profes-*  
21        *sional associations, and Federal and private health*  
22        *plans, and other relevant stakeholders. In dissemi-*  
23        *nating 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 may  
9 be needed, as appropriate;

10           “(D) not include any data that the dissemi-  
11 nation of which would violate the privacy of re-  
12 search 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 to  
17 promote the timely incorporation of such find-  
18 ings into clinical practices and promote the ease  
19 of use of such incorporation.

20           “(2) *DISSEMINATION PROTOCOLS AND STRATE-*  
21 *GIES.*—The Center shall develop protocols and strate-  
22 gies for the appropriate dissemination of research  
23 findings in order to ensure effective communication of  
24 findings and the use and incorporation of such find-  
25 ings into relevant activities for the purpose of inform-

1 *ing higher quality and more effective and efficient de-*  
2 *isions regarding medical items and services. In de-*  
3 *veloping and adopting such protocols and strategies,*  
4 *the Center shall consult with stakeholders concerning*  
5 *the types of dissemination that will be most useful to*  
6 *the end users of information and may provide for the*  
7 *utilization of multiple formats for conveying findings*  
8 *to different audiences, including dissemination to in-*  
9 *dividuals with limited English proficiency.*

10 “(f) *REPORTS TO CONGRESS.—*

11 *“(1) ANNUAL REPORTS.—Beginning not later*  
12 *than one year after the date of the enactment of this*  
13 *section, the Director of the Agency of Healthcare Re-*  
14 *search and Quality and the Commission shall submit*  
15 *to Congress an annual report on the activities of the*  
16 *Center and the Commission, as well as the research,*  
17 *conducted under this section. Each such report shall*  
18 *include a discussion of the Center’s compliance with*  
19 *subsection (c)(4)(B), including any reasons for lack of*  
20 *compliance with such subsection.*

21 *“(2) RECOMMENDATION FOR FAIR SHARE PER*  
22 *CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Begin-*  
23 *ning not later than December 31, 2011, the Secretary*  
24 *shall submit to Congress an annual recommendation*  
25 *for a fair share per capita amount described in sub-*



1        *section (c)(1) of section 9511 of the Internal Revenue*  
2        *Code of 1986 for purposes of funding the CERTF*  
3        *under such section.*

4            *“(3) ANALYSIS AND REVIEW.—Not later than De-*  
5        *cember 31, 2013, the Secretary, in consultation with*  
6        *the Commission, shall submit to Congress a report on*  
7        *all activities conducted or supported under this sec-*  
8        *tion as of such date. Such report shall include an*  
9        *evaluation of the overall costs of such activities and*  
10       *an analysis of the backlog of any research proposals*  
11       *approved by the Commission but not funded.*

12          *“(g) FUNDING OF COMPARATIVE EFFECTIVENESS RE-*  
13       *SEARCH.—For fiscal year 2010 and each subsequent fiscal*  
14       *year, amounts in the Comparative Effectiveness Research*  
15       *Trust Fund (referred to in this section as the ‘CERTF’)*  
16       *under section 9511 of the Internal Revenue Code of 1986*  
17       *shall be available, without the need for further appropria-*  
18       *tions and without fiscal year limitation, to the Secretary*  
19       *to carry out this section.*

20          *“(h) CONSTRUCTION.—Nothing in this section shall be*  
21       *construed to permit the Commission or the Center to man-*  
22       *date coverage, reimbursement, or other policies for any pub-*  
23       *lic or private payer.*

24          *“(i) RESEARCH NOT TO BE USED TO DENY OR RA-*  
25       *TION CARE.—In no case may any research conducted, sup-*

1 *ported, or developed by the Center, the Commission, or the*  
2 *Federal Coordinating Council for Comparative Effective-*  
3 *ness Research be used by the federal government to deny*  
4 *or ration care.*

5       “(j) *APPLICATION OF FEDERALLY FUNDED CLINICAL*  
6 *COMPARATIVE EFFECTIVENESS RESEARCH.—The Centers*  
7 *for Medicare & Medicaid Services may not use Federally*  
8 *funded clinical comparative effectiveness research data*  
9 *under this section to make coverage determinations for med-*  
10 *ical treatments, services, or items under title XVIII on the*  
11 *basis of cost.*

12       “(k) *CONDITIONS ON RECOMMENDATIONS OF STAND-*  
13 *ARDS OR PROTOCOLS.—*

14               “(1) *IN GENERAL.—The work performed by the*  
15 *Commission or the Center shall be based upon con-*  
16 *sultation with, and review by, the specialty colleges*  
17 *and academies of medicine to determine best practices*  
18 *within their field of specialty. Any recommendations*  
19 *made or best practices developed by the Commission*  
20 *or the Center —*

21                       “(A) *shall be based upon evidence-based*  
22 *medicine; and*

23                       “(B) *shall not violate standards and proto-*  
24 *cols of clinical excellence of the specialty colleges*  
25 *and academies.*

1           “(2) *DEFINITIONS.*—*For purposes of this sub-*  
2           *section:*

3                   “(A) *SPECIALTY COLLEGES AND ACADEMIES*  
4                   *OF MEDICINE.*—*The term ‘specialty colleges and*  
5                   *academies of medicine’ means the trade associa-*  
6                   *tions and professional membership societies that*  
7                   *represent physicians based on the field of medi-*  
8                   *cine in which each such physician practices or*  
9                   *is board certified.*

10                   “(B) *STANDARDS AND PROTOCOLS OF CLIN-*  
11                   *ICAL EXCELLENCE.*—*The term ‘standards and*  
12                   *protocols of clinical excellence’ means clinical or*  
13                   *practice guidelines that consist of a set of direc-*  
14                   *tions or principles that is based on evidence and*  
15                   *is designed to assist a health care practitioner*  
16                   *with decisions about appropriate diagnostic,*  
17                   *therapeutic, or other clinical procedures for spe-*  
18                   *cific clinical circumstances.”.*

19           (b) *COMPARATIVE EFFECTIVENESS RESEARCH TRUST*  
20 *FUND; FINANCING FOR THE TRUST FUND.*—*For provision*  
21 *establishing a Comparative Effectiveness Research Trust*  
22 *Fund and financing such Trust Fund, see section 1802.*

1                   ***Subtitle B—Nursing Home***  
 2                                   ***Transparency***

3 ***PART 1—IMPROVING TRANSPARENCY OF INFOR-***  
 4 ***MATION ON SKILLED NURSING FACILITIES***  
 5 ***AND NURSING FACILITIES***

6 ***SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND AD-***  
 7 ***DITIONAL DISCLOSABLE PARTIES INFORMA-***  
 8 ***TION.***

9           (a) *IN GENERAL.*—Section 1124 of the Social Security  
 10 Act (42 U.S.C. 1320a–3) is amended by adding at the end  
 11 the following new subsection:

12           “(c) *REQUIRED DISCLOSURE OF OWNERSHIP AND AD-*  
 13 *DITIONAL DISCLOSABLE PARTIES INFORMATION.*—

14                   “(1) *DISCLOSURE.*—A facility (as defined in  
 15 paragraph (7)(B)) shall have the information de-  
 16 scribed in paragraph (3) available—

17                           “(A) during the period beginning on the  
 18 date of the enactment of this subsection and end-  
 19 ing on the date such information is made avail-  
 20 able to the public under section 1411(b) of the  
 21 America’s Affordable Health Choices Act of 2009,  
 22 for submission to the Secretary, the Inspector  
 23 General of the Department of Health and  
 24 Human Services, the State in which the facility  
 25 is located, and the State long-term care ombuds-

1           *man in the case where the Secretary, the Inspec-*  
2           *tor General, the State, or the State long-term*  
3           *care ombudsman requests such information; and*

4           *“(B) beginning on the effective date of the*  
5           *final regulations promulgated under paragraph*  
6           *(4)(A), for reporting such information in accord-*  
7           *ance with such final regulations.*

8           *Nothing in subparagraph (A) shall be construed as*  
9           *authorizing a facility to dispose of or delete informa-*  
10          *tion described in such subparagraph after the effective*  
11          *date of the final regulations promulgated under para-*  
12          *graph (4)(A).*

13          “(2) *PUBLIC AVAILABILITY OF INFORMATION.—*  
14          *During the period described in paragraph (1)(A), a*  
15          *facility shall—*

16                 “(A) *make the information described in*  
17                 *paragraph (3) available to the public upon re-*  
18                 *quest and update such information as may be*  
19                 *necessary to reflect changes in such information;*  
20                 *and*

21                 “(B) *post a notice of the availability of such*  
22                 *information in the lobby of the facility in a*  
23                 *prominent manner.*

24          “(3) *INFORMATION DESCRIBED.—*

1           “(A) *IN GENERAL.*—*The following informa-*  
2           *tion is described in this paragraph:*

3           “(i) *The information described in sub-*  
4           *sections (a) and (b), subject to subpara-*  
5           *graph (C).*

6           “(ii) *The identity of and information*  
7           *on—*

8           “(I) *each member of the governing*  
9           *body of the facility, including the*  
10           *name, title, and period of service of*  
11           *each such member;*

12           “(II) *each person or entity who is*  
13           *an officer, director, member, partner,*  
14           *trustee, or managing employee of the*  
15           *facility, including the name, title, and*  
16           *date of start of service of each such per-*  
17           *son or entity; and*

18           “(III) *each person or entity who*  
19           *is an additional disclosable party of*  
20           *the facility.*

21           “(iii) *The organizational structure of*  
22           *each person and entity described in sub-*  
23           *clauses (II) and (III) of clause (ii) and a*  
24           *description of the relationship of each such*

1            *person or entity to the facility and to one*  
2            *another.*

3            “(B) *SPECIAL RULE WHERE INFORMATION*  
4            *IS ALREADY REPORTED OR SUBMITTED.—To the*  
5            *extent that information reported by a facility to*  
6            *the Internal Revenue Service on Form 990, in-*  
7            *formation submitted by a facility to the Securi-*  
8            *ties and Exchange Commission, or information*  
9            *otherwise submitted to the Secretary or any other*  
10           *Federal agency contains the information de-*  
11           *scribed in clauses (i), (ii), or (iii) of subpara-*  
12           *graph (A), the Secretary may allow, to the extent*  
13           *practicable, such Form or such information to*  
14           *meet the requirements of paragraph (1) and to*  
15           *be submitted in a manner specified by the Sec-*  
16           *retary.*

17           “(C) *SPECIAL RULE.—In applying sub-*  
18           *paragraph (A)(i)—*

19                      *“(i) with respect to subsections (a) and*  
20                      *(b), ‘ownership or control interest’ shall in-*  
21                      *clude direct or indirect interests, including*  
22                      *such interests in intermediate entities; and*

23                      *“(ii) subsection (a)(3)(A)(ii) shall in-*  
24                      *clude the owner of a whole or part interest*  
25                      *in any mortgage, deed of trust, note, or*

1            *other obligation secured, in whole or in*  
2            *part, by the entity or any of the property*  
3            *or assets thereof, if the interest is equal to*  
4            *or exceeds 5 percent of the total property or*  
5            *assets of the entirety.*

6            “(4) *REPORTING.*—

7            “(A) *IN GENERAL.*—Not later than the date  
8            *that is 2 years after the date of the enactment of*  
9            *this subsection, the Secretary shall promulgate*  
10           *regulations requiring, effective on the date that is*  
11           *90 days after the date on which such final regu-*  
12           *lations are published in the Federal Register, a*  
13           *facility to report the information described in*  
14           *paragraph (3) to the Secretary in a standardized*  
15           *format, and such other regulations as are nec-*  
16           *essary to carry out this subsection. Such final*  
17           *regulations shall ensure that the facility certifies,*  
18           *as a condition of participation and payment*  
19           *under the program under title XVIII or XIX,*  
20           *that the information reported by the facility in*  
21           *accordance with such final regulations is accu-*  
22           *rate and current.*

23           “(B) *GUIDANCE.*—The Secretary shall pro-  
24           *vide guidance and technical assistance to States*



1           *on how to adopt the standardized format under*  
2           *subparagraph (A).*

3           “(5) *NO EFFECT ON EXISTING REPORTING RE-*  
4           *QUIREMENTS.—Nothing in this subsection shall re-*  
5           *duce, diminish, or alter any reporting requirement*  
6           *for a facility that is in effect as of the date of the en-*  
7           *actment of this subsection.*

8           “(6) *DEFINITIONS.—In this subsection:*

9           “(A) *ADDITIONAL DISCLOSABLE PARTY.—*  
10           *The term ‘additional disclosable party’ means,*  
11           *with respect to a facility, any person or entity*  
12           *who—*

13                   “(i) *exercises operational, financial, or*  
14                   *managerial control over the facility or a*  
15                   *part thereof, or provides policies or proce-*  
16                   *dures for any of the operations of the facil-*  
17                   *ity, or provides financial or cash manage-*  
18                   *ment services to the facility;*

19                   “(ii) *leases or subleases real property*  
20                   *to the facility, or owns a whole or part in-*  
21                   *terest equal to or exceeding 5 percent of the*  
22                   *total value of such real property;*

23                   “(iii) *lends funds or provides a finan-*  
24                   *cial guarantee to the facility in an amount*  
25                   *which is equal to or exceeds \$50,000; or*

1           “(iv) provides management or admin-  
2           istrative services, clinical consulting serv-  
3           ices, or accounting or financial services to  
4           the facility.

5           “(B) FACILITY.—The term ‘facility’ means  
6           a disclosing entity which is—

7                   “(i) a skilled nursing facility (as de-  
8                   fined in section 1819(a)); or

9                   “(ii) a nursing facility (as defined in  
10                  section 1919(a)).

11           “(C) MANAGING EMPLOYEE.—The term  
12           ‘managing employee’ means, with respect to a fa-  
13           cility, an individual (including a general man-  
14           ager, business manager, administrator, director,  
15           or consultant) who directly or indirectly man-  
16           ages, advises, or supervises any element of the  
17           practices, finances, or operations of the facility.

18           “(D) ORGANIZATIONAL STRUCTURE.—The  
19           term ‘organizational structure’ means, in the  
20           case of—

21                   “(i) a corporation, the officers, direc-  
22                   tors, and shareholders of the corporation  
23                   who have an ownership interest in the cor-  
24                   poration which is equal to or exceeds 5 per-  
25                   cent;

1           “(ii) a limited liability company, the  
2           members and managers of the limited liabil-  
3           ity company (including, as applicable, what  
4           percentage each member and manager has  
5           of the ownership interest in the limited li-  
6           ability company);

7           “(iii) a general partnership, the part-  
8           ners of the general partnership;

9           “(iv) a limited partnership, the general  
10          partners and any limited partners of the  
11          limited partnership who have an ownership  
12          interest in the limited partnership which is  
13          equal to or exceeds 10 percent;

14          “(v) a trust, the trustees of the trust;

15          “(vi) an individual, contact informa-  
16          tion for the individual; and

17          “(vii) any other person or entity, such  
18          information as the Secretary determines ap-  
19          propriate.”.

20          (b) *PUBLIC AVAILABILITY OF INFORMATION.*—

21                 (1) *IN GENERAL.*—Not later than the date that  
22                 is 1 year after the date on which the final regulations  
23                 promulgated under section 1124(c)(4)(A) of the Social  
24                 Security Act, as added by subsection (a), are pub-  
25                 lished in the Federal Register, the information re-

1       ported in accordance with such final regulations shall  
2       be made available to the public in accordance with  
3       procedures established by the Secretary.

4               (2) *DEFINITIONS.*—*In this subsection:*

5                       (A) *NURSING FACILITY.*—*The term “nurs-*  
6                       *ing facility” has the meaning given such term in*  
7                       *section 1919(a) of the Social Security Act (42*  
8                       *U.S.C. 1396r(a)).*

9                       (B) *SECRETARY.*—*The term “Secretary”*  
10                      *means the Secretary of Health and Human Serv-*  
11                      *ices.*

12                      (C) *SKILLED NURSING FACILITY.*—*The term*  
13                      *“skilled nursing facility” has the meaning given*  
14                      *such term in section 1819(a) of the Social Secu-*  
15                      *rity Act (42 U.S.C. 1395i–3(a)).*

16       (c) *CONFORMING AMENDMENTS.*—

17                      (1) *SKILLED NURSING FACILITIES.*—*Section*  
18                      *1819(d)(1) of the Social Security Act (42 U.S.C.*  
19                      *1395i–3(d)(1)) is amended by striking subparagraph*  
20                      *(B) and redesignating subparagraph (C) as subpara-*  
21                      *graph (B).*

22                      (2) *NURSING FACILITIES.*—*Section 1919(d)(1) of*  
23                      *the Social Security Act (42 U.S.C. 1396r(d)(1)) is*  
24                      *amended by striking subparagraph (B) and redesign-*  
25                      *ating subparagraph (C) as subparagraph (B).*

1 **SEC. 1412. ACCOUNTABILITY REQUIREMENTS.**

2 (a) *EFFECTIVE COMPLIANCE AND ETHICS PRO-*  
3 *GRAMS.—*

4 (1) *SKILLED NURSING FACILITIES.—Section*  
5 *1819(d)(1) of the Social Security Act (42 U.S.C.*  
6 *1395i–3(d)(1)), as amended by section 1411(c)(1), is*  
7 *amended by adding at the end the following new sub-*  
8 *paragraph:*

9 (C) *COMPLIANCE AND ETHICS PRO-*  
10 *GRAMS.—*

11 (i) *REQUIREMENT.—On or after the*  
12 *date that is 36 months after the date of the*  
13 *enactment of this subparagraph, a skilled*  
14 *nursing facility shall, with respect to the*  
15 *entity that operates the facility (in this sub-*  
16 *paragraph referred to as the ‘operating or-*  
17 *ganization’ or ‘organization’), have in oper-*  
18 *ation a compliance and ethics program that*  
19 *is effective in preventing and detecting*  
20 *criminal, civil, and administrative viola-*  
21 *tions under this Act and in promoting qual-*  
22 *ity of care consistent with regulations devel-*  
23 *oped under clause (ii).*

24 (ii) *DEVELOPMENT OF REGULA-*  
25 *TIONS.—*

1           “(I) *IN GENERAL.*—Not later than  
2           the date that is 2 years after such date  
3           of the enactment, the Secretary, in con-  
4           sultation with the Inspector General of  
5           the Department of Health and Human  
6           Services, shall promulgate regulations  
7           for an effective compliance and ethics  
8           program for operating organizations,  
9           which may include a model compliance  
10          program.

11           “(II) *DESIGN OF REGULATIONS.*—  
12          Such regulations with respect to spe-  
13          cific elements or formality of a pro-  
14          gram may vary with the size of the or-  
15          ganization, such that larger organiza-  
16          tions should have a more formal and  
17          rigorous program and include estab-  
18          lished written policies defining the  
19          standards and procedures to be fol-  
20          lowed by its employees. Such require-  
21          ments shall specifically apply to the  
22          corporate level management of multi-  
23          unit nursing home chains.

24           “(III) *EVALUATION.*—Not later  
25          than 3 years after the date of promul-

1                    *gation of regulations under this clause,*  
2                    *the Secretary shall complete an evalua-*  
3                    *tion of the compliance and ethics pro-*  
4                    *grams required to be established under*  
5                    *this subparagraph. Such evaluation*  
6                    *shall determine if such programs led to*  
7                    *changes in deficiency citations, changes*  
8                    *in quality performance, or changes in*  
9                    *other metrics of resident quality of*  
10                   *care. The Secretary shall submit to*  
11                   *Congress a report on such evaluation*  
12                   *and shall include in such report such*  
13                   *recommendations regarding changes in*  
14                   *the requirements for such programs as*  
15                   *the Secretary determines appropriate.*

16                   *“(iii) REQUIREMENTS FOR COMPLI-*  
17                   *ANCE AND ETHICS PROGRAMS.—In this sub-*  
18                   *paragraph, the term ‘compliance and ethics*  
19                   *program’ means, with respect to a skilled*  
20                   *nursing facility, a program of the operating*  
21                   *organization that—*

22                   *“(I) has been reasonably designed,*  
23                   *implemented, and enforced so that it*  
24                   *generally will be effective in preventing*  
25                   *and detecting criminal, civil, and ad-*

1            *ministrative violations under this Act*  
2            *and in promoting quality of care; and*

3            *“(II) includes at least the required*  
4            *components specified in clause (iv).*

5            *“(iv) REQUIRED COMPONENTS OF PRO-*  
6            *GRAM.—The required components of a com-*  
7            *pliance and ethics program of an organiza-*  
8            *tion are the following:*

9            *“(I) The organization must have*  
10           *established compliance standards and*  
11           *procedures to be followed by its em-*  
12           *ployees, contractors, and other agents*  
13           *that are reasonably capable of reducing*  
14           *the prospect of criminal, civil, and ad-*  
15           *ministrative violations under this Act.*

16           *“(II) Specific individuals within*  
17           *high-level personnel of the organization*  
18           *must have been assigned overall re-*  
19           *sponsibility to oversee compliance with*  
20           *such standards and procedures and*  
21           *have sufficient resources and authority*  
22           *to assure such compliance.*

23           *“(III) The organization must have*  
24           *used due care not to delegate substan-*  
25           *tial discretionary authority to individ-*



1           uals whom the organization knew, or  
2           should have known through the exercise  
3           of due diligence, had a propensity to  
4           engage in criminal, civil, and admin-  
5           istrative violations under this Act.

6                   “(IV) The organization must have  
7           taken steps to communicate effectively  
8           its standards and procedures to all em-  
9           ployees and other agents, such as by re-  
10          quiring participation in training pro-  
11          grams or by disseminating publica-  
12          tions that explain in a practical man-  
13          ner what is required.

14                   “(V) The organization must have  
15          taken reasonable steps to achieve com-  
16          pliance with its standards, such as by  
17          utilizing monitoring and auditing sys-  
18          tems reasonably designed to detect  
19          criminal, civil, and administrative  
20          violations under this Act by its em-  
21          ployees and other agents and by having  
22          in place and publicizing a reporting  
23          system whereby employees and other  
24          agents could report violations by others

1           *within the organization without fear of*  
2           *retribution.*

3           “(VI) *The standards must have*  
4           *been consistently enforced through ap-*  
5           *propriate disciplinary mechanisms, in-*  
6           *cluding, as appropriate, discipline of*  
7           *individuals responsible for the failure*  
8           *to detect an offense.*

9           “(VII) *After an offense has been*  
10          *detected, the organization must have*  
11          *taken all reasonable steps to respond*  
12          *appropriately to the offense and to pre-*  
13          *vent further similar offenses, including*  
14          *repayment of any funds to which it*  
15          *was not entitled and any necessary*  
16          *modification to its program to prevent*  
17          *and detect criminal, civil, and admin-*  
18          *istrative violations under this Act.*

19          “(VIII) *The organization must pe-*  
20          *riodically undertake reassessment of its*  
21          *compliance program to identify*  
22          *changes necessary to reflect changes*  
23          *within the organization and its facili-*  
24          *ties.*

1                   “(v) *COORDINATION.*—*The provisions*  
2                   *of this subparagraph shall apply with re-*  
3                   *spect to a skilled nursing facility in lieu of*  
4                   *section 1874(d).”.*

5                   (2) *NURSING FACILITIES.*—*Section 1919(d)(1) of*  
6                   *the Social Security Act (42 U.S.C. 1396r(d)(1)), as*  
7                   *amended by section 1411(c)(2), is amended by adding*  
8                   *at the end the following new subparagraph:*

9                   “(C) *COMPLIANCE AND ETHICS PROGRAM.*—

10                   “(i) *REQUIREMENT.*—*On or after the*  
11                   *date that is 36 months after the date of the*  
12                   *enactment of this subparagraph, a nursing*  
13                   *facility shall, with respect to the entity that*  
14                   *operates the facility (in this subparagraph*  
15                   *referred to as the ‘operating organization’*  
16                   *or ‘organization’), have in operation a com-*  
17                   *pliance and ethics program that is effective*  
18                   *in preventing and detecting criminal, civil,*  
19                   *and administrative violations under this*  
20                   *Act and in promoting quality of care con-*  
21                   *sistent with regulations developed under*  
22                   *clause (ii).*

23                   “(ii) *DEVELOPMENT OF REGULA-*  
24                   *TIONS.*—

1           “(I) *IN GENERAL.*—Not later than  
2           the date that is 2 years after such date  
3           of the enactment, the Secretary, in con-  
4           sultation with the Inspector General of  
5           the Department of Health and Human  
6           Services, shall develop regulations for  
7           an effective compliance and ethics pro-  
8           gram for operating organizations,  
9           which may include a model compliance  
10          program.

11           “(II) *DESIGN OF REGULATIONS.*—  
12          Such regulations with respect to spe-  
13          cific elements or formality of a pro-  
14          gram may vary with the size of the or-  
15          ganization, such that larger organiza-  
16          tions should have a more formal and  
17          rigorous program and include estab-  
18          lished written policies defining the  
19          standards and procedures to be fol-  
20          lowed by its employees. Such require-  
21          ments may specifically apply to the  
22          corporate level management of multi-  
23          unit nursing home chains.

24           “(III) *EVALUATION.*—Not later  
25          than 3 years after the date of promul-

1                    *gation of regulations under this clause*  
2                    *the Secretary shall complete an evalua-*  
3                    *tion of the compliance and ethics pro-*  
4                    *grams required to be established under*  
5                    *this subparagraph. Such evaluation*  
6                    *shall determine if such programs led to*  
7                    *changes in deficiency citations, changes*  
8                    *in quality performance, or changes in*  
9                    *other metrics of resident quality of*  
10                   *care. The Secretary shall submit to*  
11                   *Congress a report on such evaluation*  
12                   *and shall include in such report such*  
13                   *recommendations regarding changes in*  
14                   *the requirements for such programs as*  
15                   *the Secretary determines appropriate.*

16                   *“(iii) REQUIREMENTS FOR COMPLI-*  
17                   *ANCE AND ETHICS PROGRAMS.—In this sub-*  
18                   *paragraph, the term ‘compliance and ethics*  
19                   *program’ means, with respect to a nursing*  
20                   *facility, a program of the operating organi-*  
21                   *zation that—*

22                   *“(I) has been reasonably designed,*  
23                   *implemented, and enforced so that it*  
24                   *generally will be effective in preventing*  
25                   *and detecting criminal, civil, and ad-*

1            *ministrative violations under this Act*  
2            *and in promoting quality of care; and*

3            *“(II) includes at least the required*  
4            *components specified in clause (iv).*

5            *“(iv) REQUIRED COMPONENTS OF PRO-*  
6            *GRAM.—The required components of a com-*  
7            *pliance and ethics program of an organiza-*  
8            *tion are the following:*

9            *“(I) The organization must have*  
10           *established compliance standards and*  
11           *procedures to be followed by its em-*  
12           *ployees and other agents that are rea-*  
13           *sonably capable of reducing the pros-*  
14           *pect of criminal, civil, and adminis-*  
15           *trative violations under this Act.*

16           *“(II) Specific individuals within*  
17           *high-level personnel of the organization*  
18           *must have been assigned overall re-*  
19           *sponsibility to oversee compliance with*  
20           *such standards and procedures and has*  
21           *sufficient resources and authority to*  
22           *assure such compliance.*

23           *“(III) The organization must have*  
24           *used due care not to delegate substan-*  
25           *tial discretionary authority to individ-*

1           uals whom the organization knew, or  
2           should have known through the exercise  
3           of due diligence, had a propensity to  
4           engage in criminal, civil, and admin-  
5           istrative violations under this Act.

6                   “(IV) The organization must have  
7           taken steps to communicate effectively  
8           its standards and procedures to all em-  
9           ployees and other agents, such as by re-  
10          quiring participation in training pro-  
11          grams or by disseminating publica-  
12          tions that explain in a practical man-  
13          ner what is required.

14                   “(V) The organization must have  
15          taken reasonable steps to achieve com-  
16          pliance with its standards, such as by  
17          utilizing monitoring and auditing sys-  
18          tems reasonably designed to detect  
19          criminal, civil, and administrative  
20          violations under this Act by its em-  
21          ployees and other agents and by having  
22          in place and publicizing a reporting  
23          system whereby employees and other  
24          agents could report violations by others

1           *within the organization without fear of*  
2           *retribution.*

3           “(VI) *The standards must have*  
4           *been consistently enforced through ap-*  
5           *propriate disciplinary mechanisms, in-*  
6           *cluding, as appropriate, discipline of*  
7           *individuals responsible for the failure*  
8           *to detect an offense.*

9           “(VII) *After an offense has been*  
10          *detected, the organization must have*  
11          *taken all reasonable steps to respond*  
12          *appropriately to the offense and to pre-*  
13          *vent further similar offenses, including*  
14          *repayment of any funds to which it*  
15          *was not entitled and any necessary*  
16          *modification to its program to prevent*  
17          *and detect criminal, civil, and admin-*  
18          *istrative violations under this Act.*

19          “(VIII) *The organization must pe-*  
20          *riodically undertake reassessment of its*  
21          *compliance program to identify*  
22          *changes necessary to reflect changes*  
23          *within the organization and its facili-*  
24          *ties.*



1                   “(v) *COORDINATION.*—*The provisions*  
2                   *of this subparagraph shall apply with re-*  
3                   *spect to a nursing facility in lieu of section*  
4                   *1902(a)(77).”.*

5           (b) *QUALITY ASSURANCE AND PERFORMANCE IM-*  
6 *PROVEMENT PROGRAM.*—

7           (1) *SKILLED NURSING FACILITIES.*—*Section*  
8           *1819(b)(1)(B) of the Social Security Act (42 U.S.C.*  
9           *1396r(b)(1)(B)) is amended—*

10                   (A) *by striking “ASSURANCE” and inserting*  
11                   *“ASSURANCE AND QUALITY ASSURANCE AND PER-*  
12                   *FORMANCE IMPROVEMENT PROGRAM”;*

13                   (B) *by designating the matter beginning*  
14                   *with “A skilled nursing facility” as a clause (i)*  
15                   *with the heading “IN GENERAL.—” and the ap-*  
16                   *propriate indentation;*

17                   (C) *in clause (i) (as so designated by sub-*  
18                   *paragraph (B)), by redesignating clauses (i) and*  
19                   *(ii) as subclauses (I) and (II), respectively; and*

20                   (D) *by adding at the end the following new*  
21                   *clause:*

22                           “(i) *QUALITY ASSURANCE AND PER-*  
23                           *FORMANCE IMPROVEMENT PROGRAM.*—

24                                   “(I) *IN GENERAL.*—*Not later than*  
25                                   *December 31, 2011, the Secretary shall*

1           *establish and implement a quality as-*  
2           *urance and performance improvement*  
3           *program (in this clause referred to as*  
4           *the ‘QAPI program’) for skilled nurs-*  
5           *ing facilities, including multi-unit*  
6           *chains of such facilities. Under the*  
7           *QAPI program, the Secretary shall es-*  
8           *tablish standards relating to such fa-*  
9           *ilities and provide technical assist-*  
10          *ance to such facilities on the develop-*  
11          *ment of best practices in order to meet*  
12          *such standards. Not later than 1 year*  
13          *after the date on which the regulations*  
14          *are promulgated under subclause (II),*  
15          *a skilled nursing facility must submit*  
16          *to the Secretary a plan for the facility*  
17          *to meet such standards and implement*  
18          *such best practices, including how to*  
19          *coordinate the implementation of such*  
20          *plan with quality assessment and as-*  
21          *urance activities conducted under*  
22          *clause (i).*

23                   “(II) REGULATIONS.—The Sec-

24                   *retary shall promulgate regulations to*

25                   *carry out this clause.”.*

1           (2)           *NURSING           FACILITIES.—Section*  
2           *1919(b)(1)(B) of the Social Security Act (42 U.S.C.*  
3           *1396r(b)(1)(B)) is amended—*

4                   (A) *by striking “ASSURANCE” and inserting*  
5                   *“ASSURANCE AND QUALITY ASSURANCE AND PER-*  
6                   *FORMANCE IMPROVEMENT PROGRAM”;*

7                   (B) *by designating the matter beginning*  
8                   *with “A nursing facility” as a clause (i) with*  
9                   *the heading “IN GENERAL.—” and the appro-*  
10                   *priate indentation; and*

11                   (C) *by adding at the end the following new*  
12                   *clause:*

13                           *“(i) QUALITY ASSURANCE AND PER-*  
14                           *FORMANCE IMPROVEMENT PROGRAM.—*

15                                   *“(I) IN GENERAL.—Not later than*  
16                                   *December 31, 2011, the Secretary shall*  
17                                   *establish and implement a quality as-*  
18                                   *surance and performance improvement*  
19                                   *program (in this clause referred to as*  
20                                   *the ‘QAPI program’) for nursing facili-*  
21                                   *ties, including multi-unit chains of*  
22                                   *such facilities. Under the QAPI pro-*  
23                                   *gram, the Secretary shall establish*  
24                                   *standards relating to such facilities*  
25                                   *and provide technical assistance to*

1            *such facilities on the development of*  
2            *best practices in order to meet such*  
3            *standards. Not later than 1 year after*  
4            *the date on which the regulations are*  
5            *promulgated under subclause (II), a*  
6            *nursing facility must submit to the*  
7            *Secretary a plan for the facility to*  
8            *meet such standards and implement*  
9            *such best practices, including how to*  
10           *coordinate the implementation of such*  
11           *plan with quality assessment and as-*  
12           *urance activities conducted under*  
13           *clause (i).*

14                            *“(II) REGULATIONS.—The Sec-*  
15                            *retary shall promulgate regulations to*  
16                            *carry out this clause.”.*

17                            *(3) PROPOSAL TO REVISE QUALITY ASSURANCE*  
18                            *AND PERFORMANCE IMPROVEMENT PROGRAMS.—The*  
19                            *Secretary shall include in the proposed rule published*  
20                            *under section 1888(e) of the Social Security Act (42*  
21                            *U.S.C. 1395yy(e)(5)(A)) for the subsequent fiscal year*  
22                            *to the extent otherwise authorized under section*  
23                            *1819(b)(1)(B) or 1819(d)(1)(C) of the Social Security*  
24                            *Act or other statutory or regulatory authority, one or*  
25                            *more proposals for skilled nursing facilities to modify*

1 *and strengthen quality assurance and performance*  
2 *improvement programs in such facilities. At the time*  
3 *of publication of such proposed rule and to the extent*  
4 *otherwise authorized under section 1919(b)(1)(B) or*  
5 *1919(d)(1)(C) of such Act or other regulatory author-*  
6 *ity.*

7 (4) *FACILITY PLAN.*—*Not later than 1 year after*  
8 *the date on which the regulations are promulgated*  
9 *under subclause (II) of clause (ii) of sections*  
10 *1819(b)(1)(B) and 1919(b)(1)(B) of the Social Secu-*  
11 *rity Act, as added by paragraphs (1) and (2), a*  
12 *skilled nursing facility and a nursing facility must*  
13 *submit to the Secretary a plan for the facility to meet*  
14 *the standards under such regulations and implement*  
15 *such best practices, including how to coordinate the*  
16 *implementation of such plan with quality assessment*  
17 *and assurance activities conducted under clause (i) of*  
18 *such sections.*

19 (c) *GAO STUDY ON NURSING FACILITY UNDER-*  
20 *CAPITALIZATION.*—

21 (1) *IN GENERAL.*—*The Comptroller General of*  
22 *the United States shall conduct a study that examines*  
23 *the following:*

24 (A) *The extent to which corporations that*  
25 *own or operate large numbers of nursing facili-*

1           ties, taking into account ownership type (includ-  
2           ing private equity and control interests), are  
3           undercapitalizing such facilities.

4           (B) *The effects of such undercapitalization*  
5           *on quality of care, including staffing and food*  
6           *costs, at such facilities.*

7           (C) *Options to address such undercapital-*  
8           *ization, such as requirements relating to surety*  
9           *bonds, liability insurance, or minimum capital-*  
10          *ization.*

11          (2) *REPORT.—Not later than 18 months after the*  
12          *date of the enactment of this Act, the Comptroller*  
13          *General shall submit to Congress a report on the*  
14          *study conducted under paragraph (1).*

15          (3) *NURSING FACILITY.—In this subsection, the*  
16          *term “nursing facility” includes a skilled nursing fa-*  
17          *cility.*

18          **SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.**

19          (a) *SKILLED NURSING FACILITIES.—*

20                 (1) *IN GENERAL.—Section 1819 of the Social Se-*  
21                 *curity Act (42 U.S.C. 1395i–3) is amended—*

22                         (A) *by redesignating subsection (i) as sub-*  
23                         *section (j); and*

24                         (B) *by inserting after subsection (h) the fol-*  
25                         *lowing new subsection:*

1       “(i) *NURSING HOME COMPARE WEBSITE.*—

2               “(1) *INCLUSION OF ADDITIONAL INFORMATION.*—

3                       “(A) *IN GENERAL.*—*The Secretary shall en-*  
4                       *sure that the Department of Health and Human*  
5                       *Services includes, as part of the information pro-*  
6                       *vided for comparison of nursing homes on the of-*  
7                       *ficial Internet website of the Federal Government*  
8                       *for Medicare beneficiaries (commonly referred to*  
9                       *as the ‘Nursing Home Compare’ Medicare*  
10                      *website) (or a successor website), the following*  
11                      *information in a manner that is prominent, eas-*  
12                      *ily accessible, readily understandable to con-*  
13                      *sumers of long-term care services, and searchable:*

14                               “(i) *Information that is reported to the*  
15                               *Secretary under section 1124(c)(4).*

16                               “(ii) *Information on the ‘Special Focus*  
17                               *Facility program’ (or a successor program)*  
18                               *established by the Centers for Medicare and*  
19                               *Medicaid Services, according to procedures*  
20                               *established by the Secretary. Such proce-*  
21                               *dures shall provide for the inclusion of in-*  
22                               *formation with respect to, and the names*  
23                               *and locations of, those facilities that, since*  
24                               *the previous quarter—*

1           “(I) were newly enrolled in the  
2           program;

3           “(II) are enrolled in the program  
4           and have failed to significantly im-  
5           prove;

6           “(III) are enrolled in the program  
7           and have significantly improved;

8           “(IV) have graduated from the  
9           program; and

10          “(V) have closed voluntarily or no  
11          longer participate under this title.

12          “(iii) Staffing data for each facility  
13          (including resident census data and data on  
14          the hours of care provided per resident per  
15          day) based on data submitted under sub-  
16          section (b)(8)(C), including information on  
17          staffing turnover and tenure, in a format  
18          that is clearly understandable to consumers  
19          of long-term care services and allows such  
20          consumers to compare differences in staffing  
21          between facilities and State and national  
22          averages for the facilities. Such format shall  
23          include—

24                 “(I) concise explanations of how  
25                 to interpret the data (such as a plain



1            *English explanation of data reflecting*  
2            *‘nursing home staff hours per resident*  
3            *day’);*

4            *“(II) differences in types of staff*  
5            *(such as training associated with dif-*  
6            *ferent categories of staff);*

7            *“(III) the relationship between*  
8            *nurse staffing levels and quality of*  
9            *care; and*

10           *“(IV) an explanation that appro-*  
11           *priate staffing levels vary based on pa-*  
12           *tient case mix.*

13           *“(iv) Links to State Internet websites*  
14           *with information regarding State survey*  
15           *and certification programs, links to Form*  
16           *2567 State inspection reports (or a suc-*  
17           *cessor form) on such websites, information*  
18           *to guide consumers in how to interpret and*  
19           *understand such reports, and the facility*  
20           *plan of correction or other response to such*  
21           *report.*

22           *“(v) The standardized complaint form*  
23           *developed under subsection (f)(8), including*  
24           *explanatory material on what complaint*  
25           *forms are, how they are used, and how to*

1           *file a complaint with the State survey and*  
2           *certification program and the State long-*  
3           *term care ombudsman program.*

4           “(vi) *Summary information on the*  
5           *number, type, severity, and outcome of sub-*  
6           *stantiated complaints.*

7           “(vii) *The number of adjudicated in-*  
8           *stances of criminal violations by employees*  
9           *of a a nursing facility—*

10           “(I) *that were committed inside*  
11           *the facility;*

12           “(II) *with respect to such in-*  
13           *stances of violations or crimes com-*  
14           *mitted inside of the facility that were*  
15           *the violations or crimes of abuse, ne-*  
16           *glect, and exploitation, criminal sexual*  
17           *abuse, or other violations or crimes*  
18           *that resulted in serious bodily injury;*  
19           *and*

20           “(III) *the number of civil mone-*  
21           *tary penalties levied against the facil-*  
22           *ity, employees, contractors, and other*  
23           *agents.*

24           “(B) *DEADLINE FOR PROVISION OF INFOR-*  
25           *MATION.—*

1           “(i) *IN GENERAL.*—*Except as provided*  
2           *in clause (ii), the Secretary shall ensure*  
3           *that the information described in subpara-*  
4           *graph (A) is included on such website (or a*  
5           *successor website) not later than 1 year*  
6           *after the date of the enactment of this sub-*  
7           *section.*

8           “(ii) *EXCEPTION.*—*The Secretary shall*  
9           *ensure that the information described in*  
10           *subparagraph (A)(i) and (A)(iii) is in-*  
11           *cluded on such website (or a successor*  
12           *website) not later than the date on which*  
13           *the requirements under section 1124(c)(4)*  
14           *and subsection (b)(8)(C)(ii) are imple-*  
15           *mented.*

16           “(2) *REVIEW AND MODIFICATION OF WEBSITE.*—

17           “(A) *IN GENERAL.*—*The Secretary shall es-*  
18           *tablish a process—*

19           “(i) *to review the accuracy, clarity of*  
20           *presentation, timeliness, and comprehensive-*  
21           *ness of information reported on such website*  
22           *as of the day before the date of the enact-*  
23           *ment of this subsection; and*

24           “(ii) *not later than 1 year after the*  
25           *date of the enactment of this subsection, to*

1           *modify or revamp such website in accord-*  
2           *ance with the review conducted under clause*  
3           *(i).*

4           “(B) *CONSULTATION.*—*In conducting the*  
5           *review under subparagraph (A)(i), the Secretary*  
6           *shall consult with—*

7                   “(i) *State long-term care ombudsman*  
8                   *programs;*

9                   “(ii) *consumer advocacy groups;*

10                   “(iii) *provider stakeholder groups; and*

11                   “(iv) *any other representatives of pro-*  
12                   *grams or groups the Secretary determines*  
13                   *appropriate.”.*

14           (2) *TIMELINESS OF SUBMISSION OF SURVEY AND*  
15           *CERTIFICATION INFORMATION.—*

16                   (A) *IN GENERAL.*—*Section 1819(g)(5) of the*  
17                   *Social Security Act (42 U.S.C. 1395i–3(g)(5)) is*  
18                   *amended by adding at the end the following new*  
19                   *subparagraph:*

20                           “(E) *SUBMISSION OF SURVEY AND CERTIFI-*  
21                           *CATION INFORMATION TO THE SECRETARY.*—*In*  
22                           *order to improve the timeliness of information*  
23                           *made available to the public under subparagraph*  
24                           *(A) and provided on the Nursing Home Compare*  
25                           *Medicare website under subsection (i), each State*

1           *shall submit information respecting any survey*  
2           *or certification made respecting a skilled nursing*  
3           *facility (including any enforcement actions taken*  
4           *by the State) to the Secretary not later than the*  
5           *date on which the State sends such information*  
6           *to the facility. The Secretary shall use the infor-*  
7           *mation submitted under the preceding sentence*  
8           *to update the information provided on the Nurs-*  
9           *ing Home Compare Medicare website as expedi-*  
10          *tiously as practicable but not less frequently*  
11          *than quarterly.”.*

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 1819(f) of such Act is amended by adding at the*  
17          *end 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 skilled nursing fa-*  
22          *ilities that the Secretary has identified as hav-*  
23          *ing substantially failed to meet applicable re-*  
24          *quirement of this Act.*

1                   “(B) *PERIODIC SURVEYS*.—Under such pro-  
2                   gram the Secretary shall conduct surveys of each  
3                   facility in the program not less than once every  
4                   6 months.”.

5                   (b) *NURSING FACILITIES*.—

6                   (1) *IN GENERAL*.—Section 1919 of the Social Se-  
7                   curity Act (42 U.S.C. 1396r) is amended—

8                   (A) by redesignating subsection (i) as sub-  
9                   section (j); and

10                   (B) by inserting after subsection (h) the fol-  
11                   lowing new subsection:

12                   “(i) *NURSING HOME COMPARE WEBSITE*.—

13                   “(1) *INCLUSION OF ADDITIONAL INFORMATION*.—

14                   “(A) *IN GENERAL*.—The Secretary shall en-  
15                   sure that the Department of Health and Human  
16                   Services includes, as part of the information pro-  
17                   vided for comparison of nursing homes on the of-  
18                   ficial Internet website of the Federal Government  
19                   for Medicare beneficiaries (commonly referred to  
20                   as the ‘Nursing Home Compare’ Medicare  
21                   website) (or a successor website), the following  
22                   information in a manner that is prominent, eas-  
23                   ily accessible, readily understandable to con-  
24                   sumers of long-term care services, and searchable:

1           “(i) Staffing data for each facility (in-  
2           cluding resident census data and data on  
3           the hours of care provided per resident per  
4           day) based on data submitted under sub-  
5           section (b)(8)(C)(ii), including information  
6           on staffing turnover and tenure, in a for-  
7           mat that is clearly understandable to con-  
8           sumers of long-term care services and allows  
9           such consumers to compare differences in  
10          staffing between facilities and State and na-  
11          tional averages for the facilities. Such for-  
12          mat shall include—

13                 “(I) concise explanations of how  
14                 to interpret the data (such as plain  
15                 English explanation of data reflecting  
16                 ‘nursing home staff hours per resident  
17                 day’);

18                 “(II) differences in types of staff  
19                 (such as training associated with dif-  
20                 ferent categories of staff);

21                 “(III) the relationship between  
22                 nurse staffing levels and quality of  
23                 care; and

1                   “(IV) an explanation that appro-  
2                   priate staffing levels vary based on pa-  
3                   tient case mix.

4                   “(ii) Links to State Internet websites  
5                   with information regarding State survey  
6                   and certification programs, links to Form  
7                   2567 State inspection reports (or a suc-  
8                   cessor form) on such websites, information  
9                   to guide consumers in how to interpret and  
10                  understand such reports, and the facility  
11                  plan of correction or other response to such  
12                  report.

13                  “(iii) The standardized complaint form  
14                  developed under subsection (f)(10), includ-  
15                  ing explanatory material on what com-  
16                  plaint forms are, how they are used, and  
17                  how to file a complaint with the State sur-  
18                  vey and certification program and the State  
19                  long-term care ombudsman program.

20                  “(iv) Summary information on the  
21                  number, type, severity, and outcome of sub-  
22                  stantiated complaints.

23                  “(v) The number of adjudicated in-  
24                  stances of criminal violations by employees  
25                  of a nursing facility—



1                   “(I) that were committed inside of  
2                   the facility; and

3                   “(II) with respect to such in-  
4                   stances of violations or crimes com-  
5                   mitted outside of the facility, that were  
6                   the violations or crimes that resulted  
7                   in the serious bodily injury of an elder.

8                   “(B) DEADLINE FOR PROVISION OF INFOR-  
9                   MATION.—

10                   “(i) IN GENERAL.—Except as provided  
11                   in clause (ii), the Secretary shall ensure  
12                   that the information described in subpara-  
13                   graph (A) is included on such website (or a  
14                   successor website) not later than 1 year  
15                   after the date of the enactment of this sub-  
16                   section.

17                   “(ii) EXCEPTION.—The Secretary shall  
18                   ensure that the information described in  
19                   subparagraph (A)(i) and (A)(iii) is in-  
20                   cluded on such website (or a successor  
21                   website) not later than the date on which  
22                   the requirements under section 1124(c)(4)  
23                   and subsection (b)(8)(C)(ii) are imple-  
24                   mented.

25                   “(2) REVIEW AND MODIFICATION OF WEBSITE.—

1           “(A) *IN GENERAL.*—*The Secretary shall es-*  
2           *tablish a process—*

3                     “(i) *to review the accuracy, clarity of*  
4                     *presentation, timeliness, and comprehensive-*  
5                     *ness of information reported on such website*  
6                     *as of the day before the date of the enact-*  
7                     *ment 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 clause*  
12                    *(i).*

13           “(B) *CONSULTATION.*—*In conducting the*  
14           *review under subparagraph (A)(i), the Secretary*  
15           *shall consult with—*

16                    “(i) *State long-term care ombudsman*  
17                    *programs;*

18                    “(ii) *consumer advocacy groups;*

19                    “(iii) *provider stakeholder groups;*

20                    “(iv) *skilled nursing facility employees*  
21                    *and their representatives; and*

22                    “(v) *any other representatives of pro-*  
23                    *grams or groups the Secretary determines*  
24                    *appropriate.”.*

1           (2) *TIMELINESS OF SUBMISSION OF SURVEY AND*  
2           *CERTIFICATION INFORMATION.*—

3           (A) *IN GENERAL.*—*Section 1919(g)(5) of the*  
4           *Social Security Act (42 U.S.C. 1396r(g)(5)) is*  
5           *amended by adding at the end the following new*  
6           *subparagraph:*

7           “(E) *SUBMISSION OF SURVEY AND CERTIFI-*  
8           *CATION INFORMATION TO THE SECRETARY.*—*In*  
9           *order to improve the timeliness of information*  
10           *made available to the public under subparagraph*  
11           *(A) and provided on the Nursing Home Compare*  
12           *Medicare website under subsection (i), each State*  
13           *shall submit information respecting any survey*  
14           *or certification made respecting a nursing facil-*  
15           *ity (including any enforcement actions taken by*  
16           *the State) to the Secretary not later than the*  
17           *date on which the State sends such information*  
18           *to the facility. The Secretary shall use the infor-*  
19           *mation submitted under the preceding sentence*  
20           *to update the information provided on the Nurs-*  
21           *ing Home Compare Medicare website as expedi-*  
22           *tiously as practicable but not less frequently*  
23           *than quarterly.”.*

1           (B) *EFFECTIVE DATE.*—*The amendment*  
2           *made by this paragraph shall take effect 1 year*  
3           *after the date of the enactment of this Act.*

4           (3) *SPECIAL FOCUS FACILITY PROGRAM.*—*Sec-*  
5           *tion 1919(f) of such Act is amended by adding at the*  
6           *end of the following new paragraph:*

7           “(10) *SPECIAL FOCUS FACILITY PROGRAM.*—

8           “(A) *IN GENERAL.*—*The Secretary shall*  
9           *conduct a special focus facility program for en-*  
10           *forcement of requirements for nursing facilities*  
11           *that the Secretary has identified as having sub-*  
12           *stantially failed to meet applicable requirements*  
13           *of this Act.*

14           “(B) *PERIODIC SURVEYS.*—*Under such pro-*  
15           *gram the Secretary shall conduct surveys of each*  
16           *facility in the program not less often than once*  
17           *every 6 months.”.*

18           (c) *AVAILABILITY OF REPORTS ON SURVEYS, CERTIFI-*  
19           *CATIONS, AND COMPLAINT INVESTIGATIONS.*—

20           (1) *SKILLED NURSING FACILITIES.*—*Section*  
21           *1819(d)(1) of the Social Security Act (42 U.S.C.*  
22           *1395i–3(d)(1)), as amended by sections 1411 and*  
23           *1412, is amended by adding at the end the following*  
24           *new subparagraph:*

1           “(D) AVAILABILITY OF SURVEY, CERTIFI-  
2           CATION, AND COMPLAINT INVESTIGATION RE-  
3           PORTS.—A skilled nursing facility must—

4                   “(i) have reports with respect to any  
5                   surveys, certifications, and complaint inves-  
6                   tigations made respecting the facility dur-  
7                   ing the 3 preceding years available for any  
8                   individual to review upon request; and

9                   “(ii) post notice of the availability of  
10                  such reports in areas of the facility that are  
11                  prominent and accessible to the public.

12           The facility shall not make available under  
13           clause (i) identifying information about com-  
14           plainants or residents.”.

15           (2) NURSING FACILITIES.—Section 1919(d)(1) of  
16           the Social Security Act (42 U.S.C. 1396r(d)(1)), as  
17           amended by sections 1411 and 1412, is amended by  
18           adding at the end the following new subparagraph:

19                   “(D) AVAILABILITY OF SURVEY, CERTIFI-  
20                   CATION, AND COMPLAINT INVESTIGATION RE-  
21                   PORTS.—A nursing facility must—

22                   “(i) have reports with respect to any  
23                   surveys, certifications, and complaint inves-  
24                   tigations made respecting the facility dur-

1            *ing the 3 preceding years available for any*  
2            *individual to review upon request; and*

3            *“(ii) post notice of the availability of*  
4            *such reports in areas of the facility that are*  
5            *prominent and accessible to the public.*

6            *The facility shall not make available under*  
7            *clause (i) identifying information about com-*  
8            *plainants or residents.”.*

9            *(3) EFFECTIVE DATE.—The amendments made*  
10          *by this subsection shall take effect 1 year after the*  
11          *date of the enactment of this Act.*

12          *(d) GUIDANCE TO STATES ON FORM 2567 STATE IN-*  
13          *SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-*  
14          *PORTS.—*

15                  *(1) GUIDANCE.—The Secretary of Health and*  
16          *Human Services (in this subtitle referred to as the*  
17          *“Secretary”) shall provide guidance to States on how*  
18          *States can establish electronic links to Form 2567*  
19          *State inspection reports (or a successor form), com-*  
20          *plaint investigation reports, and a facility’s plan of*  
21          *correction or other response to such Form 2567 State*  
22          *inspection reports (or a successor form) on the Inter-*  
23          *net website of the State that provides information on*  
24          *skilled nursing facilities and nursing facilities and*

1        *the Secretary shall, if possible, include such informa-*  
2        *tion on Nursing Home Compare.*

3            (2) *REQUIREMENT.*—*Section 1902(a)(9) of the*  
4        *Social Security Act (42 U.S.C. 1396a(a)(9)) is*  
5        *amended—*

6            (A) *by striking “and” at the end of sub-*  
7        *paragraph (B);*

8            (B) *by striking the semicolon at the end of*  
9        *subparagraph (C) and inserting “, and”; and*

10          (C) *by adding at the end the following new*  
11        *subparagraph:*

12            “(D) *that the State maintain a consumer-*  
13        *oriented website providing useful information to*  
14        *consumers regarding all skilled nursing facilities*  
15        *and all nursing facilities in the State, including*  
16        *for each facility, Form 2567 State inspection re-*  
17        *ports (or a successor form), complaint investiga-*  
18        *tion reports, the facility’s plan of correction, and*  
19        *such other information that the State or the Sec-*  
20        *retary considers useful in assisting the public to*  
21        *assess the quality of long term care options and*  
22        *the quality of care provided by individual facili-*  
23        *ties;”.*

24          (3) *DEFINITIONS.*—*In this subsection:*

1           (A) *NURSING FACILITY.*—*The term “nurs-*  
2           *ing facility” has the meaning given such term in*  
3           *section 1919(a) of the Social Security Act (42*  
4           *U.S.C. 1396r(a)).*

5           (B) *SECRETARY.*—*The term “Secretary”*  
6           *means the Secretary of Health and Human Serv-*  
7           *ices.*

8           (C) *SKILLED NURSING FACILITY.*—*The term*  
9           *“skilled nursing facility” has the meaning given*  
10           *such term in section 1819(a) of the Social Secu-*  
11           *rity Act (42 U.S.C. 1395i–3(a)).*

12 **SEC. 1414. REPORTING OF EXPENDITURES.**

13           *Section 1888 of the Social Security Act (42 U.S.C.*  
14           *1395yy) is amended by adding at the end the following new*  
15           *subsection:*

16           “(f) *REPORTING OF DIRECT CARE EXPENDITURES.*—

17           “(1) *IN GENERAL.*—*For cost reports submitted*  
18           *under this title for cost reporting periods beginning*  
19           *on or after the date that is 3 years after the date of*  
20           *the enactment of this subsection, skilled nursing fa-*  
21           *cilities shall separately report expenditures for wages*  
22           *and benefits for direct care staff (breaking out (at a*  
23           *minimum) registered nurses, licensed professional*  
24           *nurses, certified nurse assistants, and other medical*  
25           *and therapy staff).*



1           “(2) *MODIFICATION OF FORM.*—*The Secretary,*  
2           *in consultation with private sector accountants expe-*  
3           *rienced with skilled nursing facility cost reports, shall*  
4           *redesign such reports to meet the requirement of para-*  
5           *graph (1) not later than 1 year after the date of the*  
6           *enactment of this subsection.*

7           “(3) *CATEGORIZATION BY FUNCTIONAL AC-*  
8           *COUNTS.*—*Not later than 30 months after the date of*  
9           *the enactment of this subsection, the Secretary, work-*  
10          *ing in consultation with the Medicare Payment Advi-*  
11          *sory Commission, the Inspector General of the De-*  
12          *partment of Health and Human Services, and other*  
13          *expert parties the Secretary determines appropriate,*  
14          *shall take the expenditures listed on cost reports, as*  
15          *modified under paragraph (1), submitted by skilled*  
16          *nursing facilities and categorize such expenditures,*  
17          *regardless of any source of payment for such expendi-*  
18          *tures, for each skilled nursing facility into the fol-*  
19          *lowing functional accounts on an annual basis:*

20                   “(A) *Spending on direct care services (in-*  
21                   *cluding nursing, therapy, and medical services).*

22                   “(B) *Spending on indirect care (including*  
23                   *housekeeping and dietary services).*

24                   “(C) *Capital assets (including building and*  
25                   *land costs).*

1                   “(D) *Administrative services costs.*

2                   “(4) *AVAILABILITY OF INFORMATION SUB-*  
3                   *MITTED.—The Secretary shall establish procedures to*  
4                   *make information on expenditures submitted under*  
5                   *this subsection readily available to interested parties*  
6                   *upon request, subject to such requirements as the Sec-*  
7                   *retary may specify under the procedures established*  
8                   *under this paragraph.”.*

9 **SEC. 1415. STANDARDIZED COMPLAINT FORM.**

10                   (a) *SKILLED NURSING FACILITIES.—*

11                   (1) *DEVELOPMENT BY THE SECRETARY.—Section*  
12                   *1819(f) of the Social Security Act (42 U.S.C. 1395i-*  
13                   *3(f)), as amended by section 1413(a)(3), is amended*  
14                   *by adding at the end the following new 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-term*  
20                   *care ombudsman program with respect to a skilled*  
21                   *nursing facility.”.*

22                   (2) *STATE REQUIREMENTS.—Section 1819(e) of*  
23                   *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 developed*  
5           *under subsection (f)(9) available upon request*  
6           *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 not*  
19           *retaliated against if the resident, legal represent-*  
20           *ative, or responsible party has complained, in*  
21           *good faith, about the quality of care or other*  
22           *issues relating to the skilled nursing facility,*  
23           *that the legal representative of a resident of a*  
24           *skilled nursing facility or other responsible party*  
25           *is not denied access to such resident or otherwise*

1           *retaliated against if such representative party*  
2           *has complained, in good faith, about the quality*  
3           *of care provided by the facility or other issues re-*  
4           *lating to the facility, and that a person who*  
5           *works at a skilled nursing facility is not retali-*  
6           *ated against if the worker has complained, in*  
7           *good faith, about quality of care or services or an*  
8           *issue relating to the quality of care or services*  
9           *provided at the facility, whether the resident,*  
10          *legal representative, other responsible party, or*  
11          *worker used the form developed under subsection*  
12          *(f)(9) or some other method for submitting the*  
13          *complaint. Such complaint resolution process*  
14          *shall include—*

15                   *“(i) procedures to assure accurate*  
16                   *tracking of complaints received, including*  
17                   *notification to the complainant that a com-*  
18                   *plaint has been received;*

19                   *“(ii) procedures to determine the likely*  
20                   *severity of a complaint and for the inves-*  
21                   *tigation of the complaint;*

22                   *“(iii) deadlines for responding to a*  
23                   *complaint and for notifying the complain-*  
24                   *ant of the outcome of the investigation; and*

1           “(iv) procedures to ensure that the  
2           identity of the complainant will be kept  
3           confidential.

4           “(C) WHISTLEBLOWER PROTECTION.—

5           “(i) PROHIBITION AGAINST RETALIA-  
6           TION.—No person who works at a skilled  
7           nursing facility may be penalized, discrimi-  
8           nated, or retaliated against with respect to  
9           any aspect of employment, including dis-  
10          charge, promotion, compensation, terms,  
11          conditions, or privileges of employment, or  
12          have a contract for services terminated, be-  
13          cause the person (or anyone acting at the  
14          person’s request) complained, in good faith,  
15          about the quality of care or services pro-  
16          vided by a nursing facility or about other  
17          issues relating to quality of care or services,  
18          whether using the form developed under sub-  
19          section (f)(9) or some other method for sub-  
20          mitting the complaint.

21          “(ii) RETALIATORY REPORTING.—A  
22          skilled nursing facility may not file a com-  
23          plaint or a report against a person who  
24          works (or has worked at the facility with  
25          the appropriate State professional discipli-

1           nary agency because the person (or anyone  
2           acting at the person's request) complained  
3           in good faith, as described in clause (i).

4           “(iii) COMMENCEMENT OF ACTION.—

5           Any person who believes the person has been  
6           penalized, discriminated , or retaliated  
7           against or had a contract for services termi-  
8           nated in violation of clause (i) or against  
9           whom a complaint has been filed in viola-  
10          tion of clause (ii) may bring an action at  
11          law or equity in the appropriate district  
12          court of the United States, which shall have  
13          jurisdiction over such action without regard  
14          to the amount in controversy or the citizen-  
15          ship of the parties, and which shall have ju-  
16          risdiction to grant complete relief, includ-  
17          ing, but not limited to, injunctive relief  
18          (such as reinstatement, compensatory dam-  
19          ages (which may include reimbursement of  
20          lost wages, compensation, and benefits),  
21          costs of litigation (including reasonable at-  
22          torney and expert witness fees), exemplary  
23          damages where appropriate, and such other  
24          relief as the court deems just and proper.

1           “(iv) *RIGHTS NOT WAIVABLE.*—*The*  
2           *rights protected by this paragraph may not*  
3           *be diminished by contract or other agree-*  
4           *ment, and nothing in this paragraph shall*  
5           *be construed to diminish any greater or ad-*  
6           *ditional protection provided by Federal or*  
7           *State law or by contract or other agreement.*

8           “(v) *REQUIREMENT TO POST NOTICE*  
9           *OF EMPLOYEE RIGHTS.*—*Each skilled nurs-*  
10          *ing facility shall post conspicuously in an*  
11          *appropriate location a sign (in a form spec-*  
12          *ified by the Secretary) specifying the rights*  
13          *of persons under this paragraph and in-*  
14          *cluding a statement that an employee may*  
15          *file a complaint with the Secretary against*  
16          *a skilled nursing facility that violates the*  
17          *provisions of this paragraph and informa-*  
18          *tion with respect to the manner of filing*  
19          *such a complaint.*

20          “(D) *RULE OF CONSTRUCTION.*—*Nothing in*  
21          *this paragraph shall be construed as preventing*  
22          *a resident of a skilled nursing facility (or a per-*  
23          *son acting on the resident’s behalf) from submit-*  
24          *ting a complaint in a manner or format other*  
25          *than by using the standardized complaint form*

1           developed under subsection (f)(9) (including sub-  
2           mitting a complaint orally).

3           “(E) *GOOD FAITH DEFINED.*—For purposes  
4           of this paragraph, an individual shall be deemed  
5           to be acting in good faith with respect to the fil-  
6           ing of a complaint if the individual reasonably  
7           believes—

8                   “(i) the information reported or dis-  
9                   closed in the complaint is true; and

10                   “(ii) the violation of this title has oc-  
11                   curred or may occur in relation to such in-  
12                   formation.”.

13       (b) *NURSING FACILITIES.*—

14           (1) *DEVELOPMENT BY THE SECRETARY.*—Section  
15           1919(f) of the Social Security Act (42 U.S.C. 1395i-  
16           3(f)), as amended by section 1413(b), is amended by  
17           adding at the end the following new paragraph:

18                   “(11) *STANDARDIZED COMPLAINT FORM.*—The  
19                   Secretary shall develop a standardized complaint  
20                   form for use by a resident (or a person acting on the  
21                   resident’s behalf) in filing a complaint with a State  
22                   survey and certification agency and a State long-term  
23                   care ombudsman program with respect to a nursing  
24                   facility.”.



1           (2) *STATE REQUIREMENTS.*—Section 1919(e) of  
2     *the Social Security Act (42 U.S.C. 1395i–3(e)) is*  
3     *amended by adding at the end the following new*  
4     *paragraph:*

5           “(8) *COMPLAINT PROCESSES AND WHISTLE-*  
6     *BLOWER PROTECTION.*—

7           “(A) *COMPLAINT FORMS.*—*The State must*  
8     *make the standardized complaint form developed*  
9     *under subsection (f)(11) available upon request*  
10    *to—*

11           “(i) *a resident of a nursing facility;*

12           “(ii) *any person acting on the resi-*  
13     *dent’s behalf; and*

14           “(iii) *any person who works at a nurs-*  
15     *ing facility or a representative of such a*  
16     *worker.*

17           “(B) *COMPLAINT RESOLUTION PROCESS.*—

18     *The State must establish a complaint resolution*  
19     *process in order to ensure that a resident, the*  
20     *legal representative of a resident of a nursing fa-*  
21     *ility, or other responsible party is not retaliated*  
22     *against if the resident, legal representative, or re-*  
23     *sponsible party has complained, in good faith,*  
24     *about the quality of care or other issues relating*  
25     *to the nursing facility, that the legal representa-*

1           *tive of a resident of a nursing facility or other*  
2           *responsible party is not denied access to such*  
3           *resident or otherwise retaliated against if such*  
4           *representative party has complained, in good*  
5           *faith, about the quality of care provided by the*  
6           *facility or other issues relating to the facility,*  
7           *and that a person who works at a nursing facil-*  
8           *ity is not retaliated against if the worker has*  
9           *complained, in good faith, about quality of care*  
10          *or services or an issue relating to the quality of*  
11          *care or services provided at the facility, whether*  
12          *the resident, legal representative, other respon-*  
13          *sible party, or worker used the form developed*  
14          *under subsection (f)(11) or some other method for*  
15          *submitting the complaint. Such complaint reso-*  
16          *lution process shall include—*

17                   *“(i) procedures to assure accurate*  
18                   *tracking of complaints received, including*  
19                   *notification to the complainant that a com-*  
20                   *plaint has been received;*

21                   *“(ii) procedures to determine the likely*  
22                   *severity of a complaint and for the inves-*  
23                   *tigation of the complaint;*

1           “(iii) deadlines for responding to a  
2           complaint and for notifying the complain-  
3           ant of the outcome of the investigation; and

4           “(iv) procedures to ensure that the  
5           identity of the complainant will be kept  
6           confidential.

7           “(C) WHISTLEBLOWER PROTECTION.—

8           “(i) PROHIBITION AGAINST RETALIA-  
9           TION.—No person who works at a nursing  
10          facility may be penalized, discriminated, or  
11          retaliated against with respect to any as-  
12          pect of employment, including discharge,  
13          promotion, compensation, terms, conditions,  
14          or privileges of employment, or have a con-  
15          tract for services terminated, because the  
16          person (or anyone acting at the person’s re-  
17          quest) complained, in good faith, about the  
18          quality of care or services provided by a  
19          nursing facility or about other issues relat-  
20          ing to quality of care or services, whether  
21          using the form developed under subsection  
22          (f)(11) or some other method for submitting  
23          the complaint.

24          “(ii) RETALIATORY REPORTING.—A  
25          nursing facility may not file a complaint or

1           *a report against a person who works (or has*  
2           *worked at the facility with the appropriate*  
3           *State professional disciplinary agency be-*  
4           *cause the person (or anyone acting at the*  
5           *person's request) complained in good faith,*  
6           *as described in clause (i).*

7           “(iii) *COMMENCEMENT OF ACTION.—*  
8           *Any person who believes the person has been*  
9           *penalized, discriminated, or retaliated*  
10           *against or had a contract for services termi-*  
11           *nated in violation of clause (i) or against*  
12           *whom a complaint has been filed in viola-*  
13           *tion of clause (ii) may bring an action at*  
14           *law or equity in the appropriate district*  
15           *court of the United States, which shall have*  
16           *jurisdiction over such action without regard*  
17           *to the amount in controversy or the citizen-*  
18           *ship of the parties, and which shall have ju-*  
19           *risdiction to grant complete relief, includ-*  
20           *ing, but not limited to, injunctive relief*  
21           *(such as reinstatement, compensatory dam-*  
22           *ages (which may include reimbursement of*  
23           *lost wages, compensation, and benefits),*  
24           *costs of litigation (including reasonable at-*  
25           *torney and expert witness fees), exemplary*

1 *damages where appropriate, and such other*  
2 *relief as the court deems just 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 ad-*  
8 *ditional protection provided by Federal or*  
9 *State law or by contract or other agreement.*

10 *“(v) REQUIREMENT TO POST NOTICE*  
11 *OF EMPLOYEE RIGHTS.—Each nursing fa-*  
12 *cility shall post conspicuously in an appro-*  
13 *priate location a sign (in a form specified*  
14 *by the Secretary) specifying the rights of*  
15 *persons under this paragraph and includ-*  
16 *ing a statement that an employee may file*  
17 *a complaint with the Secretary against a*  
18 *nursing facility that violates the provisions*  
19 *of this paragraph and information with re-*  
20 *spect to the manner of filing such a com-*  
21 *plaint.*

22 *“(D) RULE OF CONSTRUCTION.—Nothing in*  
23 *this paragraph shall be construed as preventing*  
24 *a resident of a nursing facility (or a person act-*  
25 *ing on the resident’s behalf) from submitting a*

1           *complaint in a manner or format other than by*  
2           *using the standardized complaint form developed*  
3           *under subsection (f)(11) (including submitting a*  
4           *complaint orally).*

5           “(E) *GOOD FAITH DEFINED.*—*For purposes*  
6           *of this paragraph, an individual shall be deemed*  
7           *to be acting in good faith with respect to the fil-*  
8           *ing of a complaint if the individual reasonably*  
9           *believes—*

10                   “(i) *the information reported or dis-*  
11                   *closed in the complaint is true; and*

12                   “(ii) *the violation of this title has oc-*  
13                   *curred or may occur in relation to such in-*  
14                   *formation.”.*

15           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
16           *section shall take effect 1 year after the date of the enact-*  
17           *ment of this Act.*

18   **SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.**

19           (a) *SKILLED NURSING FACILITIES.*—*Section*  
20           *1819(b)(8) of the Social Security Act (42 U.S.C. 1395i-*  
21           *3(b)(8)) is amended by adding at the end the following new*  
22           *subparagraph:*

23                   “(C) *SUBMISSION OF STAFFING INFORMA-*  
24                   *TION BASED ON PAYROLL DATA IN A UNIFORM*  
25                   *FORMAT.*—*Beginning not later than 2 years*

1           *after the date of the enactment of this subpara-*  
2           *graph, and after consulting with State long-term*  
3           *care ombudsman programs, consumer advocacy*  
4           *groups, provider stakeholder groups, employees*  
5           *and their representatives, and other parties the*  
6           *Secretary deems appropriate, the Secretary shall*  
7           *require a skilled nursing facility to electronically*  
8           *submit to the Secretary direct care staffing infor-*  
9           *mation (including information with respect to*  
10           *agency and contract staff) based on payroll and*  
11           *other verifiable and auditable data in a uniform*  
12           *format (according to specifications established by*  
13           *the Secretary in consultation with such pro-*  
14           *grams, groups, and parties). Such specifications*  
15           *shall require that the information submitted*  
16           *under the preceding sentence—*

17                   *“(i) specify the category of work a cer-*  
18                   *tified employee performs (such as whether*  
19                   *the employee is a registered nurse, licensed*  
20                   *practical nurse, licensed vocational nurse,*  
21                   *certified nursing assistant, therapist, or*  
22                   *other medical personnel);*

23                   *“(ii) include resident census data and*  
24                   *information on resident case mix;*

1           “(iii) include a regular reporting  
2           schedule; and

3           “(iv) include information on employee  
4           turnover and tenure and on the hours of  
5           care provided by each category of certified  
6           employees referenced in clause (i) per resi-  
7           dent per day.

8           *Nothing in this subparagraph shall be construed*  
9           *as preventing the Secretary from requiring sub-*  
10           *mission of such information with respect to spe-*  
11           *cific categories, such as nursing staff, before*  
12           *other categories of certified employees. Informa-*  
13           *tion under this subparagraph with respect to*  
14           *agency and contract staff shall be kept separate*  
15           *from information on employee staffing.”.*

16           **(b) NURSING FACILITIES.**—Section 1919(b)(8) of the  
17           *Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by*  
18           *adding at the end the following new subparagraph:*

19           “(C) **SUBMISSION OF STAFFING INFORMA-**  
20           **TION BASED ON PAYROLL DATA IN A UNIFORM**  
21           **FORMAT.**—*Beginning not later than 2 years*  
22           *after the date of the enactment of this subpara-*  
23           *graph, and after consulting with State long-term*  
24           *care ombudsman programs, consumer advocacy*  
25           *groups, provider stakeholder groups, employees*



1           *and their representatives, and other parties the*  
2           *Secretary deems appropriate, the Secretary shall*  
3           *require a nursing facility to electronically sub-*  
4           *mit to the Secretary direct care staffing informa-*  
5           *tion (including information with respect to agen-*  
6           *cy and contract staff) based on payroll and other*  
7           *verifiable and auditable data in a uniform for-*  
8           *mat (according to specifications established by*  
9           *the Secretary in consultation with such pro-*  
10          *grams, groups, and parties). Such specifications*  
11          *shall require that the information submitted*  
12          *under the preceding sentence—*

13                   *“(i) specify the category of work a cer-*  
14                   *tified employee performs (such as whether*  
15                   *the employee is a registered nurse, licensed*  
16                   *practical nurse, licensed vocational nurse,*  
17                   *certified nursing assistant, therapist, or*  
18                   *other medical personnel);*

19                   *“(ii) include resident census data and*  
20                   *information on resident case mix;*

21                   *“(iii) include a regular reporting*  
22                   *schedule; and*

23                   *“(iv) include information on employee*  
24                   *turnover and tenure and on the hours of*  
25                   *care provided by each category of certified*

1            *employees referenced in clause (i) per resi-*  
2            *dent per day.*

3            *Nothing in this subparagraph shall be construed*  
4            *as preventing the Secretary from requiring sub-*  
5            *mission of such information with respect to spe-*  
6            *cific categories, such as nursing staff, before*  
7            *other categories of certified employees. Informa-*  
8            *tion under this subparagraph with respect to*  
9            *agency and contract staff shall be kept separate*  
10           *from information on employee staffing.”.*

11            ***PART 2—TARGETING ENFORCEMENT***

12            ***SEC. 1421. CIVIL MONEY PENALTIES.***

13            *(a) SKILLED NURSING FACILITIES.—*

14            *(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of*  
15            *the Social Security Act (42 U.S.C. 1395i-*  
16            *3(h)(2)(B)(ii)) is amended to read as follows:*

17                            *“(ii) AUTHORITY WITH RESPECT TO*  
18                            *CIVIL MONEY PENALTIES.—*

19                                    *“(I) AMOUNT.—The Secretary*  
20                                    *may impose a civil money penalty in*  
21                                    *the applicable per instance or per day*  
22                                    *amount (as defined in subclause (II)*  
23                                    *and (III)) for each day or instance, re-*  
24                                    *spectively, of noncompliance (as deter-*  
25                                    *mined appropriate by the Secretary).*

1                   “(II) *APPLICABLE PER INSTANCE*  
2                   *AMOUNT.*—*In this clause, the term ‘ap-*  
3                   *plicable per instance amount’ means—*

4                   “*(aa) in the case where the*  
5                   *deficiency is found to be a direct*  
6                   *proximate cause of death of a resi-*  
7                   *dent of the facility, an amount*  
8                   *not to exceed \$100,000;*

9                   “*(bb) in each case of a defi-*  
10                   *ciency where the facility is cited*  
11                   *for actual harm or immediate*  
12                   *jeopardy, an amount not less than*  
13                   *\$3,050 and not more than*  
14                   *\$25,000; and*

15                   “*(cc) in each case of any*  
16                   *other deficiency, an amount not*  
17                   *less than \$250 and not to exceed*  
18                   *\$3050.*

19                   “(III) *APPLICABLE PER DAY*  
20                   *AMOUNT.*—*In this clause, the term ‘ap-*  
21                   *plicable per day amount’ means—*

22                   “*(aa) in each case of a defi-*  
23                   *ciency where the facility is cited*  
24                   *for actual harm or immediate*  
25                   *jeopardy, an amount not less than*

1                   \$3,050 and not more than  
2                   \$25,000, and

3                   “(bb) in each case of any  
4                   other deficiency, an amount not  
5                   less than \$250 and not to exceed  
6                   \$3,050.

7                   “(IV) REDUCTION OF CIVIL  
8                   MONEY PENALTIES IN CERTAIN CIR-  
9                   CUMSTANCES.—Subject to subclauses  
10                  (V) and (VI), in the case where a facil-  
11                  ity self-reports and promptly corrects a  
12                  deficiency for which a penalty was im-  
13                  posed under this clause not later than  
14                  10 calendar days after the date of such  
15                  imposition, the Secretary may reduce  
16                  the amount of the penalty imposed by  
17                  not more than 50 percent.

18                  “(V) PROHIBITION ON REDUCTION  
19                  FOR CERTAIN DEFICIENCIES.—

20                  “(aa) REPEAT DEFICI-  
21                  CIENCIES.—The Secretary may  
22                  not reduce under subclause (IV)  
23                  the amount of a penalty if the de-  
24                  ficiency is a repeat deficiency.

1                   “(bb) *CERTAIN OTHER DEFICIENCIES.*—*The Secretary may*  
2                   *not reduce under subclause (IV)*  
3                   *the amount of a penalty if the*  
4                   *penalty is imposed for a defi-*  
5                   *ciency described in subclause*  
6                   *(II)(aa) or (III)(aa) and the ac-*  
7                   *tual harm or widespread harm*  
8                   *immediately jeopardizes the health*  
9                   *or safety of a resident or residents*  
10                   *of the facility, or if the penalty is*  
11                   *imposed for a deficiency described*  
12                   *in subclause (II)(bb).*

13                   “(VI) *LIMITATION ON AGGREGATE*  
14                   *REDUCTIONS.*—*The aggregate reduction*  
15                   *in a penalty under subclause (IV) may*  
16                   *not exceed 35 percent on the basis of*  
17                   *self-reporting, on the basis of a waiver*  
18                   *or an appeal (as provided for under*  
19                   *regulations under section 488.436 of*  
20                   *title 42, Code of Federal Regulations),*  
21                   *or on the basis of both.*

22                   “(VII) *COLLECTION OF CIVIL*  
23                   *MONEY PENALTIES.*—*In the case of a*  
24

1 *civil money penalty imposed under*  
2 *this clause, the Secretary—*

3 *“(aa) subject to item (cc),*  
4 *shall, not later than 30 days after*  
5 *the date of imposition of the pen-*  
6 *alty, provide the opportunity for*  
7 *the facility to participate in an*  
8 *independent informal dispute res-*  
9 *olution process which generates a*  
10 *written record prior to the collec-*  
11 *tion of such penalty, but such op-*  
12 *portunity shall not affect the re-*  
13 *sponsibility of the State survey*  
14 *agency for making final rec-*  
15 *ommendations for such penalties;*

16 *“(bb) in the case where the*  
17 *penalty is imposed for each day of*  
18 *noncompliance, shall not impose a*  
19 *penalty for any day during the*  
20 *period beginning on the initial*  
21 *day of the imposition of the pen-*  
22 *alty and ending on the day on*  
23 *which the informal dispute resolu-*  
24 *tion process under item (aa) is*  
25 *completed;*

1           “(cc) may provide for the col-  
2           lection of such civil money pen-  
3           alty and the placement of such  
4           amounts collected in an escrow  
5           account under the direction of the  
6           Secretary on the earlier of the  
7           date on which the informal dis-  
8           pute resolution process under item  
9           (aa) is completed or the date that  
10          is 90 days after the date of the  
11          imposition of the penalty;

12          “(dd) may provide that such  
13          amounts collected are kept in such  
14          account pending the resolution of  
15          any subsequent appeals;

16          “(ee) in the case where the  
17          facility successfully appeals the  
18          penalty, may provide for the re-  
19          turn of such amounts collected  
20          (plus interest) to the facility; and

21          “(ff) in the case where all  
22          such appeals are unsuccessful,  
23          may provide that some portion of  
24          such amounts collected may be  
25          used to support activities that

1 benefit residents, including assist-  
2 ance to support and protect resi-  
3 dents of a facility that closes (vol-  
4 untarily or involuntarily) or is  
5 decertified (including offsetting  
6 costs of relocating residents to  
7 home and community-based set-  
8 tings or another facility), projects  
9 that support resident and family  
10 councils and other consumer in-  
11 volvement in assuring quality  
12 care in facilities, and facility im-  
13 provement initiatives approved by  
14 the Secretary (including joint  
15 training of facility staff and sur-  
16 veyors, technical assistance for fa-  
17 cilities under quality assurance  
18 programs, the appointment of  
19 temporary management, and  
20 other activities approved by the  
21 Secretary).

22 “(VIII) PROCEDURE.—The provi-  
23 sions of section 1128A (other than sub-  
24 sections (a) and (b) and except to the  
25 extent that such provisions require a



1                    *hearing prior to the imposition of a*  
2                    *civil money penalty) shall apply to a*  
3                    *civil money penalty under this clause*  
4                    *in the same manner as such provisions*  
5                    *apply to a penalty or proceeding under*  
6                    *section 1128A(a).”.*

7                    (2) *CONFORMING AMENDMENT.—The second sen-*  
8                    *tence of section 1819(h)(5) of the Social Security Act*  
9                    *(42 U.S.C. 1395i–3(h)(5)) is amended by inserting*  
10                    *“(ii),” after “(i),”.*

11                    (b) *NURSING FACILITIES.—*

12                    (1) *PENALTIES IMPOSED BY THE STATE.—*

13                    (A) *IN GENERAL.—Section 1919(h)(2) of the*  
14                    *Social Security Act (42 U.S.C. 1396r(h)(2)) is*  
15                    *amended—*

16                    (i) *in subparagraph (A)(ii), by strik-*  
17                    *ing the first sentence and inserting the fol-*  
18                    *lowing: “A civil money penalty in accord-*  
19                    *ance with subparagraph (G).”; and*

20                    (ii) *by adding at the end the following*  
21                    *new subparagraph:*

22                    *“(G) CIVIL MONEY PENALTIES.—*

23                    *“(i) IN GENERAL.—The State may im-*  
24                    *pose a civil money penalty under subpara-*  
25                    *graph (A)(ii) in the applicable per instance*

1                   or per day amount (as defined in subclause  
2                   (II) and (III)) for each day or instance, re-  
3                   spectively, of noncompliance (as determined  
4                   appropriate by the Secretary).

5                   “(ii) *APPLICABLE PER INSTANCE*  
6                   *AMOUNT.*—In this subparagraph, the term  
7                   ‘applicable per instance amount’ means—

8                   “(I) in the case where the defi-  
9                   ciency is found to be a direct proxi-  
10                  mate cause of death of a resident of the  
11                  facility, an amount not to exceed  
12                  \$100,000.

13                  “(II) in each case of a deficiency  
14                  where the facility is cited for actual  
15                  harm or immediate jeopardy, an  
16                  amount not less than \$3,050 and not  
17                  more than \$25,000; and

18                  “(III) in each case of any other  
19                  deficiency, an amount not less than  
20                  \$250 and not to exceed \$3050.

21                  “(iii) *APPLICABLE PER DAY*  
22                  *AMOUNT.*—In this subparagraph, the term  
23                  ‘applicable per day amount’ means—

24                  “(I) in each case of a deficiency  
25                  where the facility is cited for actual

1           *harm or immediate jeopardy, an*  
2           *amount not less than \$3,050 and not*  
3           *more than \$25,000 and*

4                   “(II) *in each case of any other de-*  
5           *ficiency, an amount not less than \$250*  
6           *and not to exceed \$3,050.*

7                   “(iv) *REDUCTION OF CIVIL MONEY*  
8           *PENALTIES IN CERTAIN CIRCUMSTANCES.—*

9           *Subject to clauses (v) and (vi), in the case*  
10          *where a facility self-reports and promptly*  
11          *corrects a deficiency for which a penalty*  
12          *was imposed under subparagraph (A)(ii)*  
13          *not later than 10 calendar days after the*  
14          *date of such imposition, the State may re-*  
15          *duce the amount of the penalty imposed by*  
16          *not more than 50 percent.*

17                   “(v) *PROHIBITION ON REDUCTION FOR*  
18          *CERTAIN DEFICIENCIES.—*

19                   “(I) *REPEAT DEFICIENCIES.—The*  
20          *State may not reduce under clause (iv)*  
21          *the amount of a penalty if the State*  
22          *had reduced a penalty imposed on the*  
23          *facility in the preceding year under*  
24          *such clause with respect to a repeat de-*  
25          *ficiency.*

1                   “(II) CERTAIN OTHER DEFICI-  
2                   CIENCIES.—The State may not reduce  
3                   under clause (iv) the amount of a pen-  
4                   alty if the penalty is imposed for a de-  
5                   ficiency described in clause (ii)(II) or  
6                   (iii)(I) and the actual harm or wide-  
7                   spread harm that immediately jeopard-  
8                   izes the health or safety of a resident or  
9                   residents of the facility, or if the pen-  
10                  alty is imposed for a deficiency de-  
11                  scribed in clause (ii)(I).

12                   “(III) LIMITATION ON AGGREGATE  
13                   REDUCTIONS.—The aggregate reduction  
14                   in a penalty under clause (iv) may not  
15                   exceed 35 percent on the basis of self-  
16                   reporting, on the basis of a waiver or  
17                   an appeal (as provided for under regu-  
18                   lations under section 488.436 of title  
19                   42, Code of Federal Regulations), or on  
20                   the basis of both.

21                   “(vi) COLLECTION OF CIVIL MONEY  
22                   PENALTIES.—In the case of a civil money  
23                   penalty imposed under subparagraph  
24                   (A)(ii), the State—

1           “(I) subject to subclause (III),  
2           shall, not later than 30 days after the  
3           date of imposition of the penalty, pro-  
4           vide the opportunity for the facility to  
5           participate in an independent infor-  
6           mal dispute resolution process which  
7           generates a written record prior to the  
8           collection of such penalty, but such op-  
9           portunity shall not affect the responsi-  
10          bility of the State survey agency for  
11          making final recommendations for  
12          such penalties;

13           “(II) in the case where the pen-  
14          alty is imposed for each day of non-  
15          compliance, shall not impose a penalty  
16          for any day during the period begin-  
17          ning on the initial day of the imposi-  
18          tion of the penalty and ending on the  
19          day on which the informal dispute res-  
20          olution process under subclause (I) is  
21          completed;

22           “(III) may provide for the collec-  
23          tion of such civil money penalty and  
24          the placement of such amounts collected  
25          in an escrow account under the direc-

1            *tion of the State on the earlier of the*  
2            *date on which the informal dispute res-*  
3            *olution process under subclause (I) is*  
4            *completed or the date that is 90 days*  
5            *after the date of the imposition of the*  
6            *penalty;*

7            *“(IV) may provide that such*  
8            *amounts collected are kept in such ac-*  
9            *count pending the resolution of any*  
10           *subsequent appeals;*

11           *“(V) in the case where the facility*  
12           *successfully appeals the penalty, may*  
13           *provide for the return of such amounts*  
14           *collected (plus interest) to the facility;*  
15           *and*

16           *“(VI) in the case where all such*  
17           *appeals are unsuccessful, may provide*  
18           *that such funds collected shall be used*  
19           *for the purposes described in the second*  
20           *sentence of subparagraph (A)(i).”.*

21           *(B) CONFORMING AMENDMENT.—The second*  
22           *sentence of section 1919(h)(2)(A)(ii) of the Social*  
23           *Security Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is*  
24           *amended by inserting before the period at the*  
25           *end the following: “, and some portion of such*

1        *funds may be used to support activities that ben-*  
2        *efit residents, including assistance to support*  
3        *and protect residents of a facility that closes*  
4        *(voluntarily or involuntarily) or is decertified*  
5        *(including offsetting costs of relocating residents*  
6        *to home and community-based settings or an-*  
7        *other facility), projects that support resident and*  
8        *family councils and other consumer involvement*  
9        *in assuring quality care in facilities, and facil-*  
10       *ity improvement initiatives approved by the Sec-*  
11       *retary (including joint training of facility staff*  
12       *and surveyors, providing technical assistance to*  
13       *facilities under quality assurance programs, the*  
14       *appointment of temporary management, and*  
15       *other activities approved by the Secretary)”.*

16       (2) *PENALTIES IMPOSED BY THE SECRETARY.—*

17                (A)                *IN                GENERAL.—Section*  
18       *1919(h)(3)(C)(i) of the Social Security Act (42*  
19       *U.S.C. 1396r(h)(3)(C)) is amended to read as*  
20       *follows:*

21                                *“(i) AUTHORITY WITH RESPECT TO*  
22                                *CIVIL MONEY PENALTIES.—*

23                                        *“(I) AMOUNT.—Subject to sub-*  
24                                        *clause (II), the Secretary may impose*  
25                                        *a civil money penalty in an amount*

1            *not to exceed \$10,000 for each day or*  
2            *each instance of noncompliance (as de-*  
3            *termined appropriate by the Sec-*  
4            *retary).*

5            *“(II) REDUCTION OF CIVIL MONEY*  
6            *PENALTIES IN CERTAIN CIR-*  
7            *CUMSTANCES.—Subject to subclause*  
8            *(III), in the case where a facility self-*  
9            *reports and promptly corrects a defi-*  
10           *ciency for which a penalty was im-*  
11           *posed under this clause not later than*  
12           *10 calendar days after the date of such*  
13           *imposition, the Secretary may reduce*  
14           *the amount of the penalty imposed by*  
15           *not more than 50 percent.*

16           *“(III) PROHIBITION ON REDUC-*  
17           *TION FOR REPEAT DEFICIENCIES.—The*  
18           *Secretary may not reduce the amount*  
19           *of a penalty under subclause (II) if the*  
20           *Secretary had reduced a penalty im-*  
21           *posed on the facility in the preceding*  
22           *year under such subclause with respect*  
23           *to a repeat deficiency.*

24           *“(IV) COLLECTION OF CIVIL*  
25           *MONEY PENALTIES.—In the case of a*



1 *civil money penalty imposed under*  
2 *this clause, the Secretary—*

3 *“(aa) subject to item (bb),*  
4 *shall, not later than 30 days after*  
5 *the date of imposition of the pen-*  
6 *alty, provide the opportunity for*  
7 *the facility to participate in an*  
8 *independent informal dispute res-*  
9 *olution process which generates a*  
10 *written record prior to the collec-*  
11 *tion of such penalty;*

12 *“(bb) in the case where the*  
13 *penalty is imposed for each day of*  
14 *noncompliance, shall not impose a*  
15 *penalty for any day during the*  
16 *period beginning on the initial*  
17 *day of the imposition of the pen-*  
18 *alty and ending on the day on*  
19 *which the informal dispute resolu-*  
20 *tion process under item (aa) is*  
21 *completed;*

22 *“(cc) may provide for the col-*  
23 *lection of such civil money pen-*  
24 *alty and the placement of such*  
25 *amounts collected in an escrow*

1                    *account under the direction of the*  
2                    *Secretary on the earlier of the*  
3                    *date on which the informal dis-*  
4                    *pute resolution process under item*  
5                    *(aa) is completed or the date that*  
6                    *is 90 days after the date of the*  
7                    *imposition of the penalty;*

8                    *“(dd) may provide that such*  
9                    *amounts collected are kept in such*  
10                   *account pending the resolution of*  
11                   *any subsequent appeals;*

12                   *“(ee) in the case where the*  
13                   *facility successfully appeals the*  
14                   *penalty, may provide for the re-*  
15                   *turn of such amounts collected*  
16                   *(plus interest) to the facility; and*

17                   *“(ff) in the case where all*  
18                   *such appeals are unsuccessful,*  
19                   *may provide that some portion of*  
20                   *such amounts collected may be*  
21                   *used to support activities that*  
22                   *benefit residents, including assist-*  
23                   *ance to support and protect resi-*  
24                   *dents of a facility that closes (vol-*  
25                   *untarily or involuntarily) or is*

1            *decertified (including offsetting*  
2            *costs of relocating residents to*  
3            *home and community-based set-*  
4            *tings or another facility), projects*  
5            *that support resident and family*  
6            *councils and other consumer in-*  
7            *volvement in assuring quality*  
8            *care in facilities, and facility im-*  
9            *provement initiatives approved by*  
10           *the Secretary (including joint*  
11           *training of facility staff and sur-*  
12           *veyors, technical assistance for fa-*  
13           *cilities under quality assurance*  
14           *programs, the appointment of*  
15           *temporary management, and*  
16           *other activities approved by the*  
17           *Secretary).*

18           “(V) *PROCEDURE.—The provi-*  
19           *sions of section 1128A (other than sub-*  
20           *sections (a) and (b) and except to the*  
21           *extent that such provisions require a*  
22           *hearing prior to the imposition of a*  
23           *civil money penalty) shall apply to a*  
24           *civil money penalty under this clause*  
25           *in the same manner as such provisions*

1                   *apply to a penalty or proceeding under*  
2                   *section 1128A(a).”.*

3                   (B) *CONFORMING AMENDMENT.*—*Section*  
4                   *1919(h)(8) of the Social Security Act (42 U.S.C.*  
5                   *1396r(h)(5)(8)) is amended by inserting “and in*  
6                   *paragraph (3)(C)(ii)” after “paragraph (2)(A)”.*

7                   (c) *EFFECTIVE DATE.*—*The amendments made by this*  
8                   *section shall take effect 1 year after the date of the enact-*  
9                   *ment of this Act.*

10 **SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PRO-**  
11 **GRAM.**

12                   (a) *ESTABLISHMENT.*—

13                   (1) *IN GENERAL.*—*The Secretary, in consultation*  
14                   *with the Inspector General of the Department of*  
15                   *Health and Human Services, shall establish a pilot*  
16                   *program (in this section referred to as the “pilot pro-*  
17                   *gram”) to develop, test, and implement use of an*  
18                   *independent monitor to oversee interstate and large*  
19                   *intrastate chains of skilled nursing facilities and*  
20                   *nursing facilities.*

21                   (2) *SELECTION.*—*The Secretary shall select*  
22                   *chains of skilled nursing facilities and nursing facili-*  
23                   *ties described in paragraph (1) to participate in the*  
24                   *pilot program from among those chains that submit*  
25                   *an application to the Secretary at such time, in such*

1        *manner, and containing such information as the Sec-*  
2        *retary may require.*

3            (3) *DURATION.*—*The Secretary shall conduct the*  
4        *pilot program for a two-year period.*

5            (4) *IMPLEMENTATION.*—*The Secretary shall im-*  
6        *plement the pilot program not later than one year*  
7        *after the date of the enactment of this Act.*

8            (b) *REQUIREMENTS.*—*The Secretary shall evaluate*  
9        *chains selected to participate in the pilot program based*  
10       *on criteria selected by the Secretary, including where evi-*  
11       *dence suggests that one or more facilities of the chain are*  
12       *experiencing serious safety and quality of care problems.*  
13       *Such criteria may include the evaluation of a chain that*  
14       *includes one or more facilities participating in the “Special*  
15       *Focus Facility” program (or a successor program) or one*  
16       *or more facilities with a record of repeated serious safety*  
17       *and quality of care deficiencies.*

18            (c) *RESPONSIBILITIES OF THE INDEPENDENT MON-*  
19       *ITOR.*—*An independent monitor that enters into a contract*  
20       *with the Secretary to participate in the conduct of such pro-*  
21       *gram shall—*

22            (1) *conduct periodic reviews and prepare root-*  
23       *cause quality and deficiency analyses of a chain to*  
24       *assess if facilities of the chain are in compliance with*

1       *State and Federal laws and regulations applicable to*  
2       *the facilities;*

3             (2) *undertake sustained oversight of the chain,*  
4       *whether publicly or privately held, to involve the own-*  
5       *ers of the chain and the principal business partners*  
6       *of such owners in facilitating compliance by facilities*  
7       *of the chain with State and Federal laws and regula-*  
8       *tions applicable to the facilities;*

9             (3) *analyze the management structure, distribu-*  
10       *tion of expenditures, and nurse staffing levels of fa-*  
11       *cilities of the chain in relation to resident census,*  
12       *staff turnover rates, and tenure;*

13            (4) *report findings and recommendations with*  
14       *respect to such reviews, analyses, and oversight to the*  
15       *chain and facilities of the chain, to the Secretary and*  
16       *to relevant States; and*

17            (5) *publish the results of such reviews, analyses,*  
18       *and oversight.*

19        (d) *IMPLEMENTATION OF RECOMMENDATIONS.—*

20            (1) *RECEIPT OF FINDING BY CHAIN.—Not later*  
21       *than 10 days after receipt of a finding of an inde-*  
22       *pendent monitor under subsection (c)(4), a chain par-*  
23       *ticipating in the pilot program shall submit to the*  
24       *independent monitor a report—*

1           (A) *outlining corrective actions the chain*  
2           *will take to implement the recommendations in*  
3           *such report; or*

4           (B) *indicating that the chain will not im-*  
5           *plement such recommendations and why it will*  
6           *not do so.*

7           (2) *RECEIPT OF REPORT BY INDEPENDENT MON-*  
8           *ITOR.—Not later than 10 days after the date of re-*  
9           *ceipt of a report submitted by a chain under para-*  
10          *graph (1), an independent monitor shall finalize its*  
11          *recommendations and submit a report to the chain*  
12          *and facilities of the chain, the Secretary, and the*  
13          *State (or States) involved, as appropriate, containing*  
14          *such final recommendations.*

15          (e) *COST OF APPOINTMENT.—A chain shall be respon-*  
16          *sible for a portion of the costs associated with the appoint-*  
17          *ment of independent monitors under the pilot program. The*  
18          *chain shall pay such portion to the Secretary (in an*  
19          *amount and in accordance with procedures established by*  
20          *the Secretary).*

21          (f) *WAIVER AUTHORITY.—The Secretary may waive*  
22          *such requirements of titles XVIII and XIX of the Social Se-*  
23          *curity Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may*  
24          *be necessary for the purpose of carrying out the pilot pro-*  
25          *gram.*

1       (g) *AUTHORIZATION OF APPROPRIATIONS.*—*There are*  
2 *authorized to be appropriated such sums as may be nec-*  
3 *essary to carry out this section.*

4       (h) *DEFINITIONS.*—*In this section:*

5           (1) *FACILITY.*—*The term “facility” means a*  
6 *skilled nursing facility or a nursing facility.*

7           (2) *NURSING FACILITY.*—*The term “nursing fa-*  
8 *cility” has the meaning given such term in section*  
9 *1919(a) of the Social Security Act (42 U.S.C.*  
10 *1396r(a)).*

11          (3) *SECRETARY.*—*The term “Secretary” means*  
12 *the Secretary of Health and Human Services, acting*  
13 *through the Assistant Secretary for Planning and*  
14 *Evaluation.*

15          (4) *SKILLED NURSING FACILITY.*—*The term*  
16 *“skilled nursing facility” has the meaning given such*  
17 *term in section 1819(a) of the Social Security Act (42*  
18 *U.S.C. 1395(a)).*

19       (i) *EVALUATION AND REPORT.*—

20           (1) *EVALUATION.*—*The Inspector General of the*  
21 *Department of Health and Human Services shall*  
22 *evaluate the pilot program. Such evaluation shall—*

23                   (A) *determine whether the independent*  
24 *monitor program should be established on a per-*  
25 *manent basis; and*



1           (B) if the Inspector General determines that  
2           the independent monitor program should be es-  
3           tablished on a permanent basis, recommend ap-  
4           propriate procedures and mechanisms for such  
5           establishment.

6           (2) *REPORT.*—Not later than 180 days after the  
7           completion of the pilot program, the Inspector Gen-  
8           eral shall submit to Congress and the Secretary a re-  
9           port containing the results of the evaluation con-  
10          ducted under paragraph (1), together with rec-  
11          ommendations for such legislation and administrative  
12          action as the Inspector General determines appro-  
13          priate.

14 **SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.**

15        (a) *SKILLED NURSING FACILITIES.*—

16           (1) *IN GENERAL.*—Section 1819(c) of the Social  
17           Security Act (42 U.S.C. 1395i–3(c)) is amended by  
18           adding at the end the following new paragraph:

19           “(7) *NOTIFICATION OF FACILITY CLOSURE.*—

20           “(A) *IN GENERAL.*—Any individual who is  
21           the administrator of a skilled nursing facility  
22           must—

23           “(i) submit to the Secretary, the State  
24           long-term care ombudsman, residents of the  
25           facility, and the legal representatives of

1           *such residents or other responsible parties,*  
2           *written notification of an impending clo-*  
3           *sure—*

4                     *“(I) subject to subclause (II), not*  
5                     *later than the date that is 60 days*  
6                     *prior to the date of such closure; and*

7                     *“(II) in the case of a facility*  
8                     *where the Secretary terminates the fa-*  
9                     *ility’s participation under this title,*  
10                    *not later than the date that the Sec-*  
11                    *retary determines appropriate;*

12                    *“(ii) ensure that the facility does not*  
13                    *admit any new residents on or after the*  
14                    *date on which such written notification is*  
15                    *submitted; and*

16                    *“(iii) include in the notice a plan for*  
17                    *the transfer and adequate relocation of the*  
18                    *residents of the facility by a specified date*  
19                    *prior to closure that has been approved by*  
20                    *the State, including assurances that the*  
21                    *residents will be transferred to the most ap-*  
22                    *propriate facility or other setting in terms*  
23                    *of quality, services, and location, taking*  
24                    *into consideration the needs and best inter-*  
25                    *ests of each resident.*

1           “(B) *RELOCATION.*—

2                   “(i) *IN GENERAL.*—*The State shall en-*  
3                   *sure that, before a facility closes, all resi-*  
4                   *dents of the facility have been successfully*  
5                   *relocated to another facility or an alter-*  
6                   *native home and community-based setting.*

7                   “(ii) *CONTINUATION OF PAYMENTS*  
8                   *UNTIL RESIDENTS RELOCATED.*—*The Sec-*  
9                   *retary may, as the Secretary determines ap-*  
10                   *propriate, continue to make payments*  
11                   *under this title with respect to residents of*  
12                   *a facility that has submitted a notification*  
13                   *under subparagraph (A) during the period*  
14                   *beginning on the date such notification is*  
15                   *submitted and ending on the date on which*  
16                   *the resident is successfully relocated.”.*

17           (2) *CONFORMING AMENDMENTS.*—*Section*  
18           *1819(h)(4) of the Social Security Act (42 U.S.C.*  
19           *1395i–3(h)(4)) is amended—*

20                   (A) *in the first sentence, by striking “the*  
21                   *Secretary shall terminate” and inserting “the*  
22                   *Secretary, subject to subsection (c)(7), shall ter-*  
23                   *minate”;* and

1           (B) *in the second sentence, by striking “sub-*  
2           *section (c)(2)” and inserting “paragraphs (2)*  
3           *and (7) of subsection (c)”.*

4           **(b) NURSING FACILITIES.—**

5           (1) *IN GENERAL.—Section 1919(c) of the Social*  
6           *Security Act (42 U.S.C. 1396r(c)) is amended by*  
7           *adding at the end the following new paragraph:*

8           **“(9) NOTIFICATION OF FACILITY CLOSURE.—**

9           **“(A) IN GENERAL.—Any individual who is**  
10           *an administrator of a nursing facility must—*

11                   *“(i) submit to the Secretary, the State*  
12                   *long-term care ombudsman, residents of the*  
13                   *facility, and the legal representatives of*  
14                   *such residents or other responsible parties,*  
15                   *written notification of an impending clo-*  
16                   *sure—*

17                           *“(I) subject to subclause (II), not*  
18                           *later than the date that is 60 days*  
19                           *prior to the date of such closure; and*

20                                   *“(II) in the case of a facility*  
21                                   *where the Secretary terminates the fa-*  
22                                   *ility’s participation under this title,*  
23                                   *not later than the date that the Sec-*  
24                                   *retary determines appropriate;*

1           “(ii) ensure that the facility does not  
2 admit any new residents on or after the  
3 date on which such written notification is  
4 submitted; and

5           “(iii) include in the notice a plan for  
6 the transfer and adequate relocation of the  
7 residents of the facility by a specified date  
8 prior to closure that has been approved by  
9 the State, including assurances that the  
10 residents will be transferred to the most ap-  
11 propriate facility or other setting in terms  
12 of quality, services, and location, taking  
13 into consideration the needs and best inter-  
14 ests of each resident.

15       “(B) RELOCATION.—

16           “(i) IN GENERAL.—The State shall en-  
17 sure that, before a facility closes, all resi-  
18 dents of the facility have been successfully  
19 relocated to another facility or an alter-  
20 native home and community-based setting.

21           “(ii) CONTINUATION OF PAYMENTS  
22 UNTIL RESIDENTS RELOCATED.—The Sec-  
23 retary may, as the Secretary determines ap-  
24 propriate, continue to make payments  
25 under this title with respect to residents of

1           a facility that has submitted a notification  
2           under subparagraph (A) during the period  
3           beginning on the date such notification is  
4           submitted and ending on the date on which  
5           the resident is successfully relocated.”.

6           (c) *EFFECTIVE DATE.*—The amendments made by this  
7 section shall take effect 1 year after the date of the enact-  
8 ment of this Act.

9           **PART 3—IMPROVING STAFF TRAINING**

10          **SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.**

11          (a) *SKILLED NURSING FACILITIES.*—Section  
12 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.  
13 1395i–3(f)(2)(A)(i)(I)) is amended by inserting “(includ-  
14 ing, in the case of initial training and, if the Secretary  
15 determines appropriate, in the case of ongoing training, de-  
16 mentia management training and resident abuse preven-  
17 tion training)” after “curriculum”.

18          (b) *NURSING FACILITIES.*—Section 1919(f)(2)(A)(i)(I)  
19 of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I))  
20 is amended by inserting “(including, in the case of initial  
21 training and, if the Secretary determines appropriate, in  
22 the case of ongoing training, dementia management train-  
23 ing and resident abuse prevention training)” after “cur-  
24 riculum”.

1       (c) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall take effect 1 year after the date of the enact-*  
3 *ment of this Act.*

4 **SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED**  
5 **FOR CERTIFIED NURSE AIDES AND SUPER-**  
6 **VISORY STAFF.**

7       (a) *STUDY.*—

8           (1) *IN GENERAL.*—*The Secretary shall conduct a*  
9 *study on the content of training for certified nurse*  
10 *aides and supervisory staff of skilled nursing facilities*  
11 *and nursing facilities. The study shall include an*  
12 *analysis of the following:*

13           (A) *Whether the number of initial training*  
14 *hours for certified nurse aides required under*  
15 *sections 1819(f)(2)(A)(i)(II) and*  
16 *1919(f)(2)(A)(i)(II) of the Social Security Act*  
17 *(42 U.S.C. 1395i–3(f)(2)(A)(i)(II);*  
18 *1396r(f)(2)(A)(i)(II)) should be increased from*  
19 *75 and, if so, what the required number of ini-*  
20 *tial training hours should be, including any rec-*  
21 *ommendations for the content of such training*  
22 *(including training related to dementia).*

23           (B) *Whether requirements for ongoing*  
24 *training under such sections 1819(f)(2)(A)(i)(II)*  
25 *and 1919(f)(2)(A)(i)(II) should be increased from*

1           12 hours per year, including any recommenda-  
2           tions for the content of such training.

3           (2) *CONSULTATION.*—In conducting the analysis  
4           under paragraph (1)(A), the Secretary shall consult  
5           with States that, as of the date of the enactment of  
6           this Act, require more than 75 hours of training for  
7           certified nurse aides.

8           (3) *DEFINITIONS.*—In this section:

9                   (A) *NURSING FACILITY.*—The term “nurs-  
10                  ing facility” has the meaning given such term in  
11                  section 1919(a) of the Social Security Act (42  
12                  U.S.C. 1396r(a)).

13                  (B) *SECRETARY.*—The term “Secretary”  
14                  means the Secretary of Health and Human Serv-  
15                  ices, acting through the Assistant Secretary for  
16                  Planning and Evaluation.

17                  (C) *SKILLED NURSING FACILITY.*—The term  
18                  “skilled nursing facility” has the meaning given  
19                  such term in section 1819(a) of the Social Secu-  
20                  rity Act (42 U.S.C. 1395(a)).

21           (b) *REPORT.*—Not later than 2 years after the date  
22           of the enactment of this Act, the Secretary shall submit to  
23           Congress a report containing the results of the study con-  
24           ducted under subsection (a), together with recommendations



1 *for such legislation and administrative action as the Sec-*  
2 *retary determines appropriate.*

3 **SEC. 1433. QUALIFICATION OF DIRECTOR OF FOOD SERV-**  
4 **ICES OF A MEDICAID NURSING FACILITY.**

5 *(a) IN GENERAL.—Section 1919(b)(4)(A) of the Social*  
6 *Security Act (42 U.S.C. 1396r(b)(4)(A)) is amended by*  
7 *adding at the end the following: “With respect to meeting*  
8 *the staffing requirement imposed by the Secretary to carry*  
9 *out clause (iv), the full-time director of food services of the*  
10 *facility, if not a qualified dietitian (as defined in section*  
11 *483.35(a)(2) of title 42, Code of Federal Regulations, as in*  
12 *effect as of the date of the enactment of this section), shall*  
13 *be a Certified Dietary Manager meeting the requirements*  
14 *of the Certifying Board for Dietary Managers, or a Dietetic*  
15 *Technician, Registered meeting the requirements of the*  
16 *Commission on Dietetic Registration or have equivalent*  
17 *military or academic qualifications (as specified by the Sec-*  
18 *retary).”.*

19 *(b) EFFECTIVE DATE.—The amendment made by sub-*  
20 *section (a) shall take effect on the date that is 180 days*  
21 *after the date of enactment of this Act.*

1 ***Subtitle C—Quality Measurements***

2 ***SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR***  
 3 ***QUALITY IMPROVEMENT.***

4 *Title XI of the Social Security Act, as amended by*  
 5 *section 1401(a), is further amended by adding at the end*  
 6 *the following new part:*

7 ***“PART E—QUALITY IMPROVEMENT***

8 ***“ESTABLISHMENT OF NATIONAL PRIORITIES FOR***  
 9 ***PERFORMANCE IMPROVEMENT***

10 ***“SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRI-***  
 11 ***ORITIES BY THE SECRETARY.—The Secretary shall estab-***  
 12 ***lish and periodically update, not less frequently than tri-***  
 13 ***ennially, national priorities for performance improvement.***

14 ***“(b) RECOMMENDATIONS FOR NATIONAL PRIOR-***  
 15 ***ITIES.—In establishing and updating national priorities***  
 16 ***under subsection (a), the Secretary shall solicit and con-***  
 17 ***sider recommendations from multiple outside stakeholders.***

18 ***“(c) CONSIDERATIONS IN SETTING NATIONAL PRIOR-***  
 19 ***ITIES.—With respect to such priorities, the Secretary shall***  
 20 ***ensure that priority is given to areas in the delivery of***  
 21 ***health care services in the United States that—***

22 ***“(1) contribute to a large burden of disease, in-***  
 23 ***cluding those that address the health care provided to***  
 24 ***patients with prevalent, high-cost chronic diseases;***

1           “(2) *have the greatest potential to decrease mor-*  
2 *bidity and mortality in this country, including those*  
3 *that are designed to eliminate harm to patients;*

4           “(3) *have the greatest potential for improving*  
5 *the performance, affordability, and patient-*  
6 *centeredness of health care, including those due to*  
7 *variations in care;*

8           “(4) *address health disparities across groups and*  
9 *areas; and*

10           “(5) *have the potential for rapid improvement*  
11 *due to existing evidence, standards of care or other*  
12 *reasons.*

13           “(d) *DEFINITIONS.—In this part:*

14           “(1) *CONSENSUS-BASED ENTITY.—The term ‘con-*  
15 *sensus-based entity’ means an entity with a contract*  
16 *with the Secretary under section 1890.*

17           “(2) *QUALITY MEASURE.—The term ‘quality*  
18 *measure’ means a national consensus standard for*  
19 *measuring the performance and improvement of pop-*  
20 *ulation health, or of institutional providers of serv-*  
21 *ices, physicians, and other health care practitioners*  
22 *in the delivery of health care services.*

23           “(e) *FUNDING.—*

24           “(1) *IN GENERAL.—The Secretary shall provide*  
25 *for the transfer, from the Federal Hospital Insurance*

1 *Trust Fund under section 1817 and the Federal Sup-*  
2 *plementary Medical Insurance Trust Fund under sec-*  
3 *tion 1841 (in such proportion as the Secretary deter-*  
4 *mines appropriate), of \$2,000,000, for the activities*  
5 *under this section for each of the fiscal years 2010*  
6 *through 2014.*

7 “(2) *AUTHORIZATION OF APPROPRIATIONS.—For*  
8 *purposes of carrying out the provisions of this section,*  
9 *in addition to funds otherwise available, out of any*  
10 *funds in the Treasury not otherwise appropriated,*  
11 *there are appropriated to the Secretary of Health and*  
12 *Human Services \$2,000,000 for each of the fiscal*  
13 *years 2010 through 2014.”.*

14 **SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES;**  
15 **GAO EVALUATION OF DATA COLLECTION**  
16 **PROCESS FOR QUALITY MEASUREMENT.**

17 *Part E of title XI of the Social Security Act, as added*  
18 *by section 1441, is amended by adding at the end the fol-*  
19 *lowing new sections:*

20 **“SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.**

21 **“(a) AGREEMENTS WITH QUALIFIED ENTITIES.—**

22 **“(1) IN GENERAL.—The Secretary shall enter**  
23 **into agreements with qualified entities to develop**  
24 **quality measures for the delivery of health care serv-**  
25 **ices in the United States.**

1           “(2) *FORM OF AGREEMENTS.*—*The Secretary*  
2           *may carry out paragraph (1) by contract, grant, or*  
3           *otherwise.*

4           “(3) *RECOMMENDATIONS OF CONSENSUS-BASED*  
5           *ENTITY.*—*In carrying out this section, the Secretary*  
6           *shall—*

7                     “(A) *seek public input; and*

8                     “(B) *take into consideration recommenda-*  
9                     *tions of the consensus-based entity with a con-*  
10                    *tract with the Secretary under section 1890(a).*

11           “(b) *DETERMINATION OF AREAS WHERE QUALITY*  
12           *MEASURES ARE REQUIRED.*—*Consistent with the national*  
13           *priorities established under this part and with the pro-*  
14           *grams administered by the Centers for Medicare & Med-*  
15           *icaid Services and in consultation with other relevant Fed-*  
16           *eral agencies, the Secretary shall determine areas in which*  
17           *quality measures for assessing health care services in the*  
18           *United States are needed.*

19           “(c) *DEVELOPMENT OF QUALITY MEASURES.*—

20                     “(1) *PATIENT-CENTERED AND POPULATION-*  
21                     *BASED MEASURES.*—*Quality measures developed*  
22                     *under agreements under subsection (a) shall be de-*  
23                     *signed—*

24                     “(A) *to assess outcomes, presence of impair-*  
25                     *ment, and functional status of patients;*

1           “(B) to assess the continuity and coordina-  
2           tion of care and care transitions for patients  
3           across providers and health care settings, includ-  
4           ing end of life care;

5           “(C) to assess patient experience and pa-  
6           tient engagement;

7           “(D) to assess the safety, effectiveness, and  
8           timeliness of care;

9           “(E) to assess health disparities including  
10          those associated with individual race, ethnicity,  
11          age, gender, place of residence or language;

12          “(F) to assess the efficiency and resource use  
13          in the provision of care;

14          “(G) to the extent feasible, to be collected as  
15          part of health information technologies sup-  
16          porting better delivery of health care services;

17          “(H) to be available free of charge to users  
18          for the use of such measures; and

19          “(I) to assess delivery of health care services  
20          to individuals regardless of age.

21          “(2) AVAILABILITY OF MEASURES.—The Sec-  
22          retary shall make quality measures developed under  
23          this section available to the public.

24          “(3) TESTING OF PROPOSED MEASURES.—The  
25          Secretary may use amounts made available under

1        *subsection (f) to fund the testing of proposed quality*  
2        *measures by qualified entities. Testing funded under*  
3        *this paragraph shall include testing of the feasibility*  
4        *and usability of proposed measures.*

5            *“(4) UPDATING OF ENDORSED MEASURES.—The*  
6        *Secretary may use amounts made available under*  
7        *subsection (f) to fund the updating (and testing, if*  
8        *applicable) by consensus-based entities of quality*  
9        *measures that have been previously endorsed by such*  
10       *an entity as new evidence is developed, in a manner*  
11       *consistent with section 1890(b)(3).*

12          *“(d) QUALIFIED ENTITIES.—Before entering into*  
13       *agreements with a qualified entity, the Secretary shall en-*  
14       *sure that the entity is a public, nonprofit or academic insti-*  
15       *tution with technical expertise in the area of health quality*  
16       *measurement.*

17          *“(e) APPLICATION FOR GRANT.—A grant may be made*  
18       *under this section only if an application for the grant is*  
19       *submitted to the Secretary and the application is in such*  
20       *form, is made in such manner, and contains such agree-*  
21       *ments, assurances, and information as the Secretary deter-*  
22       *mines to be necessary to carry out this section.*

23          *“(f) FUNDING.—*

24            *“(1) IN GENERAL.—The Secretary shall provide*  
25       *for the transfer, from the Federal Hospital Insurance*

1       *Trust Fund under section 1817 and the Federal Sup-*  
2       *plementary Medical Insurance Trust Fund under sec-*  
3       *tion 1841 (in such proportion as the Secretary deter-*  
4       *mines appropriate), of \$25,000,000, to the Secretary*  
5       *for purposes of carrying out this section for each of*  
6       *the fiscal years 2010 through 2014.*

7               “(2) *AUTHORIZATION OF APPROPRIATIONS.—For*  
8       *purposes of carrying out the provisions of this section,*  
9       *in addition to funds otherwise available, out of any*  
10       *funds in the Treasury not otherwise appropriated,*  
11       *there are appropriated to the Secretary of Health and*  
12       *Human Services \$25,000,000 for each of the fiscal*  
13       *years 2010 through 2014.*

14       **“SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROC-**  
15               **ESS FOR QUALITY MEASUREMENT.**

16               “(a) *GAO EVALUATIONS.—The Comptroller General of*  
17       *the United States shall conduct periodic evaluations of the*  
18       *implementation of the data collection processes for quality*  
19       *measures used by the Secretary.*

20               “(b) *CONSIDERATIONS.—In carrying out the evalua-*  
21       *tion under subsection (a), the Comptroller General shall de-*  
22       *termine—*

23               “(1) *whether the system for the collection of data*  
24       *for quality measures provides for validation of data*  
25       *as relevant and scientifically credible;*



1           “(2) *whether data collection efforts under the sys-*  
 2           *tem use the most efficient and cost-effective means in*  
 3           *a manner that minimizes administrative burden on*  
 4           *persons required to collect data and that adequately*  
 5           *protects the privacy of patients’ personal health infor-*  
 6           *mation and provides data security;*

7           “(3) *whether standards under the system provide*  
 8           *for an appropriate opportunity for physicians and*  
 9           *other clinicians and institutional providers of services*  
 10          *to review and correct findings; and*

11          “(4) *the extent to which quality measures are*  
 12          *consistent with section 1192(c)(1) or result in direct*  
 13          *or indirect costs to users of such measures.*

14          “(c) *REPORT.—The Comptroller General shall submit*  
 15          *reports to Congress and to the Secretary containing a de-*  
 16          *scription of the findings and conclusions of the results of*  
 17          *each such evaluation.”.*

18          **SEC. 1443. MULTISTAKEHOLDER PRERULEMAKING INPUT**

19                               **INTO SELECTION OF QUALITY MEASURES.**

20          *Section 1808 of the Social Security Act (42 U.S.C.*  
 21          *1395b–9) is amended by adding at the end the following*  
 22          *new subsection:*

23          “(d) *MULTI-STAKEHOLDER PRE-RULEMAKING INPUT*  
 24          *INTO SELECTION OF QUALITY MEASURES.—*

1           “(1) *LIST OF MEASURES.*—Not later than De-  
2           cember 1 before each year (beginning with 2011), the  
3           Secretary shall make public a list of measures being  
4           considered for selection for quality measurement by  
5           the Secretary in rulemaking with respect to payment  
6           systems under this title beginning in the payment  
7           year beginning in such year and for payment systems  
8           beginning in the calendar year following such year,  
9           as the case may be.

10           “(2) *CONSULTATION ON SELECTION OF EN-*  
11           *DORSED QUALITY MEASURES.*—A consensus-based en-  
12           tity that has entered into a contract under section  
13           1890 shall, as part of such contract, convene multi-  
14           stakeholder groups to provide recommendations on the  
15           selection of individual or composite quality measures,  
16           for use in reporting performance information to the  
17           public or for use in public health care programs.

18           “(3) *MULTI-STAKEHOLDER INPUT.*—Not later  
19           than February 1 of each year (beginning with 2011),  
20           the consensus-based entity described in paragraph (2)  
21           shall transmit to the Secretary the recommendations  
22           of multi-stakeholder groups provided under paragraph  
23           (2). Such recommendations shall be included in the  
24           transmissions the consensus-based entity makes to the

1       *Secretary under the contract provided for under sec-*  
2       *tion 1890.*

3               “(4) *REQUIREMENT FOR TRANSPARENCY IN*  
4       *PROCESS.—*

5               “(A) *IN GENERAL.—In convening multi-*  
6       *stakeholder groups under paragraph (2) with re-*  
7       *spect to the selection of quality measures, the*  
8       *consensus-based entity described in such para-*  
9       *graph shall provide for an open and transparent*  
10       *process for the activities conducted pursuant to*  
11       *such convening.*

12               “(B) *SELECTION OF ORGANIZATIONS PAR-*  
13       *TICIPATING IN MULTI-STAKEHOLDER GROUPS.—*  
14       *The process under paragraph (2) shall ensure*  
15       *that the selection of representatives of multi-*  
16       *stakeholder groups includes provision for public*  
17       *nominations for, and the opportunity for public*  
18       *comment on, such selection.*

19               “(5) *USE OF INPUT.—The respective proposed*  
20       *rule shall contain a summary of the recommendations*  
21       *made by the multi-stakeholder groups under para-*  
22       *graph (2), as well as other comments received regard-*  
23       *ing the proposed measures, and the extent to which*  
24       *such proposed rule follows such recommendations and*  
25       *the rationale for not following such recommendations.*

1           “(6) *MULTI-STAKEHOLDER GROUPS.*—*For pur-*  
2           *poses of this subsection, the term ‘multi-stakeholder*  
3           *groups’ means, with respect to a quality measure, a*  
4           *voluntary collaborative of organizations representing*  
5           *persons interested in or affected by the use of such*  
6           *quality measure, such as the following:*

7                   “(A) *Hospitals and other institutional pro-*  
8                   *viders.*

9                   “(B) *Physicians.*

10                  “(C) *Health care quality alliances.*

11                  “(D) *Nurses and other health care practi-*  
12                  *tioners.*

13                  “(E) *Health plans.*

14                  “(F) *Patient advocates and consumer*  
15                  *groups.*

16                  “(G) *Employers.*

17                  “(H) *Public and private purchasers of*  
18                  *health care items and services.*

19                  “(I) *Labor organizations.*

20                  “(J) *Relevant departments or agencies of*  
21                  *the United States.*

22                  “(K) *Biopharmaceutical companies and*  
23                  *manufacturers of medical devices.*

24                  “(L) *Licensing, credentialing, and accred-*  
25                  *iting bodies.*

1 “(7) *FUNDING.*—

2 “(A) *IN GENERAL.*—*The Secretary shall*  
 3 *provide for the transfer, from the Federal Hos-*  
 4 *pital Insurance Trust Fund under section 1817*  
 5 *and the Federal Supplementary Medical Insur-*  
 6 *ance Trust Fund under section 1841 (in such*  
 7 *proportion as the Secretary determines appro-*  
 8 *priate), of \$1,000,000, to the Secretary for pur-*  
 9 *poses of carrying out this subsection for each of*  
 10 *the fiscal years 2010 through 2014.*

11 “(B) *AUTHORIZATION OF APPROPRIA-*  
 12 *TIONS.*—*For purposes of carrying out the provi-*  
 13 *sions of this subsection, in addition to funds oth-*  
 14 *erwise available, out of any funds in the Treas-*  
 15 *ury not otherwise appropriated, there are appro-*  
 16 *priated to the Secretary of Health and Human*  
 17 *Services \$1,000,000 for each of the fiscal years*  
 18 *2010 through 2014.”.*

19 **SEC. 1444. APPLICATION OF QUALITY MEASURES.**

20 (a) *INPATIENT HOSPITAL SERVICES.*—*Section*  
 21 *1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is*  
 22 *amended by adding at the end the following new clause:*

23 “(x)(I) *Subject to subclause (II), for purposes of report-*  
 24 *ing data on quality measures for inpatient hospital services*  
 25 *furnished during fiscal year 2012 and each subsequent fis-*

1 *cal year, the quality measures specified under clause (viii)*  
2 *shall be measures selected by the Secretary from measures*  
3 *that have been endorsed by the entity with a contract with*  
4 *the Secretary under section 1890(a).*

5       “(II) *In the case of a specified area or medical topic*  
6 *determined appropriate by the Secretary for which a fea-*  
7 *sible and practical quality measure has not been endorsed*  
8 *by the entity with a contract under section 1890(a), the*  
9 *Secretary may specify a measure that is not so endorsed*  
10 *as long as due consideration is given to measures that have*  
11 *been endorsed or adopted by a consensus organization iden-*  
12 *tified by the Secretary. The Secretary shall submit such a*  
13 *non-endorsed measure to the entity for consideration for en-*  
14 *dorsement. If the entity considers but does not endorse such*  
15 *a measure and if the Secretary does not phase-out use of*  
16 *such measure, the Secretary shall include the rationale for*  
17 *continued use of such a measure in rulemaking.”.*

18       (b) *OUTPATIENT HOSPITAL SERVICES.—Section*  
19 *1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is amended*  
20 *by adding at the end the following new subparagraph:*

21               “(F) *USE OF ENDORSED QUALITY MEAS-*  
22               *URES.—The provisions of clause (x) of section*  
23               *1886(b)(3)(C) shall apply to quality measures*  
24               *for covered OPD services under this paragraph*  
25               *in the same manner as such provisions apply to*

1           *quality measures for inpatient hospital serv-*  
2           *ices.”.*

3           (c) *PHYSICIANS’ SERVICES.*—Section 1848(k)(2)(C)(ii)  
4 *of such Act (42 U.S.C. 1395w-4(k)(2)(C)(ii)) is amended*  
5 *by adding at the end the following: “The Secretary shall*  
6 *submit such a non-endorsed measure to the entity for con-*  
7 *sideration for endorsement. If the entity considers but does*  
8 *not endorse such a measure and if the Secretary does not*  
9 *phase-out use of such measure, the Secretary shall include*  
10 *the rationale for continued use of such a measure in rule-*  
11 *making.”.*

12           (d) *RENAL DIALYSIS SERVICES.*—Section  
13 *1881(h)(2)(B)(ii) of such Act (42 U.S.C.*  
14 *1395rr(h)(2)(B)(ii)) is amended by adding at the end the*  
15 *following: “The Secretary shall submit such a non-endorsed*  
16 *measure to the entity for consideration for endorsement. If*  
17 *the entity considers but does not endorse such a measure*  
18 *and if the Secretary does not phase-out use of such measure,*  
19 *the Secretary shall include the rationale for continued use*  
20 *of such a measure in rulemaking.”.*

21           (e) *ENDORSEMENT OF STANDARDS.*—Section  
22 *1890(b)(2) of the Social Security Act (42 U.S.C.*  
23 *1395aaa(b)(2)) is amended by adding after and below sub-*  
24 *paragraph (B) the following:*

1       *“If the entity does not endorse a measure, such entity*  
2       *shall explain the reasons and provide suggestions*  
3       *about changes to such measure that might make it a*  
4       *potentially endorsable measure.”.*

5       *(f) EFFECTIVE DATE.—Except as otherwise provided,*  
6       *the amendments made by this section shall apply to quality*  
7       *measures applied for payment years beginning with 2012*  
8       *or fiscal year 2012, as the case may be.*

9       **SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.**

10       *Section 1890(d) of the Social Security Act (42 U.S.C.*  
11       *1395aaa(d)) is amended by striking “for each of fiscal years*  
12       *2009 through 2012” and inserting “for fiscal year 2009,*  
13       *and \$12,000,000 for each of the fiscal years 2010 through*  
14       *2012”.*

15       **SEC. 1446. QUALITY INDICATORS FOR CARE OF PEOPLE**  
16                                       **WITH ALZHEIMER’S DISEASE.**

17       *(a) QUALITY INDICATORS.—The Secretary of Health*  
18       *and Human Services, acting through the Agency for*  
19       *Healthcare Research and Quality (AHRQ), shall develop,*  
20       *either directly or with commissioned projects, a core set of*  
21       *quality indicators for the provision of medical services to*  
22       *people with Alzheimer’s disease and other dementias and*  
23       *a plan for implementing the indicators to measure the qual-*  
24       *ity of care provided for people with these conditions by phy-*



1 sicians, hospitals, and other medical, residential and home  
2 care agencies and providers.

3 (b) *REPORT.*—The Secretary shall submit a report to  
4 the Committees on Energy and Commerce and Ways and  
5 Means of the United States House of Representatives and  
6 to the Committees on Finance and Health, Education, and  
7 Pensions of the United States Senate not later than 12  
8 months after the date of the enactment of this Act setting  
9 forth the status of their efforts to implement the require-  
10 ments of subsection (a).

11 **SEC. 1447. STUDY ON FIVE STAR QUALITY RATING SYSTEM.**

12 (a) *STUDY.*—The Comptroller General of the United  
13 States shall conduct a study on the Five-Star Quality Rat-  
14 ing System (or a successor program) established by the  
15 Centers for Medicare & Medicaid Services. The study  
16 shall—

17 (1) determine whether the composite star rating  
18 should be eliminated in favor of a multi-dimensional  
19 system under which a star rating is assigned to each  
20 individual domain;

21 (2) determine whether an appeals process should  
22 be implemented for the Five Star Rating System to  
23 address situations in which questionable, inaccurate,  
24 or incomplete data has been identified;

1           (3) evaluate the appropriateness of any  
2           weighting methodology used to adjust quality meas-  
3           ures, including an assessment of whether such method-  
4           ology is validated, whether it takes into account resi-  
5           dent characteristics, the appropriateness of the  
6           weighting of individual quality measures, and wheth-  
7           er the accuracy of information to consumers would be  
8           enhanced if the standard survey were weighted more  
9           heavily than the complaint survey;

10           (4) assess the appropriateness of the case-mix ad-  
11           justment methodology used to evaluate staffing levels,  
12           along with the appropriateness of the staffing levels  
13           established by the Centers for Medicare & Medicaid  
14           Services to achieve a 5-star rating given the absence  
15           of any existing Federal nursing home staffing  
16           guidelines or Medicare funding to support these staff-  
17           ing levels;

18           (5) if the Comptroller General determines that  
19           such target staffing levels are appropriate, evaluate,  
20           in consultation with the Secretary of Health and  
21           Human Services, the cost of modifying the Medicare  
22           Skilled Nursing Facility Resource Utilization Groups  
23           to reflect the costs to facilities of providing staffing at  
24           these target levels;

1           (6) *evaluate how best to represent resident/con-*  
2           *sumer satisfaction under the rating system, and re-*  
3           *view approaches to report other facility-specific char-*  
4           *acteristics to enable consumers to better identify fa-*  
5           *ilities that will meet their individual needs;*

6           (7) *evaluate the impact of the rating system on*  
7           *Medicare skilled nursing facilities and Medicaid nurs-*  
8           *ing facilities, including a review of potential prob-*  
9           *lems associated with inaccurate or incomplete data*  
10          *and other unanticipated consequences reported by fa-*  
11          *ilities; and*

12          (8) *assess whether the national program should*  
13          *be suspended and replaced with a pilot program test-*  
14          *ing potential nursing home quality rating systems in*  
15          *a limited number of States.*

16          (b) *REPORT.*—*Not later than 1 year after the date of*  
17          *the enactment of this Act, the Comptroller General of the*  
18          *United States shall submit to Congress and the Secretary*  
19          *of Health and Human Services a report containing the re-*  
20          *sults of the study conducted under subsection (a), together*  
21          *with recommendations for such modifications to the Five-*  
22          *Star Quality Rating System as the Comptroller General de-*  
23          *termines appropriate.*

1       ***Subtitle D—Physician Payments***  
2                   ***Sunshine Provision***

3       ***SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BE-***  
4                   ***TWEEN MANUFACTURERS AND DISTRIBUTU-***  
5                   ***TORS OF COVERED DRUGS, DEVICES,***  
6                   ***BIOLOGICALS, OR MEDICAL SUPPLIES UNDER***  
7                   ***MEDICARE, MEDICAID, OR CHIP AND PHYSI-***  
8                   ***CIA NS AND OTHER HEALTH CARE ENTITIES***  
9                   ***AND BETWEEN PHYSICIANS AND OTHER***  
10                  ***HEALTH CARE ENTITIES.***

11       *(a) IN GENERAL.—Part A of title XI of the Social Se-*  
12 *curity Act (42 U.S.C. 1301 et seq.), as amended by section*  
13 *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 MANUFACTUR-***  
17                   ***ERS AND DISTRIBUTORS OF COVERED***  
18                   ***DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL***  
19                   ***SUPPLIES UNDER MEDICARE, MEDICAID, OR***  
20                   ***CHIP AND WITH ENTITIES THAT BILL FOR***  
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, 2011 and annu-***

1 *ally thereafter, each applicable manufacturer or dis-*  
2 *tributor that provides a payment or other transfer of*  
3 *value to a covered recipient, or to an entity or indi-*  
4 *vidual at the request of or designated on behalf of a*  
5 *covered recipient, shall submit to the Secretary, in*  
6 *such electronic form as the Secretary shall require, the*  
7 *following information with respect to the preceding*  
8 *calendar year:*

9 *“(A) With respect to the covered recipient,*  
10 *the recipient’s name, business address, physician*  
11 *specialty, and national provider identifier.*

12 *“(B) With respect to the payment or other*  
13 *transfer of value, other than a drug sample—*

14 *“(i) its value and date;*

15 *“(ii) the name of the related drug, de-*  
16 *vice, or supply, if available; and*

17 *“(iii) a description of its form, indi-*  
18 *cated (as appropriate for all that apply)*

19 *as—*

20 *“(I) cash or a cash equivalent;*

21 *“(II) in-kind items or services;*

22 *“(III) stock, a stock option, or*  
23 *any other ownership interest, dividend,*  
24 *profit, or other return on investment;*

25 *or*

1                   “(IV) any other form (as defined  
2                   by the Secretary).

3                   “(C) With respect to a drug sample, the  
4                   name, number, date, and dosage units of the  
5                   sample.

6                   “(2) *AGGREGATE REPORTING.*—Information sub-  
7                   mitted by an applicable manufacturer or distributor  
8                   under paragraph (1) shall include the aggregate  
9                   amount of all payments or other transfers of value  
10                  provided by the manufacturer or distributor to cov-  
11                  ered recipients (and to entities or individuals at the  
12                  request of or designated on behalf of a covered recipi-  
13                  ent) during the year involved, including all payments  
14                  and transfers of value regardless of whether such pay-  
15                  ments or transfer of value were individually disclosed.

16                  “(3) *SPECIAL RULE FOR CERTAIN PAYMENTS OR*  
17                  *OTHER TRANSFERS OF VALUE.*—In the case where an  
18                  applicable manufacturer or distributor provides a  
19                  payment or other transfer of value to an entity or in-  
20                  dividual at the request of or designated on behalf of  
21                  a covered recipient, the manufacturer or distributor  
22                  shall disclose that payment or other transfer of value  
23                  under the name of the covered recipient.

24                  “(4) *DELAYED REPORTING FOR PAYMENTS MADE*  
25                  *PURSUANT TO PRODUCT DEVELOPMENT AGREE-*

1        *MENTS.—In the case of a payment or other transfer*  
2        *of value made to a covered recipient by an applicable*  
3        *manufacturer or distributor pursuant to a product*  
4        *development agreement for services furnished in con-*  
5        *nection with the development of a new drug, device,*  
6        *biological, or medical supply, the applicable manufac-*  
7        *turer or distributor may report the value and recipi-*  
8        *ent of such payment or other transfer of value in the*  
9        *first reporting period under this subsection in the*  
10       *next reporting deadline after the earlier of the fol-*  
11       *lowing:*

12                *“(A) The date of the approval or clearance*  
13                *of the covered drug, device, biological, or medical*  
14                *supply by the Food and Drug Administration.*

15                *“(B) Two calendar years after the date such*  
16                *payment or other transfer of value was made.*

17                *“(5) DELAYED REPORTING FOR PAYMENTS MADE*  
18        *PURSUANT TO CLINICAL INVESTIGATIONS.—In the case*  
19        *of a payment or other transfer of value made to a*  
20        *covered recipient by an applicable manufacturer or*  
21        *distributor in connection with a clinical investigation*  
22        *regarding a new drug, device, biological, or medical*  
23        *supply, the applicable manufacturer or distributor*  
24        *may report as required under this section in the next*

1       *reporting period under this subsection after the ear-*  
2       *lier of the following:*

3               “(A) *The date that the clinical investigation*  
4               *is registered on the website maintained by the*  
5               *National Institutes of Health pursuant to section*  
6               *671 of the Food and Drug Administration*  
7               *Amendments Act of 2007.*

8               “(B) *Two calendar years after the date such*  
9               *payment or other transfer of value was made.*

10              “(6) *CONFIDENTIALITY.—Information described*  
11              *in paragraph (4) or (5) shall be considered confiden-*  
12              *tial and shall not be subject to disclosure under sec-*  
13              *tion 552 of title 5, United States Code, or any other*  
14              *similar Federal, State, or local law, until or after the*  
15              *date on which the information is made available to*  
16              *the public under such paragraph.*

17              “(b) *REPORTING OF OWNERSHIP INTEREST BY PHYSI-*  
18              *CANS IN HOSPITALS AND OTHER ENTITIES THAT BILL*  
19              *MEDICARE.—Not later than March 31 of each year (begin-*  
20              *ning with 2011), each hospital or other health care entity*  
21              *(not including a Medicare Advantage organization) that*  
22              *bills the Secretary under part A or part B of title XVIII*  
23              *for services shall report on the ownership shares (other than*  
24              *ownership shares described in section 1877(c)) of each phy-*  
25              *sician who, directly or indirectly, owns an interest in the*



1 *entity. In this subsection, the term ‘physician’ includes a*  
2 *physician’s immediate family members (as defined for pur-*  
3 *poses of section 1877(a)).*

4 “(c) *PUBLIC AVAILABILITY.—*

5 “(1) *IN GENERAL.—The Secretary shall establish*  
6 *procedures to ensure that, not later than September*  
7 *30, 2011, and on June 30 of each year beginning*  
8 *thereafter, the information submitted under sub-*  
9 *sections (a) and (b), other than information regard*  
10 *drug samples, with respect to the preceding calendar*  
11 *year is made available through an Internet website*  
12 *that—*

13 “(A) *is searchable and is in a format that*  
14 *is clear and understandable;*

15 “(B) *contains information that is presented*  
16 *by the name of the applicable manufacturer or*  
17 *distributor, the name of the covered recipient, the*  
18 *business address of the covered recipient, the spe-*  
19 *cialty (if applicable) of the covered recipient, the*  
20 *value of the payment or other transfer of value,*  
21 *the date on which the payment or other transfer*  
22 *of value was provided to the covered recipient,*  
23 *the form of the payment or other transfer of*  
24 *value, indicated (as appropriate) under sub-*  
25 *section (a)(1)(B)(ii), the nature of the payment*

1           or other transfer of value, indicated (as appro-  
2           priate) under subsection (a)(1)(B)(iii), and the  
3           name of the covered drug, device, biological, or  
4           medical supply, as applicable;

5           “(C) contains information that is able to be  
6           easily aggregated and downloaded;

7           “(D) contains a description of any enforce-  
8           ment actions taken to carry out this section, in-  
9           cluding any penalties imposed under subsection  
10          (d), during the preceding year;

11          “(E) contains background information on  
12          industry-physician relationships;

13          “(F) in the case of information submitted  
14          with respect to a payment or other transfer of  
15          value described in subsection (a)(5), lists such  
16          information separately from the other informa-  
17          tion submitted under subsection (a) and des-  
18          ignates such separately listed information as  
19          funding for clinical research;

20          “(G) contains any other information the  
21          Secretary determines would be helpful to the av-  
22          erage consumer; and

23          “(H) provides the covered recipient an op-  
24          portunity to submit corrections to the informa-

1            *tion made available to the public with respect to*  
2            *the covered recipient.*

3            “(2) *ACCURACY OF REPORTING.*—*The accuracy*  
4            *of the information that is submitted under subsections*  
5            *(a) and (b) and made available under paragraph (1)*  
6            *shall be the responsibility of the applicable manufac-*  
7            *turer or distributor of a covered drug, device, biologi-*  
8            *cal, or medical supply reporting under subsection (a)*  
9            *or hospital or other health care entity reporting phy-*  
10           *sician ownership under subsection (b). The Secretary*  
11           *shall establish procedures to ensure that the covered*  
12           *recipient is provided with an opportunity to submit*  
13           *corrections to the manufacturer, distributor, hospital,*  
14           *or other entity reporting under subsection (a) or (b)*  
15           *with regard to information made public with respect*  
16           *to the covered recipient and, under such procedures,*  
17           *the corrections shall be transmitted to the Secretary.*

18           “(3) *SPECIAL RULE FOR DRUG SAMPLES.*—*Infor-*  
19           *mation relating to drug samples provided under sub-*  
20           *section (a) shall not be made available to the public*  
21           *by the Secretary but may be made available outside*  
22           *the Department of Health and Human Services by*  
23           *the Secretary for research or legitimate business pur-*  
24           *poses pursuant to data use agreements.*

1           “(4) *SPECIAL RULE FOR NATIONAL PROVIDER*  
2           *IDENTIFIERS.—Information relating to national pro-*  
3           *vider identifiers provided under subsection (a) shall*  
4           *not be made available to the public by the Secretary*  
5           *but may be made available outside the Department of*  
6           *Health and Human Services by the Secretary for re-*  
7           *search or legitimate business purposes pursuant to*  
8           *data use agreements.*

9           “(d) *PENALTIES FOR NONCOMPLIANCE.—*

10           “(1) *FAILURE TO REPORT.—*

11           “(A) *IN GENERAL.—Subject to subpara-*  
12           *graph (B), except as provided in paragraph (2),*  
13           *any applicable manufacturer or distributor that*  
14           *fails to submit information required under sub-*  
15           *section (a) in a timely manner in accordance*  
16           *with regulations promulgated to carry out such*  
17           *subsection, and any hospital or other entity that*  
18           *fails to submit information required under sub-*  
19           *section (b) in a timely manner in accordance*  
20           *with regulations promulgated to carry out such*  
21           *subsection shall be subject to a civil money pen-*  
22           *alty of not less than \$1,000, but not more than*  
23           *\$10,000, for each payment or other transfer of*  
24           *value or ownership or investment interest not re-*  
25           *ported as required under such subsection. Such*

1           *penalty shall be imposed and collected in the*  
2           *same manner as civil money penalties under*  
3           *subsection (a) of section 1128A are imposed and*  
4           *collected under that section.*

5           “(B) *LIMITATION.*—*The total amount of*  
6           *civil money penalties imposed under subpara-*  
7           *graph (A) with respect to each annual submis-*  
8           *sion of information under subsection (a) by an*  
9           *applicable manufacturer or distributor or other*  
10          *entity shall not exceed \$150,000.*

11          “(2) *KNOWING FAILURE TO REPORT.*—

12          “(A) *IN GENERAL.*—*Subject to subpara-*  
13          *graph (B), any applicable manufacturer or dis-*  
14          *tributor that knowingly fails to submit informa-*  
15          *tion required under subsection (a) in a timely*  
16          *manner in accordance with regulations promul-*  
17          *gated to carry out such subsection and any hos-*  
18          *pital or other entity that fails to submit infor-*  
19          *mation required under subsection (b) in a timely*  
20          *manner in accordance with regulations promul-*  
21          *gated to carry out such subsection, shall be sub-*  
22          *ject to a civil money penalty of not less than*  
23          *\$10,000, but not more than \$100,000, for each*  
24          *payment or other transfer of value or ownership*  
25          *or investment interest not reported as required*

1           *under such subsection. Such penalty shall be im-*  
2           *posed and collected in the same manner as civil*  
3           *money penalties under subsection (a) of section*  
4           *1128A are imposed and collected under that sec-*  
5           *tion.*

6           “(B) *LIMITATION.*—*The total amount of*  
7           *civil money penalties imposed under subpara-*  
8           *graph (A) with respect to each annual submis-*  
9           *sion of information under subsection (a) or (b)*  
10          *by an applicable manufacturer, distributor, or*  
11          *entity shall not exceed \$1,000,000, or, if greater,*  
12          *0.1 percentage of the total annual revenues of the*  
13          *manufacturer, distributor, or entity.*

14          “(3) *USE OF FUNDS.*—*Funds collected by the*  
15          *Secretary as a result of the imposition of a civil*  
16          *money penalty under this subsection shall be used to*  
17          *carry out this section.*

18          “(4) *ENFORCEMENT THROUGH STATE ATTOR-*  
19          *NEYS GENERAL.*—*The attorney general of a State,*  
20          *after providing notice to the Secretary of an intent to*  
21          *proceed under this paragraph in a specific case and*  
22          *providing the Secretary with an opportunity to bring*  
23          *an action under this subsection and the Secretary de-*  
24          *clining such opportunity, may proceed under this*

1 subsection against a manufacturer or distributor in  
2 the State.

3 “(e) *ANNUAL REPORT TO CONGRESS.*—Not later than  
4 April 1 of each year beginning with 2011, the Secretary  
5 shall submit to Congress a report that includes the fol-  
6 lowing:

7 “(1) *The information submitted under this sec-*  
8 *tion during the preceding year, aggregated for each*  
9 *applicable manufacturer or distributor of a covered*  
10 *drug, device, biological, or medical supply that sub-*  
11 *mitted such information during such year.*

12 “(2) *A description of any enforcement actions*  
13 *taken to carry out this section, including any pen-*  
14 *alties imposed under subsection (d), during the pre-*  
15 *ceding year.*

16 “(f) *DEFINITIONS.*—*In this section:*

17 “(1) *APPLICABLE MANUFACTURER; APPLICABLE*  
18 *DISTRIBUTOR.*—*The term ‘applicable manufacturer’*  
19 *means a manufacturer of a covered drug, device, bio-*  
20 *logical, or medical supply, and the term ‘applicable*  
21 *distributor’ means a distributor of a covered drug, de-*  
22 *vice, or medical supply.*

23 “(2) *CLINICAL INVESTIGATION.*—*The term ‘clin-*  
24 *ical investigation’ means any experiment involving*  
25 *one or more human subjects, or materials derived*

1       *from human subjects, in which a drug or device is ad-*  
2       *ministered, dispensed, or used.*

3               “(3) *COVERED DRUG, DEVICE, BIOLOGICAL, OR*  
4       *MEDICAL SUPPLY.—The term ‘covered’ means, with*  
5       *respect to a drug, device, biological, or medical sup-*  
6       *ply, such a drug, device, biological, or medical supply*  
7       *for which payment is available under title XVIII or*  
8       *a State plan under title XIX or XXI (or a waiver of*  
9       *such a plan).*

10              “(4) *COVERED RECIPIENT.—The term ‘covered*  
11       *recipient’ means the following:*

12                   “(A) *A physician.*

13                   “(B) *A physician group practice.*

14                   “(C) *Any other prescriber of a covered drug,*  
15       *device, biological, or medical supply.*

16                   “(D) *A pharmacy or pharmacist.*

17                   “(E) *A health insurance issuer, group*  
18       *health plan, or other entity offering a health ben-*  
19       *efits plan, including any employee of such an*  
20       *issuer, plan, or entity.*

21                   “(F) *A pharmacy benefit manager, includ-*  
22       *ing any employee of such a manager.*

23                   “(G) *A hospital.*

24                   “(H) *A medical school.*



1           “(I) A sponsor of a continuing medical edu-  
2           cation program.

3           “(J) A patient advocacy or disease specific  
4           group.

5           “(K) A organization of health care profes-  
6           sionals.

7           “(L) A biomedical researcher.

8           “(M) A group purchasing organization.

9           “(5) DISTRIBUTOR OF A COVERED DRUG, DE-  
10          VICE, OR MEDICAL SUPPLY.—The term ‘distributor of  
11          a covered drug, device, or medical supply’ means any  
12          entity which is engaged in the marketing or distribu-  
13          tion of a covered drug, device, or medical supply (or  
14          any subsidiary of or entity affiliated with such enti-  
15          ty), but does not include a wholesale pharmaceutical  
16          distributor.

17          “(6) EMPLOYEE.—The term ‘employee’ has the  
18          meaning given such term in section 1877(h)(2).

19          “(7) KNOWINGLY.—The term ‘knowingly’ has the  
20          meaning given such term in section 3729(b) of title  
21          31, United States Code.

22          “(8) MANUFACTURER OF A COVERED DRUG, DE-  
23          VICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term  
24          ‘manufacturer of a covered drug, device, biological, or  
25          medical supply’ means any entity which is engaged

1       *in the production, preparation, propagation,*  
2       *compounding, conversion, processing, marketing, or*  
3       *distribution of a covered drug, device, biological, or*  
4       *medical supply (or any subsidiary of or entity affili-*  
5       *ated with such entity).*

6               “(9) *PAYMENT OR OTHER TRANSFER OF*  
7       *VALUE.—*

8               “(A) *IN GENERAL.—The term ‘payment or*  
9       *other transfer of value’ means a transfer of any-*  
10       *thing of value for or of any of the following:*

11                   “(i) *Gift, food, or entertainment.*

12                   “(ii) *Travel or trip.*

13                   “(iii) *Honoraria.*

14                   “(iv) *Research funding or grant.*

15                   “(v) *Education or conference funding.*

16                   “(vi) *Consulting fees.*

17                   “(vii) *Ownership or investment inter-*  
18       *est and royalties or license fee.*

19               “(B) *INCLUSIONS.—Subject to subpara-*  
20       *graph (C), the term ‘payment or other transfer*  
21       *of value’ includes any compensation, gift, hono-*  
22       *rarium, speaking fee, consulting fee, travel, serv-*  
23       *ices, dividend, profit distribution, stock or stock*  
24       *option grant, or any ownership or investment*  
25       *interest held by a physician in a manufacturer*

1           *(excluding a dividend or other profit distribution*  
2           *from, or ownership or investment interest in, a*  
3           *publicly traded security or mutual fund (as de-*  
4           *scribed in section 1877(c)).*

5           “(C) *EXCLUSIONS.—The term ‘payment or*  
6           *other transfer of value’ does not include the fol-*  
7           *lowing:*

8                   “(i) *Any payment or other transfer of*  
9                   *value provided by an applicable manufac-*  
10                  *turer or distributor to a covered recipient*  
11                  *where the amount transferred to, requested*  
12                  *by, or designated on behalf of the covered re-*  
13                  *ipient does not exceed \$5.*

14                  “(ii) *The loan of a covered device for*  
15                  *a short-term trial period, not to exceed 90*  
16                  *days, to permit evaluation of the covered de-*  
17                  *vice by the covered recipient.*

18                  “(iii) *Items or services provided under*  
19                  *a contractual warranty, including the re-*  
20                  *placement of a covered device, where the*  
21                  *terms of the warranty are set forth in the*  
22                  *purchase or lease agreement for the covered*  
23                  *device.*

24                  “(iv) *A transfer of anything of value to*  
25                  *a covered recipient when the covered recipi-*

1            *ent is a patient and not acting in the pro-*  
2            *fessional capacity of a covered recipient.*

3            *“(v) In-kind items used for the provi-*  
4            *sion of charity care.*

5            *“(vi) A dividend or other profit dis-*  
6            *tribution from, or ownership or investment*  
7            *interest in, a publicly traded security and*  
8            *mutual fund (as described in section*  
9            *1877(c)).*

10           *“(vii) Compensation paid by a manu-*  
11           *facturer or distributor of a covered drug, de-*  
12           *vice, biological, or medical supply to a cov-*  
13           *ered recipient who is directly employed by*  
14           *and works solely for such manufacturer or*  
15           *distributor.*

16           *“(viii) Any discount or cash rebate.*

17           *“(10) PHYSICIAN.—The term ‘physician’ has the*  
18           *meaning given that term in section 1861(r). For pur-*  
19           *poses of this section, such term does not include a*  
20           *physician who is an employee of the applicable man-*  
21           *ufacturer that is required to submit information*  
22           *under subsection (a).*

23           *“(g) ANNUAL REPORTS TO STATES.—Not later than*  
24           *April 1 of each year beginning with 2011, the Secretary*  
25           *shall submit to States a report that includes a summary*

1 *of the information submitted under subsections (a) and (d)*  
2 *during the preceding year with respect to covered recipients*  
3 *or other hospitals and entities in the State.*

4 “(h) *RELATION TO STATE LAWS.—*

5 “(1) *IN GENERAL.—Effective on January 1,*  
6 *2011, subject to paragraph (2), the provisions of this*  
7 *section shall preempt any law or regulation of a State*  
8 *or of a political subdivision of a State that requires*  
9 *an applicable manufacturer and applicable dis-*  
10 *tributor (as such terms are defined in subsection (f))*  
11 *to disclose or report, in any format, the type of infor-*  
12 *mation (described in subsection (a)) regarding a pay-*  
13 *ment or other transfer of value provided by the manu-*  
14 *facturer to a covered recipient (as so defined).*

15 “(2) *NO PREEMPTION OF ADDITIONAL REQUIRE-*  
16 *MENTS.—Paragraph (1) shall not preempt any law or*  
17 *regulation of a State or of a political subdivision of*  
18 *a State that requires any of the following:*

19 “(A) *The disclosure or reporting of informa-*  
20 *tion not of the type required to be disclosed or*  
21 *reported under this section.*

22 “(B) *The disclosure or reporting, in any*  
23 *format, of the type of information required to be*  
24 *disclosed or reported under this section to a Fed-*  
25 *eral, State, or local governmental agency for*

1           *public health surveillance, investigation, or other*  
2           *public health purposes or health oversight pur-*  
3           *poses.*

4                     “(C) *The discovery or admissibility of infor-*  
5           *mation described in this section in a criminal,*  
6           *civil, or administrative proceeding.”.*

7           **(b) AVAILABILITY OF INFORMATION FROM THE DIS-**  
8           **CLOSURE OF FINANCIAL RELATIONSHIP REPORT**  
9           **(DFRR).—***The Secretary of Health and Human Services*  
10          *shall submit to Congress a report on the full results of the*  
11          *Disclosure of Physician Financial Relationships surveys re-*  
12          *quired pursuant to section 5006 of the Deficit Reduction*  
13          *Act of 2005. Such report shall be submitted to Congress not*  
14          *later than the date that is 6 months after the date such*  
15          *surveys are collected and shall be made publicly available*  
16          *on an Internet website of the Department of Health and*  
17          *Human Services.*

1       ***Subtitle E—Public Reporting on***  
2       ***Health Care-Associated Infections***

3       ***SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY HOS-***  
4                               ***PITALS AND AMBULATORY SURGICAL CEN-***  
5                               ***TERS ON HEALTH CARE-ASSOCIATED INFEC-***  
6                               ***TIONS.***

7           (a) *IN GENERAL.*—*Title XI of the Social Security Act*  
8       *is amended by inserting after section 1138 the following sec-*  
9       *tion:*

10       ***“SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY***  
11                               ***HOSPITALS AND AMBULATORY SURGICAL***  
12                               ***CENTERS ON HEALTH CARE-ASSOCIATED IN-***  
13                               ***FECTIONS.***

14           “(a) *REPORTING REQUIREMENT.*—

15                       “(1) *IN GENERAL.*—*The Secretary shall provide*  
16       *that a hospital (as defined in subsection (g)) or am-*  
17       *bulatory surgical center meeting the requirements of*  
18       *titles XVIII or XIX may participate in the programs*  
19       *established under such titles (pursuant to the applica-*  
20       *ble provisions of law, including sections 1866(a)(1)*  
21       *and 1832(a)(1)(F)(i)) only if, in accordance with this*  
22       *section, the hospital or center reports such informa-*  
23       *tion on health care-associated infections that develop*  
24       *in the hospital or center (and such demographic in-*

1        *formation associated with such infections) as the Sec-*  
2        *retary specifies.*

3            “(2) *REPORTING PROTOCOLS.*—*Such information*  
4        *shall be reported in accordance with reporting proto-*  
5        *cols established by the Secretary through the Director*  
6        *of the Centers for Disease Control and Prevention (in*  
7        *this section referred to as the ‘CDC’) and to the Na-*  
8        *tional Healthcare Safety Network of the CDC or*  
9        *under such another reporting system of such Centers*  
10       *as determined appropriate by the Secretary in con-*  
11       *sultation with such Director.*

12           “(3) *COORDINATION WITH HIT.*—*The Secretary,*  
13       *through the Director of the CDC and the Office of the*  
14       *National Coordinator for Health Information Tech-*  
15       *nology, shall ensure that the transmission of informa-*  
16       *tion under this subsection is coordinated with systems*  
17       *established under the HITECH Act, where appro-*  
18       *priate.*

19           “(4) *PROCEDURES TO ENSURE THE VALIDITY OF*  
20       *INFORMATION.*—*The Secretary shall establish proce-*  
21       *dures regarding the validity of the information sub-*  
22       *mitted under this subsection in order to ensure that*  
23       *such information is appropriately compared across*  
24       *hospitals and centers. Such procedures shall address*  
25       *failures to report as well as errors in reporting.*



1           “(5) *IMPLEMENTATION.*—Not later than 1 year  
2           after the date of enactment of this section, the Sec-  
3           retary, through the Director of CDC, shall promulgate  
4           regulations to carry out this section.

5           “(b) *PUBLIC POSTING OF INFORMATION.*—The Sec-  
6           retary shall promptly post, on the official public Internet  
7           site of the Department of Health and Human Services, the  
8           information reported under subsection (a). Such informa-  
9           tion shall be set forth in a manner that allows for the com-  
10          parison of information on health care-associated infec-  
11          tions—

12           “(1) among hospitals and ambulatory surgical  
13          centers; and

14           “(2) by demographic information.

15          “(c) *ANNUAL REPORT TO CONGRESS.*—On an annual  
16          basis the Secretary shall submit to the Congress a report  
17          that summarizes each of the following:

18           “(1) The number and types of health care-associ-  
19          ated infections reported under subsection (a) in hos-  
20          pitals and ambulatory surgical centers during such  
21          year.

22           “(2) Factors that contribute to the occurrence of  
23          such infections, including health care worker immuni-  
24          zation rates.

1           “(3) *Based on the most recent information avail-*  
2           *able to the Secretary on the composition of the profes-*  
3           *sional staff of hospitals and ambulatory surgical cen-*  
4           *ters, the number of certified infection control profes-*  
5           *sionals on the staff of hospitals and ambulatory sur-*  
6           *gical centers.*

7           “(4) *The total increases or decreases in health*  
8           *care costs that resulted from increases or decreases in*  
9           *the rates of occurrence of each such type of infection*  
10          *during such year.*

11          “(5) *Recommendations, in coordination with the*  
12          *Center for Quality Improvement established under*  
13          *section 931 of the Public Health Service Act, for best*  
14          *practices to eliminate the rates of occurrence of each*  
15          *such type of infection in hospitals and ambulatory*  
16          *surgical centers.*

17          “(d) *NON-PREEMPTION OF STATE LAWS.—Nothing in*  
18          *this section shall be construed as preempting or otherwise*  
19          *affecting any provision of State law relating to the disclo-*  
20          *sure of information on health care-associated infections or*  
21          *patient safety procedures for a hospital or ambulatory sur-*  
22          *gical center.*

23          “(e) *HEALTH CARE-ASSOCIATED INFECTION.—For*  
24          *purposes of this section:*

1           “(1) *IN GENERAL.*—*The term ‘health care-associated*  
2           *infection’ means an infection that develops in a*  
3           *patient who has received care in any institutional*  
4           *setting where health care is delivered and is related*  
5           *to receiving health care.*”

6           “(2) *RELATED TO RECEIVING HEALTH CARE.*—  
7           *The term ‘related to receiving health care’, with re-*  
8           *spect to an infection, means that the infection was not*  
9           *incubating or present at the time health care was pro-*  
10          *vided.*”

11          “(f) *APPLICATION TO CRITICAL ACCESS HOSPITALS.*—  
12          *For purposes of this section, the term ‘hospital’ includes a*  
13          *critical access hospital, as defined in section*  
14          *1861(mm)(1).”.*

15          “(b) *EFFECTIVE DATE.*—*With respect to section 1138A*  
16          *of the Social Security Act (as inserted by subsection (a)*  
17          *of this section), the requirement under such section that hos-*  
18          *pitals and ambulatory surgical centers submit reports takes*  
19          *effect on such date (not later than 2 years after the date*  
20          *of the enactment of this Act) as the Secretary of Health*  
21          *and Human Services shall specify. In order to meet such*  
22          *deadline, the Secretary may implement such section*  
23          *through guidance or other instructions.*”

24          “(c) *GAO REPORT.*—*Not later than 18 months after the*  
25          *date of the enactment of this Act, the Comptroller General*

1 of the United States shall submit to Congress a report on  
2 the program established under section 1138A of the Social  
3 Security Act, as inserted by subsection (a). Such report  
4 shall include an analysis of the appropriateness of the types  
5 of information required for submission, compliance with re-  
6 porting requirements, the success of the validity procedures  
7 established, and any conflict or overlap between the report-  
8 ing required under such section and any other reporting  
9 systems mandated by either the States or the Federal Gov-  
10 ernment.

11 (d) *REPORT ON ADDITIONAL DATA.*—Not later than  
12 18 months after the date of the enactment of this Act, the  
13 Secretary of Health and Human Services shall submit to  
14 the Congress a report on the appropriateness of expanding  
15 the requirements under such section to include additional  
16 information (such as health care worker immunization  
17 rates), in order to improve health care quality and patient  
18 safety.

19 **TITLE V—MEDICARE GRADUATE**  
20 **MEDICAL EDUCATION**

21 **SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSI-**  
22 **TIONS.**

23 (a) *IN GENERAL.*—Section 1886(h) of the Social Secu-  
24 rity Act (42 U.S.C. 1395ww(h)) is amended—

1           (1) in paragraph (4)(F)(i), by striking “para-  
2           graph (7)” and inserting “paragraphs (7) and (8)”;

3           (2) in paragraph (4)(H)(i), by striking “para-  
4           graph (7)” and inserting “paragraphs (7) and (8)”;

5           (3) in paragraph (7)(E), by inserting “and  
6           paragraph (8)” after “this paragraph”; and

7           (4) by adding at the end the following new para-  
8           graph:

9           “(8) *ADDITIONAL REDISTRIBUTION OF UNUSED*  
10          *RESIDENCY POSITIONS.—*

11           “(A) *REDUCTIONS IN LIMIT BASED ON UN-*  
12          *USED POSITIONS.—*

13           “(i) *PROGRAMS SUBJECT TO REDUC-*  
14          *TION.—If a hospital’s reference resident*  
15          *level (specified in clause (ii)) is less than*  
16          *the otherwise applicable resident limit (as*  
17          *defined in subparagraph (C)(ii)), effective*  
18          *for portions of cost reporting periods occur-*  
19          *ring on or after July 1, 2011, the otherwise*  
20          *applicable resident limit shall be reduced by*  
21          *90 percent of the difference between such*  
22          *otherwise applicable resident limit and such*  
23          *reference resident level.*

24           “(ii) *REFERENCE RESIDENT LEVEL.—*

1           “(I) *IN GENERAL.*—*Except as oth-*  
2           *erwise provided in a subsequent sub-*  
3           *clause, the reference resident level spec-*  
4           *ified in this clause for a hospital is the*  
5           *highest resident level for any of the 3*  
6           *most recent cost reporting periods*  
7           *(ending before the date of the enact-*  
8           *ment of this paragraph) of the hospital*  
9           *for which a cost report has been settled*  
10           *(or, if not, submitted (subject to*  
11           *audit)), as determined by the Sec-*  
12           *retary.*

13           “(II) *USE OF MOST RECENT AC-*  
14           *COUNTING PERIOD TO RECOGNIZE EX-*  
15           *PANSION OF EXISTING PROGRAMS.*—*If*  
16           *a hospital submits a timely request to*  
17           *increase its resident level due to an ex-*  
18           *ansion, or planned expansion, of an*  
19           *existing residency training program*  
20           *that is not reflected on the most recent*  
21           *settled or submitted cost report, after*  
22           *audit and subject to the discretion of*  
23           *the Secretary, subject to subclause (IV),*  
24           *the reference resident level for such hos-*  
25           *pital is the resident level that includes*

1           *the additional residents attributable to*  
2           *such expansion or establishment, as de-*  
3           *termined by the Secretary. The Sec-*  
4           *retary is authorized to determine an*  
5           *alternative reference resident level for a*  
6           *hospital that submitted to the Sec-*  
7           *retary a timely request, before the start*  
8           *of the 2009–2010 academic year, for*  
9           *an increase in its reference resident*  
10          *level due to a planned expansion.*

11           “(III) *SPECIAL PROVIDER AGREE-*  
12          *MENT.—In the case of a hospital de-*  
13          *scribed in paragraph (4)(H)(v), the*  
14          *reference resident level specified in this*  
15          *clause is the limitation applicable*  
16          *under subclause (I) of such paragraph.*

17           “(IV) *PREVIOUS REDISTRIBU-*  
18          *TION.—The reference resident level*  
19          *specified in this clause for a hospital*  
20          *shall be increased to the extent required*  
21          *to take into account an increase in*  
22          *resident positions made available to*  
23          *the hospital under paragraph (7)(B)*  
24          *that are not otherwise taken into ac-*  
25          *count under a previous subclause.*

1           “(iii) *AFFILIATION.*—*The provisions of*  
2           *clause (i) shall be applied to hospitals*  
3           *which are members of the same affiliated*  
4           *group (as defined by the Secretary under*  
5           *paragraph (4)(H)(ii)) and to the extent the*  
6           *hospitals can demonstrate that they are fill-*  
7           *ing any additional resident slots allocated*  
8           *to other hospitals through an affiliation*  
9           *agreement, the Secretary shall adjust the de-*  
10           *termination of available slots accordingly,*  
11           *or which the Secretary otherwise has per-*  
12           *mitted the resident positions (under section*  
13           *402 of the Social Security Amendments of*  
14           *1967) to be aggregated for purposes of ap-*  
15           *plying the resident position limitations*  
16           *under this subsection.*

17           “(B) *REDISTRIBUTION.*—

18           “(i) *IN GENERAL.*—*The Secretary shall*  
19           *increase the otherwise applicable resident*  
20           *limit for each qualifying hospital that sub-*  
21           *mits an application under this subpara-*  
22           *graph by such number as the Secretary may*  
23           *approve for portions of cost reporting peri-*  
24           *ods occurring on or after July 1, 2011. The*  
25           *estimated aggregate number of increases in*



1           *the otherwise applicable resident limit*  
2           *under this subparagraph may not exceed the*  
3           *Secretary's estimate of the aggregate reduc-*  
4           *tion in such limits attributable to subpara-*  
5           *graph (A).*

6           “(ii) *REQUIREMENTS FOR QUALIFYING*  
7           *HOSPITALS.—A hospital is not a qualifying*  
8           *hospital for purposes of this paragraph un-*  
9           *less the following requirements are met:*

10           “(I) *MAINTENANCE OF PRIMARY*  
11           *CARE RESIDENT LEVEL.—The hospital*  
12           *maintains the number of primary care*  
13           *residents at a level that is not less than*  
14           *the base level of primary care residents*  
15           *increased by the number of additional*  
16           *primary care resident positions pro-*  
17           *vided to the hospital under this sub-*  
18           *paragraph. For purposes of this sub-*  
19           *paragraph, the ‘base level of primary*  
20           *care residents’ for a hospital is the*  
21           *level of such residents as of a base pe-*  
22           *riod (specified by the Secretary), deter-*  
23           *mined without regard to whether such*  
24           *positions were in excess of the other-*  
25           *wise applicable resident limit for such*

1                    *period but taking into account the ap-*  
2                    *plication of subclauses (II) and (III) of*  
3                    *subparagraph (A)(ii).*

4                    *“(II) DEDICATED ASSIGNMENT OF*  
5                    *ADDITIONAL RESIDENT POSITIONS TO*  
6                    *PRIMARY CARE.—The hospital assigns*  
7                    *all such additional resident positions*  
8                    *for primary care residents.*

9                    *“(III) ACCREDITATION.—The hos-*  
10                   *pital’s residency programs in primary*  
11                   *care are fully accredited or, in the case*  
12                   *of a residency training program not in*  
13                   *operation as of the base year, the hos-*  
14                   *pital is actively applying for such ac-*  
15                   *creditation for the program for such*  
16                   *additional resident positions (as deter-*  
17                   *mined by the Secretary).*

18                   *“(iii) CONSIDERATIONS IN REDIS-*  
19                   *TRIBUTION.—In determining for which*  
20                   *qualifying hospitals the increase in the oth-*  
21                   *erwise applicable resident limit is provided*  
22                   *under this subparagraph, the Secretary*  
23                   *shall take into account the demonstrated*  
24                   *likelihood of the hospital filling the posi-*  
25                   *tions within the first 3 cost reporting peri-*

1            *ods beginning on or after July 1, 2011,*  
2            *made available under this subparagraph, as*  
3            *determined by the Secretary.*

4            *“(iv) PRIORITY FOR CERTAIN HOS-*  
5            *PITALS.—In determining for which quali-*  
6            *fying hospitals the increase in the otherwise*  
7            *applicable resident limit is provided under*  
8            *this subparagraph, the Secretary shall dis-*  
9            *tribute the increase to qualifying hospitals*  
10           *based on the following criteria:*

11           *“(I) The Secretary shall give pref-*  
12           *erence to hospitals that had a reduc-*  
13           *tion in resident training positions*  
14           *under subparagraph (A).*

15           *“(II) The Secretary shall give*  
16           *preference to hospitals with 3-year pri-*  
17           *mary care residency training pro-*  
18           *grams, such as family practice and*  
19           *general internal medicine.*

20           *“(III) The Secretary shall give*  
21           *preference to hospitals insofar as they*  
22           *have in effect formal arrangements (as*  
23           *determined by the Secretary) that*  
24           *place greater emphasis upon training*  
25           *in Federally qualified health centers,*

1            *rural health clinics, and other nonpro-*  
2            *vider settings, and to hospitals that re-*  
3            *ceive additional payments under sub-*  
4            *section (d)(5)(F) and emphasize train-*  
5            *ing in an outpatient department.*

6            *“(IV) The Secretary shall give*  
7            *preference to hospitals with a number*  
8            *of positions (as of July 1, 2009) in ex-*  
9            *cess of the otherwise applicable resident*  
10           *limit for such period.*

11           *“(V) The Secretary shall give*  
12           *preference to hospitals that place great-*  
13           *er emphasis upon training in a health*  
14           *professional shortage area (designated*  
15           *under section 332 of the Public Health*  
16           *Service Act) or a health professional*  
17           *needs area (designated under section*  
18           *2211 of such Act).*

19           *“(VI) The Secretary shall give*  
20           *preference to hospitals in States that*  
21           *have low resident-to-population ratios*  
22           *(including a greater preference for*  
23           *those States with lower resident-to-pop-*  
24           *ulation ratios).*

1           “(v) *LIMITATION.*—*In no case shall*  
2           *more than 20 full-time equivalent addi-*  
3           *tional residency positions be made available*  
4           *under this subparagraph with respect to*  
5           *any hospital.*

6           “(vi) *APPLICATION OF PER RESIDENT*  
7           *AMOUNTS FOR PRIMARY CARE.*—*With re-*  
8           *spect to additional residency positions in a*  
9           *hospital attributable to the increase pro-*  
10           *vided under this subparagraph, the ap-*  
11           *proved FTE resident amounts are deemed to*  
12           *be equal to the hospital per resident*  
13           *amounts for primary care and nonprimary*  
14           *care computed under paragraph (2)(D) for*  
15           *that hospital.*

16           “(vi) *DISTRIBUTION.*—*The Secretary*  
17           *shall distribute the increase in resident*  
18           *training positions to qualifying hospitals*  
19           *under this subparagraph not later than*  
20           *July 1, 2011.*

21           “(C) *RESIDENT LEVEL AND LIMIT DE-*  
22           *FINED.*—*In this paragraph:*

23           “(i) *The term ‘resident level’ has the*  
24           *meaning given such term in paragraph*  
25           *(7)(C)(i).*

1           “(ii) The term ‘otherwise applicable  
2           resident limit’ means, with respect to a hos-  
3           pital, the limit otherwise applicable under  
4           subparagraphs (F)(i) and (H) of paragraph  
5           (4) on the resident level for the hospital de-  
6           termined without regard to this paragraph  
7           but taking into account paragraph (7)(A).

8           “(D) MAINTENANCE OF PRIMARY CARE  
9           RESIDENT LEVEL.—In carrying out this para-  
10          graph, the Secretary shall require hospitals that  
11          receive additional resident positions under sub-  
12          paragraph (B)—

13               “(i) to maintain records, and periodi-  
14               cally report to the Secretary, on the number  
15               of primary care residents in its residency  
16               training programs; and

17               “(ii) as a condition of payment for a  
18               cost reporting period under this subsection  
19               for such positions, to maintain the level of  
20               such positions at not less than the sum of—

21                       “(I) the base level of primary care  
22                       resident positions (as determined  
23                       under subparagraph (B)(ii)(I)) before  
24                       receiving such additional positions;  
25                       and

1                                   “(II) the number of such addi-  
2                                   tional positions.”.

3       (b) *IME*.—

4                   (1) *IN GENERAL*.—Section 1886(d)(5)(B)(v) of  
5       the Social Security Act (42 U.S.C.  
6       1395ww(d)(5)(B)(v)), in the third sentence, is amend-  
7       ed—

8                                   (A) by striking “subsection (h)(7)” and in-  
9                                   serting “subsections (h)(7) and (h)(8)”; and

10                                   (B) by striking “it applies” and inserting  
11                                   “they apply”.

12                   (2) *CONFORMING PROVISION*.—Section  
13       1886(d)(5)(B) of the Social Security Act (42 U.S.C.  
14       1395ww(d)(5)(B)) is amended by adding at the end  
15       the following clause:

16                                   “(x) For discharges occurring on or after July 1,  
17       2011, insofar as an additional payment amount  
18       under this subparagraph is attributable to resident  
19       positions distributed to a hospital under subsection  
20       (h)(8)(B), the indirect teaching adjustment factor  
21       shall be computed in the same manner as provided  
22       under clause (ii) with respect to such resident posi-  
23       tions.”.

24                   (c) *CONFORMING AMENDMENT*.—Section 422(b)(2) of  
25       the Medicare Prescription Drug, Improvement, and Mod-

1 *ernization Act of 2003 (Public Law 108-173) is amended*  
2 *by striking “section 1886(h)(7)” and all that follows and*  
3 *inserting “paragraphs (7) and (8) of subsection (h) of sec-*  
4 *tion 1886 of the Social Security Act.”.*

5 **SEC. 1502. INCREASING TRAINING IN NONPROVIDER SET-**  
6 **TINGS.**

7 (a) *DIRECT GME.*—Section 1886(h)(4)(E) of the So-  
8 *cial Security Act (42 U.S.C. 1395ww(h)) is amended—*

9 (1) *by designating the first sentence as a clause*  
10 *(i) with the heading “IN GENERAL.—” and appro-*  
11 *priate indentation;*

12 (2) *by striking “shall be counted and that all the*  
13 *time” and inserting “shall be counted and that—*

14 *“(I) effective for cost reporting pe-*  
15 *riods beginning before July 1, 2009, all*  
16 *the time”;*

17 (3) *in subclause (I), as inserted by paragraph*  
18 *(1), by striking the period at the end and inserting*  
19 *“; and”; and*

20 (A) *by inserting after subclause (I), as so*  
21 *inserted, the following:*

22 *“(II) effective for cost reporting*  
23 *periods beginning on or after July 1,*  
24 *2009, all the time so spent by a resi-*  
25 *dent shall be counted towards the deter-*



1                    *mination of full-time equivalency,*  
2                    *without regard to the setting in which*  
3                    *the activities are performed, if the hos-*  
4                    *pital incurs the costs of the stipends*  
5                    *and fringe benefits of the resident dur-*  
6                    *ing the time the resident spends in that*  
7                    *setting.*

8                    *Any hospital claiming under this subpara-*  
9                    *graph for time spent in a nonprovider set-*  
10                   *ting shall maintain and make available to*  
11                   *the Secretary records regarding the amount*  
12                   *of such time and such amount in compari-*  
13                   *son with amounts of such time in such base*  
14                   *year as the Secretary shall specify.”.*

15                   *(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Se-*  
16 *curity Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—*

17                   *(1) by striking “(iv) Effective for discharges oc-*  
18                   *curring on or after October 1, 1997” and inserting*  
19                   *“(iv)(I) Effective for discharges occurring on or after*  
20                   *October 1, 1997, and before July 1, 2009”; and*

21                   *(2) by inserting after subclause (I), as inserted*  
22                   *by paragraph (1), the following new subclause:*

23                   *“(II) Effective for discharges occurring on or*  
24                   *after July 1, 2009, all the time spent by an intern*  
25                   *or resident in patient care activities at an entity in*

1        *a nonprovider setting shall be counted towards the de-*  
2        *termination of full-time equivalency if the hospital*  
3        *incurs the costs of the stipends and fringe benefits of*  
4        *the intern or resident during the time the intern or*  
5        *resident spends in that setting.”.*

6        *(c) OIG STUDY ON IMPACT ON TRAINING.—The In-*  
7        *pector General of the Department of Health and Human*  
8        *Services shall analyze the data collected by the Secretary*  
9        *of Health and Human Services from the records made*  
10       *available to the Secretary under section 1886(h)(4)(E) of*  
11       *the Social Security Act, as amended by subsection (a), in*  
12       *order to assess the extent to which there is an increase in*  
13       *time spent by medical residents in training in nonprovider*  
14       *settings as a result of the amendments made by this section.*  
15       *Not later than 4 years after the date of the enactment of*  
16       *this Act, the Inspector General shall submit a report to Con-*  
17       *gress on such analysis and assessment.*

18       *(d) DEMONSTRATION PROJECT FOR APPROVED*  
19       *TEACHING HEALTH CENTERS.—*

20                *(1) IN GENERAL.—The Secretary of Health and*  
21        *Human Services shall conduct a demonstration*  
22        *project under which an approved teaching health cen-*  
23        *ter (as defined in paragraph (3)) would be eligible for*  
24        *payment under subsections (h) and (k) of section*  
25        *1886 of the Social Security Act (42 U.S.C. 1395ww)*

1       of amounts for its own direct costs of graduate med-  
2       ical education activities for primary care residents,  
3       as well as for the direct costs of graduate medical edu-  
4       cation activities of its contracting hospital for such  
5       residents, in a manner similar to the manner in  
6       which such payments would be made to a hospital if  
7       the hospital were to operate such a program.

8           (2) *CONDITIONS.*—Under the demonstration  
9       project—

10           (A) an approved teaching health center  
11       shall contract with an accredited teaching hos-  
12       pital to carry out the inpatient responsibilities  
13       of the primary care residency program of the  
14       hospital involved and is responsible for payment  
15       to the hospital for the hospital’s costs of the sal-  
16       ary and fringe benefits for residents in the pro-  
17       gram;

18           (B) the number of primary care residents of  
19       the center shall not count against the contracting  
20       hospital’s resident limit; and

21           (C) the contracting hospital shall agree not  
22       to diminish the number of residents in its pri-  
23       mary care residency training program.

24           (3) *APPROVED TEACHING HEALTH CENTER DE-*  
25       *FINED.*—In this subsection, the term “approved teach-

1        *ing health center” means a nonprovider setting, such*  
2        *as a Federally qualified health center or rural health*  
3        *clinic (as defined in section 1861(aa) of the Social*  
4        *Security Act), that develops and operates an accred-*  
5        *ited primary care residency program for which fund-*  
6        *ing would be available if it were operated by a hos-*  
7        *pital.*

8        **SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DI-**  
9                                    **DACTIC AND SCHOLARLY ACTIVITIES AND**  
10                                  **OTHER ACTIVITIES.**

11        *(a) DIRECT GME.—Section 1886(h) of the Social Se-*  
12        *curity Act (42 U.S.C. 1395ww(h)) is amended—*

13                    *(1) in paragraph (4)(E), as amended by section*  
14                    *1502(a)—*

15                    *(A) in clause (i), by striking “Such rules”*  
16                    *and inserting “Subject to clause (ii), such rules”;*  
17                    *and*

18                    *(B) by adding at the end the following new*  
19                    *clause:*

20                    *“(ii) TREATMENT OF CERTAIN NON-*  
21                    *PROVIDER AND DIDACTIC ACTIVITIES.—Such*  
22                    *rules shall provide that all time spent by an*  
23                    *intern or resident in an approved medical*  
24                    *residency training program in a nonpro-*  
25                    *vider setting that is primarily engaged in*

1           *furnishing patient care (as defined in para-*  
2           *graph (5)(K)) in nonpatient care activities,*  
3           *such as didactic conferences and seminars,*  
4           *but not including research not associated*  
5           *with the treatment or diagnosis of a par-*  
6           *ticular patient, as such time and activities*  
7           *are defined by the Secretary, shall be count-*  
8           *ed toward the determination of full-time*  
9           *equivalency.”;*

10           (2) *in paragraph (4), by adding at the end the*  
11           *following new subparagraph:*

12                   “(I) *TREATMENT OF CERTAIN TIME IN*  
13           *APPROVED MEDICAL RESIDENCY TRAINING PRO-*  
14           *GRAM.—In determining the hospital’s number of*  
15           *full-time equivalent residents for purposes of this*  
16           *subsection, all the time that is spent by an in-*  
17           *tern or resident in an approved medical resi-*  
18           *dency training program on vacation, sick leave,*  
19           *or other approved leave, as such time is defined*  
20           *by the Secretary, and that does not prolong the*  
21           *total time the resident is participating in the*  
22           *approved program beyond the normal duration*  
23           *of the program shall be counted toward the deter-*  
24           *mination of full-time equivalency.”; and*

1           (3) in paragraph (5), by adding at the end the  
2 following new subparagraph:

3           “(K) *NONPROVIDER SETTING THAT IS PRI-*  
4           *MARILY ENGAGED IN FURNISHING PATIENT*  
5           *CARE.—The term ‘nonprovider setting that is*  
6           *primarily engaged in furnishing patient care’*  
7           *means a nonprovider setting in which the pri-*  
8           *mary activity is the care and treatment of pa-*  
9           *tients, as defined by the Secretary.”.*

10          (b) *IME DETERMINATIONS.—Section 1886(d)(5)(B) of*  
11 *such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by sec-*  
12 *tion 1501(b), is amended by adding at the end the following*  
13 *new clause:*

14           “(xi)(I) *The provisions of subparagraph (I) of*  
15 *subsection (h)(4) shall apply under this subparagraph*  
16 *in the same manner as they apply under such sub-*  
17 *section.*

18           “(II) *In determining the hospital’s number of*  
19 *full-time equivalent residents for purposes of this sub-*  
20 *paragraph, all the time spent by an intern or resident*  
21 *in an approved medical residency training program*  
22 *in nonpatient care activities, such as didactic con-*  
23 *ferences and seminars, as such time and activities are*  
24 *defined by the Secretary, that occurs in the hospital*

1 shall be counted toward the determination of full-time  
2 equivalency if the hospital—

3 “(aa) is recognized as a subsection (d) hos-  
4 pital;

5 “(bb) is recognized as a subsection (d) Puer-  
6 to Rico hospital;

7 “(cc) is reimbursed under a reimbursement  
8 system authorized under section 1814(b)(3); or

9 “(dd) is a provider-based hospital out-  
10 patient department.

11 “(III) In determining the hospital’s number of  
12 full-time equivalent residents for purposes of this sub-  
13 paragraph, all the time spent by an intern or resident  
14 in an approved medical residency training program  
15 in research activities that are not associated with the  
16 treatment or diagnosis of a particular patient, as  
17 such time and activities are defined by the Secretary,  
18 shall not be counted toward the determination of full-  
19 time equivalency.”.

20 (c) *EFFECTIVE DATES; APPLICATION.*—

21 (1) *IN GENERAL.*—Except as otherwise provided,  
22 the Secretary of Health and Human Services shall  
23 implement the amendments made by this section in a  
24 manner so as to apply to cost reporting periods begin-  
25 ning on or after January 1, 1983.

1           (2) *DIRECT GME.*—Section 1886(h)(4)(E)(ii) of  
2     the Social Security Act, as added by subsection  
3     (a)(1)(B), shall apply to cost reporting periods begin-  
4     ning on or after July 1, 2008.

5           (3) *IME.*—Section 1886(d)(5)(B)(x)(III) of the  
6     Social Security Act, as added by subsection (b), shall  
7     apply to cost reporting periods beginning on or after  
8     October 1, 2001. Such section, as so added, shall not  
9     give rise to any inference on how the law in effect  
10    prior to such date should be interpreted.

11          (4) *APPLICATION.*—The amendments made by  
12    this section shall not be applied in a manner that re-  
13    quires reopening of any settled hospital cost reports as  
14    to which there is not a jurisdictionally proper appeal  
15    pending as of the date of the enactment of this Act  
16    on the issue of payment for indirect costs of medical  
17    education under section 1886(d)(5)(B) of the Social  
18    Security Act or for direct graduate medical education  
19    costs under section 1886(h) of such Act.

20    **SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS**  
21                           **FROM CLOSED HOSPITALS.**

22          (a) *DIRECT GME.*—Section 1886(h)(4)(H) of the So-  
23    cial Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is  
24    amended by adding at the end the following new clause:



1                   “(vi) *REDISTRIBUTION OF RESIDENCY*  
2                   *SLOTS AFTER A HOSPITAL CLOSES.—*

3                   “(I) *IN GENERAL.—The Secretary*  
4                   *shall, by regulation, establish a process*  
5                   *consistent with subclauses (II) and*  
6                   *(III) under which, in the case where a*  
7                   *hospital (other than a hospital de-*  
8                   *scribed in clause (v)) with an approved*  
9                   *medical residency program in a State*  
10                   *closes on or after the date that is 2*  
11                   *years before the date of the enactment*  
12                   *of this clause, the Secretary shall in-*  
13                   *crease the otherwise applicable resident*  
14                   *limit under this paragraph for other*  
15                   *hospitals in the State in accordance*  
16                   *with this clause.*

17                   “(II) *PROCESS FOR HOSPITALS IN*  
18                   *CERTAIN AREAS.—In determining for*  
19                   *which hospitals the increase in the oth-*  
20                   *erwise applicable resident limit de-*  
21                   *scribed in subclause (I) is provided, the*  
22                   *Secretary shall establish a process to*  
23                   *provide for such increase to one or*  
24                   *more hospitals located in the State.*  
25                   *Such process shall take into consider-*

1            *ation the recommendations submitted*  
2            *to the Secretary by the senior health of-*  
3            *ficial (as designated by the chief execu-*  
4            *tive officer of such State) if such rec-*  
5            *ommendations are submitted not later*  
6            *than 180 days after the date of the hos-*  
7            *pital closure involved (or, in the case of*  
8            *a hospital that closed after the date*  
9            *that is 2 years before the date of the*  
10           *enactment of this clause, 180 days*  
11           *after such date of enactment).*

12                    *“(III) LIMITATION.—The esti-*  
13                    *mated aggregate number of increases*  
14                    *in the otherwise applicable resident*  
15                    *limits for hospitals under this clause*  
16                    *shall be equal to the estimated number*  
17                    *of resident positions in the approved*  
18                    *medical residency programs that closed*  
19                    *on or after the date described in sub-*  
20                    *clause (I).”.*

21            *(b) NO EFFECT ON TEMPORARY FTE CAP ADJUST-*  
22            *MENTS.—The amendments made by this section shall not*  
23            *effect any temporary adjustment to a hospital’s FTE cap*  
24            *under section 413.79(h) of title 42, Code of Federal Regula-*  
25            *tions (as in effect on the date of enactment of this Act) and*

1 *shall not affect the application of section 1886(h)(4)(H)(v)*  
2 *of the Social Security Act.*

3 (c) *CONFORMING AMENDMENTS.*—

4 (1) *Section 422(b)(2) of the Medicare Prescrip-*  
5 *tion Drug, Improvement, and Modernization Act of*  
6 *2003 (Public Law 108-173), as amended by section*  
7 *1501(c), is amended by striking “(7) and” and insert-*  
8 *ing “(4)(H)(vi), (7), and”.*

9 (2) *Section 1886(h)(7)(E) of the Social Security*  
10 *Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by in-*  
11 *serting “or under paragraph (4)(H)(vi)” after “under*  
12 *this paragraph”.*

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 sub-*  
24 *paragraph:*

1           “(B) GOALS AND ACCOUNTABILITY FOR AP-  
2           PROVED MEDICAL RESIDENCY TRAINING PRO-  
3           GRAMS.—The goals of medical residency training  
4           programs are to foster a physician workforce so  
5           that physicians are trained to be able to do the  
6           following:

7                   “(i) Work effectively in various health  
8                   care delivery settings, such as nonprovider  
9                   settings.

10                   “(ii) Coordinate patient care within  
11                   and across settings relevant to their special-  
12                   ties.

13                   “(iii) Understand the relevant cost and  
14                   value of various diagnostic and treatment  
15                   options.

16                   “(iv) Work in inter-professional teams  
17                   and multi-disciplinary team-based models  
18                   in provider and nonprovider settings to en-  
19                   hance safety and improve quality of patient  
20                   care.

21                   “(v) Be knowledgeable in methods of  
22                   identifying systematic errors in health care  
23                   delivery and in implementing systematic  
24                   solutions in case of such errors, including  
25                   experience and participation in continuous

1           *quality improvement projects to improve*  
2           *health outcomes of the population the physi-*  
3           *cians serve.*

4           “(vi) *Be meaningful EHR users (as*  
5           *determined under section 1848(o)(2)) in the*  
6           *delivery of care and in improving the qual-*  
7           *ity of the health of the community and the*  
8           *individuals that the hospital serves.”*

9           **(b) GAO STUDY ON EVALUATION OF TRAINING PRO-**  
10 **GRAMS.—**

11           **(1) IN GENERAL.—***The Comptroller General of*  
12 *the United States shall conduct a study to evaluate*  
13 *the extent to which medical residency training pro-*  
14 *grams—*

15           **(A)** *are meeting the goals described in sec-*  
16 *tion 1886(h)(1)(B) of the Social Security Act, as*  
17 *added by subsection (a), in a range of residency*  
18 *programs, including primary care and other spe-*  
19 *cialties; and*

20           **(B)** *have the appropriate faculty expertise*  
21 *to teach the topics required to achieve such goals.*

22           **(2) REPORT.—***Not later than 18 months after the*  
23 *date of the enactment of this Act, the Comptroller*  
24 *General shall submit to Congress a report on such*  
25 *study and shall include in such report recommenda-*

1        *tions as to how medical residency training programs*  
 2        *could be further encouraged to meet such goals*  
 3        *through means such as—*

4                *(A) development of curriculum require-*  
 5                *ments; and*

6                *(B) assessment of the accreditation processes*  
 7                *of the Accreditation Council for Graduate Med-*  
 8                *ical Education and the American Osteopathic*  
 9                *Association and effectiveness of those processes in*  
 10                *accrediting medical residency programs that*  
 11                *meet the goals referred to in paragraph (1)(A).*

12        ***TITLE VI—PROGRAM INTEGRITY***

13        ***Subtitle A—Increased Funding To***  
 14        ***Fight Waste, Fraud, and Abuse***

15        ***SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO***  
 16        ***FIGHT FRAUD AND ABUSE.***

17                *(a) IN GENERAL.—Section 1817(k) of the Social Secu-*  
 18                *rity Act (42 U.S.C. 1395i(k)) is amended—*

19                        *(1) by adding at the end the following new para-*  
 20                        *graph:*

21                                *“(7) ADDITIONAL FUNDING.—In addition to the*  
 22                                *funds otherwise appropriated to the Account from the*  
 23                                *Trust Fund under paragraphs (3) and (4) and for*  
 24                                *purposes described in paragraphs (3)(C) and (4)(A),*  
 25                                *there are hereby appropriated an additional*

1       \$100,000,000 to such Account from such Trust Fund  
 2       for each fiscal year beginning with 2011. The funds  
 3       appropriated under this paragraph shall be allocated  
 4       in the same proportion as the total funding appro-  
 5       priated with respect to paragraphs (3)(A) and (4)(A)  
 6       was allocated with respect to fiscal year 2010, and  
 7       shall be available without further appropriation until  
 8       expended.”.

9               (2) in paragraph (4)(A)—

10                   (A) by inserting “for activities described in  
 11                   paragraph (3)(C) and” after “necessary”; and

12                   (B) by inserting “until expended” after  
 13                   “appropriation”.

14       (b) *FLEXIBILITY IN PURSUING FRAUD AND ABUSE.*—  
 15       Section 1893(a) of the Social Security Act (42 U.S.C.  
 16       1395ddd(a)) is amended by inserting “, or otherwise,” after  
 17       “entities”.

18       ***Subtitle B—Enhanced Penalties for***  
 19       ***Fraud and Abuse***

20       ***SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS***  
 21       ***ON PROVIDER OR SUPPLIER ENROLLMENT***  
 22       ***APPLICATIONS.***

23       (a) *IN GENERAL.*—Section 1128A(a) of the Social Se-  
 24       curity Act (42 U.S.C. 1320a–7a(a)) is amended—

1           (1) in paragraph (1)(D), by striking all that fol-  
2           lows “in which the person was excluded” and insert-  
3           ing “under Federal law from the Federal health care  
4           program under which the claim was made, or”;

5           (2) by striking “or” at the end of paragraph (6);

6           (3) in paragraph (7), by inserting at the end  
7           “or”;

8           (4) by inserting after paragraph (7) the fol-  
9           lowing new paragraph:

10           “(8) knowingly makes or causes to be made any  
11           false statement, omission, or misrepresentation of a  
12           material fact in any application, agreement, bid, or  
13           contract to participate or enroll as a provider of serv-  
14           ices or supplier under a Federal health care program,  
15           including managed care organizations under title  
16           XIX, Medicare Advantage organizations under part C  
17           of title XVIII, prescription drug plan sponsors under  
18           part D of title XVIII, and entities that apply to par-  
19           ticipate as providers of services or suppliers in such  
20           managed care organizations and such plans;”;

21           (5) in the matter following paragraph (8), as in-  
22           serted by paragraph (4), by striking “or in cases  
23           under paragraph (7), \$50,000 for each such act)” and  
24           inserting “in cases under paragraph (7), \$50,000 for  
25           each such act, or in cases under paragraph (8),



1       \$50,000 for each false statement, omission, or mis-  
2       representation of a material fact)”; and

3           (6) in the second sentence, by striking “for a  
4       lawful purpose)” and inserting “for a lawful purpose,  
5       or in cases under paragraph (8), an assessment of not  
6       more than 3 times the amount claimed as the result  
7       of the false statement, omission, or misrepresentation  
8       of material fact claimed by a provider of services or  
9       supplier whose application to participate contained  
10      such false statement, omission, or misrepresenta-  
11      tion)”.

12      (b) *EFFECTIVE DATE.*—The amendments made by sub-  
13      section (a) shall apply to acts committed on or after Janu-  
14      ary 1, 2010.

15      **SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF**  
16                                    **FALSE STATEMENTS MATERIAL TO A FALSE**  
17                                    **CLAIM.**

18      (a) *IN GENERAL.*—Section 1128A(a) of the Social Se-  
19      curity Act (42 U.S.C. 1320a–7a(a)), as amended by section  
20      1611, is further amended—

21           (1) in paragraph (7), by striking “or” at the  
22      end;

23           (2) in paragraph (8), by inserting “or” at the  
24      end; and

1           (3) by inserting after paragraph (8), the fol-  
2           lowing new paragraph:

3           “(9) knowingly makes, uses, or causes to be made  
4           or used, a false record or statement material to a false  
5           or fraudulent claim for payment for items and serv-  
6           ices furnished under a Federal health care program;”;  
7           and

8           (4) in the matter following paragraph (9), as in-  
9           serted by paragraph (3)—

10           (A) by striking “or in cases under para-  
11           graph (8)” and inserting “in cases under para-  
12           graph (8)”; and

13           (B) by striking “a material fact)” and in-  
14           serting “a material fact, in cases under para-  
15           graph (9), \$50,000 for each false record or state-  
16           ment)”.

17           (b) *EFFECTIVE DATE.*—The amendments made by sub-  
18           section (a) shall apply to acts committed on or after Janu-  
19           ary 1, 2010.

20           **SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPEC-**  
21           **TIONS.**

22           (a) *IN GENERAL.*—Section 1128A(a) of the Social Se-  
23           curity Act (42 U.S.C. 1320a–7a(a)), as amended by sections  
24           1611 and 1612, is further amended—

1           (1) *in paragraph (8), by striking “or” at the*  
2 *end;*

3           (2) *in paragraph (9), by inserting “or” at the*  
4 *end;*

5           (3) *by inserting after paragraph (9) the fol-*  
6 *lowing new paragraph:*

7           “(10) *fails to grant timely access, upon reason-*  
8 *able request (as defined by the Secretary in regula-*  
9 *tions), to the Inspector General of the Department of*  
10 *Health and Human Services, for the purpose of au-*  
11 *ditions, investigations, evaluations, or other statutory*  
12 *functions of the Inspector General of the Department*  
13 *of Health and Human Services;”;* and

14           (4) *in the matter following paragraph (10), as*  
15 *inserted by paragraph (3), by inserting “, or in cases*  
16 *under paragraph (10), \$15,000 for each day of the*  
17 *failure described in such paragraph” after “false*  
18 *record or statement”.*

19           (b) *ENSURING TIMELY INSPECTIONS RELATING TO*  
20 *CONTRACTS WITH MA ORGANIZATIONS.—Section*  
21 *1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is*  
22 *amended—*

23           (1) *in subparagraph (A), by inserting “timely”*  
24 *before “inspect”; and*

1 (2) in subparagraph (B), by inserting “timely”  
2 before “audit and inspect”.

3 (c) *EFFECTIVE DATE*.—The amendments made by sub-  
4 section (a) shall apply to violations committed on or after  
5 January 1, 2010.

6 **SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.**

7 (a) *MEDICARE*.—Part A of title XVIII of the Social  
8 Security Act is amended by inserting after section 1819 the  
9 following new section:

10 **“SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE**  
11 **CARE.**

12 “(a) *IN GENERAL*.—If the Secretary determines on the  
13 basis of a survey or otherwise, that a hospice program that  
14 is certified for participation under this title has dem-  
15 onstrated a substandard quality of care and failed to meet  
16 such other requirements as the Secretary may find nec-  
17 essary in the interest of the health and safety of the individ-  
18 uals who are provided care and services by the agency or  
19 organization involved and determines—

20 “(1) that the deficiencies involved immediately  
21 jeopardize the health and safety of the individuals to  
22 whom the program furnishes items and services, the  
23 Secretary shall take immediate action to remove the  
24 jeopardy and correct the deficiencies through the rem-  
25 edy specified in subsection (b)(2)(A)(iii) or terminate

1       *the certification of the program, and may provide, in*  
2       *addition, for 1 or more of the other remedies described*  
3       *in subsection (b)(2)(A); or*

4               *“(2) that the deficiencies involved do not imme-*  
5       *diately jeopardize the health and safety of the individ-*  
6       *uals to whom the program furnishes items and serv-*  
7       *ices, the Secretary may—*

8               *“(A) impose intermediate sanctions devel-*  
9       *oped pursuant to subsection (b), in lieu of termi-*  
10       *nating the 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-*  
14       *minate 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 July 1, 2012—*

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 such*  
9                   *sanctions.*

10           “(2) *SPECIFIED SANCTIONS.*—

11                   “(A) *IN GENERAL.*—*The intermediate sanc-*  
12                   *tions developed under paragraph (1) may in-*  
13                   *clude—*

14                           “(i) *civil money penalties in an*  
15                           *amount not to exceed \$10,000 for each day*  
16                           *of noncompliance or, in the case of a per in-*  
17                           *stance penalty applied by the Secretary, not*  
18                           *to exceed \$25,000,*

19                           “(ii) *denial of all or part of the pay-*  
20                           *ments to which a hospice program would*  
21                           *otherwise be entitled under this title with*  
22                           *respect to items and services furnished by a*  
23                           *hospice program on or after the date on*  
24                           *which the Secretary determines that inter-*

1            *mediate sanctions should be imposed pursu-*  
2            *ant to subsection (a)(2),*

3            *“(iii) the appointment of temporary*  
4            *management to oversee the operation of the*  
5            *hospice program and to protect and assure*  
6            *the health and safety of the individuals*  
7            *under the care of the program while im-*  
8            *provements are made,*

9            *“(iv) corrective action plans, and*

10           *“(v) in-service training for staff.*

11           *The provisions of section 1128A (other than sub-*  
12           *sections (a) and (b)) shall apply to a civil money*  
13           *penalty under clause (i) in the same manner as*  
14           *such provisions apply to a penalty or proceeding*  
15           *under section 1128A(a). The temporary manage-*  
16           *ment under clause (iii) shall not be terminated*  
17           *until the Secretary has determined that the pro-*  
18           *gram has the management capability to ensure*  
19           *continued compliance with all requirements re-*  
20           *ferred to in that clause.*

21           *“(B) CLARIFICATION.—The sanctions speci-*  
22           *fied in subparagraph (A) are in addition to*  
23           *sanctions otherwise available under State or*  
24           *Federal law and shall not be construed as lim-*

1            *iting other remedies, including any remedy*  
2            *available to an individual at common law.*

3            *“(C) COMMENCEMENT OF PAYMENT.—A de-*  
4             *denial of payment under subparagraph (A)(ii)*  
5            *shall terminate when the Secretary determines*  
6            *that the hospice program no longer demonstrates*  
7            *a substandard quality of care and meets such*  
8            *other requirements as the Secretary may find*  
9            *necessary in the interest of the health and safety*  
10           *of the individuals who are provided care and*  
11           *services by the agency or organization involved.*

12           *“(3) SECRETARIAL AUTHORITY.—The Secretary*  
13           *shall develop and implement, by not later than July*  
14           *1, 2011, specific procedures with respect to the condi-*  
15           *tions under which each of the intermediate sanctions*  
16           *developed under paragraph (1) is to be applied, in-*  
17           *cluding the amount of any fines and the severity of*  
18           *each of these sanctions. Such procedures shall be de-*  
19           *signed so as to minimize the time between identifica-*  
20           *tion of deficiencies and imposition of these sanctions*  
21           *and shall provide for the imposition of incrementally*  
22           *more severe fines for repeated or uncorrected defi-*  
23           *ciencies.”.*



1           (b) *APPLICATION TO MEDICAID.*—Section 1905(o) of  
2 *the Social Security Act (42 U.S.C. 1396d(o)) is amended*  
3 *by adding at the end the following new paragraph:*

4           “(4) *The provisions of section 1819A shall apply to*  
5 *a hospice program providing hospice care under this title*  
6 *in the same manner as such provisions apply to a hospice*  
7 *program providing hospice care under title XVIII.”.*

8           (c) *APPLICATION TO CHIP.*—Title XXI of the Social  
9 *Security Act is amended by adding at the end the following*  
10 *new section:*

11 **“SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.**

12           *“The provisions of section 1819A shall apply to a hos-*  
13 *pice program providing hospice care under this title in the*  
14 *same manner such provisions apply to a hospice program*  
15 *providing hospice care under title XVIII.”.*

16 **SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EX-**  
17 **CLUDED FROM PROGRAM PARTICIPATION.**

18           (a) *IN GENERAL.*—Section 1128A(a) of the Social Se-  
19 *curity Act (42 U.S.C. 1320a–7a(a)), as amended by the pre-*  
20 *vious sections, is further amended—*

21                   (1) *by striking “or” at the end of paragraph (9);*

22                   (2) *by inserting “or” at the end of paragraph*  
23 *(10);*

24                   (3) *by inserting after paragraph (10) the fol-*  
25 *lowing new paragraph:*

1           “(11) orders or prescribes an item or service, in-  
2           cluding without limitation home health care, diag-  
3           nostic and clinical lab tests, prescription drugs, dura-  
4           ble medical equipment, ambulance services, physical  
5           or occupational therapy, or any other item or service,  
6           during a period when the person has been excluded  
7           from participation in a Federal health care program,  
8           and the person knows or should know that a claim for  
9           such item or service will be presented to such a pro-  
10          gram;” and

11           (4) in the matter following paragraph (11), as  
12          inserted by paragraph (3), by striking “or in cases  
13          under paragraph (10), \$15,000 for each day of the  
14          failure described in such paragraph” and inserting  
15          “in cases under paragraph (10), \$15,000 for each day  
16          of the failure described in such paragraph, or in cases  
17          under paragraph (11), \$50,000 for each order or pre-  
18          scription for an item or service by an excluded indi-  
19          vidual”.

20          (b) *EFFECTIVE DATE.*—The amendments made by sub-  
21          section (a) shall apply to violations committed on or after  
22          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 Social  
5 Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended  
6 by inserting “except with respect to a determination under  
7 subparagraph (E), an assessment of not more than 3 times  
8 the amount claimed by such plan or plan sponsor based  
9 upon the misrepresentation or falsified information in-  
10 volved,” after “for each such determination,”.

11 (b) *EFFECTIVE DATE.*—The amendment made by sub-  
12 section (a) shall apply to violations committed on or after  
13 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 Se-  
17 curity Act (42 U.S.C. 1395w—27(g)(1)), as amended by  
18 section 1221(b), is amended—

19 (1) in subparagraph (G), by striking “or” at the  
20 end;

21 (2) by inserting after subparagraph (H) the fol-  
22 lowing new subparagraphs:

23 “(I) except as provided under subparagraph  
24 (C) or (D) of section 1860D–1(b)(1), enrolls an  
25 individual in any plan under this part without

1           *the prior consent of the individual or the des-*  
2           *ignee 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 of*  
6           *the individual or solely for the purpose of earn-*  
7           *ing a commission;*

8           *“(K) fails to comply with marketing restric-*  
9           *tions described in subsections (h) and (j) of sec-*  
10          *tion 1851 or applicable implementing regula-*  
11          *tions or guidance; 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 this*  
15          *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) *EFFECTIVE DATE.*—*The amendments made by sub-*  
2 *section (a) shall apply to violations committed on or after*  
3 *January 1, 2010.*

4 **SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF**  
5 **PROGRAM AUDITS.**

6           (a) *IN GENERAL.*—*Section 1128(b)(2) of the Social Se-*  
7 *curity Act (42 U.S.C. 1320a–7(b)(2)) is amended—*

8                 (1) *in the heading, by inserting “OR AUDIT”*  
9 *after “INVESTIGATION”; and*

10                (2) *by striking “investigation into” and all that*  
11 *follows through the period and inserting “investiga-*  
12 *tion or audit related to—”*

13                         *“(A) any offense described in paragraph (1)*  
14 *or in subsection (a); or*

15                         *“(B) the use of funds received, directly or*  
16 *indirectly, from any Federal health care pro-*  
17 *gram (as defined in section 1128B(f)).”.*

18           (b) *EFFECTIVE DATE.*—*The amendments made by sub-*  
19 *section (a) shall apply to violations committed on or after*  
20 *January 1, 2010.*

1 **SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND EN-**  
2 **TITIES FROM PARTICIPATION IN MEDICARE**  
3 **AND STATE HEALTH CARE PROGRAMS.**

4 (a) *IN GENERAL.*—Section 1128(c) of the Social Secu-  
5 rity Act, as previously amended by this division, is further  
6 amended—

7 (1) *in the heading, by striking “AND PERIOD”*  
8 *and inserting “PERIOD, AND EFFECT”;* and

9 (2) *by adding at the end the following new para-*  
10 *graph:*

11 “(4)(A) *For purposes of this Act, subject to subpara-*  
12 *graph (C), the effect of exclusion is that no payment may*  
13 *be made by any Federal health care program (as defined*  
14 *in section 1128B(f)) with respect to any item or service fur-*  
15 *nished—*

16 *“(i) by an excluded individual or entity; or*

17 *“(ii) at the medical direction or on the prescrip-*  
18 *tion of a physician or other authorized individual*  
19 *when the person submitting a claim for such item or*  
20 *service knew or had reason to know of the exclusion*  
21 *of such individual.*

22 “(B) *For purposes of this section and sections 1128A*  
23 *and 1128B, subject to subparagraph (C), an item or service*  
24 *has been furnished by an individual or entity if the indi-*  
25 *vidual or entity directly or indirectly provided, ordered,*  
26 *manufactured, distributed, prescribed, or otherwise supplied*

1 *the item or service regardless of how the item or service was*  
2 *paid for by a Federal health care program or to whom such*  
3 *payment was made.*

4       “(C)(i) *Payment may be made under a Federal health*  
5 *care program for emergency items or services (not including*  
6 *items or services furnished in an emergency room of a hos-*  
7 *pital) furnished by an excluded individual or entity, or at*  
8 *the medical direction or on the prescription of an excluded*  
9 *physician or other authorized individual during the period*  
10 *of such individual’s exclusion.*

11       “(ii) *In the case that an individual eligible for benefits*  
12 *under title XVIII or XIX submits a claim for payment for*  
13 *items or services furnished by an excluded individual or*  
14 *entity, and such individual eligible for such benefits did not*  
15 *know or have reason to know that such excluded individual*  
16 *or entity was so excluded, then, notwithstanding such exclu-*  
17 *sion, payment shall be made for such items or services. In*  
18 *such case the Secretary shall notify such individual eligible*  
19 *for such benefits of the exclusion of the individual or entity*  
20 *furnishing the items or services. Payment shall not be made*  
21 *for items or services furnished by an excluded individual*  
22 *or entity to an individual eligible for such benefits after*  
23 *a reasonable time (as determined by the Secretary in regu-*  
24 *lations) after the Secretary has notified the individual eligi-*

1 ble for such benefits of the exclusion of the individual or  
2 entity furnishing the items or services.

3       “(iii) In the case that a claim for payment for items  
4 or services furnished by an excluded individual or entity  
5 is submitted by an individual or entity other than an indi-  
6 vidual eligible for benefits under title XVIII or XIX or the  
7 excluded individual or entity, and the Secretary determines  
8 that the individual or entity that submitted the claim took  
9 reasonable steps to learn of the exclusion and reasonably  
10 relied upon inaccurate or misleading information from the  
11 relevant Federal health care program or its contractor, the  
12 Secretary may waive repayment of the amount paid in vio-  
13 lation of the exclusion to the individual or entity that sub-  
14 mitted the claim for the items or services furnished by the  
15 excluded individual or entity. If a Federal health care pro-  
16 gram contractor provided inaccurate or misleading infor-  
17 mation that resulted in the waiver of an overpayment under  
18 this clause, the Secretary shall take appropriate action to  
19 recover the improperly paid amount from the contractor.”.



1 ***Subtitle C—Enhanced Program and***  
2 ***Provider Protections***

3 ***SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AU-***  
4 ***THORITY.***

5 *(a) IN GENERAL.—Title XI of the Social Security Act*  
6 *(42 U.S.C. 1301 et seq.) is amended by inserting after sec-*  
7 *tion 1128F the following new section:*

8 ***“SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PRO-***  
9 ***TECTIONS IN THE MEDICARE, MEDICAID, AND***  
10 ***CHIP PROGRAMS.***

11 *“(a) CERTAIN AUTHORIZED SCREENING, ENHANCED*  
12 *OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—*

13 *“(1) IN GENERAL.—For periods beginning after*  
14 *January 1, 2011, in the case that the Secretary deter-*  
15 *mines there is a significant risk of fraudulent activity*  
16 *(as determined by the Secretary based on relevant*  
17 *complaints, reports, referrals by law enforcement or*  
18 *other sources, data analysis, trending information, or*  
19 *claims submissions by providers of services and sup-*  
20 *pliers) with respect to a category of provider of serv-*  
21 *ices or supplier of items or services, including a cat-*  
22 *egory within a geographic area, under title XVIII,*  
23 *XIX, or XXI, the Secretary may impose any of the*  
24 *following requirements with respect to a provider of*  
25 *services or a supplier (whether such provider or sup-*

1        *plier is initially enrolling in the program or is re-*  
2        *newing such enrollment):*

3                *“(A) Screening under paragraph (2).*

4                *“(B) Enhanced oversight periods under*  
5        *paragraph (3).*

6                *“(C) Enrollment moratoria under para-*  
7        *graph (4).*

8        *In applying this subsection for purposes of title XIX*  
9        *and XXI the Secretary may require a State to carry*  
10        *out the provisions of this subsection as a requirement*  
11        *of the State plan under title XIX or the child health*  
12        *plan under title XXI. Actions taken and determina-*  
13        *tions made under this subsection shall not be subject*  
14        *to review by a judicial tribunal.*

15                *“(2) SCREENING.—For purposes of paragraph*  
16        *(1), the Secretary shall establish procedures under*  
17        *which screening is conducted with respect to providers*  
18        *of services and suppliers described in such paragraph.*  
19        *Such screening may include—*

20                *“(A) licensing board checks;*

21                *“(B) screening against the list of individ-*  
22        *uals and entities excluded from the program*  
23        *under title XVIII, XIX, or XXI;*

24                *“(C) the excluded provider list system;*

25                *“(D) background checks; and*

1           “(E) unannounced pre-enrollment or other  
2           site visits.

3           “(3) *ENHANCED OVERSIGHT PERIOD.*—For pur-  
4           poses of paragraph (1), the Secretary shall establish  
5           procedures to provide for a period of not less than 30  
6           days and not more than 365 days during which pro-  
7           viders of services and suppliers described in such  
8           paragraph, as the Secretary determines appropriate,  
9           would be subject to enhanced oversight, such as re-  
10          quired or unannounced (or required and unan-  
11          nounced) site visits or inspections, prepayment re-  
12          view, enhanced review of claims, and such other ac-  
13          tions as specified by the Secretary, under the pro-  
14          grams under titles XVIII, XIX, and XXI. Under such  
15          procedures, the Secretary may extend such period for  
16          more than 365 days if the Secretary determines that  
17          after the initial period such additional period of over-  
18          sight is necessary.

19          “(4) *MORATORIUM ON ENROLLMENT OF PRO-*  
20          *VIDERS AND SUPPLIERS.*—For purposes of paragraph  
21          (1), the Secretary, based upon a finding of a risk of  
22          serious ongoing fraud within a program under title  
23          XVIII, XIX, or XXI, may impose a moratorium on  
24          the enrollment of providers of services and suppliers  
25          within a category of providers of services and sup-

1       pliers (including a category within a specific geo-  
2       graphic area) under such title. Such a moratorium  
3       may only be imposed if the Secretary makes a deter-  
4       mination that the moratorium would not adversely  
5       impact access of individuals to care under such pro-  
6       gram.

7               “(5) CLARIFICATION.—Nothing in this subsection  
8       shall be interpreted to preclude or limit the ability of  
9       a State to engage in provider screening or enhanced  
10      provider oversight activities beyond those required by  
11      the Secretary.”.

12      (b) CONFORMING AMENDMENTS.—

13              (1) MEDICAID.—Section 1902(a) of the Social  
14      Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is  
15      amended—

16              (A) in paragraph (23), by inserting before  
17      the semicolon at the end the following: “or by a  
18      person to whom or entity to which a moratorium  
19      under section 1128G(a)(4) is applied during the  
20      period of such moratorium”;

21              (B) in paragraph (72); by striking at the  
22      end “and”;

23              (C) in paragraph (73), by striking the pe-  
24      riod at the end and inserting “; and”; and

1                   (D) by inserting after paragraph (73) the  
2                   following new paragraph:

3                   “(74) provide that the State will enforce any de-  
4                   termination made by the Secretary under subsection  
5                   (a) of section 1128G (relating to a significant risk of  
6                   fraudulent activity with respect to a category of pro-  
7                   vider or supplier described in such subsection (a)  
8                   through use of the appropriate procedures described in  
9                   such subsection (a)), and that the State will carry out  
10                  any activities as required by the Secretary for pur-  
11                  poses of such subsection (a).”.

12                  (2) CHIP.—Section 2102 of such Act (42 U.S.C.  
13                  1397bb) is amended by adding at the end the fol-  
14                  lowing new subsection:

15                  “(d) PROGRAM INTEGRITY.—A State child health plan  
16                  shall include a description of the procedures to be used by  
17                  the State—

18                         “(1) to enforce any determination made by the  
19                         Secretary under subsection (a) of section 1128G (re-  
20                         lating to a significant risk of fraudulent activity with  
21                         respect to a category of provider or supplier described  
22                         in such subsection through use of the appropriate pro-  
23                         cedures described in such subsection); and

24                         “(2) to carry out any activities as required by  
25                         the Secretary for purposes of such subsection.”.

1           (3) *MEDICARE*.—Section 1866(j) of such Act (42  
2           *U.S.C. 1395cc(j)*) is amended by adding at the end  
3           the following new paragraph:

4           “(3) *PROGRAM INTEGRITY*.—The provisions of  
5           section 1128G(a) apply to enrollments and renewals  
6           of enrollments of providers of services and suppliers  
7           under this title.”.

8   **SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP**  
9                           **PROGRAM DISCLOSURE REQUIREMENTS RE-**  
10                          **LATING TO PREVIOUS AFFILIATIONS.**

11           (a) *IN GENERAL*.—Section 1128G of the Social Secu-  
12           rity Act, as inserted by section 1631, is amended by adding  
13           at the end the following new subsection:

14           “(b) *ENHANCED PROGRAM DISCLOSURE REQUIRE-*  
15           *MENTS*.—

16           “(1) *DISCLOSURE*.—A provider of services or  
17           supplier who submits on or after July 1, 2011, an ap-  
18           plication for enrollment and renewing enrollment in  
19           a program under title XVIII, XIX, or XXI shall dis-  
20           close (in a form and manner determined by the Sec-  
21           retary) any current affiliation or affiliation within  
22           the previous 10-year period with a provider of serv-  
23           ices or supplier that has uncollected debt or with a  
24           person or entity that has been suspended or excluded

1        *under such program, subject to a payment suspension,*  
2        *or has had its billing privileges revoked.*

3            “(2) *ENHANCED SAFEGUARDS.*—*If the Secretary*  
4        *determines that such previous affiliation of such pro-*  
5        *vider or supplier poses a risk of fraud, waste, or*  
6        *abuse, the Secretary may apply such enhanced safe-*  
7        *guards as the Secretary determines necessary to re-*  
8        *duce such risk associated with such provider or sup-*  
9        *plier enrolling or participating in the program under*  
10       *title XVIII, XIX, or XXI. Such safeguards may in-*  
11       *clude enhanced oversight, such as enhanced screening*  
12       *of claims, required or unannounced (or required and*  
13       *unannounced) site visits or inspections, additional*  
14       *information reporting requirements, and conditioning*  
15       *such enrollment on the provision of a surety bond.*

16            “(3) *AUTHORITY TO DENY PARTICIPATION.*—*If*  
17        *the Secretary determines that there has been at least*  
18        *one such affiliation and that such affiliation or affili-*  
19        *ations, as applicable, of such provider or supplier*  
20        *poses a serious risk of fraud, waste, or abuse, the Sec-*  
21        *retary may deny the application of such provider or*  
22        *supplier.”.*

23        (b) *CONFORMING AMENDMENTS.*—

1           (1) *MEDICAID.*—Paragraph (74) of section  
2           1902(a) of such Act (42 U.S.C. 1396a(a)), as added  
3           by section 1631(b)(1), is amended—

4                   (A) by inserting “or subsection (b) of such  
5                   section (relating to disclosure requirements)” be-  
6                   fore “, and that the State”; and

7                   (B) by inserting before the period the fol-  
8                   lowing: “and apply any enhanced safeguards,  
9                   with respect to a provider or supplier described  
10                  in such subsection (b), as the Secretary deter-  
11                  mines necessary under such subsection (b)”.

12          (2) *CHIP.*—Subsection (d) of section 2102 of  
13          such Act (42 U.S.C. 1397bb), as added by section  
14          1631(b)(2), is amended—

15                  (A) in paragraph (1), by striking at the end  
16                  “and”;

17                  (B) in paragraph (2) by striking the period  
18                  at the end and inserting “; and’” and

19                  (C) by adding at the end the following new  
20                  paragraph:

21                  “(3) to enforce any determination made by the  
22                  Secretary under subsection (b) of section 1128G (re-  
23                  lating to disclosure requirements) and to apply any  
24                  enhanced safeguards, with respect to a provider or



1        *supplier described in such subsection, as the Secretary*  
2        *determines necessary under such subsection.”.*

3    **SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER**  
4                    **FOR CERTAIN EVALUATION AND MANAGE-**  
5                    **MENT SERVICES.**

6        *Section 1848 of the Social Security Act (42 U.S.C.*  
7        *1395w-4), as amended by section 4101 of the HITECH Act*  
8        *(Public Law 111-5), is amended by adding at the end the*  
9        *following new subsection:*

10        *“(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION*  
11        *AND MANAGEMENT SERVICES.—The Secretary shall estab-*  
12        *lish a payment modifier under the fee schedule under this*  
13        *section for evaluation and management services (as speci-*  
14        *fied in section 1842(b)(16)(B)(ii)) that result in the order-*  
15        *ing of additional services (such as lab tests), the prescrip-*  
16        *tion of drugs, the furnishing or ordering of durable medical*  
17        *equipment in order to enable better monitoring of claims*  
18        *for payment for such additional services under this title,*  
19        *or the ordering, furnishing, or prescribing of other items*  
20        *and services determined by the Secretary to pose a high risk*  
21        *of waste, fraud, and abuse. The Secretary may require pro-*  
22        *viders of services or suppliers to report such modifier in*  
23        *claims submitted for payment.”.*

1 **SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER**  
2 **MEDICARE INTEGRITY PROGRAM.**

3 (a) *IN GENERAL.*—Section 1893(c) of the Social Secu-  
4 rity Act (42 U.S.C. 1395ddd(c)) is amended—

5 (1) in paragraph (3), by striking at the end  
6 “and”;

7 (2) by redesignating paragraph (4) as para-  
8 graph (5); and

9 (3) by inserting after paragraph (3) the fol-  
10 lowing new paragraph:

11 “(4) for the contract year beginning in 2011 and  
12 each subsequent contract year, the entity provides as-  
13 surances to the satisfaction of the Secretary that the  
14 entity will conduct periodic evaluations of the effec-  
15 tiveness of the activities carried out by such entity  
16 under the Program and will submit to the Secretary  
17 an annual report on such activities; and”.

18 (b) *REFERENCE TO MEDICAID INTEGRITY PRO-*  
19 *GRAM.*—For a similar provision with respect to the Med-  
20 icaid Integrity Program, see section 1752.

21 **SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT**  
22 **PROGRAMS TO REDUCE WASTE, FRAUD, AND**  
23 **ABUSE.**

24 (a) *IN GENERAL.*—Section 1874 of the Social Security  
25 Act (42 U.S.C. 42 U.S.C. 1395kk) is amended by adding  
26 at the end the following new subsection:

1       “(e) *COMPLIANCE PROGRAMS FOR PROVIDERS OF*  
2 *SERVICES AND SUPPLIERS.*—

3               “(1) *IN GENERAL.*—*The Secretary may disenroll*  
4 *a provider of services or a supplier (other than a phy-*  
5 *sician or a skilled nursing facility) under this title*  
6 *(or may impose any civil monetary penalty or other*  
7 *intermediate sanction under paragraph (4)) if such*  
8 *provider of services or supplier fails to, subject to*  
9 *paragraph (5), establish a compliance program that*  
10 *contains the core elements established under para-*  
11 *graph (2).*

12               “(2) *ESTABLISHMENT OF CORE ELEMENTS.*—*The*  
13 *Secretary, in consultation with the Inspector General*  
14 *of the Department of Health and Human Services,*  
15 *shall establish core elements for a compliance pro-*  
16 *gram under paragraph (1). Such elements may in-*  
17 *clude written policies, procedures, and standards of*  
18 *conduct, a designated compliance officer and a com-*  
19 *pliance committee; effective training and education*  
20 *pertaining to fraud, waste, and abuse for the organi-*  
21 *zation’s employees and contractors; a confidential or*  
22 *anonymous mechanism, such as a hotline, to receive*  
23 *compliance questions and reports of fraud, waste, or*  
24 *abuse; disciplinary guidelines for enforcement of*  
25 *standards; internal monitoring and auditing proce-*

1        *dures, including monitoring and auditing of contrac-*  
2        *tors; procedures for ensuring prompt responses to de-*  
3        *tected offenses and development of corrective action*  
4        *initiatives, including responses to potential offenses;*  
5        *and procedures to return all identified overpayments*  
6        *to the programs under this title, title XIX, and title*  
7        *XXI.*

8                *“(3) TIMELINE FOR IMPLEMENTATION.—The Sec-*  
9        *retary shall determine a timeline for the establish-*  
10        *ment of the core elements under paragraph (2) and*  
11        *the date on which a provider of services and suppliers*  
12        *(other than physicians) shall be required to have es-*  
13        *tablished such a program for purposes of this sub-*  
14        *section.*

15                *“(4) CMS ENFORCEMENT AUTHORITY.—The Ad-*  
16        *ministrator for the Centers of Medicare & Medicaid*  
17        *Services shall have the authority to determine whether*  
18        *a provider of services or supplier described in sub-*  
19        *paragraph (3) has met the requirement of this sub-*  
20        *section and to impose a civil monetary penalty not*  
21        *to exceed \$50,000 for each violation. The Secretary*  
22        *may also impose other intermediate sanctions, includ-*  
23        *ing corrective action plans and additional monitoring*  
24        *in the case of a violation of this subsection.*

1           “(5) *PILOT PROGRAM.*—*The Secretary may con-*  
2           *duct a pilot program on the application of this sub-*  
3           *section with respect to a category of providers of serv-*  
4           *ices or suppliers (other than physicians) that the Sec-*  
5           *retary determines to be a category which is at high*  
6           *risk for waste, fraud, and abuse before implementing*  
7           *the requirements of this subsection to all providers of*  
8           *services and suppliers described in paragraph (3).”.*

9           *(b) REFERENCE TO SIMILAR MEDICAID PROVISION.*—  
10          *For a similar provision with respect to the Medicaid pro-*  
11          *gram under title XIX of the Social Security Act, see section*  
12          *1753.*

13          ***SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-***  
14   ***CARE CLAIMS REDUCED TO NOT MORE THAN***  
15   ***12 MONTHS.***

16          *(a) PURPOSE.*—*In general, the 36-month period cur-*  
17          *rently allowed for claims filing under parts A, B, C, and,*  
18          *D of title XVIII of the Social Security Act presents opportu-*  
19          *nities for fraud schemes in which processing patterns of the*  
20          *Centers for Medicare & Medicaid Services can be observed*  
21          *and exploited. Narrowing the window for claims processing*  
22          *will not overburden providers and will reduce fraud and*  
23          *abuse.*

24          *(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION.*—

1           (1) *PART A.*—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

2  
3           (A) in paragraph (1), by striking “period of  
4           3 calendar years” and all that follows and inserting “period of 1 calendar year from which  
5           such services are furnished; and”; and

6  
7           (B) by adding at the end the following new  
8           sentence: “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar  
9           year period specified in such paragraph.”.

10  
11          (2) *PART B.*—Section 1835(a) of such Act (42  
12          U.S.C. 1395n(a)) is amended—

13           (A) in paragraph (1), by striking “period of  
14           3 calendar years” and all that follows and inserting “period of 1 calendar year from which  
15           such services are furnished; and”; and

16  
17           (B) by adding at the end the following new  
18           sentence: “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar  
19           year period specified in such paragraph.”.

20  
21          (3) *PARTS C AND D.*—Section 1857(d) of such  
22          Act is amended by adding at the end the following  
23          new paragraph:

24           “(7) *PERIOD FOR SUBMISSION OF CLAIMS.*—The  
25          contract shall require an MA organization or PDP

1 sponsor to require any provider of services under con-  
2 tract with, in partnership with, or affiliated with  
3 such organization or sponsor to ensure that, with re-  
4 spect to items and services furnished by such provider  
5 to an enrollee of such organization, written request,  
6 signed by such enrollee, except in cases in which the  
7 Secretary finds it impracticable for the enrollee to do  
8 so, is filed for payment for such items and services in  
9 such form, in such manner, and by such person or  
10 persons as the Secretary may by regulation prescribe,  
11 no later than the close of the 1 calendar year period  
12 after such items and services are furnished. In apply-  
13 ing the previous sentence, the Secretary may specify  
14 exceptions to the 1 calendar year period specified.”.

15 (c) *EFFECTIVE DATE.*—The amendments made by sub-  
16 section (b) shall be effective for items and services furnished  
17 on or after January 1, 2011.

18 **SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL**  
19 **EQUIPMENT OR HOME HEALTH SERVICES RE-**  
20 **QUIRED TO BE MEDICARE-ENROLLED PHYSI-**  
21 **CANS OR ELIGIBLE PROFESSIONALS.**

22 (a) *DME.*—Section 1834(a)(11)(B) of the Social Secu-  
23 rity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by strik-  
24 ing “physician” and inserting “physician enrolled under

1 *section 1866(j) or an eligible professional under section*  
2 *1848(k)(3)(B)”.*

3 *(b) HOME HEALTH SERVICES.—*

4 *(1) PART A.—Section 1814(a)(2) of such Act (42*  
5 *U.S.C. 1395(a)(2)) is amended in the matter pre-*  
6 *ceding subparagraph (A) by inserting “in the case of*  
7 *services described in subparagraph (C), a physician*  
8 *enrolled under section 1866(j) or an eligible profes-*  
9 *sional under section 1848(k)(3)(B),” before “or, in the*  
10 *case of services”.*

11 *(2) PART B.—Section 1835(a)(2) of such Act (42*  
12 *U.S.C. 1395n(a)(2)) is amended in the matter pre-*  
13 *ceding subparagraph (A) by inserting “, or in the*  
14 *case of services described in subparagraph (A), a phy-*  
15 *sician enrolled under section 1866(j) or an eligible*  
16 *professional under section 1848(k)(3)(B),” after “a*  
17 *physician”.*

18 *(c) DISCRETION TO EXPAND APPLICATION.—The Sec-*  
19 *retary may extend the requirement applied by the amend-*  
20 *ments made by subsections (a) and (b) to durable medical*  
21 *equipment and home health services (relating to requiring*  
22 *certifications and written orders to be made by enrolled*  
23 *physicians and health professions) to other categories of*  
24 *items or services under this title, including covered part D*  
25 *drugs as defined in section 1860D-2(e), if the Secretary de-*



1 *termines that such application would help to reduce the risk*  
2 *of waste, fraud, and abuse with respect to such other cat-*  
3 *egories under title XVIII of the Social Security Act.*

4 *(d) EFFECTIVE DATE.—The amendments made by this*  
5 *section shall apply to written orders and certifications*  
6 *made on or after July 1, 2010.*

7 **SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE**  
8 **DOCUMENTATION ON REFERRALS TO PRO-**  
9 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

10 *(a) PHYSICIANS AND OTHER SUPPLIERS.—Section*  
11 *1842(h) of the Social Security Act is amended by adding*  
12 *at the end the following new paragraph*

13 *“(10) The Secretary may disenroll, for a period of not*  
14 *more than one year for each act, a physician or supplier*  
15 *under section 1866(j) if such physician or supplier fails to*  
16 *maintain and, upon request of the Secretary, provide access*  
17 *to documentation relating to written orders or requests for*  
18 *payment for durable medical equipment, certifications for*  
19 *home health services, or referrals for other items or services*  
20 *written or ordered by such physician or supplier under this*  
21 *title, as specified by the Secretary.”.*

22 *(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of*  
23 *such Act (42 U.S.C. 1395cc) is amended—*

24 *(1) in subparagraph (U), by striking at the end*  
25 *“and”;*

1           (2) *in subparagraph (V), 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           “(W) *maintain and, upon request of the Sec-*  
6           *retary, provide access to documentation relating to*  
7           *written orders or requests for payment for durable*  
8           *medical equipment, certifications for home health*  
9           *services, or referrals for other items or services written*  
10          *or ordered by the provider under this title, as speci-*  
11          *fied by the Secretary.”.*

12          (c) *OIG PERMISSIVE EXCLUSION AUTHORITY.—Sec-*  
13          *tion 1128(b)(11) of the Social Security Act (42 U.S.C.*  
14          *1320a–7(b)(11)) is amended by inserting “, ordering, refer-*  
15          *ring for furnishing, or certifying the need for” after “fur-*  
16          *nishing”.*

17          (d) *EFFECTIVE DATE.—The amendments made by this*  
18          *section shall apply to orders, certifications, and referrals*  
19          *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 **OR DURABLE MEDICAL EQUIPMENT UNDER**  
5 **MEDICARE.**

6 (a) *CONDITION OF PAYMENT FOR HOME HEALTH*  
7 *SERVICES.*—

8 (1) *PART A.*—*Section 1814(a)(2)(C) of such Act*  
9 *is amended—*

10 (A) *by striking “and such services” and in-*  
11 *serting “such services”; and*

12 (B) *by inserting after “care of a physician”*  
13 *the following: “, and, in the case of a certifi-*  
14 *cation or recertification made by a physician*  
15 *after January 1, 2010, prior to making such cer-*  
16 *tification the physician must document that the*  
17 *physician has had a face-to-face encounter (in-*  
18 *cluding through use of telehealth and other than*  
19 *with respect to encounters that are incident to*  
20 *services involved) with the individual during the*  
21 *6-month period preceding such certification, or*  
22 *other reasonable timeframe as determined by the*  
23 *Secretary”.*

24 (2) *PART B.*—*Section 1835(a)(2)(A) of the Social*  
25 *Security Act is amended—*

26 (A) *by striking “and” before “(iii)”;* and

1           (B) by inserting after “care of a physician”  
2           the following: “, and (iv) in the case of a certifi-  
3           cation or recertification after January 1, 2010,  
4           prior to making such certification the physician  
5           must document that the physician has had a  
6           face-to-face encounter (including through use of  
7           telehealth and other than with respect to encoun-  
8           ters that are incident to services involved) with  
9           the individual during the 6-month period pre-  
10          ceding such certification or recertification, or  
11          other reasonable timeframe as determined by the  
12          Secretary”.

13          (b) *CONDITION OF PAYMENT FOR DURABLE MEDICAL*  
14          *EQUIPMENT.*—Section 1834(a)(11)(B) of the Social Secu-  
15          rity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by add-  
16          ing before the period at the end the following: “and shall  
17          require that such an order be written pursuant to the physi-  
18          cian documenting that the physician has had a face-to-face  
19          encounter (including through use of telehealth and other  
20          than with respect to encounters that are incident to services  
21          involved) with the individual involved during the 6-month  
22          period preceding such written order, or other reasonable  
23          timeframe as determined by the Secretary”.

24          (c) *APPLICATION TO OTHER AREAS UNDER MEDI-*  
25          *CARE.*—The Secretary may apply the face-to-face encounter

1 *requirement described in the amendments made by sub-*  
2 *sections (a) and (b) to other items and services for which*  
3 *payment is provided under title XVIII of the Social Secu-*  
4 *rity Act based upon a finding that such an decision would*  
5 *reduce the risk of waste, fraud, or abuse.*

6 *(d) APPLICATION TO MEDICAID AND CHIP.—The re-*  
7 *quirements pursuant to the amendments made by sub-*  
8 *sections (a) and (b) shall apply in the case of physicians*  
9 *making certifications for home health services under title*  
10 *XIX or XXI of the Social Security Act, in the same manner*  
11 *and to the same extent as such requirements apply in the*  
12 *case of physicians making such certifications under title*  
13 *XVIII of such Act.*

14 **SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AU-**  
15 **THORITY TO PROGRAM EXCLUSION INVES-**  
16 **TIGATIONS.**

17 *(a) IN GENERAL.—Section 1128(f) of the Social Secu-*  
18 *rity Act (42 U.S.C. 1320a-7(f)) is amended by adding at*  
19 *the end the following new paragraph:*

20 *“(4) The provisions of subsections (d) and (e) of section*  
21 *205 shall apply with respect to this section to the same ex-*  
22 *tent as they are applicable with respect to title II. The Sec-*  
23 *retary may delegate the authority granted by section 205(d)*  
24 *(as made applicable to this section) to the Inspector General*  
25 *of the Department of Health and Human Services or the*

1 *Administrator of the Centers for Medicare & Medicaid Serv-*  
2 *ices for purposes of any investigation under this section.”.*

3 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
4 *section (a) shall apply to investigations beginning on or*  
5 *after January 1, 2010.*

6 **SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND**  
7 **MEDICAID OVERPAYMENTS.**

8 *Section 1128G of the Social Security Act, as inserted*  
9 *by section 1631 and amended by section 1632, is further*  
10 *amended by adding at the end the following new subsection:*

11 “(c) *REPORTS ON AND REPAYMENT OF OVERPAYMENTS*  
12 *IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.*—

13 “(1) *REPORTING AND RETURNING OVERPAY-*  
14 *MENTS.*—*If a person knows of an overpayment, the*  
15 *person must—*

16 “(A) *report and return the overpayment to*  
17 *the Secretary, the State, an intermediary, a car-*  
18 *rier, or a contractor, as appropriate, at the cor-*  
19 *rect address, and*

20 “(B) *notify the Secretary, the State, inter-*  
21 *mediary, carrier, or contractor to whom the over-*  
22 *payment was returned in writing of the reason*  
23 *for the overpayment.*

24 “(2) *TIMING.*—*An overpayment must be reported*  
25 *and returned under paragraph (1)(A) by not later*

1       *than the date that is 60 days after the date the person*  
2       *knows of the overpayment. Any known overpayment*  
3       *retained later than the applicable date specified in*  
4       *this paragraph creates an obligation as defined in*  
5       *section 3729(b)(3) of title 31 of the United States*  
6       *Code.*

7               “(3) *CLARIFICATION.—Repayment of any over-*  
8       *payments (or refunding by withholding of future pay-*  
9       *ments) by a provider of services or supplier does not*  
10       *otherwise limit the provider or supplier’s potential li-*  
11       *ability for administrative obligations such as applica-*  
12       *ble interests, fines, and specialties or civil or criminal*  
13       *sanctions involving the same claim if it is determined*  
14       *later that the reason for the overpayment was related*  
15       *to fraud by the provider or supplier or the employees*  
16       *or agents of such provider or supplier.*

17               “(4) *DEFINITIONS.—In this subsection:*

18                       “(A) *KNOWS.—The term ‘knows’ has the*  
19       *meaning given the terms ‘knowing’ and ‘know-*  
20       *ingly’ in section 3729(b) of title 31 of the United*  
21       *States Code.*

22                       “(B) *OVERPAYMENT.—The term “overpay-*  
23       *ment” means any finally determined funds that*  
24       *a person receives or retains under title XVIII,*

1           *XIX, or XXI to which the person, after applica-*  
2           *ble reconciliation, is not entitled under such title.*

3           “(C) *PERSON.*—*The term ‘person’ means a*  
4           *provider of services, supplier, Medicaid managed*  
5           *care organization (as defined in section*  
6           *1903(m)(1)(A)), Medicare Advantage organiza-*  
7           *tion (as defined in section 1859(a)(1)), or PDP*  
8           *sponsor (as defined in section 1860D–41(a)(13)),*  
9           *but excluding a beneficiary.”*

10 ***SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIVERS***  
11                           ***FOR OIG EXCLUSIONS TO BENEFICIARIES OF***  
12                           ***ANY FEDERAL HEALTH CARE PROGRAM.***

13           *Section 1128(c)(3)(B) of the Social Security Act (42*  
14 *U.S.C. 1320a–7(c)(3)(B)) is amended by striking “individ-*  
15 *uals entitled to benefits under part A of title XVIII or en-*  
16 *rolled under part B of such title, or both” and inserting*  
17 *“beneficiaries (as defined in section 1128A(i)(5)) of that*  
18 *program”.*

19 ***SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL***  
20                           ***DIALYSIS FACILITIES.***

21           *Section 1881(b) of the Social Security Act (42 U.S.C.*  
22 *1395rr(b)) is amended by adding at the end the following*  
23 *new paragraph:*

24           “(15) *For purposes of evaluating or auditing pay-*  
25 *ments made to renal dialysis facilities for items and serv-*



1 *ices under this section under paragraph (1), each such renal*  
 2 *dialysis facility, upon the request of the Secretary, shall*  
 3 *provide to the Secretary access to information relating to*  
 4 *any ownership or compensation arrangement between such*  
 5 *facility and the medical director of such facility or between*  
 6 *such facility and any physician.”.*

7 **SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**  
 8 **ALTERNATE PAYEES REQUIRED TO REGISTER**  
 9 **UNDER MEDICARE.**

10 *(a) MEDICARE.—Section 1866(j)(1) of the Social Secu-*  
 11 *rity Act (42 U.S.C. 1395cc(j)(1)) is amended by adding at*  
 12 *the end the following new subparagraph:*

13 *“(D) BILLING AGENTS AND CLEARING-*  
 14 *HOUSES REQUIRED TO BE REGISTERED UNDER*  
 15 *MEDICARE.—Any agent, clearinghouse, or other*  
 16 *alternate payee that submits claims on behalf of*  
 17 *a health care provider must be registered with*  
 18 *the Secretary in a form and manner specified by*  
 19 *the Secretary.”.*

20 *(b) MEDICAID.—For a similar provision with respect*  
 21 *to the Medicaid program under title XIX of the Social Secu-*  
 22 *rity Act, see section 1759.*

23 *(c) EFFECTIVE DATE.—The amendment made by sub-*  
 24 *section (a) shall apply to claims submitted on or after Jan-*  
 25 *uary 1, 2012.*

1 **SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO**  
2 **FALSE CLAIMS ACT AMENDMENTS.**

3 *Section 1128A of the Social Security Act, as amended*  
4 *by sections 1611, 1612, 1613, and 1615, is further amend-*  
5 *ed—*

6 *(1) in subsection (a)—*

7 *(A) in paragraph (1), by striking “to an of-*  
8 *ficer, employee, or agent of the United States, or*  
9 *of any department or agency thereof, or of any*  
10 *State agency (as defined in subsection (i)(1))”;*

11 *(B) in paragraph (4)—*

12 *(i) in the matter preceding subpara-*  
13 *graph (A), by striking “participating in a*  
14 *program under title XVIII or a State health*  
15 *care program” and inserting “participating*  
16 *in a Federal health care program (as de-*  
17 *fined in section 1128B(f))”; and*

18 *(ii) in subparagraph (A), by striking*  
19 *“title XVIII or a State health care pro-*  
20 *gram” and inserting “a Federal health care*  
21 *program (as defined in section 1128B(f))”;*

22 *(C) by striking “or” at the end of para-*  
23 *graph (10);*

24 *(D) by inserting after paragraph (11) the*  
25 *following new paragraphs:*

1           “(12) conspires to commit a violation of this sec-  
2           tion; or

3           “(13) knowingly makes, uses, or causes to be  
4           made or used, a false record or statement material to  
5           an obligation to pay or transmit money or property  
6           to a Federal health care program, or knowingly con-  
7           ceals or knowingly and improperly avoids or de-  
8           creases an obligation to pay or transmit money or  
9           property to a Federal health care program;” and

10           (E) in the matter following paragraph (13),  
11           as inserted by subparagraph (D),—

12           (i) by striking “or” before “in cases  
13           under paragraph (11)”; and

14           (ii) by inserting “, in cases under  
15           paragraph (12), \$50,000 for any violation  
16           described in this section committed in fur-  
17           therance of the conspiracy involved; or in  
18           cases under paragraph (13), \$50,000 for  
19           each false record or statement, or conceal-  
20           ment, avoidance, or decrease” after “by an  
21           excluded individual”; and

22           (F) in the second sentence, by striking “such  
23           false statement, omission, or misrepresentation)”  
24           and inserting “such false statement or misrepre-  
25           sentation, in cases under paragraph (12), an as-

1           *assessment of not more than 3 times the total*  
2           *amount that would otherwise apply for any vio-*  
3           *lation described in this section committed in fur-*  
4           *therance of the conspiracy involved, or in cases*  
5           *under paragraph (13), an assessment of not more*  
6           *than 3 times the total amount of the obligation*  
7           *to which the false record or statement was mate-*  
8           *rial or that was avoided or decreased)”.*

9           *(2) in subsection (c)(1), by striking “six years”*  
10          *and inserting “10 years”; and*

11          *(3) in subsection (i)—*

12                 *(A) by amending paragraph (2) to read as*  
13                 *follows:*

14                 *“(2) The term ‘claim’ means any application, re-*  
15                 *quest, or demand, whether under contract, or other-*  
16                 *wise, for money or property for items and services*  
17                 *under a Federal health care program (as defined in*  
18                 *section 1128B(f)), whether or not the United States or*  
19                 *a State agency has title to the money or property,*  
20                 *that—*

21                         *“(A) is presented or caused to be presented*  
22                         *to an officer, employee, or agent of the United*  
23                         *States, or of any department or agency thereof,*  
24                         *or of any State agency (as defined in subsection*  
25                         *(i)(1)); or*

1           “(B) is made to a contractor, grantee, or  
2           other recipient if the money or property is to be  
3           spent or used on the Federal health care pro-  
4           gram’s behalf or to advance a Federal health  
5           care program interest, and if the Federal health  
6           care program—

7                   “(i) provides or has provided any por-  
8                   tion of the money or property requested or  
9                   demanded; or

10                   “(ii) will reimburse such contractor,  
11                   grantee, or other recipient for any portion  
12                   of the money or property which is requested  
13                   or demanded.”;

14           (B) by amending paragraph (3) to read as  
15           follows:

16                   “(3) The term ‘item or service’ means, without  
17                   limitation, any medical, social, management, admin-  
18                   istrative, or other item or service used in connection  
19                   with or directly or indirectly related to a Federal  
20                   health care program.”;

21           (C) in paragraph (6)—

22                   (i) in subparagraph (C), by striking at  
23                   the end “or”;

1                   (ii) in the first subparagraph (D), by  
2                   striking at the end the period and inserting  
3                   “; or”; and

4                   (iii) by redesignating the second sub-  
5                   paragraph (D) as a subparagraph (E);

6                   (D) by amending paragraph (7) to read as  
7                   follows:

8                   “(7) The terms ‘knowing’, ‘knowingly’, and  
9                   ‘should know’ mean that a person, with respect to in-  
10                  formation—

11                  “(A) has actual knowledge of the informa-  
12                  tion;

13                  “(B) acts in deliberate ignorance of the  
14                  truth or falsity of the information; or

15                  “(C) acts in reckless disregard of the truth  
16                  or falsity of the information;

17                  and require no proof of specific intent to defraud.”;  
18                  and

19                  (E) by adding at the end the following new  
20                  paragraphs:

21                  “(8) The term ‘obligation’ means an established  
22                  duty, whether or not fixed, arising from an express or  
23                  implied contractual, grantor-grantee, or licensor-li-  
24                  censee relationship, from a fee-based or similar rela-

1        *tionship, from statute or regulation, or from the re-*  
2        *tention of any overpayment.*

3            “(9) *The term ‘material’ means having a natural*  
4        *tendency to influence, or be capable of influencing, the*  
5        *payment or receipt of money or property.”*

6        ***Subtitle D—Access to Information***  
7        ***Needed To Prevent Fraud,***  
8        ***Waste, and Abuse***

9        ***SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDEN-***  
10        ***TIFY FRAUD, WASTE, AND ABUSE.***

11        *Section 1128G of the Social Security Act, as added*  
12        *by section 1631 and amended by sections 1632 and 1641,*  
13        *is further amended by adding at the end the following new*  
14        *subsection;*

15        “(d) *ACCESS TO INFORMATION NECESSARY TO IDEN-*  
16        *TIFY FRAUD, WASTE, AND ABUSE.—For purposes of law*  
17        *enforcement activity, and to the extent consistent with ap-*  
18        *plicable disclosure, privacy, and security laws, including*  
19        *the Health Insurance Portability and Accountability Act*  
20        *of 1996 and the Privacy Act of 1974, and subject to any*  
21        *information systems security requirements enacted by law*  
22        *or otherwise required by the Secretary, the Attorney General*  
23        *shall have access, facilitation by the Inspector General of*  
24        *the Department of Health and Human Services, to claims*  
25        *and payment data relating to titles XVIII and XIX, in con-*

1 *sultation with the Centers for Medicare & Medicaid Services*  
 2 *or the owner of such data.”.*

3 **SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE**  
 4 **HEALTHCARE INTEGRITY AND PROTECTION**  
 5 **DATA BANK AND THE NATIONAL PRACTI-**  
 6 **TIONER DATA BANK.**

7 *(a) IN GENERAL.—To eliminate duplication between*  
 8 *the Healthcare Integrity and Protection Data Bank*  
 9 *(HIPDB) established under section 1128E of the Social Se-*  
 10 *curity Act and the National Practitioner Data Bank*  
 11 *(NPBD) established under the Health Care Quality Im-*  
 12 *provement Act of 1986, section 1128E of the Social Security*  
 13 *Act (42 U.S.C. 1320a-7e) is amended—*

14 *(1) in subsection (a), by striking “Not later*  
 15 *than” and inserting “Subject to subsection (h), not*  
 16 *later than”;*

17 *(2) in the first sentence of subsection (d)(2), by*  
 18 *striking “(other than with respect to requests by Fed-*  
 19 *eral agencies)”;* and

20 *(3) by adding at the end the following new sub-*  
 21 *section:*

22 *“(h) SUNSET OF THE HEALTHCARE INTEGRITY AND*  
 23 *PROTECTION DATA BANK; TRANSITION PROCESS.—Effec-*  
 24 *tive upon the enactment of this subsection, the Secretary*  
 25 *shall implement a process to eliminate duplication between*



1 *the Healthcare Integrity and Protection Data Bank (in this*  
2 *subsection referred to as the ‘HIPDB’ established pursuant*  
3 *to subsection (a) and the National Practitioner Data Bank*  
4 *(in this subsection referred to as the ‘NPDB’) as imple-*  
5 *mented under the Health Care Quality Improvement Act*  
6 *of 1986 and section 1921 of this Act, including systems test-*  
7 *ing necessary to ensure that information formerly collected*  
8 *in the HIPDB will be accessible through the NPDB, and*  
9 *other activities necessary to eliminate duplication between*  
10 *the two data banks. Upon the completion of such process,*  
11 *notwithstanding any other provision of law, the Secretary*  
12 *shall cease the operation of the HIPDB and shall collect*  
13 *information required to be reported under the preceding*  
14 *provisions of this section in the NPDB. Except as otherwise*  
15 *provided in this subsection, the provisions of subsections (a)*  
16 *through (g) shall continue to apply with respect to the re-*  
17 *porting of (or failure to report), access to, and other treat-*  
18 *ment of the information specified in this section.”.*

19 (b) *ELIMINATION OF THE RESPONSIBILITY OF THE*  
20 *HHS OFFICE OF THE INSPECTOR GENERAL.—Section*  
21 *1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-*  
22 *7c(a)(1)) is amended—*

23 (1) *in subparagraph (C), by adding at the end*  
24 *“and”;*

1           (2) *in subparagraph (D), by striking at the end*  
2           “*, and*” *and inserting a period; and*

3           (3) *by striking subparagraph (E).*

4           (c) *SPECIAL PROVISION FOR ACCESS TO THE NA-*  
5 *TIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT*  
6 *OF VETERANS AFFAIRS.—*

7           (1) *IN GENERAL.—Notwithstanding any other*  
8 *provision of law, during the one year period that be-*  
9 *gins on the effective date specified in subsection (e)(1),*  
10 *the information described in paragraph (2) shall be*  
11 *available from the National Practitioner Data Bank*  
12 *(described in section 1921 of the Social Security Act)*  
13 *to the Secretary of Veterans Affairs without charge.*

14           (2) *INFORMATION DESCRIBED.—For purposes of*  
15 *paragraph (1), the information described in this*  
16 *paragraph is the information that would, but for the*  
17 *amendments made by this section, have been available*  
18 *to the Secretary of Veterans Affairs from the*  
19 *Healthcare Integrity and Protection Data Bank.*

20           (d) *FUNDING.—Notwithstanding any provisions of this*  
21 *Act, sections 1128E(d)(2) and 1817(k)(3) of the Social Se-*  
22 *curity Act, or any other provision of law, there shall be*  
23 *available for carrying out the transition process under sec-*  
24 *tion 1128E(h) of the Social Security Act over the period*  
25 *required to complete such process, and for operation of the*

1 *National Practitioner Data Bank until such process is com-*  
2 *pleted, without fiscal year limitation—*

3           (1) *any fees collected pursuant to section*  
4 *1128E(d)(2) of such Act; and*

5           (2) *such additional amounts as necessary, from*  
6 *appropriations available to the Secretary and to the*  
7 *Office of the Inspector General of the Department of*  
8 *Health and Human Services under clauses (i) and*  
9 *(ii), respectively, of section 1817(k)(3)(A) of such Act,*  
10 *for costs of such activities during the first 12 months*  
11 *following the date of the enactment of this Act.*

12       (e) *EFFECTIVE DATE.—The amendments made—*

13           (1) *by subsection (a)(2) shall take effect on the*  
14 *first day after the Secretary of Health and Human*  
15 *Services certifies that the process implemented pursu-*  
16 *ant to section 1128E(h) of the Social Security Act (as*  
17 *added by subsection (a)(3)) is complete; and*

18           (2) *by subsection (b) shall take effect on the ear-*  
19 *lier of the date specified in paragraph (1) or the first*  
20 *day of the second succeeding fiscal year after the fis-*  
21 *cal year during which this Act is enacted.*

22 **SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECU-**  
23 **RITY STANDARDS.**

24       *The provisions of sections 262(a) and 264 of the Health*  
25 *Insurance Portability and Accountability Act of 1996 (and*

1 standards promulgated pursuant to such sections) and the  
 2 Privacy Act of 1974 shall apply with respect to the provi-  
 3 sions of this subtitle and amendments made by this subtitle.

4 **TITLE VII—MEDICAID AND CHIP**  
 5 **Subtitle A—Medicaid and Health**  
 6 **Reform**

7 **SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME**  
 8 **BELOW 133<sup>1</sup>/<sub>3</sub> PERCENT OF THE FEDERAL POV-**  
 9 **ERTY LEVEL.**

10 (a) *ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS*  
 11 *WITH INCOME BELOW 133<sup>1</sup>/<sub>3</sub> PERCENT OF THE FEDERAL*  
 12 *POVERTY LEVEL.—*

13 (1) *IN GENERAL.—Section 1902(a)(10)(A)(i) of*  
 14 *the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)*  
 15 *is amended—*

16 (A) *by striking “or” at the end of subclause*  
 17 *(VI);*

18 (B) *by adding “or” at the end of subclause*  
 19 *(VII); and*

20 (C) *by adding at the end the following new*  
 21 *subclause:*

22 “(VIII) *who are under 65 years of*  
 23 *age, who are not described in a pre-*  
 24 *vious subclause of this clause, and who*  
 25 *are in families whose income (deter-*

1                    *mined using methodologies and proce-*  
2                    *dures specified by the Secretary in con-*  
3                    *sultation with the Health Choices Com-*  
4                    *missioner) does not exceed 133<sup>1</sup>/<sub>3</sub> per-*  
5                    *cent of the income official poverty line*  
6                    *(as defined by the Office of Manage-*  
7                    *ment and Budget, and revised annu-*  
8                    *ally in accordance with section 673(2)*  
9                    *of the Omnibus Budget Reconciliation*  
10                   *Act of 1981) applicable to a family of*  
11                   *the size involved;”.*

12                    (2) *INCREASED FMAP FOR NON-TRADITIONAL*  
13                    *MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of*  
14                    *such Act (42 U.S.C. 1396d) is amended—*

15                    (A) *in the first sentence of subsection (b), by*  
16                    *striking “and” before “(4)” and by inserting be-*  
17                    *fore the period at the end the following: “, and*  
18                    *(5) 100 percent (or 90 percent for periods begin-*  
19                    *ning with 2015) with respect to amounts de-*  
20                    *scribed in subsection (y)”;* and

21                    (B) *by adding at the end the following new*  
22                    *subsection:*

23                    “(y) *ADDITIONAL EXPENDITURES SUBJECT TO IN-*  
24                    *CREASED FMAP.—For purposes of section 1905(b)(5), the*  
25                    *amounts described in this subsection are the following:*

1           “(1) Amounts expended for medical assistance  
2 for individuals described in subclause (VIII) of sec-  
3 tion 1902(a)(10)(A)(i).”.

4           (3) CONSTRUCTION.—Nothing in this subsection  
5 shall be construed as not providing for coverage under  
6 subclause (VIII) of section 1902(a)(10)(A)(i) of the  
7 Social Security Act, as added by paragraph (1) of,  
8 and an increased FMAP under the amendment made  
9 by paragraph (2) for, an individual who has been  
10 provided medical assistance under title XIX of the Act  
11 under a demonstration waiver approved under section  
12 1115 of such Act or with State funds.

13           (4) CONFORMING AMENDMENTS.—

14           (A) Section 1903(f)(4) of the Social Secu-  
15 rity Act (42 U.S.C. 1396b(f)(4)) is amended by  
16 inserting “1902(a)(10)(A)(i)(VIII),” after  
17 “1902(a)(10)(A)(i)(VII),”.

18           (B) Section 1905(a) of such Act (42 U.S.C.  
19 1396d(a)), as amended by sections 1714(a)(4)  
20 and 1731(c), is further amended, in the matter  
21 preceding paragraph (1)—

22                   (i) by striking “or” at the end of clause  
23 (xiv);

24                   (ii) by adding “or” at the end of clause  
25 (xv); and

1                   *(iii) by inserting after clause (xv) the*  
2                   *following:*

3                   *“(xvi) individuals described in section*  
4                   *1902(a)(10)(A)(i)(VIII),”.*

5           ***(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGI-***  
6 ***BLE INDIVIDUALS WITH INCOME NOT EXCEEDING 133<sup>1</sup>/<sub>3</sub>***  
7 ***PERCENT OF THE FEDERAL POVERTY LEVEL .—***

8                   ***(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of***  
9 ***the Social Security Act (42 U.S.C.***  
10 ***1396b(a)(10)(A)(i)), as amended by subsection (a), is***  
11 ***amended—***

12                   ***(A) by striking “or” at the end of subclause***  
13 ***(VII);***

14                   ***(B) by adding “or” at the end of subclause***  
15 ***(VIII); and***

16                   ***(C) by adding at the end the following new***  
17 ***subclause:***

18                                   ***“(IX) who are under 65 years of***  
19 ***age, who would be eligible for medical***  
20 ***assistance under the State plan under***  
21 ***one of subclauses (I) through (VII)***  
22 ***(based on the income standards, meth-***  
23 ***odologies, and procedures in effect as of***  
24 ***June 16, 2009) but for income and***  
25 ***who are in families whose income does***

1                   not exceed 133<sup>1</sup>/<sub>3</sub> percent of the income  
2                   official poverty line (as defined by the  
3                   Office of Management and Budget, and  
4                   revised annually in accordance with  
5                   section 673(2) of the Omnibus Budget  
6                   Reconciliation Act of 1981) applicable  
7                   to a family of the size involved;”.

8                   (2) *INCREASED FMAP FOR CERTAIN TRADITIONAL*  
9                   *MEDICAID ELIGIBLE INDIVIDUALS.*—Section 1905(y)  
10                  of such Act (42 U.S.C. 1396d(b)), as added by sub-  
11                  section (a)(2)(B), is amended by inserting “or (IX)”  
12                  after “(VIII)”.

13                  (3) *CONSTRUCTION.*—Nothing in this subsection  
14                  shall be construed as not providing for coverage under  
15                  subclause (IX) of section 1902(a)(10)(A)(i) of the So-  
16                  cial Security Act, as added by paragraph (1) of, and  
17                  an increased FMAP under the amendment made by  
18                  paragraph (2) for, an individual who has been pro-  
19                  vided medical assistance under title XIX of the Act  
20                  under a demonstration waiver approved under section  
21                  1115 of such Act or with State funds.

22                  (4) *CONFORMING AMENDMENT.*—Section  
23                  1903(f)(4) of the Social Security Act (42 U.S.C.  
24                  1396b(f)(4)), as amended by subsection (a)(4), is



1       amended by inserting “1902(a)(10)(A)(i)(IX),” after  
2       “1902(a)(10)(A)(i)(VIII),”.

3       (c) *INCREASED MATCHING RATE FOR TEMPORARY*  
4 *COVERAGE OF CERTAIN NEWBORNS.*—Section 1905(y) of  
5 such Act, as added by subsection (a)(2)(B), is amended—  
6       (1) in paragraph (1), by inserting before the pe-  
7       riod at the end the following: “, and who is not pro-  
8       vided medical assistance under section 1943(b)(2) of  
9       this title or section 205(d)(1)(B) of the America’s Af-  
10      fordable Health Choices Act of 2009”; and

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

12      “(2) Amounts expended for medical assistance  
13      for children described in section 203(d)(1)(A) of the  
14      America’s Affordable Health Choices Act of 2009 dur-  
15      ing the time period specified in such section.”.

16      (d) *NETWORK ADEQUACY.*—Section 1932(a)(2) of the  
17 *Social Security Act (42 U.S.C. 1396u–2(a)(2))* is amended  
18 by adding at the end the following new subparagraph:

19      “(D) *ENROLLMENT OF NON-TRADITIONAL*  
20 *MEDICAID ELIGIBLES.*—A State may not require  
21      under paragraph (1) the enrollment in a man-  
22      aged care entity of an individual described in  
23      section 1902(a)(10)(A)(i)(VIII) unless the State  
24      demonstrates, to the satisfaction of the Secretary,  
25      that the entity, through its provider network and

1           *other arrangements, has the capacity to meet the*  
2           *health, mental health, and substance abuse needs*  
3           *of such individuals.”.*

4           *(e) EFFECTIVE DATE.—The amendments made by this*  
5           *section shall take effect on the first day of Y1, and shall*  
6           *apply with respect to items and services furnished on or*  
7           *after such date.*

8           **SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CER-**  
9                                   **TAIN MEDICAID ELIGIBLE INDIVIDUALS.**

10           *(a) IN GENERAL.—Title XIX of the Social Security*  
11           *Act is amended by adding at the end the following new sec-*  
12           *tion:*

13           “*REQUIREMENTS AND SPECIAL RULES FOR CERTAIN*  
14                                   *MEDICAID ELIGIBLE INDIVIDUALS*

15           “*SEC. 1943. (a) COORDINATION WITH NHI EXCHANGE*  
16           *THROUGH MEMORANDUM OF UNDERSTANDING.—*

17                   “*(1) IN GENERAL.—The State shall enter into a*  
18           *Medicaid memorandum of understanding described in*  
19           *section 205(e)(3) of the America’s Affordable Health*  
20           *Choices Act of 2009 with the Health Choices Commis-*  
21           *sioner, acting in consultation with the Secretary,*  
22           *with respect to coordinating the implementation of*  
23           *the provisions of division A of such Act with the State*  
24           *plan under this title in order to ensure the enrollment*  
25           *of Medicaid eligible individuals in acceptable cov-*  
26           *erage. Nothing in this section shall be construed as*

1        *permitting such memorandum to modify or vitiate*  
2        *any requirement of a State plan under this title.*

3                *“(2) ENROLLMENT OF EXCHANGE-REFERRED IN-*  
4        *DIVIDUALS.—*

5                *“(A) NON-TRADITIONAL INDIVIDUALS.—*

6        *Pursuant to such memorandum the State shall*  
7        *accept without further determination the enroll-*  
8        *ment under this title of an individual deter-*  
9        *mined by the Commissioner to be a non-tradi-*  
10       *tional Medicaid eligible individual. The State*  
11       *shall not do any redeterminations of eligibility*  
12       *for such individuals unless the periodicity of*  
13       *such redeterminations is consistent with the peri-*  
14       *odicity for redeterminations by the Commis-*  
15       *sioner of eligibility for affordability credits*  
16       *under subtitle C of title II of division A of the*  
17       *America’s Affordable Health Choices Act of 2009,*  
18       *as specified under such memorandum.*

19               *“(B) TRADITIONAL INDIVIDUALS.—Pursu-*  
20       *ant to such memorandum, the State shall accept*  
21       *without further determination the enrollment*  
22       *under this title of an individual determined by*  
23       *the Commissioner to be a traditional Medicaid*  
24       *eligible individual. The State may do redeter-*

1           *minations of eligibility of such individual con-*  
2           *sistent with such section and the memorandum.*

3           “(3) *DETERMINATIONS OF ELIGIBILITY FOR AF-*  
4           *FORDABILITY CREDITS.—If the Commissioner deter-*  
5           *mines that a State Medicaid agency has the capacity*  
6           *to make determinations of eligibility for affordability*  
7           *credits under subtitle C of title II of division A of the*  
8           *America’s Affordable Health Choices Act of 2009,*  
9           *under such memorandum—*

10           “(A) *the State Medicaid agency shall con-*  
11           *duct such determinations for any Exchange-eli-*  
12           *gible individual who requests such a determina-*  
13           *tion;*

14           “(B) *in the case that a State Medicaid*  
15           *agency determines that an Exchange-eligible in-*  
16           *dividual is not eligible for affordability credits,*  
17           *the agency shall forward the information on the*  
18           *basis of which such determination was made to*  
19           *the Commissioner; and*

20           “(C) *the Commissioner shall reimburse the*  
21           *State Medicaid agency for the costs of conducting*  
22           *such determinations.*

23           “(b) *TREATMENT OF CERTAIN NEWBORNS.—*

24           “(1) *IN GENERAL.—In the case of a child who is*  
25           *deemed under section 205(d)(1) of the America’s Af-*

1 *fordable Health Choices Act of 2009 to be a non-tradi-*  
2 *tional Medicaid eligible individual and enrolled*  
3 *under this title pursuant to such section, the State*  
4 *shall provide for a determination, by not later than*  
5 *the end of the period referred to in subparagraph (A)*  
6 *of such section, of the child’s eligibility for medical*  
7 *assistance under this title.*

8 “(2) *EXTENDED TREATMENT AS TRADITIONAL*  
9 *MEDICAID ELIGIBLE INDIVIDUAL.*—*In accordance*  
10 *with subparagraph (B) of section 205(d)(1) of the*  
11 *America’s Affordable Health Choices Act of 2009, in*  
12 *the case of a child described in subparagraph (A) of*  
13 *such section who at the end of the period referred to*  
14 *in such subparagraph is not otherwise covered under*  
15 *acceptable coverage, the child shall be deemed (until*  
16 *such time as the child obtains such coverage or the*  
17 *State otherwise makes a determination of the child’s*  
18 *eligibility for medical assistance under its plan under*  
19 *this title pursuant to paragraph (1)) to be a tradi-*  
20 *tional Medicaid eligible individual described in sec-*  
21 *tion 1902(l)(1)(B).*

22 “(c) *DEFINITIONS.*—*In this section:*

23 “(1) *MEDICAID ELIGIBLE INDIVIDUALS.*—*In this*  
24 *section, the terms ‘Medicaid eligible individual’, ‘tra-*  
25 *ditional Medicaid eligible individual’, and ‘non-tradi-*

1        *tional Medicaid eligible individual’ have the mean-*  
2        *ings given such terms in section 205(e)(4) of the*  
3        *America’s Affordable Health Choices Act of 2009.*

4            “(2) *MEMORANDUM.—The term ‘memorandum’*  
5        *means a Medicaid memorandum of understanding*  
6        *under section 205(e)(3) of the America’s Affordable*  
7        *Health Choices Act of 2009.*

8            “(3) *Y1.—The term ‘Y1’ has the meaning given*  
9        *such term in section 100(c) of the America’s Afford-*  
10       *able Health Choices Act of 2009.”.*

11        *(b) CONFORMING AMENDMENTS TO ERROR RATE.—*

12            *(1) Section 1903(u)(1)(D) of the Social Security*  
13        *Act (42 U.S.C. 1396b(u)(1)(D)) is amended by add-*  
14        *ing at the end the following new clause:*

15            “(vi) *In determining the amount of erroneous excess*  
16        *payments, there shall not be included any erroneous pay-*  
17        *ments made that are attributable to an error in an eligi-*  
18        *bility determination under subtitle C of title II of division*  
19        *A of the America’s Affordable Health Choices Act of 2009.”.*

20            *(2) Section 2105(c)(11) of such Act (42 U.S.C.*  
21        *1397ee(c)(11)) is amended by adding at the end the*  
22        *following new sentence: “Clause (vi) of section*  
23        *1903(u)(1)(D) shall apply with respect to the applica-*  
24        *tion of such requirements under this title and title*  
25        *XIX.”.*

1 **SEC. 1703. CHIP AND MEDICAID MAINTENANCE OF ELIGI-**  
2 **BILITY.**

3 (a) *CHIP MAINTENANCE OF ELIGIBILITY.*—Section  
4 1902 of the Social Security Act (42 U.S.C. 1396a) is  
5 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 (73);

10 (B) by striking the period at the end of  
11 paragraph (74) and inserting “; and”; and

12 (C) by inserting after paragraph (74) the  
13 following new paragraph:

14 “(75) provide for maintenance of effort under the  
15 State child health plan under title XXI in accordance  
16 with subsection (gg).”; and

17 (2) by adding at the end the following new sub-  
18 section:

19 “(gg) *CHIP MAINTENANCE OF ELIGIBILITY REQUIRE-*  
20 *MENT.*—

21 “(1) *IN GENERAL.*—Subject to paragraph (2), as  
22 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 of  
26 this subsection and before CHIP MOE termination

1     *date specified in paragraph (3), a State shall not*  
2     *have in effect eligibility standards, methodologies, or*  
3     *procedures under its State child health plan under*  
4     *title XXI (including any waiver under such title or*  
5     *under section 1115 that is permitted to continue ef-*  
6     *fect) that are more restrictive than the eligibility*  
7     *standards, methodologies, or procedures, respectively,*  
8     *under such plan (or waiver) as in effect on June 16,*  
9     *2009.*

10           “(2) *LIMITATION.*—*Paragraph (1) shall not be*  
11     *construed as preventing a State from imposing a lim-*  
12     *itation described in section 2110(b)(5)(C)(i)(II) for a*  
13     *fiscal year in order to limit expenditures under its*  
14     *State child health plan under title XXI to those for*  
15     *which Federal financial participation is available*  
16     *under section 2105 for the fiscal year.*

17           “(3) *CHIP MOE TERMINATION DATE.*—*In para-*  
18     *graph (1), the ‘CHIP MOE termination date’ for a*  
19     *State is the date that is the first day of Y1 (as defined*  
20     *in section 100(c) of the America’s Affordable Health*  
21     *Choices Act of 2009) or, if later, the first day after*  
22     *such date that both of the following determinations*  
23     *have been made:*

24                   “(A) *The Health Choices Commissioner has*  
25     *determined that the Health Insurance Exchange*



1           *has the capacity to support the participation of*  
2           *CHIP enrollees who are Exchange-eligible indi-*  
3           *viduals (as defined in section 202(b) of the*  
4           *America’s Affordable Health Choices Act of*  
5           *2009),*

6           “(B) *The Secretary has determined that—*

7                   “(i) *comparable coverage, as specified*  
8                   *in section 202(g) of the America’s Afford-*  
9                   *able Health Choices Act of 2009, is avail-*  
10                  *able through such Exchange; and*

11                  “(ii) *procedures have been established*  
12                  *for transferring CHIP enrollees into accept-*  
13                  *able coverage (as defined for purposes of*  
14                  *such Act) without interruption of coverage*  
15                  *or a written plan of treatment.*

16           *The Secretary shall recommend to Congress any legis-*  
17           *lative changes needed to effectuate this paragraph. In*  
18           *this paragraph, the term ‘CHIP enrollee’ means a*  
19           *targeted low-income child or (if the State has elected*  
20           *the option under section 2112, a targeted low-income*  
21           *pregnant woman) who is or otherwise would be (but*  
22           *for acceptable coverage) eligible for child health assist-*  
23           *ance or pregnancy-related assistance, respectively,*  
24           *under the State child health plan referred to in para-*  
25           *graph (1).”.*

1           (b) *MEDICAID MAINTENANCE OF EFFORT; SIMPLI-*  
2 *FYING AND COORDINATING ELIGIBILITY RULES BETWEEN*  
3 *EXCHANGE AND MEDICAID.*—

4           (1) *IN GENERAL.*—Section 1903 of such Act (42  
5 *U.S.C. 1396b)* is amended by adding at the end the  
6 *following new subsection:*

7           “(aa) *MAINTENANCE OF MEDICAID EFFORT; SIMPLI-*  
8 *FYING AND COORDINATING ELIGIBILITY RULES BETWEEN*  
9 *HEALTH INSURANCE EXCHANGE AND MEDICAID.*—

10           “(1) *MAINTENANCE OF EFFORT.*—

11           “(A) *IN GENERAL.*—Subject to subpara-  
12 *graph (B), a State is not eligible for payment*  
13 *under subsection (a) for a calendar quarter be-*  
14 *ginning after the date of the enactment of this*  
15 *subsection if eligibility standards, methodologies,*  
16 *or procedures under its plan under this title (in-*  
17 *cluding any waiver under this title or under sec-*  
18 *tion 1115 that is permitted to continue effect)*  
19 *that are more restrictive than the eligibility*  
20 *standards, methodologies, or procedures, respec-*  
21 *tively, under such plan (or waiver) as in effect*  
22 *on June 16, 2009. The Secretary shall extend*  
23 *such a waiver (including the availability of Fed-*  
24 *eral financial participation under such waiver)*

1           *for such period as may be required for a State*  
2           *to meet the requirement of the previous sentence.*

3           “(B) *EXCEPTION FOR CERTAIN WAIVERS.—*  
4           *In the case of a State waiver under section 1115*  
5           *in effect on June 16, 2009, that permits individ-*  
6           *uals to be eligible solely to receive a premium or*  
7           *cost-sharing subsidy for individual or group*  
8           *health insurance coverage, effective for coverage*  
9           *provided in Y1—*

10           “(i) *the Secretary shall permit the*  
11           *State to amend such waiver to apply more*  
12           *restrictive eligibility standards, methodolo-*  
13           *gies, or procedures with respect to such in-*  
14           *dividuals under such waiver; and*

15           “(ii) *the application of such more re-*  
16           *strictive, standards, methodologies, or proce-*  
17           *dures under such an amendment shall not*  
18           *be considered in violation of the require-*  
19           *ment of subparagraph (A).*

20           “(2) *REMOVAL OF ASSET TEST FOR CERTAIN*  
21           *ELIGIBILITY CATEGORIES.—*

22           “(A) *IN GENERAL.—A State is not eligible*  
23           *for payment under subsection (a) for a calendar*  
24           *quarter beginning on or after the first day of Y1*  
25           *(as defined in section 100(c) of the America’s Af-*

1        *fordable Health Choices Act of 2009), if the State*  
 2        *applies any asset or resource test in determining*  
 3        *(or redetermining) eligibility of any individual*  
 4        *on or after such first day under any of the fol-*  
 5        *lowing:*

6                *“(i) Subclause (I), (III), (IV), or (VI)*  
 7                *of section 1902(a)(10)(A)(i).*

8                *“(ii) Subclause (II), (IX), (XIV) or*  
 9                *(XVII) of section 1902(a)(10)(A)(ii).*

10               *“(iii) Section 1931(b).*

11               *“(B) OVERRIDING CONTRARY PROVISIONS;*  
 12               *REFERENCES.—The provisions of this title that*  
 13               *prevent the waiver of an asset or resource test de-*  
 14               *scribed in subparagraph (A) are hereby waived.*

15               *“(C) REFERENCES.—Any reference to a*  
 16               *provision described in a provision in subpara-*  
 17               *graph (A) shall be deemed to be a reference to*  
 18               *such provision as modified through the applica-*  
 19               *tion of subparagraphs (A) and (B).”.*

20               *(2) CONFORMING AMENDMENTS.—(A) Section*  
 21               *1902(a)(10)(A) of such Act (42 U.S.C.*  
 22               *1396a(a)(10)(A)) is amended, in the matter before*  
 23               *clause (i), by inserting “subject to section*  
 24               *1903(aa)(2),” after “(A)”.*

1           (B) Section 1931(b)(1) of such Act (42 U.S.C.  
2           1396u-1(b)(1)) is amended by inserting “and section  
3           1903(aa)(2)” after “and (3)”.

4           (c) *STANDARDS FOR BENCHMARK PACKAGES.*—Sec-  
5           tion 1937(b) of such Act (42 U.S.C. 1396u-7(b)) is amend-  
6           ed—

7           (1) in each of paragraphs (1) and (2), by insert-  
8           ing “subject to paragraph (5),” after “subsection  
9           (a)(1),”; and

10           (2) by adding at the end the following new para-  
11           graph:

12           “(5) *MINIMUM STANDARDS.*—Effective January  
13           1, 2013, any benchmark benefit package (or bench-  
14           mark equivalent coverage under paragraph (2)) must  
15           meet the minimum benefits and cost-sharing stand-  
16           ards of a basic plan offered through the Health Insur-  
17           ance Exchange.”.

18           **SEC. 1704. REDUCTION IN MEDICAID DSH.**

19           (a) *REPORT.*—

20           (1) *IN GENERAL.*—Not later than January 1,  
21           2016, the Secretary of Health and Human Services  
22           (in this title referred to as the “Secretary”) shall sub-  
23           mit to Congress a report concerning the extent to  
24           which, based upon the impact of the health care re-  
25           forms carried out under division A in reducing the

1        *number of uninsured individuals, there is a continued*  
2        *role for Medicaid DSH. In preparing the report, the*  
3        *Secretary shall consult with community-based health*  
4        *care networks serving low-income beneficiaries.*

5            (2) *MATTERS TO BE INCLUDED.—The report*  
6        *shall include the following:*

7            (A)    *RECOMMENDATIONS.—Recommendations*  
8        *regarding—*

9            (i) *the appropriate targeting of Medicaid DSH*  
10        *within States; and*

11          (ii) *the distribution of Medicaid DSH*  
12        *among the States, taking into account the*  
13        *ratio of the amount of DSH funds allocated*  
14        *to a State to the number of uninsured individuals*  
15        *in such State.*

16          (B) *SPECIFICATION OF DSH HEALTH RE-*  
17        *FORM METHODOLOGY.—The DSH Health Reform*  
18        *methodology described in paragraph (2) of sub-*  
19        *section (b) for purposes of implementing the re-*  
20        *quirements of such subsection.*

21          (3) *COORDINATION WITH MEDICARE DSH RE-*  
22        *PORT.—The Secretary shall coordinate the report*  
23        *under this subsection with the report on Medicare*  
24        *DSH under section 1112.*

1           (4) *MEDICAID DSH.*—*In this section, the term*  
2           *“Medicaid DSH” means adjustments in payments*  
3           *under section 1923 of the Social Security Act for in-*  
4           *patient hospital services furnished by dispropor-*  
5           *tionate share hospitals.*

6           (b) *MEDICAID DSH REDUCTIONS.*—

7           (1) *IN GENERAL.*—*The Secretary shall reduce*  
8           *Medicaid DSH so as to reduce total Federal pay-*  
9           *ments to all States for such purpose by*  
10           *\$1,500,000,000 in fiscal year 2017, \$2,500,000,000 in*  
11           *fiscal year 2018, and \$6,000,000,000 in fiscal year*  
12           *2019.*

13           (2) *DSH HEALTH REFORM METHODOLOGY.*—*The*  
14           *Secretary shall carry out paragraph (1) through use*  
15           *of a DSH Health Reform methodology issued by the*  
16           *Secretary that imposes the largest percentage reduc-*  
17           *tions on the States that—*

18                   (A) *have the lowest percentages of uninsured*  
19                   *individuals (determined on the basis of audited*  
20                   *hospital cost reports) during the most recent year*  
21                   *for which such data are available; or*

22                   (B) *do not target their DSH payments*  
23                   *on—*

24                           (i) *hospitals with high volumes of Med-*  
25                           *icaid inpatients (as defined in section*

1                    *1923(b)(1)(A) of the Social Security Act (42*  
2                    *U.S.C. 1396r-4(b)(1)(A)); and*

3                    *(ii) hospitals that have high levels of*  
4                    *uncompensated care (excluding bad debt).*

5                    *(3) DSH ALLOTMENT PUBLICATIONS.—*

6                    *(A) IN GENERAL.—Not later than the publi-*  
7                    *cation deadline specified in subparagraph (B),*  
8                    *the Secretary shall publish in the Federal Reg-*  
9                    *ister a notice specifying the DSH allotment to*  
10                    *each State under 1923(f) of the Social Security*  
11                    *Act for the respective fiscal year specified in such*  
12                    *subparagraph, consistent with the application of*  
13                    *the DSH Health Reform methodology described*  
14                    *in paragraph (2).*

15                    *(B) PUBLICATION DEADLINE.—The publica-*  
16                    *tion deadline specified in this subparagraph is—*

17                    *(i) January 1, 2016, with respect to*  
18                    *DSH allotments described in subparagraph*  
19                    *(A) for fiscal year 2017;*

20                    *(ii) January 1, 2017, with respect to*  
21                    *DSH allotments described in subparagraph*  
22                    *(A) for fiscal year 2018; and*

23                    *(iii) January 1, 2018, with respect to*  
24                    *DSH allotments described in subparagraph*  
25                    *(A) for fiscal year 2019.*



1       (c) *CONFORMING AMENDMENTS.*—

2           (1) *Section 1923(f) of the Social Security Act*  
3 *(42 U.S.C. 1396r-4(f)) is amended—*

4           (A) *by redesignating paragraph (7) as*  
5 *paragraph (8); and*

6           (B) *by inserting after paragraph (6) the fol-*  
7 *lowing new paragraph:*

8           “(7) *SPECIAL RULE FOR FISCAL YEARS 2017,*  
9 *2018, AND 2019.*—

10           “(A) *FISCAL YEAR 2017.*—*Notwithstanding*  
11 *paragraph (2), the total DSH allotments for all*  
12 *States for—*

13           “(i) *fiscal year 2017, shall be the total*  
14 *DSH allotments that would otherwise be de-*  
15 *termined under this subsection for such fis-*  
16 *cal year decreased by \$1,500,000,000;*

17           “(ii) *fiscal year 2018, shall be the total*  
18 *DSH allotments that would otherwise be de-*  
19 *termined under this subsection for such fis-*  
20 *cal year decreased by \$2,500,000,000; and*

21           “(iii) *fiscal year 2019, shall be the*  
22 *total DSH allotments that would otherwise*  
23 *be determined under this subsection for such*  
24 *fiscal year decreased by \$6,000,000,000.”.*

1           (2) *The second sentence of section 1923(b)(4) of*  
2 *such Act (42 U.S.C. 1396r-4(b)(4)) is amended by in-*  
3 *serting before the period the following: “or to affect*  
4 *the authority of the Secretary to issue and implement*  
5 *the DSH Health Reform methodology under section*  
6 *1704(b)(2) of the America’s Health Choices Act of*  
7 *2009”.*

8           (d) *DISPROPORTIONATE SHARE HOSPITALS (DSH)*  
9 *AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DISCRIMI-*  
10 *NATION.—*

11           (1) *IN GENERAL.—Section 1923(d) of the Social*  
12 *Security Act (42 U.S.C. 1396r-4) is amended by add-*  
13 *ing at the end the following new paragraph:*

14           “*(4) No hospital may be defined or deemed as a*  
15 *disproportionate share hospital, or as an essential ac-*  
16 *cess hospital (for purposes of subsection (f)(6)(A)(iv)),*  
17 *under a State plan under this title or subsection (b)*  
18 *of this section (including any waiver under section*  
19 *1115) unless the hospital—*

20           “*(A) provides services to beneficiaries under*  
21 *this title without discrimination on the ground*  
22 *of race, color, national origin, creed, source of*  
23 *payment, status as a beneficiary under this title,*  
24 *or any other ground unrelated to such bene-*

1           *ficiary’s need for the services or the availability*  
2           *of the needed services in the hospital; and*

3           “(B) makes arrangements for, and accepts,  
4           reimbursement under this title for services pro-  
5           vided to eligible beneficiaries under this title.”.

6           (2) *EFFECTIVE DATE.*—*The amendment made by*  
7           *paragraph (1) shall apply to expenditures made on or*  
8           *after July 1, 2010.*

9   **SEC. 1705. EXPANDED OUTSTATIONING.**

10          (a) *IN GENERAL.*—*Section 1902(a)(55) of the Social*  
11          *Security Act (42 U.S.C. 1396a(a)(55)) is amended by strik-*  
12          *ing “under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),*  
13          *(a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)” and inserting*  
14          *“(including receipt and processing of applications of indi-*  
15          *viduals for affordability credits under subtitle C of title II*  
16          *of division A of the America’s Affordable Health Choices*  
17          *Act of 2009 pursuant to a Medicaid memorandum of under-*  
18          *standing under section 1943(a)(1))”.*

19          (b) *EFFECTIVE DATE.*—

20                 (1) *Except as provided in paragraph (2), the*  
21                 *amendment made by subsection (a) shall apply to*  
22                 *services furnished on or after July 1, 2010, without*  
23                 *regard to whether or not final regulations to carry*  
24                 *out such amendment have been promulgated by such*  
25                 *date.*

1           (2) *In the case of a State plan for medical assist-*  
 2 *ance under title XIX of the Social Security Act which*  
 3 *the Secretary of Health and Human Services deter-*  
 4 *mines requires State legislation (other than legisla-*  
 5 *tion appropriating funds) in order for the plan to*  
 6 *meet the additional requirement imposed by the*  
 7 *amendment made by this section, the State plan shall*  
 8 *not be regarded as failing to comply with the require-*  
 9 *ments of such title solely on the basis of its failure to*  
 10 *meet this additional requirement before the first day*  
 11 *of the first calendar quarter beginning after the close*  
 12 *of the first regular session of the State legislature that*  
 13 *begins after the date of the enactment of this Act. For*  
 14 *purposes of the previous sentence, in the case of a*  
 15 *State that has a 2-year legislative session, each year*  
 16 *of such session shall be deemed to be a separate reg-*  
 17 *ular session of the State legislature.*

## 18                           **Subtitle B—Prevention**

### 19 **SEC. 1711. REQUIRED COVERAGE OF PREVENTIVE SERV-** 20 **ICES.**

21           (a) *COVERAGE.*—*Section 1905 of the Social Security*  
 22 *Act (42 U.S.C. 1396d), as amended by section*  
 23 *1701(a)(2)(B), is amended—*

24                           (1) *in subsection (a)(4)—*

25   (A) *by striking “and” before “(C)”;* and

1                   (B) by inserting before the semicolon at the  
2                   end the following: “; and (D) preventive services  
3                   described in subsection (z)”;

4                   (2) by adding at the end the following new sub-  
5                   section:

6                   “(z) *PREVENTIVE SERVICES*.—The preventive services  
7                   described in this subsection are services not otherwise de-  
8                   scribed in subsection (a) or (r) that the Secretary deter-  
9                   mines are—

10                   “(1)(A) recommended with a grade of A or B by  
11                   the Task Force for Clinical Preventive Services; or

12                   “(B) vaccines recommended for use as appro-  
13                   priate by the Director of the Centers for Disease Con-  
14                   trol and Prevention; and

15                   “(2) appropriate for individuals entitled to med-  
16                   ical assistance under this title.”.

17                   (b) *ELIMINATION OF COST-SHARING*.—

18                   (1) Subsections (a)(2)(D) and (b)(2)(D) of sec-  
19                   tion 1916 of such Act (42 U.S.C. 1396o) are each  
20                   amended by inserting “preventive services described  
21                   in section 1905(z),” after “emergency services (as de-  
22                   fined by the Secretary),”.

23                   (2) Section 1916A(a)(1) of such Act (42 U.S.C.  
24                   1396o–1 (a)(1)) is amended by inserting “, preventive

1 *services described in section 1905(z),” after “sub-*  
2 *section (c)”.*

3 *(c) CONFORMING AMENDMENT.—Section 1928 of such*  
4 *Act (42 U.S.C. 1396s) is amended—*

5 *(1) in subsection (c)(2)(B)(i), by striking “the*  
6 *advisory committee referred to in subsection (e)” and*  
7 *inserting “the Director of the Centers for Disease Con-*  
8 *trol and Prevention”;*

9 *(2) in subsection (e), by striking “Advisory Com-*  
10 *mittee” and all that follows and inserting “Director*  
11 *of the Centers for Disease Control and Prevention.”;*  
12 *and*

13 *(3) by striking subsection (g).*

14 *(d) EFFECTIVE DATE.—*

15 *(1) Except as provided in paragraph (2), the*  
16 *amendments made by this section shall apply to serv-*  
17 *ices furnished on or after July 1, 2010, without re-*  
18 *gard to whether or not final regulations to carry out*  
19 *such amendments have been promulgated by such*  
20 *date.*

21 *(2) In the case of a State plan for medical assist-*  
22 *ance under title XIX of the Social Security Act which*  
23 *the Secretary of Health and Human Services deter-*  
24 *mines requires State legislation (other than legisla-*  
25 *tion appropriating funds) in order for the plan to*

1        *meet the additional requirements imposed by the*  
2        *amendments made by this section, the State plan*  
3        *shall not be regarded as failing to comply with the re-*  
4        *quirements of such title solely on the basis of its fail-*  
5        *ure to meet these additional requirements before the*  
6        *first day of the first calendar quarter beginning after*  
7        *the close of the first regular session of the State legis-*  
8        *lature that begins after the date of the enactment of*  
9        *this Act. For purposes of the previous sentence, in the*  
10       *case of a State that has a 2-year legislative session,*  
11       *each year of such session shall be deemed to be a sepa-*  
12       *rate regular session of the State legislature.*

13    **SEC. 1712. TOBACCO CESSATION.**

14        *(a) DROPPING TOBACCO CESSATION EXCLUSION FROM*  
15        *COVERED OUTPATIENT DRUGS.—Section 1927(d)(2) of the*  
16        *Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amend-*  
17        *ed—*

18                *(1) by striking subparagraph (E);*

19                *(2) in subparagraph (G), by inserting before the*  
20        *period at the end the following: “, except agents ap-*  
21        *proved by the Food and Drug Administration for*  
22        *purposes of promoting, and when used to promote, to-*  
23        *bacco cessation”; and*

24                *(3) by redesignating subparagraphs (F) through*  
25        *(K) as subparagraphs (E) through (J), respectively.*

1           (b) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall apply to drugs and services furnished on or*  
3 *after January 1, 2010.*

4 **SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITA-**  
5 **TION SERVICES.**

6           (a) *IN GENERAL.*—*Section 1905 of the Social Security*  
7 *Act (42 U.S.C. 1396d), as amended by sections 1701(a)(2)*  
8 *and 1711(a), is amended—*

9                   (1) *in subsection (a)—*

10                           (A) *in paragraph (27), by striking “and”*  
11 *at the end;*

12                           (B) *by redesignating paragraph (28) as*  
13 *paragraph (29); and*

14                           (C) *by inserting after paragraph (27) the*  
15 *following new paragraph:*

16                                   “(28) *nurse home visitation services (as defined*  
17 *in subsection (aa)); and”;* and

18                           (2) *by adding at the end the following new sub-*  
19 *section:*

20                                   “(aa) *The term ‘nurse home visitation services’ means*  
21 *home visits by trained nurses to families with a first-time*  
22 *pregnant woman, or a child (under 2 years of age), who*  
23 *is eligible for medical assistance under this title, but only,*  
24 *to the extent determined by the Secretary based upon evi-*



1 dence, that such services are effective in one or more of the  
2 following:

3           “(1) Improving maternal or child health and  
4 pregnancy outcomes or increasing birth intervals be-  
5 tween pregnancies.

6           “(2) Reducing the incidence of child abuse, ne-  
7 glect, and injury, improving family stability (includ-  
8 ing reduction in the incidence of intimate partner vi-  
9 olence), or reducing maternal and child involvement  
10 in the criminal justice system.

11           “(3) Increasing economic self-sufficiency, em-  
12 ployment advancement, school-readiness, and edu-  
13 cational achievement, or reducing dependence on pub-  
14 lic assistance.”.

15       (b) *EFFECTIVE DATE.*—The amendments made by this  
16 section shall apply to services furnished on or after January  
17 1, 2010.

18       (c) *CONSTRUCTION.*—Nothing in the amendments  
19 made by this section shall be construed as affecting the abil-  
20 ity of a State under title XIX or XXI of the Social Security  
21 Act to provide nurse home visitation services as part of an-  
22 other class of items and services falling within the definition  
23 of medical assistance or child health assistance under the  
24 respective title, or as an administrative expenditure for  
25 which payment is made under section 1903(a) or 2105(a)

1 of such Act, respectively, on or after the date of the enact-  
 2 ment of this Act.

3 **SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLAN-**  
 4 **NING SERVICES.**

5 (a) *COVERAGE AS OPTIONAL CATEGORICALLY NEEDY*  
 6 *GROUP.*—

7 (1) *IN GENERAL.*—Section 1902(a)(10)(A)(ii) of  
 8 the Social Security Act (42 U.S.C.  
 9 1396a(a)(10)(A)(ii)) is amended—

10 (A) in subclause (XVIII), by striking “or”  
 11 at the end;

12 (B) in subclause (XIX), by adding “or” at  
 13 the end; and

14 (C) by adding at the end the following new  
 15 subclause:

16 “(XX) who are described in sub-  
 17 section (hh) (relating to individuals  
 18 who meet certain income standards);”.

19 (2) *GROUP DESCRIBED.*—Section 1902 of such  
 20 Act (42 U.S.C. 1396a), as amended by section 1703,  
 21 is amended by adding at the end the following new  
 22 subsection:

23 “(hh)(1) Individuals described in this subsection are  
 24 individuals—

1           “(A) whose income does not exceed an in-  
2           come eligibility level established by the State that  
3           does not exceed the highest income eligibility  
4           level established under the State plan under this  
5           title (or under its State child health plan under  
6           title XXI) for pregnant women; and

7           “(B) who are not pregnant.

8           “(2) At the option of a State, individuals described  
9           in this subsection may include individuals who, had indi-  
10          viduals applied on or before January 1, 2007, would have  
11          been made eligible pursuant to the standards and processes  
12          imposed by that State for benefits described in clause (XV)  
13          of the matter following subparagraph (G) of section sub-  
14          section (a)(10) pursuant to a waiver granted under section  
15          1115.

16          “(3) At the option of a State, for purposes of subsection  
17          (a)(17)(B), in determining eligibility for services under this  
18          subsection, the State may consider only the income of the  
19          applicant or recipient.”.

20                 (3)   LIMITATION   ON   BENEFITS.—Section  
21                 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is  
22                 amended in the matter following subparagraph (G)—

23                         (A) by striking “and (XIV)” and inserting  
24                         “(XIV)”; and

1           (B) by inserting “, and (XV) the medical  
2           assistance made available to an individual de-  
3           scribed in subsection (hh) shall be limited to  
4           family planning services and supplies described  
5           in section 1905(a)(4)(C) including medical diag-  
6           nosis and treatment services that are provided  
7           pursuant to a family planning service in a fam-  
8           ily planning setting” after “cervical cancer”.

9           (4)     CONFORMING     AMENDMENTS.—Section  
10           1905(a) of such Act (42 U.S.C. 1396d(a)), as amend-  
11           ed by section 1731(c), is amended in the matter pre-  
12           ceding paragraph (1)—

13                 (A) in clause (xiii), by striking “or” at the  
14                 end;

15                 (B) in clause (xiv), by adding “or” at the  
16                 end; and

17                 (C) by inserting after clause (xiv) the fol-  
18                 lowing:

19                 “(xv)   individuals   described   in   section  
20                 1902(hh),”.

21           (b) PRESUMPTIVE ELIGIBILITY.—

22                 (1) IN GENERAL.—Title XIX of the Social Secu-  
23                 rity Act (42 U.S.C. 1396 et seq.) is amended by in-  
24                 serting after section 1920B the following:

1           “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING

2                           SERVICES

3           “SEC. 1920C. (a) STATE OPTION.—State plan ap-  
 4 proved under section 1902 may provide for making medical  
 5 assistance available to an individual described in section  
 6 1902(hh) (relating to individuals who meet certain income  
 7 eligibility standard) during a presumptive eligibility pe-  
 8 riod. In the case of an individual described in section  
 9 1902(hh), such medical assistance shall be limited to family  
 10 planning services and supplies described in 1905(a)(4)(C)  
 11 and, at the State’s option, medical diagnosis and treatment  
 12 services that are provided in conjunction with a family  
 13 planning service in a family planning setting.

14           “(b) DEFINITIONS.—For purposes of this section:

15                   “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The  
 16 term ‘presumptive eligibility period’ means, with re-  
 17 spect to an individual described in subsection (a), the  
 18 period that—

19                           “(A) begins with the date on which a quali-  
 20 fied entity determines, on the basis of prelimi-  
 21 nary information, that the individual is de-  
 22 scribed in section 1902(hh); and

23                           “(B) ends with (and includes) the earlier  
 24 of—

1           “(i) the day on which a determination  
2           is made with respect to the eligibility of  
3           such individual for services under the State  
4           plan; or

5           “(ii) in the case of such an individual  
6           who does not file an application by the last  
7           day of the month following the month dur-  
8           ing which the entity makes the determina-  
9           tion referred to in subparagraph (A), such  
10          last day.

11          “(2) QUALIFIED ENTITY.—

12           “(A) IN GENERAL.—Subject to subpara-  
13           graph (B), the term ‘qualified entity’ means any  
14           entity that—

15           “(i) is eligible for payments under a  
16           State plan approved under this title; and

17           “(ii) is determined by the State agency  
18           to be capable of making determinations of  
19           the type described in paragraph (1)(A).

20           “(B) RULE OF CONSTRUCTION.—Nothing in  
21           this paragraph shall be construed as preventing  
22           a State from limiting the classes of entities that  
23           may become qualified entities in order to prevent  
24           fraud and abuse.

25          “(c) ADMINISTRATION.—

1           “(1) *IN GENERAL.*—*The State agency shall provide qualified entities with—*

2                           “(A) *such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and*

3                           “(B) *information on how to assist such individuals in completing and filing such forms.*

4           “(2) *NOTIFICATION REQUIREMENTS.*—*A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—*

5                           “(A) *notify the State agency of the determination within 5 working days after the date on which determination is made; and*

6                           “(B) *inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.*

7           “(3) *APPLICATION FOR MEDICAL ASSISTANCE.*—*In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a*

1       *State plan, the individual shall apply for medical as-*  
2       *istance by not later than the last day of the month*  
3       *following the month during which the determination*  
4       *is made.*

5       “(d) *PAYMENT.*—*Notwithstanding any other provision*  
6       *of law, medical assistance that—*

7               “(1) *is furnished to an individual described in*  
8       *subsection (a)—*

9                       “(A) *during a presumptive eligibility pe-*  
10       *riod;*

11                      “(B) *by a entity that is eligible for pay-*  
12       *ments under the State plan; and*

13               “(2) *is included in the care and services covered*  
14       *by the State plan,*

15       *shall be treated as medical assistance provided by such plan*  
16       *for purposes of clause (4) of the first sentence of section*  
17       *1905(b).”.*

18       (2) *CONFORMING AMENDMENTS.*—

19               (A) *Section 1902(a)(47) of the Social Secu-*  
20       *rity Act (42 U.S.C. 1396a(a)(47)) is amended by*  
21       *inserting before the semicolon at the end the fol-*  
22       *lowing: “and provide for making medical assist-*  
23       *ance available to individuals described in sub-*  
24       *section (a) of section 1920C during a presump-*



1           *tive eligibility period in accordance with such*  
2           *section”.*

3           *(B) Section 1903(u)(1)(D)(v) of such Act*  
4           *(42 U.S.C. 1396b(u)(1)(D)(v)) is amended—*

5                     *(i) by striking “or for” and inserting*  
6                     *“for”; and*

7                     *(ii) by inserting before the period the*  
8                     *following: “, or for medical assistance pro-*  
9                     *vided to an individual described in sub-*  
10                    *section (a) of section 1920C during a pre-*  
11                    *sumptive eligibility period under such sec-*  
12                    *tion”.*

13           *(c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-*  
14           *NING SERVICES AND SUPPLIES.—Section 1937(b) of the So-*  
15           *cial Security Act (42 U.S.C. 1396u–7(b)), as amended by*  
16           *section 1703(c)(2), is amended by adding at the end the*  
17           *following:*

18                     *“(6) COVERAGE OF FAMILY PLANNING SERVICES*  
19                     *AND SUPPLIES.—Notwithstanding the previous provi-*  
20                     *sions of this section, a State may not provide for*  
21                     *medical assistance through enrollment of an indi-*  
22                     *vidual with benchmark coverage or benchmark-equiva-*  
23                     *lent coverage under this section unless such coverage*  
24                     *includes for any individual described in section*  
25                     *1905(a)(4)(C), medical assistance for family planning*

1 *services and supplies in accordance with such sec-*  
 2 *tion.”.*

3 *(d) EFFECTIVE DATE.—The amendments made by this*  
 4 *section take effect on the date of the enactment of this Act*  
 5 *and shall apply to items and services furnished on or after*  
 6 *such date.*

### 7 ***Subtitle C—Access***

#### 8 **SEC. 1721. PAYMENTS TO PRIMARY CARE PRACTITIONERS.**

9 *(a) IN GENERAL.—*

10 *(1) FEE-FOR-SERVICE PAYMENTS.—Section*  
 11 *1902(a)(13) of the Social Security Act (42 U.S.C.*  
 12 *1396b(a)(13)) is amended—*

13 *(A) by striking “and” at the end of sub-*  
 14 *paragraph (A);*

15 *(B) by adding “and” at the end of subpara-*  
 16 *graph (B); and*

17 *(C) by adding at the end the following new*  
 18 *subparagraph:*

19 *“(C) payment for primary care services (as*  
 20 *defined in section 1848(j)(5)(A), but applied*  
 21 *without regard to clause (ii) thereof) furnished*  
 22 *by physicians (or for services furnished by other*  
 23 *health care professionals that would be primary*  
 24 *care services under such section if furnished by*  
 25 *a physician) at a rate not less than 80 percent*

1           of the payment rate applicable to such services  
2           and physicians or professionals (as the case may  
3           be) under part B of title XVIII for services fur-  
4           nished in 2010, 90 percent of such rate for serv-  
5           ices and physicians (or professionals) furnished  
6           in 2011, and 100 percent of such payment rate  
7           for services and physicians (or professionals) fur-  
8           nished in 2012 or a subsequent year;”.

9           (2) *UNDER MEDICAID MANAGED CARE PLANS.*—

10          Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is  
11          amended—

12                 (A) in the heading, by adding at the end the  
13                 following: “; *ADEQUACY OF PAYMENT FOR PRI-*  
14                 *MARY CARE SERVICES*”; and

15                 (B) by inserting before the period at the end  
16                 the following: “and, in the case of primary care  
17                 services described in section 1902(a)(13)(C), con-  
18                 sistent with the minimum payment rates speci-  
19                 fied in such section (regardless of the manner in  
20                 which such payments are made, including in the  
21                 form of capitation or partial capitation)”.

22          (b) *INCREASE IN PAYMENT USING INCREASED*  
23          *FMAP.*—Section 1905(y) of the Social Security Act, as  
24          added by section 1701(a)(2)(B) and as amended by section  
25          1701(c)(2), is amended by adding at the end the following:

1           “(3)(A) *The portion of the amounts expended for*  
2           *medical assistance for services described in section*  
3           *1902(a)(13)(C) furnished on or after January 1,*  
4           *2010, that is attributable to the amount by which the*  
5           *minimum payment rate required under such section*  
6           *(or, by application, section 1932(f)) exceeds the pay-*  
7           *ment rate applicable to such services under the State*  
8           *plan as of June 16, 2009.*

9           “(B) *Subparagraphs (A) shall not be construed*  
10           *as preventing the payment of Federal financial par-*  
11           *ticipation based on the Federal medical assistance*  
12           *percentage for amounts in excess of those specified*  
13           *under such subparagraphs.”.*

14           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
15           *section shall apply to services furnished on or after January*  
16           *1, 2010.*

17           **SEC. 1722. MEDICAL HOME PILOT PROGRAM.**

18           (a) *IN GENERAL.*—*The Secretary of Health and*  
19           *Human Services shall establish under this section a medical*  
20           *home pilot program under which a State may apply to the*  
21           *Secretary for approval of a medical home pilot project de-*  
22           *scribed in subsection (b) (in this section referred to as a*  
23           *“pilot project”) for the application of the medical home con-*  
24           *cept under title XIX of the Social Security Act. The pilot*  
25           *program shall operate for a period of up to 5 years.*

1       **(b) PILOT PROJECT DESCRIBED.**—

2               **(1) IN GENERAL.**—*A pilot project is a project*  
3 *that applies one or more of the medical home models*  
4 *described in section 1866E(a)(3) of the Social Secu-*  
5 *rity Act (as inserted by section 1302(a)) or such other*  
6 *model as the Secretary may approve, to high need*  
7 *beneficiaries (including medically fragile children*  
8 *and high-risk pregnant women) who are eligible for*  
9 *medical assistance under title XIX of the Social Secu-*  
10 *rity Act. The Secretary shall provide for appropriate*  
11 *coordination of the pilot program under this section*  
12 *with the medical home pilot program under section*  
13 *1866E of such Act.*

14               **(2) LIMITATION.**—*A pilot project shall be for a*  
15 *duration of not more than 5 years.*

16       **(c) ADDITIONAL INCENTIVES.**—*In the case of a pilot*  
17 *project, the Secretary may—*

18               **(1)** *wave the requirements of section 1902(a)(1)*  
19 *of the Social Security Act (relating to statewideness)*  
20 *and section 1902(a)(10)(B) of such Act (relating to*  
21 *comparability); and*

22               **(2)** *increase to up to 90 percent (for the first 2*  
23 *years of the pilot program) or 75 percent (for the next*  
24 *3 years) the matching percentage for administrative*

1        *expenditures (such as those for community care work-*  
2        *ers).*

3        *(d) MEDICALLY FRAGILE CHILDREN.—In the case of*  
4        *a model involving medically fragile children, the model*  
5        *shall ensure that the patient-centered medical home services*  
6        *received by each child, in addition to fulfilling the require-*  
7        *ments under 1866E(b)(1) of the Social Security Act, pro-*  
8        *vide for continuous involvement and education of the parent*  
9        *or caregiver and for assistance to the child in obtaining*  
10       *necessary transitional care if a child’s enrollment ceases for*  
11       *any reason.*

12       *(e) EVALUATION; REPORT.—*

13                *(1) EVALUATION.—The Secretary, using the cri-*  
14        *teria described in section 1866E(g)(1) of the Social*  
15        *Security Act (as inserted by section 1123), shall con-*  
16        *duct an evaluation of the pilot program under this*  
17        *section.*

18                *(2) REPORT.—Not later than 60 days after the*  
19        *date of completion of the evaluation under paragraph*  
20        *(1), the Secretary shall submit to Congress and make*  
21        *available to the public a report on the findings of the*  
22        *evaluation under such paragraph.*

23        *(f) FUNDING.—The additional Federal financial par-*  
24        *ticipation resulting from the implementation of the pilot*

1 program under this section may not exceed in the aggregate  
2 \$1,235,000,000 over the 5-year period of the program.

3 **SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.**

4 (a) *IN GENERAL.*—Section 1903(a)(2)(E) of the Social  
5 Security Act (42 U.S.C. 1396b(a)(2)), as added by section  
6 201(b)(2)(A) of the Children’s Health Insurance Program  
7 Reauthorization Act of 2009 (Public Law 111–3), is amend-  
8 ed by inserting “and other individuals” after “children of  
9 families”.

10 (b) *EFFECTIVE DATE.*—The amendment made by sub-  
11 section (a) shall apply to payment for translation or inter-  
12 pretation services furnished on or after January 1, 2010.

13 **SEC. 1724. OPTIONAL COVERAGE FOR FREESTANDING**  
14 **BIRTH CENTER SERVICES.**

15 (a) *IN GENERAL.*—Section 1905 of the Social Security  
16 Act (42 U.S.C. 1396d), as amended by section 1713(a), is  
17 amended—

18 (1) in subsection (a)—

19 (A) by redesignating paragraph (29) as  
20 paragraph (30);

21 (B) in paragraph (28), by striking at the  
22 end “and”; and

23 (C) by inserting after paragraph (28) the  
24 following new paragraph:

1           “(29) freestanding birth center services (as de-  
2           fined in subsection (l)(3)(A)) and other ambulatory  
3           services that are offered by a freestanding birth center  
4           (as defined in subsection (l)(3)(B)) and that are oth-  
5           erwise included in the plan; and”;

6           (2) in subsection (l), by adding at the end the  
7           following new paragraph:

8           “(3)(A) The term ‘freestanding birth center services’  
9           means services furnished to an individual at a freestanding  
10          birth center (as defined in subparagraph (B)), including  
11          by a licensed birth attendant (as defined in subparagraph  
12          (C)) at such center.

13          “(B) The term ‘freestanding birth center’ means a  
14          health facility—

15                  “(i) that is not a hospital; and

16                  “(ii) where childbirth is planned to occur away  
17          from the pregnant woman’s residence.

18          “(C) The term ‘licensed birth attendant’ means an in-  
19          dividual who is licensed or registered by the State involved  
20          to provide health care at childbirth and who provides such  
21          care within the scope of practice under which the individual  
22          is legally authorized to perform such care under State law  
23          (or the State regulatory mechanism provided by State law),  
24          regardless of whether the individual is under the super-  
25          vision of, or associated with, a physician or other health



1 care provider. Nothing in this subparagraph shall be con-  
2 strued as changing State law requirements applicable to a  
3 licensed birth attendant.”.

4 (b) *EFFECTIVE DATE.*—The amendments made by this  
5 section shall apply to items and services furnished on or  
6 after the date of the enactment of this Act.

7 **SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER**  
8 **THE VACCINES FOR CHILDREN PROGRAM.**

9 Section 1928(b)(2)(A)(iii)(I) of the Social Security Act  
10 (42 U.S.C. 1396s(b)(2)(A)(iii)(I)) is amended—

11 (1) by striking “or a rural health clinic” and in-  
12 serting “, a rural health clinic”; and

13 (2) by inserting “or a public health clinic,” after  
14 “1905(l)(1),”.

15 **SEC. 1726. REQUIRING COVERAGE OF SERVICES OF PODIA-**  
16 **TRISTS.**

17 (a) *IN GENERAL.*—Section 1905(a)(5)(A) of the Social  
18 Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by  
19 striking “section 1861(r)(1)” and inserting “paragraphs  
20 (1) and (3) of section 1861(r)”.

21 (b) *EFFECTIVE DATE.*—

22 (1) *IN GENERAL.*—Except as provided in para-  
23 graph (2), the amendment made by subsection (a)  
24 shall apply to services furnished on or after January  
25 1, 2010.

1           (2) *EXTENSION OF EFFECTIVE DATE FOR STATE*  
2 *LAW AMENDMENT.—In the case of a State plan under*  
3 *title XIX of the Social Security Act (42 U.S.C. 1396*  
4 *et seq.) which the Secretary of Health and Human*  
5 *Services determines requires State legislation in order*  
6 *for the plan to meet the additional requirement im-*  
7 *posed by the amendment made by subsection (a), the*  
8 *State plan shall not be regarded as failing to comply*  
9 *with the requirements of such title solely on the basis*  
10 *of its failure to meet these additional requirements be-*  
11 *fore the first day of the first calendar quarter begin-*  
12 *ning after the close of the first regular session of the*  
13 *State legislature that begins after the date of enact-*  
14 *ment of this Act. For purposes of the previous sen-*  
15 *tence, in the case of a State that has a 2-year legisla-*  
16 *tive session, each year of the session is considered to*  
17 *be a separate regular session of the State legislature.*

18 **SEC. 1726A. REQUIRING COVERAGE OF SERVICES OF OP-**  
19 **TOMETRISTS.**

20           (a) *IN GENERAL.—Section 1905(a)(5) of the Social Se-*  
21 *curity Act (42 U.S.C. 1396d(a)(5)) is amended—*

22                   (1) *by striking “and” before “(B)”;* and

23                   (2) *by inserting before the semicolon at the end*  
24 *the following: “, and (C) medical and other health*  
25 *services (as defined in section 1861(s)) as authorized*

1 by State law, furnished by an optometrist (described  
2 in section 1861(r)(4)) to the extent such services may  
3 be performed under State law”.

4 (b) *EFFECTIVE DATE.*—

5 (1) *IN GENERAL.*—Except as provided in para-  
6 graph (2), the amendments made by subsection (a)  
7 shall take effect 90 days after the date of the enact-  
8 ment of this Act and shall apply to services furnished  
9 or other actions required on or after such date.

10 (2) *EXCEPTION IF STATE LEGISLATION RE-*  
11 *QUIRED.*—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 legis-  
15 lation appropriating funds) in order for the plan to  
16 meet the additional requirements made by the amend-  
17 ments made by subsection (a), the State plan shall  
18 not be regarded as failing to comply with the require-  
19 ments of such title solely on the basis of its failure to  
20 meet these additional requirements before the first day  
21 of the first calendar quarter beginning after the close  
22 of the first regular session of the State legislature that  
23 begins after the date of enactment of this Act. For  
24 purposes of the previous sentence, in the case of a  
25 State that has a 2-year legislative session, each year

1       *of such session shall be deemed to be a separate reg-*  
2       *ular session of the State legislature.*

3       **SEC. 1727. THERAPEUTIC FOSTER CARE.**

4       *(a) RULE OF CONSTRUCTION.—Nothing in this title*  
5       *shall prevent or limit a State from covering therapeutic fos-*  
6       *ter care for eligible children in out-of-home placements*  
7       *under section 1905(a) of the Social Security Act (42 U.S.C.*  
8       *1396d(a)).*

9       *(b) THERAPEUTIC FOSTER CARE DEFINED.—For pur-*  
10       *poses of this section, the term “therapeutic foster care”*  
11       *means a foster care program that provides—*

12               *(1) to the child—*

13                       *(A) structured daily activities that develop,*  
14                       *improve, monitor, and reinforce age-appropriate*  
15                       *social, communications, and behavioral skills;*

16                       *(B) crisis intervention and crisis support*  
17                       *services;*

18                       *(C) medication monitoring;*

19                       *(D) counseling; and*

20                       *(E) case management services; and*

21               *(2) specialized training for the foster parent and*  
22       *consultation with the foster parent on the manage-*  
23       *ment of children with mental illnesses and related*  
24       *health and developmental conditions.*

1 **SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR**  
2 **SERVICES.**

3 (a) *IN GENERAL.*—*Title XIX of the Social Security*  
4 *Act is amended by inserting after section 1925 the following*  
5 *new section:*

6 “ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

7 “SEC. 1926. (a) *IN GENERAL.*—*A State plan under*  
8 *this title shall not be considered to meet the requirement*  
9 *of section 1902(a)(30)(A) for a year (beginning with 2011)*  
10 *unless, by not later than April 1 before the beginning of*  
11 *such year, the State submits to the Secretary an amendment*  
12 *to the plan that specifies the payment rates to be used for*  
13 *such services under the plan in such year and includes in*  
14 *such submission such additional data as will assist the Sec-*  
15 *retary in evaluating the State’s compliance with such re-*  
16 *quirement, including data relating to how rates established*  
17 *for payments to medicaid managed care organizations*  
18 *under sections 1903(m) and 1932 take into account such*  
19 *payment rates.*

20 “(b) *SECRETARIAL REVIEW.*—*The Secretary, by not*  
21 *later than 90 days after the date of submission of a plan*  
22 *amendment under subsection (a), shall—*

23 “(1) *review each such amendment for compliance*  
24 *with the requirement of section 1902(a)(30)(A); and*

25 “(2) *approve or disapprove each such amend-*  
26 *ment.*

1 *If the Secretary disapproves such an amendment, the State*  
2 *shall immediately submit a revised amendment that meets*  
3 *such requirement.”.*

4 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
5 *section (a) shall take effect on the date of the enactment*  
6 *of this Act.*

7 **SEC. 1729. PRESERVING MEDICAID COVERAGE FOR YOUTHS**  
8 **UPON RELEASE FROM PUBLIC INSTITUTIONS.**

9 *Section 1902(a) of the Social Security Act (42 U.S.C.*  
10 *1396a), as amended by section 1631(b) and 1703(a), is*  
11 *amended—*

12 (1) *by striking “and” at the end of paragraph*  
13 *(74);*

14 (2) *by striking the period at the end of para-*  
15 *graph (75) and inserting “; and”; and*

16 (3) *by inserting after paragraph (75) the fol-*  
17 *lowing new paragraph:*

18 “(76) *provide that in the case of any youth who*  
19 *is 18 years of age or younger, was enrolled for med-*  
20 *ical assistance under the State plan immediately be-*  
21 *fore becoming an inmate of a public institution, is 18*  
22 *years of age or younger upon release from such insti-*  
23 *tution, and is eligible for such medical assistance*  
24 *under the State plan at the time of release from such*  
25 *institution—*

1           “(A) during the period such youth is incar-  
2           cerated in a public institution, the State shall  
3           not terminate eligibility for medical assistance  
4           under the State plan for such youth;

5           “(B) during the period such youth is incar-  
6           cerated in a public institution, the State shall es-  
7           tablish a process that ensures—

8                   “(i) that the State does not claim fed-  
9                   eral financial participation for services that  
10                  are provided to such youth and that are ex-  
11                  cluded under subsection 1905(a)(28)(A);  
12                  and

13                  “(ii) that the youth receives medical  
14                  assistance for which federal participation is  
15                  available under this title;

16           “(C) on or before the date such youth is re-  
17           leased from such institution, the State shall en-  
18           sure that such youth is enrolled for medical as-  
19           sistance under this title, unless and until there  
20           is a determination that the individual is no  
21           longer eligible to be so enrolled; and

22           “(D) the State shall ensure that enrollment  
23           under subparagraph (C) will be completed before  
24           such date so that the youth can access medical

1           *assistance under this title immediately upon*  
2           *leaving the institution.”*

3 **SEC. 1730. QUALITY MEASURES FOR MATERNITY AND**  
4           **ADULT HEALTH SERVICES UNDER MEDICAID**  
5           **AND CHIP.**

6           *Title XI of the Social Security Act (42 U.S.C. 1301*  
7 *et seq.) is amended by inserting after section 1139A the fol-*  
8 *lowing new section:*

9 **“SEC. 1139B. QUALITY MEASURES FOR MATERNITY AND**  
10           **ADULT HEALTH SERVICES UNDER MEDICAID**  
11           **AND CHIP.**

12           *“(a) MATERNITY CARE QUALITY MEASURES UNDER*  
13 *MEDICAID AND CHIP.—*

14                   *“(1) DEVELOPMENT OF MEASURES.—No later*  
15           *than January 1, 2011, the Secretary shall develop*  
16           *and publish for comment a proposed set of measures*  
17           *that accurately describe the quality of maternity care*  
18           *provided under State plans under titles XIX and*  
19           *XXI. The Secretary shall publish a final rec-*  
20           *ommended set of such measures no later than July 1,*  
21           *2011.*

22                   *“(2) STANDARDIZED REPORTING FORMAT.—No*  
23           *later than January 1, 2012, the Secretary shall de-*  
24           *velop and publish a standardized reporting format for*  
25           *maternity care quality measures for use by State pro-*



1       grams under titles XIX and XXI to collect data from  
2       managed care entities and providers and practi-  
3       tioners that participate in such programs and to re-  
4       port maternity care quality measures to the Sec-  
5       retary.

6       “(b) OTHER ADULT HEALTH QUALITY MEASURES  
7       UNDER MEDICAID.—

8               “(1) DEVELOPMENT OF MEASURES.—The Sec-  
9       retary shall develop quality measures that are not  
10      otherwise developed under section 1192 for services re-  
11      ceived under State plans under title XIX by individ-  
12      uals who are 21 years of age or older but have not  
13      attained age 65. The Secretary shall publish such  
14      quality measures through notice and comment rule-  
15      making.

16              “(2) STANDARDIZED REPORTING FORMAT.—The  
17      Secretary shall develop and publish a standardized  
18      reporting format for quality measures developed  
19      under paragraph (1) and section 1192 for services  
20      furnished under State plans under title XIX to indi-  
21      viduals who are 21 years of age or older but have not  
22      attained age 65 for use under such plans and State  
23      plans under title XXI. The format shall enable State  
24      agencies administering such plans to collect data from  
25      managed care entities and providers and practi-

1        *tioners that participate in such plans and to report*  
2        *quality measures to the Secretary.*

3        “(c) *DEVELOPMENT PROCESS.—With respect to the de-*  
4        *velopment of quality measures under subsections (a) and*  
5        *(b)—*

6                “(1) *USE OF QUALIFIED ENTITIES.—The Sec-*  
7        *retary may enter into agreements with public, non-*  
8        *profit, or academic institutions with technical exper-*  
9        *tise in the area of health quality measurement to as-*  
10        *ist in such development. The Secretary may carry*  
11        *out these agreements by contract, grant, or otherwise.*

12                “(2) *MULTI-STAKEHOLDER PRE-RULEMAKING*  
13        *INPUT.—The Secretary shall obtain the input of*  
14        *stakeholders with respect to such quality measures*  
15        *using a process similar to that described in section*  
16        *1808(d).*

17                “(3) *COORDINATION.—The Secretary shall co-*  
18        *ordinate the development of such measures under such*  
19        *subsections and with the development of child health*  
20        *quality measures under section 1139A.*

21                “(d) *ANNUAL REPORT TO CONGRESS.—No later than*  
22        *January 1, 2013, and annually thereafter, the Secretary*  
23        *shall report to the Committee on Energy and Commerce of*  
24        *the House of Representatives the Committee on Finance of*  
25        *the Senate regarding—*

1           “(1) the availability of reliable data relating to  
2           the quality of maternity care furnished under State  
3           plans under titles XIX and XXI;

4           “(2) the availability of reliable data relating to  
5           the quality of services furnished under State plans  
6           under title XIX to adults who are 21 years of age or  
7           older but have not attained age 65; and

8           “(3) recommendations for improving the quality  
9           of such care and services furnished under such State  
10          plans.

11          “(e) *RULE OF CONSTRUCTION.*—Notwithstanding any  
12          other provision in this section, no quality measure devel-  
13          oped, published, or used as a basis of measurement or re-  
14          porting under this section may be used to establish an irref-  
15          utable presumption regarding either the medical necessity  
16          of care or the maximum permissible coverage for any indi-  
17          vidual who receives medical assistance under title XIX or  
18          child health assistance under title XXI.

19          “(f) *APPROPRIATION.*—For purposes of carrying out  
20          this section, in addition to funds otherwise available, out  
21          of any funds in the Treasury not otherwise appropriated,  
22          there are appropriated \$40,000,000 for the 5-fiscal-year pe-  
23          riod beginning with fiscal year 2010. Funds appropriated  
24          under this subsection shall remain available until ex-  
25          pended.”.

1 **SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT**  
2 **PROGRAM.**

3 (a) *IN GENERAL.*—*The Secretary of Health and*  
4 *Human Services shall establish under this section an ac-*  
5 *countable care program under which a State may apply*  
6 *to the Secretary for approval of an accountable care organi-*  
7 *zation pilot program described in subsection (b) (in this*  
8 *section referred to as a “pilot program”) for the application*  
9 *of the accountable care organization concept under title XIX*  
10 *of the Social Security Act.*

11 (b) *PILOT PROGRAM DESCRIBED.*—

12 (1) *IN GENERAL.*—*The pilot program described*  
13 *in this subsection is a program that applies one or*  
14 *more of the accountable care organization models de-*  
15 *scribed in section 1866E of the Social Security Act,*  
16 *as added by section 1301 of this Act.*

17 (2) *LIMITATION.*—*The pilot program shall oper-*  
18 *ate for a period of not more than 5 years.*

19 (c) *ADDITIONAL INCENTIVES.*—*In the case of the pilot*  
20 *program under this section, the Secretary may—*

21 (1) *waive the requirements of—*

22 (A) *section 1902(a)(1) of the Social Secu-*  
23 *rity Act (relating to statewideness);*

24 (B) *section 1902(a)(10)(B) of such Act (re-*  
25 *lating to comparability); and*

1           (2) *increase the matching percentage for admin-*  
 2           *istrative expenditures up to—*

3                   (A) *90 percent (for the first 2 years of the*  
 4                   *pilot program); and*

5                   (B) *75 percent (for the next 3 years).*

6           (d) *EVALUATION; REPORT.—*

7                   (1) *EVALUATION.—The Secretary, using the cri-*  
 8                   *teria described in section 1866D(f)(1) of the Social*  
 9                   *Security Act (as inserted by section 1301 of this Act),*  
 10                   *shall conduct an evaluation of the pilot program*  
 11                   *under this section.*

12                   (2) *REPORT.—Not later than 60 days after the*  
 13                   *date of completion of the evaluation under paragraph*  
 14                   *(1), the Secretary shall submit to Congress and make*  
 15                   *available to the public a report on the findings of the*  
 16                   *evaluation under such paragraph.*

## 17                   ***Subtitle D—Coverage***

### 18           ***SEC. 1731. OPTIONAL MEDICAID COVERAGE OF LOW-IN-***

#### 19                   ***COME HIV-INFECTED INDIVIDUALS.***

20                   (a) *IN GENERAL.—Section 1902 of the Social Security*  
 21                   *Act (42 U.S.C. 1396a), as amended by section 1714(a)(1),*  
 22                   *is amended—*

23                           (1) *in subsection (a)(10)(A)(ii)—*

24                                   (A) *by striking “or” at the end of subclause*

25                                   *(XIX);*

1                   (B) by adding “or” at the end of subclause  
2                   (XX); and

3                   (C) by adding at the end the following:

4                                 “(XXI) who are described in sub-  
5                                 section (ii) (relating to HIV-infected  
6                                 individuals);” and

7                   (2) by adding at the end, as amended by sections  
8                   1703 and 1714(a), the following:

9                   “(ii) Individuals described in this subsection are indi-  
10                   viduals not described in subsection (a)(10)(A)(i)—

11                                 “(1) who have HIV infection;

12                                 “(2) whose income (as determined under the  
13                                 State plan under this title with respect to disabled in-  
14                                 dividuals) does not exceed the maximum amount of  
15                                 income a disabled individual described in subsection  
16                                 (a)(10)(A)(i) may have and obtain medical assistance  
17                                 under the plan; and

18                                 “(3) whose resources (as determined under the  
19                                 State plan under this title with respect to disabled in-  
20                                 dividuals) do not exceed the maximum amount of re-  
21                                 sources a disabled individual described in subsection  
22                                 (a)(10)(A)(i) may have and obtain medical assistance  
23                                 under the plan.”.

24                   (b) *ENHANCED MATCH*.—The first sentence of section  
25                   1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by

1 *striking “section 1902(a)(10)(A)(ii)(XVIII)” and inserting*  
2 *“subclause (XVIII) or (XXI) of section 1902(a)(10)(A)(ii)”.*

3 (c) *CONFORMING AMENDMENTS.—Section 1905(a) of*  
4 *such Act (42 U.S.C. 1396d(a)) is amended, in the matter*  
5 *preceding paragraph (1)—*

6 (1) *by striking “or” at the end of clause (xii);*

7 (2) *by adding “or” at the end of clause (xiii);*

8 *and*

9 (3) *by inserting after clause (xiii) the following:*

10 “(xiv) *individuals described in section*  
11 *1902(ii),”.*

12 (d) *EXEMPTION FROM FUNDING LIMITATION FOR TER-*  
13 *RITORIES.—Section 1108(g) of the Social Security Act (42*  
14 *U.S.C. 1308(g)) is amended by adding at the end the fol-*  
15 *lowing:*

16 “(5) *DISREGARDING MEDICAL ASSISTANCE FOR*  
17 *OPTIONAL LOW-INCOME HIV-INFECTED INDIVID-*  
18 *UALS.—The limitations under subsection (f) and the*  
19 *previous provisions of this subsection shall not apply*  
20 *to amounts expended for medical assistance for indi-*  
21 *viduals described in section 1902(ii) who are only eli-*  
22 *gible for such assistance on the basis of section*  
23 *1902(a)(10)(A)(ii)(XXI).”.*

24 (e) *EFFECTIVE DATE; SUNSET.—The amendments*  
25 *made by this section shall apply to expenditures for cal-*

1 *endar quarters beginning on or after the date of the enact-*  
2 *ment of this Act, and before January 1, 2013, without re-*  
3 *gard to whether or not final regulations to carry out such*  
4 *amendments have been promulgated by such date.*

5 **SEC. 1732. EXTENDING TRANSITIONAL MEDICAID ASSIST-**  
6 **ANCE (TMA).**

7 *Sections 1902(e)(1)(B) and 1925(f) of the Social Secu-*  
8 *rity Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)), as amend-*  
9 *ed by section 5004(a)(1) of the American Recovery and Re-*  
10 *investment Act of 2009 (Public Law 111-5), are each*  
11 *amended by striking “December 31, 2010” and inserting*  
12 *“December 31, 2012”.*

13 **SEC. 1733. REQUIREMENT OF 12-MONTH CONTINUOUS COV-**  
14 **ERAGE UNDER CERTAIN CHIP PROGRAMS.**

15 *(a) IN GENERAL.—Section 2102(b) of the Social Secu-*  
16 *rity Act (42 U.S.C. 1397bb(b)) is amended by adding at*  
17 *the end the following new paragraph:*

18 *“(6) REQUIREMENT FOR 12-MONTH CONTINUOUS*  
19 *ELIGIBILITY.—In the case of a State child health plan*  
20 *that provides child health assistance under this title*  
21 *through a means other than described in section*  
22 *2101(a)(2), the plan shall provide for implementation*  
23 *under this title of the 12-month continuous eligibility*  
24 *option described in section 1902(e)(12) for targeted*



1 *low-income children whose family income is below*  
2 *200 percent of the poverty line.”.*

3 *(b) EFFECTIVE DATE.—The amendment made by sub-*  
4 *section (a) shall apply to determinations (and redetermina-*  
5 *tions) of eligibility made on or after January 1, 2010.*

6 **SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF**  
7 **COVERAGE WAITING PERIODS FOR CERTAIN**  
8 **CHILDREN.**

9 *(a) IN GENERAL.—Section 2102(b)(1) of the Social Se-*  
10 *curity Act (42 U.S.C. 1397bb(b)(1)) is amended—*

11 *(1) in subparagraph (B)—*

12 *(A) in clause (iii), by striking “and” at the*  
13 *end;*

14 *(B) in clause (iv), by striking the period at*  
15 *the end and inserting “; and”; and*

16 *(C) by adding at the end the following new*  
17 *clause:*

18 *“(v) may not apply a waiting period*  
19 *(including a waiting period to carry out*  
20 *paragraph (3)(C)) in the case of a child de-*  
21 *scribed in subparagraph (C).”;* and

22 *(2) by adding at the end the following new sub-*  
23 *paragraph:*

24 *“(C) DESCRIPTION OF CHILDREN NOT SUB-*  
25 *JECT TO WAITING PERIOD.—For purposes of this*

1 paragraph, a child described in this subpara-  
2 graph is a child who, on the date an application  
3 is submitted for such child for child health assist-  
4 ance under this title, meets any of the following  
5 requirements:

6 “(i) *INFANTS AND TODDLERS.*—The  
7 child is under two years of age.

8 “(ii) *LOSS OF GROUP HEALTH PLAN*  
9 *COVERAGE.*—The child previously had pri-  
10 vate health insurance coverage through a  
11 group health plan or health insurance cov-  
12 erage offered through an employer and lost  
13 such coverage due to—

14 “(I) termination of an individ-  
15 ual’s employment;

16 “(II) a reduction in hours that an  
17 individual works for an employer;

18 “(III) elimination of an individ-  
19 ual’s retiree health benefits; or

20 “(IV) termination of an individ-  
21 ual’s group health plan or health in-  
22 surance coverage offered through an  
23 employer.

24 “(iii) *UNAFFORDABLE PRIVATE COV-*  
25 *ERAGE.*—

1                   “(I) *IN GENERAL.*—*The family of*  
2                   *the child demonstrates that the cost of*  
3                   *health insurance coverage (including*  
4                   *the cost of premiums, co-payments,*  
5                   *deductibles, and other cost sharing) for*  
6                   *such family exceeds 10 percent of the*  
7                   *income of such family.*

8                   “(II) *DETERMINATION OF FAMILY*  
9                   *INCOME.*—*For purposes of subclause*  
10                  *(I), family income shall be determined*  
11                  *in the same manner specified by the*  
12                  *State for purposes of determining a*  
13                  *child’s eligibility for child health as-*  
14                  *sistance under this title.”.*

15                  *(b) EFFECTIVE DATE.*—*The amendments made by this*  
16                  *section shall take effect as of the date that is 90 days after*  
17                  *the date of the enactment of this Act.*

18                  **SEC. 1735. ADULT DAY HEALTH CARE SERVICES.**

19                  *(a) IN GENERAL.*—*The Secretary of Health and*  
20                  *Human Services shall not—*

21                         *(1) withhold, suspend, disallow, or otherwise*  
22                         *deny Federal financial participation under section*  
23                         *1903(a) of the Social Security Act (42 U.S.C.*  
24                         *1396b(a)) for the provision of adult day health care*  
25                         *services, day activity and health services, or adult*

1        *medical day care services, as defined under a State*  
2        *Medicaid plan approved during or before 1994, dur-*  
3        *ing such period if such services are provided con-*  
4        *sistent with such definition and the requirements of*  
5        *such plan; or*

6                *(2) withdraw Federal approval of any such State*  
7        *plan or part thereof regarding the provision of such*  
8        *services (by regulation or otherwise).*

9        *(b) EFFECTIVE DATE.—Subsection (a) shall apply*  
10        *with respect to services provided on or after October 1, 2008.*

11        **SEC. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY**  
12                **ASSOCIATED STATES.**

13                *(a) IN GENERAL.—Section 402(b)(2) of the Personal*  
14        *Responsibility and Work Opportunity Reconciliation Act*  
15        *of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the*  
16        *end the following:*

17                        *“(G) MEDICAID EXCEPTION FOR CITIZENS*  
18                *OF FREELY ASSOCIATED STATES.—With respect*  
19        *to eligibility for benefits for the designated Fed-*  
20        *eral program defined in paragraph (3)(C) (relat-*  
21        *ing to the Medicaid program), section 401(a)*  
22        *and paragraph (1) shall not apply to any indi-*  
23        *vidual who lawfully resides in the United States*  
24        *(including territories and possessions of the*  
25        *United States) in accordance with the Compacts*

1           *of Free Association between the Government of*  
2           *the United States and the Governments of the*  
3           *Federated States of Micronesia, the Republic of*  
4           *the Marshall Islands, and the Republic of*  
5           *Palau.”.*

6           (b) *EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.*—  
7           *Section 403(d) of such Act (8 U.S.C. 1613(d)) is amended—*

8                     (1) *in paragraph (1), by striking “or” at the*  
9                     *end;*

10                    (2) *in paragraph (2), by striking the period at*  
11                    *the end and inserting “; or”; and*

12                    (3) *by adding at the end the following:*

13                    “(3) *an individual described in section*  
14                    *402(b)(2)(G), but only with respect to the designated*  
15                    *Federal program defined in section 402(b)(3)(C).”.*

16           (c) *DEFINITION OF QUALIFIED ALIEN.*—*Section*  
17           *431(b) of such Act (8 U.S.C. 1641(b)) is amended—*

18                    (1) *in paragraph (6), by striking “; or” at the*  
19                    *end and inserting a comma;*

20                    (2) *in paragraph (7), by striking the period at*  
21                    *the end and inserting “; or”; and*

22                    (3) *by adding at the end the following:*

23                    “(8) *an individual who lawfully resides in the*  
24                    *United States (including territories and possessions of*  
25                    *the United States) in accordance with a Compact of*

1 *Free Association referred to in section 402(b)(2)(G),*  
2 *but only with respect to the designated Federal pro-*  
3 *gram defined in section 402(b)(3)(C) (relating to the*  
4 *Medicaid program).”.*

5 **SEC. 1737. CONTINUING REQUIREMENT OF MEDICAID COV-**  
6 **ERAGE OF NONEMERGENCY TRANSPOR-**  
7 **TATION TO MEDICALLY NECESSARY SERV-**  
8 **ICES.**

9 *(a) REQUIREMENT.—Section 1902(a)(10) of the Social*  
10 *Security Act (42 U.S.C. 1396a(a)(10)) is amended—*

11 *(1) in subparagraph (A), in the matter preceding*  
12 *clause (i), by striking “and (21)” and inserting “,*  
13 *(21), and (28)”;* and

14 *(2) in subparagraph (C)(iv), by striking “and*  
15 *(17)” and inserting “, (17), and (28)”.*

16 *(b) DESCRIPTION OF SERVICES.—Section 1905(a) of*  
17 *such Act (42 U.S.C. 1395d(a)), as amended by sections*  
18 *1713(a)(1) and 1724(a)(1), is amended—*

19 *(1) in paragraph (29), by striking “and” at the*  
20 *end;*

21 *(2) by redesignating paragraph (30) as*  
22 *pararaph (31) and by striking the comma at the end*  
23 *and inserting a semicolon; and*

24 *(3) by inserting after paragraph (29) the fol-*  
25 *lowing new paragraph:*

1           “(30) nonemergency transportation to medically  
2           necessary services, consistent with the requirement of  
3           section 431.53 of title 42, Code of Federal Regula-  
4           tions, as in effect as of June 1, 2008; and”.

5           (c) *EFFECTIVE DATE.*—The amendments made by this  
6           section shall take effect on the date of the enactment of this  
7           Act and shall apply to transportation on or after such date.

8           **SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME**  
9                           **IN PROVIDING CONTINUED MEDICAID COV-**  
10                           **ERAGE FOR CERTAIN INDIVIDUALS WITH EX-**  
11                           **TREMELY HIGH PRESCRIPTION COSTS.**

12           Section 1902(e) of the Social Security Act (42 U.S.C.  
13           1396b(e)), as amended by section 203(a) of the Children’s  
14           Health Insurance Program Reauthorization Act of 2009  
15           (Public Law 111–3), is amended by adding at the end the  
16           following new paragraph:

17           “(14)(A) At the option of the State, in the case of an  
18           individual with extremely high prescription drug costs de-  
19           scribed in subparagraph (B) who has been determined  
20           (without the application of this paragraph) to be eligible  
21           for medical assistance under this title, the State may, in  
22           redetermining the individual’s eligibility for medical assist-  
23           ance under this title, disregard any family income of the  
24           individual to the extent such income is less than an amount  
25           that is specified by the State and does not exceed the

1 amount specified in subparagraph (C), or, if greater, in-  
2 come equal to the cost of the orphan drugs described in sub-  
3 paragraph (B)(iii).

4 “(B) An individual with extremely high prescription  
5 drug costs described in this subparagraph for a 12-month  
6 period is an individual—

7 “(i) who is covered under health insurance or a  
8 health benefits plan that has a maximum lifetime  
9 limit of not less than \$1,000,000 which includes all  
10 prescription drug coverage;

11 “(ii) who has exhausted all available prescrip-  
12 tion drug coverage under the plan as of the beginning  
13 of such period;

14 “(iii) who incurs (or is reasonably expected to  
15 incur) on an annual basis during the period costs for  
16 orphan drugs in excess of the amount specified in sub-  
17 paragraph (C) for the period; and

18 “(iv) whose annual family income (determined  
19 without regard to this paragraph) as of the beginning  
20 of the period does not exceed 75 percent of the amount  
21 incurred for such drugs (as described in clause (iii)).

22 “(C) The amount specified in this subparagraph for  
23 a 12-month period beginning in—

24 “(i) 2009 or 2010, is \$200,000; or



1           “(ii) a subsequent year, is the amount specified  
2           in clause (i) (or this subparagraph) for the previous  
3           year increased by the annual rate of increase in the  
4           medical care component of the consumer price index  
5           (U.S. city average) for the 12-month period ending in  
6           August of the previous year.

7           Any amount computed under clause (ii) that is not a mul-  
8           tiple of \$1,000 shall be rounded to the nearest multiple of  
9           \$1,000.

10          “(D) In applying this paragraph, amounts incurred  
11          for prescription drugs for cosmetic purposes shall not be  
12          taken into account.

13          “(E) With respect to an individual described in sub-  
14          paragraph (A), notwithstanding section 1916, the State  
15          plan—

16                 “(i) shall provide for the application of cost-  
17                 sharing that is at least nominal as determined under  
18                 section 1916; and

19                 “(ii) may provide, consistent with section 1916A,  
20                 for such additional cost-sharing as does not exceed a  
21                 maximum level of cost-sharing that is specified by the  
22                 Secretary and is adjusted by the Secretary on an an-  
23                 nual basis.

24          “(F) A State electing the option under this paragraph  
25          shall provide for a determination on an individual’s appli-

1 *cation for continued medical assistance under this title*  
 2 *within 30 days of the date the application is filed with the*  
 3 *State.*

4 “(G) *In this paragraph:*

5 “(i) *The term ‘orphan drugs’ means prescription*  
 6 *drugs designated under section 526 of the Federal*  
 7 *Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) as*  
 8 *a drug for a rare disease or condition.*

9 “(ii) *The term ‘health benefits plan’ includes cov-*  
 10 *erage under a plan offered under a State high risk*  
 11 *pool.’”.*

## 12 ***Subtitle E—Financing***

### 13 ***SEC. 1741. PAYMENTS TO PHARMACISTS.***

14 *(a) PHARMACY REIMBURSEMENT LIMITS.—*

15 *(1) IN GENERAL.—Section 1927(e) of the Social*  
 16 *Security Act (42 U.S.C. 1396r–8(e)) is amended—*

17 *(A) by striking paragraph (5) and inserting*  
 18 *the following:*

19 “(5) *USE OF AMP IN UPPER PAYMENT LIMITS.—*  
 20 *The Secretary shall calculate the Federal upper reim-*  
 21 *bursment limit established under paragraph (4) as*  
 22 *130 percent of the weighted average (determined on*  
 23 *the basis of manufacturer utilization) of monthly av-*  
 24 *erage manufacturer prices.’”*

1           (2) *DEFINITION OF AMP.—Section 1927(k)(1)(B)*  
2 *of such Act (42 U.S.C. 1396r–8(k)(1)(B)) is amend-*  
3 *ed—*

4                   *(B) in the heading, by striking “EXTENDED*  
5 *TO WHOLESALERS” and inserting “AND OTHER*  
6 *PAYMENTS”;* and

7                   *(C) by striking “regard to” and all that fol-*  
8 *lows through the period and inserting the fol-*  
9 *lowing: “regard to—*

10                           *“(i) customary prompt pay discounts*  
11 *extended to wholesalers;*

12                           *“(ii) bona fide service fees paid by*  
13 *manufacturers;*

14                           *“(iii) reimbursement by manufacturers*  
15 *for recalled, damaged, expired, or otherwise*  
16 *unsalable returned goods, including reim-*  
17 *bursement for the cost of the goods and any*  
18 *reimbursement of costs associated with re-*  
19 *turn goods handling and processing, reverse*  
20 *logistics, and drug destruction;*

21                           *“(iv) sales directly to, or rebates, dis-*  
22 *counts, or other price concessions provided*  
23 *to, pharmacy benefit managers, managed*  
24 *care organizations, health maintenance or-*  
25 *ganizations, insurers, mail order phar-*

1            *macies that are not open to all members of*  
2            *the public, or long term care providers, pro-*  
3            *vided that these rebates, discounts, or price*  
4            *concessions are not passed through to retail*  
5            *pharmacies;*

6            “(v) *sales directly to, or rebates, dis-*  
7            *counts, or other price concessions provided*  
8            *to, hospitals, clinics, and physicians, unless*  
9            *the drug is an inhalation, infusion, or*  
10           *injectable drug, or unless the Secretary de-*  
11           *termines, as allowed for in Agency adminis-*  
12           *trative procedures, that it is necessary to*  
13           *include such sales, rebates, discounts, and*  
14           *price concessions in order to obtain an ac-*  
15           *curate AMP for the drug. Such a deter-*  
16           *mination shall not be subject to judicial re-*  
17           *view; or*

18           “(vi) *rebates, discounts, and other*  
19           *price concessions required to be provided*  
20           *under agreements under subsections (f) and*  
21           *(g) of section 1860D–2(f).”.*

22           (3) *MANUFACTURER REPORTING REQUIRE-*  
23           *MENTS.—Section 1927(b)(3)(A) of such Act (42*  
24           *U.S.C. 1396r–8(b)(3)(A)) is amended—*

1           (A) in clause (ii), by striking “and” at the  
2           end;

3           (B) by striking the period at the end of  
4           clause (iii) and inserting “; and”; and

5           (C) by inserting after clause (iii) the fol-  
6           lowing new clause:

7                   “(iv) not later than 30 days after the  
8                   last day of each month of a rebate period  
9                   under the agreement, on the manufacturer’s  
10                  total number of units that are used to cal-  
11                  culate the monthly average manufacturer  
12                  price for each covered outpatient drug.”.

13           (4) *AUTHORITY TO PROMULGATE REGULATION.*—  
14           *The Secretary of Health and Human Services may*  
15           *promulgate regulations to clarify the requirements for*  
16           *upper payment limits and for the determination of*  
17           *the average manufacturer price in an expedited man-*  
18           *ner. Such regulations may become effective on an in-*  
19           *terim final basis, pending opportunity for public*  
20           *comment.*

21           (5) *PHARMACY REIMBURSEMENTS THROUGH DE-*  
22           *CEMBER 31, 2010.*—*The specific upper limit under sec-*  
23           *tion 447.332 of title 42, Code of Federal Regulations*  
24           *(as in effect on December 31, 2006) applicable to pay-*  
25           *ments made by a State for multiple source drugs*

1        *under a State Medicaid plan shall continue to apply*  
2        *through December 31, 2010, for purposes of the avail-*  
3        *ability of Federal financial participation for such*  
4        *payments.*

5        *(b) DISCLOSURE OF PRICE INFORMATION TO THE*  
6        *PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r-*  
7        *8(b)(3)) is amended—*

8                *(1) in subparagraph (A)—*

9                        *(A) in clause (i), in the matter preceding*  
10                        *subclause (I), by inserting “month of a” after*  
11                        *“each”; and*

12                        *(B) in the last sentence, by striking “and*  
13                        *shall,” and all that follows up to the period; and*

14                *(2) in subparagraph (D)(v), by inserting*  
15                *“weighted” before “average manufacturer prices”.*

16        **SEC. 1742. PRESCRIPTION DRUG REBATES.**

17        *(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF*  
18        *EXISTING DRUGS.—*

19                *(1) IN GENERAL.—Section 1927(c)(2) of the So-*  
20        *cial Security Act (42 U.S.C. 1396r-8(c)(2)) is*  
21        *amended by adding at the end the following new sub-*  
22        *paragraph:*

23                        *“(C) TREATMENT OF NEW FORMULA-*  
24                        *TIONS.—In the case of a drug that is a line ex-*  
25                        *tension of a single source drug or an innovator*

1           *multiple source drug that is an oral solid dosage*  
2           *form, the rebate obligation with respect to such*  
3           *drug under this section shall be the amount com-*  
4           *puted under this section for such new drug or,*  
5           *if greater, the product of—*

6                     *“(i) the average manufacturer price of*  
7                     *the line extension of a single source drug or*  
8                     *an innovator multiple source drug that is*  
9                     *an oral solid dosage form;*

10                    *“(ii) the highest additional rebate (cal-*  
11                    *culated as a percentage of average manufac-*  
12                    *turer price) under this section for any*  
13                    *strength of the original single source drug*  
14                    *or innovator multiple source drug; and*

15                    *“(iii) the total number of units of each*  
16                    *dosage form and strength of the line exten-*  
17                    *sion product paid for under the State plan*  
18                    *in the rebate period (as reported by the*  
19                    *State).*

20           *In this subparagraph, the term ‘line extension’*  
21           *means, with respect to a drug, an extended re-*  
22           *lease formulation of the drug.”.*

23            (2) *EFFECTIVE DATE.*—*The amendment made by*  
24            *paragraph (1) shall apply to drugs dispensed after*  
25            *December 31, 2009.*

1           (b) *INCREASE MINIMUM REBATE PERCENTAGE FOR*  
2 *SINGLE SOURCE DRUGS.*—Section 1927(c)(1)(B)(i) of the  
3 *Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i))* is  
4 *amended—*

5           (1) *in subclause (IV), by striking “and” at the*  
6 *end;*

7           (2) *in subclause (V)—*

8           (A) *by inserting “and before January 1,*  
9 *2010” after “December 31, 1995,”; and*

10           (B) *by striking the period at the end and*  
11 *inserting “; and”; and*

12           (3) *by adding at the end the following new sub-*  
13 *clause:*

14   *“(VI) after December 31, 2009, is*  
15   *22.1 percent.”.*

16 **SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DIS-**  
17 **COUNTS TO ENROLLEES OF MEDICAID MAN-**  
18 **AGED CARE ORGANIZATIONS.**

19           (a) *IN GENERAL.*—Section 1903(m)(2)(A) of the *So-*  
20 *cial Security Act (42 U.S.C. 1396b(m)(2)(A))* is amended—

21           (1) *in clause (xi), by striking “and” at the end;*

22           (2) *in clause (xii), by striking the period at the*  
23 *end and inserting “; and”; and*

24           (3) *by adding at the end the following:*



1           “(xiii) such contract provides that the entity  
2 shall report to the State such information, on such  
3 timely and periodic basis as specified by the Sec-  
4 retary, as the State may require in order to include,  
5 in the information submitted by the State to a manu-  
6 facturer under section 1927(b)(2)(A), information on  
7 covered outpatient drugs dispensed to individuals eli-  
8 gible for medical assistance who are enrolled with the  
9 entity and for which the entity is responsible for cov-  
10 erage of such drugs under this subsection.”.

11           (b) CONFORMING AMENDMENTS.—Section 1927 of such  
12 Act (42 U.S.C. 1396r-8) is amended—

13           (1) in the first sentence of subsection (b)(1)(A),  
14 by inserting before the period at the end the following:  
15           “; including such drugs dispensed to individuals en-  
16 rolled with a medicaid managed care organization if  
17 the organization is responsible for coverage of such  
18 drugs”;

19           (2) in subsection (b)(2), by adding at the end the  
20 following new subparagraph:

21           “(C) REPORTING ON MMCO DRUGS.—On a  
22 quarterly basis, each State shall report to the  
23 Secretary the total amount of rebates in dollars  
24 received from pharmacy manufacturers for drugs  
25 provided to individuals enrolled with Medicaid

1           *managed care organizations that contract under*  
2           *section 1903(m).”;* and

3           (3) *in subsection (j)—*

4                   (A) *in the heading by striking “EXEMP-*  
5                   *TION” and inserting “SPECIAL RULES”;* and

6                   (B) *in paragraph (1), by striking “not”.*

7           (c) *EFFECTIVE DATE.—The amendments made by this*  
8           *section take effect on July 1, 2010, and shall apply to drugs*  
9           *dispensed on or after such date, without regard to whether*  
10           *or not final regulations to carry out such amendments have*  
11           *been promulgated by such date.*

12   **SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDU-**  
13                   **CATION.**

14           (a) *IN GENERAL.—Section 1905 of the Social Security*  
15           *Act (42 U.S.C. 1396d), as amended by sections 1701(a)(2),*  
16           *1711(a), and 1713(a), is amended by adding at the end the*  
17           *following new subsection:*

18                   “(bb) *PAYMENT FOR GRADUATE MEDICAL EDU-*  
19                   *CATION.—*

20                           “(1) *IN GENERAL.—The term ‘medical assist-*  
21                           *ance’ includes payment for costs of graduate medical*  
22                           *education consistent with this subsection, whether*  
23                           *provided in or outside of a hospital.*

24                           “(2) *SUBMISSION OF INFORMATION.—For pur-*  
25                           *poses of paragraph (1) and section 1902(a)(13)(A)(v),*

1        *payment for such costs is not consistent with this sub-*  
2        *section unless—*

3                *“(A) the State submits to the Secretary, in*  
4                *a timely manner and on an annual basis speci-*  
5                *fied by the Secretary, information on total pay-*  
6                *ments for graduate medical education and how*  
7                *such payments are being used for graduate med-*  
8                *ical education, including—*

9                        *“(i) the institutions and programs eli-*  
10                        *gible for receiving the funding;*

11                        *“(ii) the manner in which such pay-*  
12                        *ments are calculated;*

13                        *“(iii) the types and fields of education*  
14                        *being supported;*

15                        *“(iv) the workforce or other goals to*  
16                        *which the funding is being applied;*

17                        *“(v) State progress in meeting such*  
18                        *goals; and*

19                        *“(vi) such other information as the*  
20                        *Secretary determines will assist in carrying*  
21                        *out paragraphs (3) and (4); and*

22                *“(B) such expenditures are made consistent*  
23                *with such goals and requirements as are estab-*  
24                *lished under paragraph (4).*

1           “(3) *REVIEW OF INFORMATION.*—*The Secretary*  
2           *shall make the information submitted under para-*  
3           *graph (2) available to the Advisory Committee on*  
4           *Health Workforce Evaluation and Assessment (estab-*  
5           *lished under section 2261 of the Public Health Service*  
6           *Act). The Secretary and the Advisory Committee shall*  
7           *independently review the information submitted*  
8           *under paragraph (2), taking into account State and*  
9           *local workforce needs.*

10           “(4) *SPECIFICATION OF GOALS AND REQUIRE-*  
11           *MENTS.*—*The Secretary shall specify by rule, initially*  
12           *published by not later than December 31, 2011—*

13                   “(A) *program goals for the use of funds de-*  
14                   *scribed in paragraph (1), taking into account*  
15                   *recommendations of the such Advisory Com-*  
16                   *mittee and the goals for approved medical resi-*  
17                   *dency training programs described in section*  
18                   *1886(h)(1)(B); and*

19                   “(B) *requirements for use of such funds con-*  
20                   *sistent with such goals.*

21           *Such rule may be effective on an interim basis pend-*  
22           *ing revision after an opportunity for public com-*  
23           *ment.”.*

1           (b)           *CONFORMING           AMENDMENT.—Section*  
2 *1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)), as*  
3 *amended by section 1721(a)(1)(A), is amended—*

4                   (1) *by striking “and” at the end of clause (iii);*

5                   (2) *by striking the semicolon in clause (iv) and*  
6 *inserting “, and”; and*

7                   (3) *by adding at the end the following new*  
8 *clause:*

9                                 *“(v) in the case of hospitals and at the*  
10                                 *option of a State, such rates may include,*  
11                                 *to the extent consistent with section*  
12                                 *1905(bb), payment for graduate medical*  
13                                 *education; and”.*

14           (c) *EFFECTIVE DATE.—The amendments made by this*  
15 *section shall take effect on the date of the enactment of this*  
16 *Act. Nothing in this section shall be construed as affecting*  
17 *payments made before such date under a State plan under*  
18 *title XIX of the Social Security Act for graduate medical*  
19 *education.*

20 **SEC. 1745. REPORT ON MEDICAID PAYMENTS.**

21           *Section 1902 of the Social Security Act (42 U.S.C.*  
22 *1396), as amended by sections 1703(a), 1714(a), and*  
23 *1731(a), is amended by adding at the end the following new*  
24 *subsection:*

1       “(jj) *REPORT ON MEDICAID PAYMENTS.*—Each year,  
2 *on or before a date determined by the Secretary, a State*  
3 *participating in the Medicaid program under this title*  
4 *shall submit to the Administrator of the Centers for Medi-*  
5 *care & Medicaid Services—*

6               “(1) *information on the determination of rates of*  
7 *payment to providers for covered services under the*  
8 *State plan, including—*

9                       “(A) *the final rates;*

10                      “(B) *the methodologies used to determine*  
11 *such rates; and*

12                      “(C) *justifications for the rates; and*

13               “(2) *an explanation of the process used by the*  
14 *State to allow providers, beneficiaries and their rep-*  
15 *resentatives, and other concerned State residents a*  
16 *reasonable opportunity to review and comment on*  
17 *such rates, methodologies, and justifications before the*  
18 *State made such rates final.”.*

19 **SEC. 1746. REVIEWS OF MEDICAID.**

20       “(a) *GAO STUDY ON FMAP.*—

21               “(1) *STUDY.*—*The Comptroller General of the*  
22 *United States shall conduct a study regarding federal*  
23 *payments made to the State Medicaid programs*  
24 *under title XIX of the Social Security Act for the*  
25 *purposes of making recommendations to Congress.*

1           (2) *REPORT.*—Not later than February 15, 2011,  
2           the Comptroller General shall submit to the appro-  
3           priate committees of Congress a report on the study  
4           conducted under paragraph (1) and the effect on the  
5           federal government, States, providers, and bene-  
6           ficiaries of—

7                   (A) removing the 50 percent floor, or 83  
8                   percent ceiling, or both, in the Federal medical  
9                   assistance percentage under section 1905(b)(1) of  
10                  the Social Security Act; and

11                  (B) revising the current formula for such  
12                  Federal medical assistance percentage to better  
13                  reflect State fiscal capacity and State effort to  
14                  pay for health and long-term care services and  
15                  to better adjust for national or regional economic  
16                  downturns.

17           (b) *GAO STUDY ON MEDICAID ADMINISTRATIVE*  
18 *COSTS.*—

19           (1) *STUDY.*—The Comptroller General of the  
20           United States shall conduct a study of the adminis-  
21           tration of the Medicaid program by the Department  
22           of Health and Human Services, State Medicaid agen-  
23           cies, and local government agencies. The report shall  
24           address the following issues:

1           (A) *The extent to which federal funds for*  
 2           *each administrative function, such as survey and*  
 3           *certification and claims processing, are being*  
 4           *used effectively and efficiently.*

5           (B) *The administrative functions on which*  
 6           *federal Medicaid funds are expended and the*  
 7           *amounts of such expenditures (whether spent di-*  
 8           *rectly or by contract).*

9           (2) *REPORT.*—*Not later than February 15, 2011,*  
 10          *the Comptroller General shall submit to the appro-*  
 11          *priate committees of Congress a report on the study*  
 12          *conducted under paragraph (1).*

13   **SEC. 1747. EXTENSION OF DELAY IN MANAGED CARE ORGA-**  
 14                                    **NIZATION PROVIDER TAX ELIMINATION.**

15          *Effective as if included in the enactment of section*  
 16          *6051 of the Deficit Reduction Act of 2005 (Public Law 109–*  
 17          *171), subsection (b)(2)(A) of such section is amended by*  
 18          *striking “October 1, 2009” and inserting “October 1, 2010”.*

19                            **Subtitle F—Waste, Fraud, and**  
 20                                    **Abuse**

21   **SEC. 1751. HEALTH CARE ACQUIRED CONDITIONS.**

22          (a) *MEDICAID NON-PAYMENT FOR CERTAIN HEALTH*  
 23          *CARE-ACQUIRED CONDITIONS.*—*Section 1903(i) of the So-*  
 24          *cial Security Act (42 U.S.C. 1396b(i)) is amended—*



1           (1) *by striking “or” at the end of paragraph*  
2           *(23);*

3           (2) *by striking the period at the end of para-*  
4           *graph (24) and inserting “; or”; and*

5           (3) *by inserting after paragraph (24) the fol-*  
6           *lowing new paragraph:*

7           *“(25) with respect to amounts expended for serv-*  
8           *ices related to the presence of a condition that could*  
9           *be identified by a secondary diagnostic code described*  
10          *in section 1886(d)(4)(D)(iv) and for any health care*  
11          *acquired condition determined as a non-covered serv-*  
12          *ice under title XVIII.”.*

13          (b) *APPLICATION TO CHIP.*—*Section 2107(e)(1)(G) of*  
14          *such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by strik-*  
15          *ing “and (17)” and inserting “(17), and (25)”.*

16          (c) *PERMISSION TO INCLUDE ADDITIONAL HEALTH*  
17          *CARE-ACQUIRED CONDITIONS.*—*Nothing in this section*  
18          *shall prevent a State from including additional health care-*  
19          *acquired conditions for non-payment in its Medicaid pro-*  
20          *gram under title XIX of the Social Security Act.*

21          (d) *EFFECTIVE DATE.*—*The amendments made by this*  
22          *section shall apply to discharges occurring on or after Jan-*  
23          *uary 1, 2010.*

1 **SEC. 1752. EVALUATIONS AND REPORTS REQUIRED UNDER**  
2 **MEDICAID INTEGRITY PROGRAM.**

3 *Section 1936(c)(2) of the Social Security Act (42*  
4 *U.S.C. 1396u-7(c)(2)) is amended—*

5 *(1) by redesignating subparagraph (D) as sub-*  
6 *paragraph (E); and*

7 *(2) by inserting after subparagraph (C) the fol-*  
8 *lowing new subparagraph:*

9 *“(D) For the contract year beginning in*  
10 *2011 and each subsequent contract year, the enti-*  
11 *ty provides assurances to the satisfaction of the*  
12 *Secretary that the entity will conduct periodic*  
13 *evaluations of the effectiveness of the activities*  
14 *carried out by such entity under the Program*  
15 *and will submit to the Secretary an annual re-*  
16 *port on such activities.”.*

17 **SEC. 1753. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT**  
18 **PROGRAMS TO REDUCE WASTE, FRAUD, AND**  
19 **ABUSE.**

20 *Section 1902(a) of such Act (42 U.S.C. 42 U.S.C.*  
21 *1396a(a)), as amended by sections 1631(b)(1), 1703, and*  
22 *1729, is further amended—*

23 *(1) in paragraph (75), by striking at the end*  
24 *“and”;*

25 *(2) in paragraph (76), by striking at the end the*  
26 *period and inserting “; and”; and*

1           (3) by inserting after paragraph (76) the fol-  
2           lowing new paragraph:

3           “(77) provide that any provider or supplier  
4           (other than a physician or nursing facility) providing  
5           services under such plan shall, subject to paragraph  
6           (5) of section 1874(d), establish a compliance pro-  
7           gram described in paragraph (1) of such section in  
8           accordance with such section.”.

9   **SEC. 1754. OVERPAYMENTS.**

10          (a) *IN GENERAL.*—Section 1903(d)(2)(C) of the Social  
11          Security Act (42 U.S.C. 1396b(d)(2)(C)) is amended—

12                 (1) in the first sentence, by inserting “(or of 1  
13                 year in the case of overpayments due to fraud)” after  
14                 “60 days”; and

15                 (2) in the second sentence, by striking “the 60  
16                 days” and inserting “such period”.

17          (b) *EFFECTIVE DATE.*—The amendments made by sub-  
18          section (a) shall apply in the case of overpayments discov-  
19          ered on or after the date of the enactment of this Act.

20   **SEC. 1755. MANAGED CARE ORGANIZATIONS.**

21          (a) *MINIMUM MEDICAL LOSS RATIO.*—

22                 (1) *MEDICAID.*—Section 1903(m)(2)(A) of the  
23                 Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as  
24                 amended by section 1743(a)(3), is amended—

1           (A) by striking “and” at the end of clause  
2           (xii);

3           (B) by striking the period at the end of  
4           clause (xiii) and inserting “; and”; and

5           (C) by adding at the end the following new  
6           clause:

7           “(xiv) such contract has a medical loss ratio, as  
8           determined in accordance with a methodology speci-  
9           fied by the Secretary that is a percentage (not less  
10          than 85 percent) as specified by the Secretary.”.

11          (2) *CHIP*.—Section 2107(e)(1) of such Act (42  
12          U.S.C. 1397gg(e)(1)) is amended—

13           (A) by redesignating subparagraphs (H)  
14           through (L) as subparagraphs (I) through (M);  
15           and

16           (B) by inserting after subparagraph (G) the  
17           following new subparagraph:

18           “(H) Section 1903(m)(2)(A)(xiv) (relating  
19           to application of minimum loss ratios), with re-  
20           spect to comparable contracts under this title.”.

21          (3) *EFFECTIVE DATE*.—The amendments made  
22          by this subsection shall apply to contracts entered  
23          into or renewed on or after July 1, 2010.

24          (b) *PATIENT ENCOUNTER DATA*.—

1           (1) *IN GENERAL.*—Section 1903(m)(2)(A)(xi) of  
2     the Social Security Act (42 U.S.C.  
3     1396b(m)(2)(A)(xi)) is amended by inserting “and for  
4     the provision of such data to the State at a frequency  
5     and level of detail to be specified by the Secretary”  
6     after “patients”.

7           (2) *EFFECTIVE DATE.*—The amendment made by  
8     paragraph (1) shall apply with respect to contract  
9     years beginning on or after January 1, 2010.

10 **SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION**  
11                           **UNDER MEDICAID AND CHIP IF TERMINATED**  
12                           **UNDER MEDICARE OR OTHER STATE PLAN OR**  
13                           **CHILD HEALTH PLAN.**

14           (a) *STATE PLAN REQUIREMENT.*—Section 1902(a)(39)  
15     of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a))  
16     is amended by inserting after “1128A,” the following: “ter-  
17     minate the participation of any individual or entity in  
18     such program if (subject to such exceptions are are per-  
19     mitted with respect to exclusion under sections  
20     1128(b)(3)(C) and 1128(d)(3)(B)) participation of such in-  
21     dividual or entity is terminated under title XVIII, any  
22     other State plan under this title, or any child health plan  
23     under title XXI.”.

24           (b) *APPLICATION TO CHIP.*—Section 2107(e)(1)(A) of  
25     such Act (42 U.S.C. 1397gg(e)(1)(A)) is amended by insert-

1 *ing before the period at the end the following: “and section*  
2 *1902(a)(39) (relating to exclusion and termination of par-*  
3 *ticipation)”.*

4 *(c) EFFECTIVE DATE.—*

5 *(1) Except as provided in paragraph (2), the*  
6 *amendments made by this section shall apply to serv-*  
7 *ices furnished on or after January 1, 2011, without*  
8 *regard to whether or not final regulations to carry*  
9 *out such amendments have been promulgated by such*  
10 *date.*

11 *(2) In the case of a State plan for medical assist-*  
12 *ance under title XIX of the Social Security Act or a*  
13 *child health plan under title XXI of such Act which*  
14 *the Secretary of Health and Human Services deter-*  
15 *mines requires State legislation (other than legisla-*  
16 *tion appropriating funds) in order for the plan to*  
17 *meet the additional requirement imposed by the*  
18 *amendments made by this section, the State plan or*  
19 *child health plan shall not be regarded as failing to*  
20 *comply with the requirements of such title solely on*  
21 *the basis of its failure to meet this additional require-*  
22 *ment before the first day of the first calendar quarter*  
23 *beginning after the close of the first regular session of*  
24 *the State legislature that begins after the date of the*  
25 *enactment of this Act. For purposes of the previous*

1 sentence, in the case of a State that has a 2-year leg-  
2 islative session, each year of such session shall be  
3 deemed to be a separate regular session of the State  
4 legislature.

5 **SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICI-**  
6 **PATION RELATING TO CERTAIN OWNERSHIP,**  
7 **CONTROL, AND MANAGEMENT AFFILIATIONS.**

8 (a) *STATE PLAN REQUIREMENT.*—Section 1902(a) of  
9 the Social Security Act (42 U.S.C. 1396a(a)), as amended  
10 by sections 1631(b)(1), 1703(a), 1729, and 1753, is further  
11 amended—

12 (1) in paragraph (76), by striking at the end  
13 “and”;

14 (2) in paragraph (77), by striking at the end the  
15 period and inserting “; and”; and

16 (3) by inserting after paragraph (77) the fol-  
17 lowing new paragraph:

18 “(78) provide that the State agency described in  
19 paragraph (9) exclude, with respect to a period, any  
20 individual or entity from participation in the pro-  
21 gram under the State plan if such individual or enti-  
22 ty owns, controls, or manages an entity that (or if  
23 such entity is owned, controlled, or managed by an  
24 individual or entity that)—

1           “(A) has unpaid overpayments under this  
2 title during such period determined by the Sec-  
3 retary or the State agency to be delinquent;

4           “(B) is suspended or excluded from partici-  
5 pation under or whose participation is termi-  
6 nated under this title during such period; or

7           “(C) is affiliated with an individual or en-  
8 tity that has been suspended or excluded from  
9 participation under this title or whose participa-  
10 tion is terminated under this title during such  
11 period.”.

12       (b) *CHILD HEALTH PLAN REQUIREMENT.*—Section  
13 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)), as  
14 amended by section 1756(b), is amended by striking “sec-  
15 tion 1902(a)(39)” and inserting “sections 1902(a)(39) and  
16 1902(a)(78)”.

17       (c) *EFFECTIVE DATE.*—

18           (1) *Except as provided in paragraph (2), the*  
19 *amendments made by this section shall apply to serv-*  
20 *ices furnished on or after January 1, 2011, without*  
21 *regard to whether or not final regulations to carry*  
22 *out such amendments have been promulgated by such*  
23 *date.*

24           (2) *In the case of a State plan for medical assist-*  
25 *ance under title XIX of the Social Security Act or a*



1 *child health plan under title XXI of such Act which*  
2 *the Secretary of Health and Human Services deter-*  
3 *mines requires State legislation (other than legisla-*  
4 *tion appropriating funds) in order for the plan to*  
5 *meet the additional requirement imposed by the*  
6 *amendments made by this section, the State plan or*  
7 *child health plan shall not be regarded as failing to*  
8 *comply with the requirements of such title solely on*  
9 *the basis of its failure to meet this additional require-*  
10 *ment before the first day of the first calendar quarter*  
11 *beginning after the close of the first regular session of*  
12 *the State legislature that begins after the date of the*  
13 *enactment of this Act. For purposes of the previous*  
14 *sentence, in the case of a State that has a 2-year leg-*  
15 *islative session, each year of such session shall be*  
16 *deemed to be a separate regular session of the State*  
17 *legislature.*

18 **SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF**  
19 **DATA ELEMENTS UNDER MMIS TO DETECT**  
20 **FRAUD AND ABUSE.**

21 *Section 1903(r)(1)(F) of the Social Security Act (42*  
22 *U.S.C. 1396b(r)(1)(F)) is amended by inserting after “nec-*  
23 *essary” the following: “and including, for data submitted*  
24 *to the Secretary on or after July 1, 2010, data elements*  
25 *from the automated data system that the Secretary deter-*

1 *mines to be necessary for detection of waste, fraud, and*  
2 *abuse”.*

3 **SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**  
4 **ALTERNATE PAYEES REQUIRED TO REGISTER**  
5 **UNDER MEDICAID.**

6 *(a) IN GENERAL.—Section 1902(a) of the Social Secu-*  
7 *rity Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by*  
8 *sections 1631(b), 1703(a), 1729, 1753, and 1757(a), is fur-*  
9 *ther amended—*

10 *(1) in paragraph (77); by striking at the end*  
11 *“and”;*

12 *(2) in paragraph (78), by striking the period at*  
13 *the end and inserting “and”; and*

14 *(3) by inserting after paragraph (78) the fol-*  
15 *lowing new paragraph:*

16 *“(79) provide that any agent, clearinghouse, or*  
17 *other alternate payee that submits claims on behalf of*  
18 *a health care provider must register with the State*  
19 *and the Secretary in a form and manner specified by*  
20 *the Secretary under section 1866(j)(1)(D).”.*

21 *(b) DENIAL OF PAYMENT.—Section 1903(i) of such Act*  
22 *(42 U.S.C. 1396b(i)), as amended by section 1751, is*  
23 *amended—*

24 *(1) by striking “or” at the end of paragraph*  
25 *(24);*

1           (2) *by striking the period at the end of para-*  
2 *graph (25) and inserting “; or”; and*

3           (3) *by inserting after paragraph (25) the fol-*  
4 *lowing new paragraph:*

5           “(26) *with respect to any amount paid to a bill-*  
6 *ing agent, clearinghouse, or other alternate payee that*  
7 *is not registered with the State and the Secretary as*  
8 *required under section 1902(a)(79).”.*

9           (c) *EFFECTIVE DATE.—*

10           (1) *Except as provided in paragraph (2), the*  
11 *amendments made by this section shall apply to*  
12 *claims submitted on or after January 1, 2012, with-*  
13 *out regard to whether or not final regulations to*  
14 *carry out such amendments have been promulgated by*  
15 *such date.*

16           (2) *In the case of a State plan for medical assist-*  
17 *ance under title XIX of the Social Security Act which*  
18 *the Secretary of Health and Human Services deter-*  
19 *mines requires State legislation (other than legisla-*  
20 *tion appropriating funds) in order for the plan to*  
21 *meet the additional requirement imposed by the*  
22 *amendments made by this section, the State plan or*  
23 *child health plan shall not be regarded as failing to*  
24 *comply with the requirements of such title solely on*  
25 *the basis of its failure to meet this additional require-*

1        *ment before the first day of the first calendar quarter*  
2        *beginning after the close of the first regular session of*  
3        *the State legislature that begins after the date of the*  
4        *enactment of this Act. For purposes of the previous*  
5        *sentence, in the case of a State that has a 2-year leg-*  
6        *islative session, each year of such session shall be*  
7        *deemed to be a separate regular session of the State*  
8        *legislature.*

9        **SEC. 1760. DENIAL OF PAYMENTS FOR LITIGATION-RE-**  
10        **LATED MISCONDUCT.**

11        *(a) IN GENERAL.—Section 1903(i) of the Social Secu-*  
12        *rity Act (42 U.S.C. 1396b(i)), as amended by sections*  
13        *1751(a) and 1759(b), is amended—*

14                *(1) by striking “or” at the end of paragraph*  
15                *(25);*

16                *(2) by striking the period at the end of para-*  
17                *graph (26) and inserting “; or”; and*

18                *(3) by inserting after paragraph (26) the fol-*  
19                *lowing new paragraph:*

20                        *“(27) with respect to any amount expended—*

21                                *“(A) on litigation in which a court imposes*  
22                                *sanctions on the State, its employees, or its coun-*  
23                                *sel for litigation-related misconduct; or*

24                                *“(B) to reimburse (or otherwise compensate)*  
25                                *a managed care entity for payment of legal ex-*

1            *penses associated with any action in which a*  
2            *court imposes sanctions on the managed care en-*  
3            *tity for litigation-related misconduct.”.*

4            *(b) EFFECTIVE DATE.—The amendments made by sub-*  
5            *section (a) shall apply to amounts expended on or after*  
6            *January 1, 2010.*

7            **SEC. 1761. MANDATORY STATE USE OF NATIONAL CORRECT**  
8            **CODING INITIATIVE.**

9            *(a) IN GENERAL.—Section 1903(r) of the Social Secu-*  
10           *rity Act (42 U.S.C. 1396b(r)) is amended—*

11           *(1) in paragraph (1)(B)—*

12           *(A) in clause (ii), by striking “and” at the*  
13           *end;*

14           *(B) in clause (iii), by adding “and” after*  
15           *the semicolon; and*

16           *(C) by adding at the end the following new*  
17           *clause:*

18           *“(iv) effective for claims filed on or*  
19           *after October 1, 2010, incorporate compat-*  
20           *ible methodologies of the National Correct*  
21           *Coding Initiative administered by the Sec-*  
22           *retary (or any successor initiative to pro-*  
23           *mote correct coding and to control improper*  
24           *coding leading to inappropriate payment)*  
25           *and such other methodologies of that Initia-*

1           *tive (or such other national correct coding*  
2           *methodologies) as the Secretary identifies in*  
3           *accordance with paragraph (3);”;* and

4           (2) *by adding at the end the following new para-*  
5           *graph:*

6           “(3) *Not later than September 1, 2010, the Secretary*  
7           *shall do the following:*

8                   “(A) *Identify those methodologies of the National*  
9                   *Correct Coding Initiative administered by the Sec-*  
10                   *retary (or any successor initiative to promote correct*  
11                   *coding and to control improper coding leading to in-*  
12                   *appropriate payment) which are compatible to claims*  
13                   *filed under this title.*

14                   “(B) *Identify those methodologies of such Initia-*  
15                   *tive (or such other national correct coding methodolo-*  
16                   *gies) that should be incorporated into claims filed*  
17                   *under this title with respect to items or services for*  
18                   *which States provide medical assistance under this*  
19                   *title and no national correct coding methodologies*  
20                   *have been established under such Initiative with re-*  
21                   *spect to title XVIII.*

22                   “(C) *Notify States of—*

23                           “(i) *the methodologies identified under sub-*  
24                           *paragraphs (A) and (B) (and of any other na-*

1           *tional correct coding methodologies identified*  
2           *under subparagraph (B)); and*

3           “(i) *how States are to incorporate such*  
4           *methodologies into claims filed under this title.*

5           “(D) *Submit a report to Congress that includes*  
6           *the notice to States under subparagraph (C) and an*  
7           *analysis supporting the identification of the meth-*  
8           *odologies made under subparagraphs (A) and (B).”.*

9           **(b) EXTENSION FOR STATE LAW AMENDMENT.**—*In the*  
10          *case of a State plan under title XIX of the Social Security*  
11          *Act (42 U.S.C. 1396 et seq.) which the Secretary of Health*  
12          *and Human Services determines requires State legislation*  
13          *in order for the plan to meet the additional requirements*  
14          *imposed by the amendment made by subsection (a)(1)(C),*  
15          *the State plan shall not be regarded as failing to comply*  
16          *with the requirements of such title solely on the basis of*  
17          *its failure to meet these additional requirements before the*  
18          *first day of the first calendar quarter beginning after the*  
19          *close of the first regular session of the State legislature that*  
20          *begins after the date of enactment of this Act. For purposes*  
21          *of the previous sentence, in the case of a State that has a*  
22          *2-year legislative session, each year of the session is consid-*  
23          *ered to be a separate regular session of the State legislature.*

1                   ***Subtitle G—Payments to the***  
2                                   ***Territories***

3   ***SEC. 1771. PAYMENT TO TERRITORIES.***

4           (a) *INCREASE IN CAP.*—*Section 1108 of the Social Se-*  
5 *curity Act (42 U.S.C. 1308) is amended—*

6                   (1) *in subsection (f), by striking “subsection (g)”*  
7 *and inserting “subsections (g) and (h)”;*

8                   (2) *in subsection (g)(1), by striking “With re-*  
9 *spect to” and inserting “Subject to subsection (h),*  
10 *with respect to”;* and

11                   (3) *by adding at the end the following new sub-*  
12 *section:*

13           “(h) *ADDITIONAL INCREASE FOR FISCAL YEARS 2011*  
14 *THROUGH 2019.*—*With respect to fiscal years 2011 through*  
15 *2019, the amounts otherwise determined under subsections*  
16 *(f) and (g) for Puerto Rico, the Virgin Islands, Guam, the*  
17 *Northern Mariana Islands and American Samoa shall be*  
18 *increased by the following amounts:*

19                   “(1) *For Puerto Rico, for fiscal year 2011,*  
20 *\$727,600,000; for fiscal year 2012, \$775,000,000; for*  
21 *fiscal year 2013, \$850,000,000; for fiscal year 2014,*  
22 *\$925,000,000; for fiscal year 2015, \$1,000,000,000; for*  
23 *fiscal year 2016, \$1,075,000,000; for fiscal year 2017,*  
24 *\$1,150,000,000; for fiscal year 2018, \$1,225,000,000;*  
25 *and for fiscal year 2019, \$1,396,400,000.*



1           “(2) For the Virgin Islands, for fiscal year 2011,  
2           \$34,000,000; for fiscal year 2012, \$37,000,000; for fis-  
3           cal year 2013, \$40,000,000; for fiscal year 2014,  
4           \$43,000,000; for fiscal year 2015, \$46,000,000; for fis-  
5           cal year 2016, \$49,000,000; for fiscal year 2017,  
6           \$52,000,000; for fiscal year 2018, \$55,000,000; and  
7           for fiscal year 2019, \$58,000,000.

8           “(3) For Guam, for fiscal year 2011,  
9           \$34,000,000; for fiscal year 2012, \$37,000,000; for fis-  
10          cal year 2013, \$40,000,000; for fiscal year 2014,  
11          \$43,000,000; for fiscal year 2015, \$46,000,000; for fis-  
12          cal year 2016, \$49,000,000; for fiscal year 2017,  
13          \$52,000,000; for fiscal year 2018, \$55,000,000; and  
14          for fiscal year 2019, \$58,000,000.

15          “(4) For the Northern Mariana Islands, for fis-  
16          cal year 2011, \$13,500,000; fiscal year 2012,  
17          \$14,500,000; for fiscal year 2013, \$15,500,000; for fis-  
18          cal year 2014, \$16,500,000; for fiscal year 2015,  
19          \$17,500,000; for fiscal year 2016, \$18,500,000; for fis-  
20          cal year 2017, \$19,500,000; for fiscal year 2018,  
21          \$21,000,000; and for fiscal year 2019, \$22,000,000.

22          “(5) For American Samoa, fiscal year 2011,  
23          \$22,000,000; fiscal year 2012, \$23,687,500; for fiscal  
24          year 2013, \$24,687,500; for fiscal year 2014,  
25          \$25,687,500; for fiscal year 2015, \$26,687,500; for fis-

1        *cal year 2016, \$27,687,500; for fiscal year 2017,*  
2        *\$28,687,500; for fiscal year 2018, \$29,687,500; and*  
3        *for fiscal year 2019, \$30,687,500.”.*

4        *(b) REPORT ON ACHIEVING MEDICAID PARITY PAY-*  
5        *MENTS BEGINNING WITH FISCAL YEAR 2020.—*

6                *(1) IN GENERAL.—Not later than October 1,*  
7        *2013, the Secretary of Health and Human Services*  
8        *shall submit to Congress a report that details a plan*  
9        *for the transition of each territory to full parity in*  
10        *Medicaid with the 50 States and the District of Co-*  
11        *lumbia in fiscal year 2020 by modifying their exist-*  
12        *ing Medicaid programs and outlining actions the Sec-*  
13        *retary and the governments of each territory must*  
14        *take by fiscal year 2020 to ensure parity in financ-*  
15        *ing. Such report shall include what the Federal med-*  
16        *ical assistance percentages would be for each territory*  
17        *if the formula applicable to the 50 States were ap-*  
18        *plied. Such report shall also include any rec-*  
19        *ommendations that the Secretary may have as to*  
20        *whether the mandatory ceiling amounts for each terri-*  
21        *tory provided for in section 1108 of the Social Secu-*  
22        *rity Act (42 U.S.C. 1308) should be increased any*  
23        *time before fiscal year 2020 due to any factors that*  
24        *the Secretary deems relevant.*

1           (2) *PER CAPITA DATA.*—As part of such report  
2           the Secretary shall include information about per  
3           capita income data that could be used to calculate  
4           Federal medical assistance percentages under section  
5           1905(b) of the Social Security Act, under section  
6           1108(a)(8)(B) of such Act, for each territory on how  
7           such data differ from the per capita income data used  
8           to promulgate Federal medical assistance percentages  
9           for the 50 States. The report under this subsection  
10          shall include recommendations on how the Federal  
11          medical assistance percentages can be calculated for  
12          the territories beginning in fiscal year 2020 to ensure  
13          parity with the 50 States.

14          (3) *SUBSEQUENT REPORTS.*—The Secretary shall  
15          submit subsequent reports to Congress in 2015, 2017,  
16          and 2019 detailing the progress that the Secretary  
17          and the governments of each territory have made in  
18          fulfilling the actions outlined in the plan submitted  
19          under paragraph (1).

20          (c) *APPLICATION OF FMAP FOR ADDITIONAL*  
21          *FUNDS.*—Section 1905(b) of such Act (42 U.S.C. 1396d(b))  
22          is amended by adding at the end the following sentence:  
23          “Notwithstanding the first sentence of this subsection and  
24          any other provision of law, for fiscal years 2011 through  
25          2019, the Federal medical assistance percentage for Puerto

1 *Rico, the Virgin Islands, Guam, the Northern Mariana Is-*  
2 *lands, and American Samoa shall be the highest Federal*  
3 *medical assistance percentage applicable to any of the 50*  
4 *States or the District of Columbia for the fiscal year in-*  
5 *volved, taking into account the application of subsections*  
6 *(a) and (b)(1) of section 5001 of division B of the American*  
7 *Recovery and Reinvestment Act of 2009 (Public Law 111-*  
8 *5) to such States and the District for calendar quarters dur-*  
9 *ing such fiscal years for which such subsections apply.”.*

10 (d) *WAIVERS.—*

11 (1) *IN GENERAL.—Section 1902(j) of the Social*  
12 *Security Act (42 U.S.C. 1396a(j)) is amended—*

13 (A) *by striking “American Samoa and the*  
14 *Northern Mariana Islands” and inserting “Puer-*  
15 *to Rico, the Virgin Islands, Guam, the Northern*  
16 *Mariana Islands, and American Samoa”;* and

17 (B) *by striking “American Samoa or the*  
18 *Northern Mariana Islands” and inserting “Puer-*  
19 *to Rico, the Virgin Islands, Guam, the Northern*  
20 *Mariana Islands, or American Samoa”.*

21 (2) *EFFECTIVE DATE.—The amendments made*  
22 *by paragraph (1) shall apply beginning with fiscal*  
23 *year 2011.*

24 (e) *TECHNICAL ASSISTANCE.—The Secretary shall*  
25 *provide technical assistance to the governments of Puerto*

1 *Rico, the Virgin Islands, Guam, the Northern Mariana Is-*  
2 *lands, and American Samoa in upgrading their existing*  
3 *computer systems in order to anticipate meeting reporting*  
4 *requirements necessary to implement the plan contained in*  
5 *the report under subsection (b)(1). The provision of such*  
6 *technical assistance shall not be counted against any limi-*  
7 *tation on payment to the territories under section 1108 of*  
8 *the Social Security Act.*

9 ***Subtitle H—Miscellaneous***

10 ***SEC. 1781. TECHNICAL CORRECTIONS.***

11 *(a) TECHNICAL CORRECTION TO SECTION 1144 OF*  
12 *THE SOCIAL SECURITY ACT.—The first sentence of section*  
13 *1144(c)(3) of the Social Security Act (42 U.S.C. 1320b—*  
14 *14(c)(3)) is amended—*

15 *(1) by striking “transmittal”; and*

16 *(2) by inserting before the period the following:*  
17 *“as specified in section 1935(a)(4)”.*

18 *(b) CLARIFYING AMENDMENT TO SECTION 1935 OF*  
19 *THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the So-*  
20 *cial Security Act (42 U.S.C. 1396u—5(a)(4)), as amended*  
21 *by section 113(b) of Public Law 110–275, is amended—*

22 *(1) by striking the second sentence;*

23 *(2) by redesignating the first sentence as a sub-*  
24 *paragraph (A) with appropriate indentation and*  
25 *with the following heading: “IN GENERAL.—”;*

1           (3) *by adding at the end the following subpara-*  
2 *graphs:*

3                   “(B) *FURNISHING MEDICAL ASSISTANCE*  
4 *WITH REASONABLE PROMPTNESS.—For the pur-*  
5 *pose of a State’s obligation under section*  
6 *1902(a)(8) to furnish medical assistance with*  
7 *reasonable promptness, the date of the electronic*  
8 *transmission of low-income subsidy program*  
9 *data, as described in section 1144(c), from the*  
10 *Commissioner of Social Security to the State*  
11 *Medicaid Agency, shall constitute the date of fil-*  
12 *ing of such application for benefits under the*  
13 *Medicare Savings Program.*”

14                   “(C) *DETERMINING AVAILABILITY OF MED-*  
15 *ICAL ASSISTANCE.—For the purpose of deter-*  
16 *mining when medical assistance will be made*  
17 *available, the State shall consider the date of the*  
18 *individual’s application for the low income sub-*  
19 *sidy program to constitute the date of filing for*  
20 *benefits under the Medicare Savings Program.*”.

21           (c) *EFFECTIVE DATE RELATING TO MEDICAID AGENCY*  
22 *CONSIDERATION OF LOW-INCOME SUBSIDY APPLICATION*  
23 *AND DATA TRANSMITTAL.—The amendments made by sub-*  
24 *sections (a) and (b) shall be effective as if included in the*  
25 *enactment of section 113(b) of Public Law 110–275.*

1           (d) *TECHNICAL CORRECTION TO SECTION 605 OF*  
2 *CHIPRA.—Section 605 of the Children’s Health Insurance*  
3 *Program Reauthorization Act of 2009 (Public Law 111–*  
4 *3) is amended by striking “legal residents” and inserting*  
5 *“lawfully residing in the United States”.*

6           (e) *TECHNICAL CORRECTION TO SECTION 1905 OF THE*  
7 *SOCIAL SECURITY ACT.—Section 1905(a) of the Social Se-*  
8 *curity Act (42 U.S.C. 1396d(a)) is amended by inserting*  
9 *“or the care and services themselves, or both” before “(if*  
10 *provided in or after”.*

11           (f) *CLARIFYING AMENDMENT TO SECTION 1115 OF THE*  
12 *SOCIAL SECURITY ACT.—Section 1115(a) of the Social Se-*  
13 *curity Act (42 U.S.C. 1315(a)) is amended by adding at*  
14 *the end the following: “If an experimental, pilot, or dem-*  
15 *onstration project that relates to title XIX is approved pur-*  
16 *suant to any part of this subsection, such project shall be*  
17 *treated as part of the State plan, all medical assistance pro-*  
18 *vided on behalf of any individuals affected by such project*  
19 *shall be medical assistance provided under the State plan,*  
20 *and all provisions of this Act not explicitly waived in ap-*  
21 *proving such project shall remain fully applicable to all in-*  
22 *dividuals receiving benefits under the State plan.”.*

1 **SEC. 1782. EXTENSION OF QI PROGRAM.**

2 (a) *IN GENERAL.*—Section 1902(a)(10)(E)(iv) of the  
3 Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is  
4 amended—

5 (1) by striking “sections 1933 and” and by in-  
6 serting “section”; and

7 (2) by striking “December 2010” and inserting  
8 “December 2012”.

9 (b) *ELIMINATION OF FUNDING LIMITATION.*—

10 (1) *IN GENERAL.*—Section 1933 of such Act (42  
11 U.S.C. 1396u–3) is amended—

12 (A) in subsection (a), by striking “who are  
13 selected to receive such assistance under sub-  
14 section (b)”;

15 (B) by striking subsections (b), (c), (e), and  
16 (g);

17 (C) in subsection (d), by striking “furnished  
18 in a State” and all that follows and inserting  
19 “the Federal medical assistance percentage shall  
20 be equal to 100 percent.”; and

21 (D) by redesignating subsections (d) and (f)  
22 as subsections (b) and (c), respectively.

23 (2) *CONFORMING AMENDMENT.*—Section 1905(b)  
24 of such Act (42 U.S.C. 1396d(b)) is amended by strik-  
25 ing “1933(d)” and inserting “1933(b)”.



1           (3) *EFFECTIVE DATE.*—*The amendments made*  
2       *by paragraph (1) shall take effect on January 1,*  
3       *2011.*

4 **SEC. 1783. OUTREACH AND ENROLLMENT OF MEDICAID**  
5                                   **AND CHIP ELIGIBLE INDIVIDUALS.**

6       (a) *IN GENERAL.*—*Not later than 12 months after date*  
7 *of enactment of this Act, the Secretary of Health and*  
8 *Human Services shall issue guidance regarding standards*  
9 *and best practices for conducting outreach to inform eligible*  
10 *individuals about healthcare coverage under Medicaid*  
11 *under title XIX of the Social Security Act or for child health*  
12 *assistance under CHIP under title XXI of such Act, pro-*  
13 *viding assistance to such individuals for enrollment in ap-*  
14 *plicable programs, and establishing methods or procedures*  
15 *for eliminating application and enrollment barriers. Such*  
16 *guidance shall include provisions to ensure that outreach,*  
17 *enrollment assistance, and administrative simplification ef-*  
18 *forts are targeted specifically to vulnerable populations such*  
19 *as children, unaccompanied homeless youth, victims of*  
20 *abuse or trauma, individuals with mental health or sub-*  
21 *stance related disorders, and individuals with HIV/AIDS.*  
22 *Guidance issued pursuant to this section relating to meth-*  
23 *ods to increase outreach and enrollment provided for under*  
24 *titles XIX and XXI of the Social Security Act shall specifi-*  
25 *cally target such vulnerable and underserved populations*

1 *and shall include, but not be limited to, guidance on*  
2 *outstationing of eligibility workers, express lane eligibility,*  
3 *residence requirements, documentation of income and as-*  
4 *sets, presumptive eligibility, continuous eligibility, and*  
5 *automatic renewal.*

6       **(b) IMPLEMENTATION.**—*In implementing the require-*  
7 *ments under subsection (a), the Secretary may use such au-*  
8 *thorities as are available under law and may work with*  
9 *such entities as the Secretary deems appropriate to facili-*  
10 *tate effective implementation of such programs. Not later*  
11 *than 2 years after the enactment of this Act and annually*  
12 *thereafter, the Secretary shall review and report to Congress*  
13 *on progress in implementing targeted outreach, application*  
14 *and enrollment assistance, and administrative simplifica-*  
15 *tion methods for such vulnerable and underserved popu-*  
16 *lations as are specified in subsection (a).*

17 **SEC. 1784. PROHIBITIONS ON FEDERAL MEDICAID AND**  
18                   **CHIP PAYMENT FOR UNDOCUMENTED**  
19                   **ALIENS.**

20       *Nothing in this title shall change current prohibitions*  
21 *against Federal Medicaid and CHIP payments under titles*  
22 *XIX and XXI of the Social Security Act on behalf of indi-*  
23 *viduals who are not lawfully present in the United States.*

1 **SEC. 1785. DEMONSTRATION PROJECT FOR STABILIZATION**  
2 **OF EMERGENCY MEDICAL CONDITIONS BY**  
3 **NONPUBLICLY OWNED OR OPERATED INSTI-**  
4 **TUTIONS FOR MENTAL DISEASES.**

5 (a) *AUTHORITY To CONDUCT DEMONSTRATION*  
6 *PROJECT.*—*The Secretary of Health and Human Services*  
7 *(in this section referred to as the “Secretary”)* shall estab-  
8 *lish a demonstration project under which an eligible State*  
9 *(as described in subsection (c)) shall provide reimbursement*  
10 *under the State Medicaid plan under title XIX of the Social*  
11 *Security Act to an institution for mental diseases that is*  
12 *not publicly owned or operated and that is subject to the*  
13 *requirements of section 1867 of the Social Security Act (42*  
14 *U.S.C. 1395dd) for the provision of medical assistance*  
15 *available under such plan to an individual who—*

16 (1) *has attained age 21, but has not attained age*  
17 *65;*

18 (2) *is eligible for medical assistance under such*  
19 *plan; and*

20 (3) *requires such medical assistance to stabilize*  
21 *an emergency medical condition.*

22 (b) *IN-STAY REVIEW.*—*The Secretary shall establish a*  
23 *mechanism for in-stay review to determine whether or not*  
24 *the patient has been stabilized (as defined in subsection*  
25 *(h)(5)). This mechanism shall commence before the third*  
26 *day of the inpatient stay. States participating in the dem-*

1 onstration project may manage the provision of these bene-  
2 fits under the project through utilization review, authoriza-  
3 tion, or management practices, or the application of med-  
4 ical necessity and appropriateness criteria applicable to be-  
5 havioral health.

6 (c) *ELIGIBLE STATE DEFINED.*—

7 (1) *APPLICATION.*—Upon approval of an appli-  
8 cation submitted by a State described in paragraph  
9 (2), the State shall be an eligible State for purposes  
10 of conducting a demonstration project under this sec-  
11 tion.

12 (2) *STATE DESCRIBED.*—States shall be selected  
13 by the Secretary in a manner so as to provide geo-  
14 graphic diversity on the basis of the application to  
15 conduct a demonstration project under this section  
16 submitted by such States.

17 (d) *LENGTH OF DEMONSTRATION PROJECT.*—The  
18 demonstration project established under this section shall  
19 be conducted for a period of 3 consecutive years.

20 (e) *LIMITATIONS ON FEDERAL FUNDING.*—

21 (1) *APPROPRIATION.*—

22 (A) *IN GENERAL.*—Out of any funds in the  
23 Treasury not otherwise appropriated, there is  
24 appropriated to carry out this section,  
25 \$75,000,000 for fiscal year 2010.

1           (B) *BUDGET AUTHORITY.*—Subparagraph  
2           (A) constitutes budget authority in advance of  
3           appropriations Act and represents the obligation  
4           of the Federal Government to provide for the  
5           payment of the amounts appropriated under that  
6           subparagraph.

7           (2) *3-YEAR AVAILABILITY.*—Funds appropriated  
8           under paragraph (1) shall remain available for obli-  
9           gation through December 31, 2012.

10          (3) *LIMITATION ON PAYMENTS.*—In no case  
11          may—

12                 (A) the aggregate amount of payments made  
13                 by the Secretary to eligible States under this sec-  
14                 tion exceed \$75,000,000; or

15                 (B) payments be provided by the Secretary  
16                 under this section after December 31, 2012.

17          (4) *FUNDS ALLOCATED TO STATES.*—The Sec-  
18          retary shall allocate funds to eligible States based on  
19          their applications and the availability of funds.

20          (5) *PAYMENTS TO STATES.*—The Secretary shall  
21          pay to each eligible State, from its allocation under  
22          paragraph (4), an amount each quarter equal to the  
23          Federal medical assistance percentage of expenditures  
24          in the quarter for medical assistance described in sub-  
25          section (a).

1 (f) *REPORTS.*—

2 (1) *ANNUAL PROGRESS REPORTS.*—*The Sec-*  
3 *retary shall submit annual reports to Congress on the*  
4 *progress of the demonstration project conducted under*  
5 *this section.*

6 (2) *FINAL REPORT AND RECOMMENDATION.*—*An*  
7 *evaluation shall be conducted of the demonstration*  
8 *project's impact on the functioning of the health and*  
9 *mental health service system and on individuals en-*  
10 *rolled in the Medicaid program. This evaluation shall*  
11 *include collection of baseline data for one-year prior*  
12 *to the initiation of the demonstration project as well*  
13 *as collection of data from matched comparison states*  
14 *not participating in the demonstration. The evalua-*  
15 *tion measures shall include the following:*

16 (A) *A determination, by State, as to wheth-*  
17 *er the demonstration project resulted in in-*  
18 *creased access to inpatient mental health services*  
19 *under the Medicaid program and whether aver-*  
20 *age length of stays were longer (or shorter) for*  
21 *individuals admitted under the demonstration*  
22 *project compared with individuals otherwise ad-*  
23 *mitted in comparison sites.*

24 (B) *An analysis, by State, regarding wheth-*  
25 *er the demonstration project produced a signifi-*

1           cant reduction in emergency room visits for in-  
2           dividuals eligible for assistance under the Med-  
3           icaid program or in the duration of emergency  
4           room lengths of stay.

5           (C) An assessment of discharge planning by  
6           participating hospitals that ensures access to  
7           further (non-emergency) inpatient or residential  
8           care as well as continuity of care for those dis-  
9           charged to outpatient care.

10          (D) An assessment of the impact of the dem-  
11          onstration project on the costs of the full range  
12          of mental health services (including inpatient,  
13          emergency and ambulatory care) under the plan  
14          as contrasted with the comparison areas.

15          (E) Data on the percentage of consumers  
16          with Medicaid coverage who are admitted to in-  
17          patient facilities as a result of the demonstration  
18          project as compared to those admitted to these  
19          same facilities through other means.

20          (F) A recommendation regarding whether  
21          the demonstration project should be continued  
22          after December 31, 2012, and expanded on a na-  
23          tional basis.

24          (g) WAIVER AUTHORITY.—

1           (1) *IN GENERAL.*—*The Secretary shall waive the*  
2 *limitation of subdivision (B) following paragraph*  
3 *(28) of section 1905(a) of the Social Security Act (42*  
4 *U.S.C. 1396d(a)) (relating to limitations on pay-*  
5 *ments for care or services for individuals under 65*  
6 *years of age who are patients in an institution for*  
7 *mental diseases) for purposes of carrying out the dem-*  
8 *onstration project under this section.*

9           (2) *LIMITED OTHER WAIVER AUTHORITY.*—*The*  
10 *Secretary may waive other requirements of titles XI*  
11 *and XIX of the Social Security Act (including the re-*  
12 *quirements of sections 1902(a)(1) (relating to*  
13 *statewideness) and 1902(1)(10)(B) (relating to com-*  
14 *parability)) only to extent necessary to carry out the*  
15 *demonstration project under this section.*

16 *(h) DEFINITIONS.*—*In this section:*

17           (1) *EMERGENCY MEDICAL CONDITION.*—*The term*  
18 *“emergency medical condition” means, with respect to*  
19 *an individual, an individual who expresses suicidal*  
20 *or homicidal thoughts or gestures, if determined dan-*  
21 *gerous to self or others.*

22           (2) *FEDERAL MEDICAL ASSISTANCE PERCENT-*  
23 *AGE.*—*The term “Federal medical assistance percent-*  
24 *age” has the meaning given that term with respect to*



1       *a State under section 1905(b) of the Social Security*  
2       *Act (42 U.S.C. 1396d(b)).*

3               (3) *INSTITUTION FOR MENTAL DISEASES.—The*  
4       *term “institution for mental diseases” has the mean-*  
5       *ing given to that term in section 1905(i) of the Social*  
6       *Security Act (42 U.S.C. 1396d(i)).*

7               (4) *MEDICAL ASSISTANCE.—The term “medical*  
8       *assistance” has the meaning given to that term in sec-*  
9       *tion 1905(a) of the Social Security Act (42 U.S.C.*  
10       *1396d(a)).*

11              (5) *STABILIZED.—The term “stabilized” means,*  
12       *with respect to an individual, that the emergency*  
13       *medical condition no longer exists with respect to the*  
14       *individual and the individual is no longer dangerous*  
15       *to self or others.*

16              (6) *STATE.—The term “State” has the meaning*  
17       *given that term for purposes of title XIX of the Social*  
18       *Security Act (42 U.S.C. 1396 et seq.).*

19       ***[TITLE VIII—REVENUE-RELATED***  
20       ***PROVISIONS]***

21       ***[For title VIII, see text of bill as introduced on July***  
22       ***14, 2009.]***

1           **TITLE IX—MISCELLANEOUS**  
2                           **PROVISIONS**

3   **SEC. 1901. REPEAL OF TRIGGER PROVISION.**

4           *Subtitle A of title VIII of the Medicare Prescription*  
5 *Drug, Improvement, and Modernization Act of 2003 (Public*  
6 *Law 108–173) is repealed and the provisions of law amend-*  
7 *ed by such subtitle are restored as if such subtitle had never*  
8 *been enacted.*

9   **SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT**  
10                           **(CCA) PROGRAM.**

11           *Section 1860C–1 of the Social Security Act (42 U.S.C.*  
12 *1395w–29), as added by section 241(a) of the Medicare Pre-*  
13 *scription Drug, Improvement, and Modernization Act of*  
14 *2003 (Public Law 108–173), is repealed.*

15   **SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.**

16           *(a) IN GENERAL.—Subsection (d)(3) of section 5007*  
17 *of the Deficit Reduction Act of 2005 (Public Law 109-171)*  
18 *is amended by inserting “(or September 30, 2011, in the*  
19 *case of a demonstration project in operation as of October*  
20 *1, 2008)” after “December 31, 2009”.*

21           *(b) FUNDING.—*

22                   *(1) IN GENERAL.—Subsection (f)(1) of such sec-*  
23 *tion is amended by inserting “and for fiscal year*  
24 *2010, \$1,600,000,” after “\$6,000,000.”*

1           (2) *AVAILABILITY.*—Subsection (f)(2) of such sec-  
 2           tion is amended by striking “2010” and inserting  
 3           “2014 or until expended”.

4           (c) *REPORTS.*—

5           (1) *QUALITY IMPROVEMENT AND SAVINGS.*—Sub-  
 6           section (e)(3) of such section is amended by striking  
 7           “December 1, 2008” and inserting “March 31, 2011”.

8           (2) *FINAL REPORT.*—Subsection (e)(4) of such  
 9           section is amended by striking “May 1, 2010” and  
 10          inserting “March 31, 2013”.

11 **SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITA-**  
 12                                   **TION PROGRAMS FOR FAMILIES WITH YOUNG**  
 13                                   **CHILDREN AND FAMILIES EXPECTING CHIL-**  
 14                                   **DREN.**

15          Part B of title IV of the Social Security Act (42 U.S.C.  
 16 621–629i) is amended by adding at the end the following:

17           **“Subpart 3—Support for Quality Home Visitation**  
 18                                   **Programs**

19 **“SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES**  
 20                                   **WITH YOUNG CHILDREN AND FAMILIES EX-**  
 21                                   **PECTING CHILDREN.**

22          “(a) *PURPOSE.*—The purpose of this section is to im-  
 23          prove the well-being, health, and development of children  
 24          by enabling the establishment and expansion of high quality

1 *programs providing voluntary home visitation for families*  
2 *with young children and families expecting children.*

3       “(b) *GRANT APPLICATION.*—*A State that desires to re-*  
4 *ceive a grant under this section shall submit to the Sec-*  
5 *retary for approval, at such time and in such manner as*  
6 *the Secretary may require, an application for the grant that*  
7 *includes the following:*

8               “(1) *DESCRIPTION OF HOME VISITATION PRO-*  
9 *GRAMS.*—*A description of the high quality programs*  
10 *of home visitation for families with young children*  
11 *and families expecting children that will be supported*  
12 *by a grant made to the State under this section, the*  
13 *outcomes the programs are intended to achieve, and*  
14 *the evidence supporting the effectiveness of the pro-*  
15 *grams.*

16               “(2) *RESULTS OF NEEDS ASSESSMENT.*—*The re-*  
17 *sults of a statewide needs assessment that describes—*

18                       “(A) *the number, quality, and capacity of*  
19 *home visitation programs for families with*  
20 *young children and families expecting children*  
21 *in the State;*

22                       “(B) *the number and types of families who*  
23 *are receiving services under the programs;*

24                       “(C) *the sources and amount of funding*  
25 *provided to the programs;*

1           “(D) the gaps in home visitation in the  
2           State, including identification of communities  
3           that are in high need of the services; and

4           “(E) training and technical assistance ac-  
5           tivities designed to achieve or support the goals  
6           of the programs.

7           “(3) ASSURANCES.—Assurances from the State  
8           that—

9           “(A) in supporting home visitation pro-  
10          grams using funds provided under this section,  
11          the State shall identify and prioritize serving  
12          communities that are in high need of such serv-  
13          ices, especially communities with a high propor-  
14          tion of low-income families or a high incidence  
15          of child maltreatment;

16          “(B) the State will reserve 5 percent of the  
17          grant funds for training and technical assistance  
18          to the home visitation programs using such  
19          funds;

20          “(C) in supporting home visitation pro-  
21          grams using funds provided under this section,  
22          the State will promote coordination and collabo-  
23          ration with other home visitation programs (in-  
24          cluding programs funded under title XIX) and  
25          with other child and family services, health serv-

1           ices, income supports, and other related assist-  
2           ance;

3           “(D) home visitation programs supported  
4           using such funds will, when appropriate, provide  
5           referrals to other programs serving children and  
6           families; and

7           “(E) the State will comply with subsection  
8           (i), and cooperate with any evaluation conducted  
9           under subsection (j).

10          “(4) OTHER INFORMATION.—Such other infor-  
11          mation as the Secretary may require.

12          “(c) ALLOTMENTS.—

13                 “(1) INDIAN TRIBES.—From the amount reserved  
14                 under subsection (l)(2) for a fiscal year, the Secretary  
15                 shall allot to each Indian tribe that meets the require-  
16                 ment of subsection (d), if applicable, for the fiscal  
17                 year the amount that bears the same ratio to the  
18                 amount so reserved as the number of children in the  
19                 Indian tribe whose families have income that does not  
20                 exceed 200 percent of the poverty line bears to the  
21                 total number of children in such Indian tribes whose  
22                 families have income that does not exceed 200 percent  
23                 of the poverty line.

24                 “(2) STATES AND TERRITORIES.—From the  
25                 amount appropriated under subsection (m) for a fis-

1        *cal year that remains after making the reservations*  
2        *required by subsection (l), the Secretary shall allot to*  
3        *each State that is not an Indian tribe and that meets*  
4        *the requirement of subsection (d), if applicable, for the*  
5        *fiscal year the amount that bears the same ratio to*  
6        *the remainder of the amount so appropriated as the*  
7        *number of children in the State whose families have*  
8        *income that does not exceed 200 percent of the poverty*  
9        *line bears to the total number of children in such*  
10       *States whose families have income that does not ex-*  
11       *ceed 200 percent of the poverty line.*

12            *“(3) REALLOTMENTS.—The amount of any allot-*  
13        *ment to a State under a paragraph of this subsection*  
14        *for any fiscal year that the State certifies to the Sec-*  
15        *retary will not be expended by the State pursuant to*  
16        *this section shall be available for reallocation using*  
17        *the allotment methodology specified in that para-*  
18        *graph. Any amount so reallocated to a State is deemed*  
19        *part of the allotment of the State under this sub-*  
20        *section.*

21            *“(d) MAINTENANCE OF EFFORT.—Beginning with fis-*  
22        *cal year 2011, a State meets the requirement of this sub-*  
23        *section for a fiscal year if the Secretary finds that the aggre-*  
24        *gate expenditures by the State from State and local sources*  
25        *for programs of home visitation for families with young*

1 *children and families expecting children for the then pre-*  
2 *ceding fiscal year was not less than 100 percent of such*  
3 *aggregate expenditures for the then 2nd preceding fiscal*  
4 *year.*

5 *“(e) PAYMENT OF GRANT.—*

6 *“(1) IN GENERAL.—The Secretary shall make a*  
7 *grant to each State that meets the requirements of*  
8 *subsections (b) and (d), if applicable, for a fiscal year*  
9 *for which funds are appropriated under subsection*  
10 *(m), in an amount equal to the reimbursable percent-*  
11 *age of the eligible expenditures of the State for the fis-*  
12 *cal year, but not more than the amount allotted to the*  
13 *State under subsection (c) for the fiscal year.*

14 *“(2) REIMBURSABLE PERCENTAGE DEFINED.—*  
15 *In paragraph (1), the term ‘reimbursable percentage’*  
16 *means, with respect to a fiscal year—*

17 *“(A) 85 percent, in the case of fiscal year*  
18 *2010;*

19 *“(B) 80 percent, in the case of fiscal year*  
20 *2011; or*

21 *“(C) 75 percent, in the case of fiscal year*  
22 *2012 and any succeeding fiscal year.*

23 *“(f) ELIGIBLE EXPENDITURES.—*

24 *“(1) IN GENERAL.—In this section, the term ‘eli-*  
25 *gible expenditures’—*



1           “(A) means expenditures to provide vol-  
2           untary home visitation for as many families  
3           with young children (under the age of school  
4           entry) and families expecting children as prac-  
5           ticable, through the implementation or expansion  
6           of high quality home visitation programs that—

7                   “(i) adhere to clear evidence-based  
8                   models of home visitation that have dem-  
9                   onstrated positive effects on important pro-  
10                  gram-determined child and parenting out-  
11                  comes, such as reducing abuse and neglect  
12                  and improving child health and develop-  
13                  ment;

14                  “(ii) employ well-trained and com-  
15                  petent staff, maintain high quality super-  
16                  vision, provide for ongoing training and  
17                  professional development, and show strong  
18                  organizational capacity to implement such  
19                  a program;

20                  “(iii) establish appropriate linkages  
21                  and referrals to other community resources  
22                  and supports;

23                  “(iv) monitor fidelity of program im-  
24                  plementation to ensure that services are de-  
25                  livered according to the specified model; and

1 “(v) provide parents with—

2 “(I) knowledge of age-appropriate  
3 child development in cognitive, lan-  
4 guage, social, emotional, and motor do-  
5 mains (including knowledge of second  
6 language acquisition, in the case of  
7 English language learners);

8 “(II) knowledge of realistic expec-  
9 tations of age-appropriate child behav-  
10 iors;

11 “(III) knowledge of health and  
12 wellness issues for children and par-  
13 ents;

14 “(IV) modeling, consulting, and  
15 coaching on parenting practices;

16 “(V) skills to interact with their  
17 child to enhance age-appropriate devel-  
18 opment;

19 “(VI) skills to recognize and seek  
20 help for issues related to health, devel-  
21 opmental delays, and social, emotional,  
22 and behavioral skills; and

23 “(VII) activities designed to help  
24 parents become full partners in the  
25 education of their children;

1           “(B) includes expenditures for training,  
2           technical assistance, and evaluations related to  
3           the programs; and

4           “(C) does not include any expenditure with  
5           respect to which a State has submitted a claim  
6           for payment under any other provision of Fed-  
7           eral law.

8           “(2) PRIORITY FUNDING FOR PROGRAMS WITH  
9           STRONGEST EVIDENCE.—

10           “(A) IN GENERAL.—The expenditures, de-  
11           scribed in paragraph (1), of a State for a fiscal  
12           year that are attributable to the cost of programs  
13           that do not adhere to a model of home visitation  
14           with the strongest evidence of effectiveness shall  
15           not be considered eligible expenditures for the fis-  
16           cal year to the extent that the total of the ex-  
17           penditures exceeds the applicable percentage for  
18           the fiscal year of the allotment of the State under  
19           subsection (c) for the fiscal year.

20           “(B) APPLICABLE PERCENTAGE DEFINED.—  
21           In subparagraph (A), the term ‘applicable per-  
22           centage’ means, with respect to a fiscal year—

23                   “(i) 60 percent for fiscal year 2010;

24                   “(ii) 55 percent for fiscal year 2011;

25                   “(iii) 50 percent for fiscal year 2012;

1                   “(iv) 45 percent for fiscal year 2013;

2                   or

3                   “(v) 40 percent for fiscal year 2014.

4           “(g) *NO USE OF OTHER FEDERAL FUNDS FOR STATE*  
5 *MATCH.*—A State to which a grant is made under this sec-  
6 tion may not expend any Federal funds to meet the State  
7 share of the cost of an eligible expenditure for which the  
8 State receives a payment under this section.

9           “(h) *WAIVER AUTHORITY.*—

10                   “(1) *IN GENERAL.*—The Secretary may waive or  
11 modify the application of any provision of this sec-  
12 tion, other than subsection (b) or (f), to an Indian  
13 tribe if the failure to do so would impose an undue  
14 burden on the Indian tribe.

15                   “(2) *SPECIAL RULE.*—An Indian tribe is deemed  
16 to meet the requirement of subsection (d) for purposes  
17 of subsections (c) and (e) if—

18                           “(A) the Secretary waives the requirement;

19                           or

20                           “(B) the Secretary modifies the require-  
21 ment, and the Indian tribe meets the modified  
22 requirement.

23           “(i) *STATE REPORTS.*—Each State to which a grant  
24 is made under this section shall submit to the Secretary  
25 an annual report on the progress made by the State in ad-

1 *dress the purposes of this section. Each such report shall*  
2 *include a description of—*

3           “(1) *the services delivered by the programs that*  
4 *received funds from the grant;*

5           “(2) *the characteristics of each such program, in-*  
6 *cluding information on the service model used by the*  
7 *program and the performance of the program;*

8           “(3) *the characteristics of the providers of serv-*  
9 *ices through the program, including staff qualifica-*  
10 *tions, work experience, and demographic characteris-*  
11 *tics;*

12           “(4) *the characteristics of the recipients of serv-*  
13 *ices provided through the program, including the*  
14 *number of the recipients, the demographic characteris-*  
15 *tics of the recipients, and family retention;*

16           “(5) *the annual cost of implementing the pro-*  
17 *gram, including the cost per family served under the*  
18 *program;*

19           “(6) *the outcomes experienced by recipients of*  
20 *services through the program;*

21           “(7) *the training and technical assistance pro-*  
22 *vided to aid implementation of the program, and how*  
23 *the training and technical assistance contributed to*  
24 *the outcomes achieved through the program;*

1           “(8) *the indicators and methods used to monitor*  
2 *whether the program is being implemented as de-*  
3 *signed; and*

4           “(9) *other information as determined necessary*  
5 *by the Secretary.*

6           “(j) *EVALUATION.—*

7           “(1) *IN GENERAL.—The Secretary shall, by*  
8 *grant or contract, provide for the conduct of an inde-*  
9 *pendent evaluation of the effectiveness of home visita-*  
10 *tion programs receiving funds provided under this*  
11 *section, which shall examine the following:*

12           “(A) *The effect of home visitation programs*  
13 *on child and parent outcomes, including child*  
14 *maltreatment, child health and development,*  
15 *school readiness, and links to community serv-*  
16 *ices.*

17           “(B) *The effectiveness of home visitation*  
18 *programs on different populations, including the*  
19 *extent to which the ability of programs to im-*  
20 *prove outcomes varies across programs and pop-*  
21 *ulations.*

22           “(2) *REPORTS TO THE CONGRESS.—*

23           “(A) *INTERIM REPORT.—Within 3 years*  
24 *after the date of the enactment of this section, the*  
25 *Secretary shall submit to the Congress an in-*

1           *terim report on the evaluation conducted pursu-*  
2           *ant to paragraph (1).*

3           “(B) *FINAL REPORT.*—*Within 5 years after*  
4           *the date of the enactment of this section, the Sec-*  
5           *retary shall submit to the Congress a final report*  
6           *on the evaluation conducted pursuant to para-*  
7           *graph (1).*

8           “(k) *ANNUAL REPORTS TO THE CONGRESS.*—*The Sec-*  
9           *retary shall submit annually to the Congress a report on*  
10          *the activities carried out using funds made available under*  
11          *this section, which shall include a description of the fol-*  
12          *lowing:*

13           “(1) *The high need communities targeted by*  
14           *States for programs carried out under this section.*

15           “(2) *The service delivery models used in the pro-*  
16           *grams receiving funds provided under this section.*

17           “(3) *The characteristics of the programs, includ-*  
18           *ing—*

19           “(A) *the qualifications and demographic*  
20           *characteristics of program staff; and*

21           “(B) *recipient characteristics including the*  
22           *number of families served, the demographic char-*  
23           *acteristics of the families served, and family re-*  
24           *tainment and duration of services.*

25           “(4) *The outcomes reported by the programs.*

1           “(5) *The research-based instruction, materials,*  
2           *and activities being used in the activities funded*  
3           *under the grant.*

4           “(6) *The training and technical activities, in-*  
5           *cluding on-going professional development, provided*  
6           *to the programs.*

7           “(7) *The annual costs of implementing the pro-*  
8           *grams, including the cost per family served under the*  
9           *programs.*

10           “(8) *The indicators and methods used by States*  
11           *to monitor whether the programs are being been im-*  
12           *plemented as designed.*

13           “(l) *RESERVATIONS OF FUNDS.—From the amounts*  
14           *appropriated for a fiscal year under subsection (m), the*  
15           *Secretary shall reserve—*

16           “(1) *an amount equal to 5 percent of the*  
17           *amounts to pay the cost of the evaluation provided for*  
18           *in subsection (j), and the provision to States of train-*  
19           *ing and technical assistance, including the dissemina-*  
20           *tion of best practices in early childhood home visita-*  
21           *tion; and*

22           “(2) *after making the reservation required by*  
23           *paragraph (1), an amount equal to 3 percent of the*  
24           *amount so appropriated, to pay for grants to Indian*  
25           *tribes under this section.*



1       “(m) *APPROPRIATIONS.*—*Out of any money in the*  
 2 *Treasury of the United States not otherwise appropriated,*  
 3 *there is appropriated to the Secretary to carry out this sec-*  
 4 *tion—*

5               “(1) \$50,000,000 for fiscal year 2010;

6               “(2) \$100,000,000 for fiscal year 2011;

7               “(3) \$150,000,000 for fiscal year 2012;

8               “(4) \$200,000,000 for fiscal year 2013; and

9               “(5) \$250,000,000 for fiscal year 2014.

10       “(n) *INDIAN TRIBES TREATED AS STATES.*—*In this*  
 11 *section, paragraphs (4), (5), and (6) of section 431(a) shall*  
 12 *apply.”.*

13 **SEC. 1905. IMPROVED COORDINATION AND PROTECTION**  
 14 **FOR DUAL ELIGIBLES.**

15       *Title XI of the Social Security Act is amended by in-*  
 16 *serting after section 1150 the following new section:*

17       “*IMPROVED COORDINATION AND PROTECTION FOR DUAL*  
 18 *ELIGIBLES*

19       “*SEC. 1150A. (a) IN GENERAL.*—*The Secretary shall*  
 20 *provide, through an identifiable office or program within*  
 21 *the Centers for Medicare & Medicaid Services, for a focused*  
 22 *effort to provide for improved coordination between Medi-*  
 23 *care and Medicaid and protection in the case of dual eligi-*  
 24 *bles (as defined in subsection (e)). The office or program*  
 25 *shall—*

1           “(1) review Medicare and Medicaid policies re-  
2           lated to enrollment, benefits, service delivery, pay-  
3           ment, and grievance and appeals processes under  
4           parts A and B of title XVIII, under the Medicare Ad-  
5           vantage program under part C of such title, and  
6           under title XIX;

7           “(2) identify areas of such policies where better  
8           coordination and protection could improve care and  
9           costs; and

10           “(3) issue guidance to States regarding improv-  
11           ing such coordination and protection.

12           “(b) *ELEMENTS.*—The improved coordination and  
13           protection under this section shall include efforts—

14           “(1) to simplify access of dual eligibles to bene-  
15           fits and services under Medicare and Medicaid;

16           “(2) to improve care continuity for dual eligibles  
17           and ensure safe and effective care transitions;

18           “(3) to harmonize regulatory conflicts between  
19           Medicare and Medicaid rules with regard to dual eli-  
20           gibles; and

21           “(4) to improve total cost and quality perform-  
22           ance under Medicare and Medicaid for dual eligibles.

23           “(c) *RESPONSIBILITIES.*—In carrying out this section,  
24           the Secretary shall provide for the following:

1           “(1) *An examination of Medicare and Medicaid*  
2           *payment systems to develop strategies to foster more*  
3           *integrated and higher quality care.*

4           “(2) *Development of methods to facilitate access*  
5           *to post-acute and community-based services and to*  
6           *identify actions that could lead to better coordination*  
7           *of community-based care.*

8           “(3) *A study of enrollment of dual eligibles in*  
9           *the Medicare Savings Program (as defined in section*  
10           *1144(c)(7)), under Medicaid, and in the low-income*  
11           *subsidy program under section 1860D–14 to identify*  
12           *methods to more efficiently and effectively reach and*  
13           *enroll dual eligibles.*

14           “(4) *An assessment of communication strategies*  
15           *for dual eligibles to determine whether additional in-*  
16           *formational materials or outreach is needed, includ-*  
17           *ing an assessment of the Medicare website, 1-800-*  
18           *MEDICARE, and the Medicare handbook.*

19           “(5) *Research and evaluation of areas where*  
20           *service utilization, quality, and access to cost sharing*  
21           *protection could be improved and an assessment of*  
22           *factors related to enrollee satisfaction with services*  
23           *and care delivery.*

24           “(6) *Collection (and making available to the*  
25           *public) of data and a database that describe the eligi-*

1        *bility, benefit and cost-sharing assistance available to*  
2        *dual eligibles by State.*

3            *“(7) Monitoring total combined Medicare and*  
4        *Medicaid program costs in serving dual eligibles and*  
5        *making recommendations for optimizing total quality*  
6        *and cost performance across both programs.*

7            *“(8) Coordination of activities relating to Medi-*  
8        *care Advantage plans under 1859(b)(6)(B)(ii) and*  
9        *Medicaid.*

10          *“(d) PERIODIC REPORTS.—Not later than 1 year after*  
11        *the date of the enactment of this section and every 3 years*  
12        *thereafter the Secretary shall submit to Congress a report*  
13        *on progress in activities conducted under this section.*

14          *“(e) DEFINITIONS.—In this section:*

15            *“(1) DUAL ELIGIBLE.—The term ‘dual eligible’*  
16        *means an individual who is dually eligible for bene-*  
17        *fits under title XVIII, and medical assistance under*  
18        *title XIX, including such individuals who are eligible*  
19        *for benefits under the Medicare Savings Program (as*  
20        *defined in section 1144(c)(7)).*

21            *“(2) MEDICARE; MEDICAID.—The terms ‘Medi-*  
22        *care’ and ‘Medicaid’ mean the programs under titles*  
23        *XVIII and XIX, respectively.”.*

1 **SEC. 1906. STANDARDIZED MARKETING REQUIREMENTS**  
2 **UNDER THE MEDICARE ADVANTAGE AND**  
3 **MEDICARE PRESCRIPTION DRUG PROGRAMS.**

4 *(a) MEDICARE ADVANTAGE PROGRAM.—*

5 *(1) IN GENERAL.—Section 1856 of the Social Se-*  
6 *curity Act (42 U.S.C. 1395w–26) is amended—*

7 *(A) in subsection (b)(1), by inserting “or*  
8 *subsection (c)” after “subsection (a)”;* and

9 *(B) by adding at the end the following new*  
10 *subsection:*

11 *“(c) STANDARDIZED MARKETING REQUIREMENTS.—*

12 *“(1) DEVELOPMENT BY THE NAIC.—*

13 *“(A) REQUIREMENTS.—The Secretary shall*  
14 *request the National Association of Insurance*  
15 *Commissioners (in this subsection referred to as*  
16 *the ‘NAIC’) to—*

17 *“(i) develop standardized marketing*  
18 *requirements for Medicare Advantage orga-*  
19 *nizations with respect to Medicare Advan-*  
20 *tage plans and PDP sponsors with respect*  
21 *to prescription drug plans under part D;*  
22 *and*

23 *“(ii) submit a report containing such*  
24 *requirements to the Secretary by not later*  
25 *than the date that is 9 months after the date*  
26 *of the enactment of this subsection.*

1           “(B) *PROHIBITED ACTIVITIES.*—Such re-  
2           quirements shall include prohibitions on the pro-  
3           hibited activities described in section 1851(j)(1).

4           “(C) *LIMITATIONS.*—Such requirements  
5           shall establish limitations that include at least  
6           the limitations described in section 1851(j)(2),  
7           except for those relating to compensation.

8           “(D) *ELECTION FORM.*—Such requirements  
9           may prohibit a Medicare Advantage organiza-  
10          tion or a PDP sponsor (or an agent of such an  
11          organization or sponsor) from completing any  
12          portion of any election form used to carry out  
13          elections under section 1851 or 1860D–1 on be-  
14          half of any individual.

15          “(E) *AGENT AND BROKER COMMISSIONS*  
16          *AND COMPENSATION.*—Such requirements shall  
17          establish standards—

18                 “(i) for fair and appropriate commis-  
19                 sions for agents and brokers of Medicare Ad-  
20                 vantage organizations and PDP sponsors,  
21                 including a prohibition on extra bonuses or  
22                 incentives;

23                 “(ii) for the disclosure of such commis-  
24                 sions; and

1                   “(iii) for the use of compensation for  
2                   agents and brokers other than such commis-  
3                   sions.

4                   *Such standards shall ensure that the use of com-  
5                   pensation creates incentives for agents and bro-  
6                   kers to enroll individuals in the Medicare Ad-  
7                   vantage plan that is intended to best meet their  
8                   health care needs.*

9                   “(F) CERTAIN CONDUCT OF AGENTS.—*Such*  
10                   *requirements shall address the conduct of agents*  
11                   *engaged in on-site promotion at a facility of an*  
12                   *organization with which the Medicare Advantage*  
13                   *organization or PDP sponsor has a co-branding*  
14                   *relationship.*

15                   “(G) OTHER STANDARDS.—*Such require-*  
16                   *ments may establish such other standards relat-*  
17                   *ing to unfair trade practices and marketing*  
18                   *under Medicare Advantage plans and prescrip-*  
19                   *tion drug plans under part D as the NAIC deter-*  
20                   *mines appropriate.*

21                   “(2) IMPLEMENTATION OF REQUIREMENTS.—

22                   “(A) ADOPTION OF NAIC DEVELOPED RE-  
23                   QUIREMENTS.—*If the NAIC develops standard-*  
24                   *ized marketing requirements and submits the re-*  
25                   *port pursuant to paragraph (1), the Secretary*

1           *shall promulgate regulations for the adoption of*  
2           *such requirements. The Secretary shall ensure*  
3           *that such regulations take effect beginning with*  
4           *the first open enrollment period beginning 12*  
5           *months after the date of the enactment of this*  
6           *subsection.*

7           “(B) *REQUIREMENTS IF NAIC DOES NOT*  
8           *SUBMIT REPORT.—If the NAIC does not develop*  
9           *standardized marketing requirements and submit*  
10           *the report pursuant to paragraph (1), the Sec-*  
11           *retary shall promulgate regulations for standard-*  
12           *ized marketing requirements for Medicare Ad-*  
13           *vantage organizations with respect to Medicare*  
14           *Advantage plans and PDP sponsors with respect*  
15           *to prescription drug plans under part D. Such*  
16           *regulations shall meet the requirements of sub-*  
17           *paragraphs (B) through (F) of paragraph (1),*  
18           *and may establish such other standards relating*  
19           *to marketing under Medicare Advantage plans*  
20           *and prescription drug plans as the Secretary de-*  
21           *termines appropriate. The Secretary shall ensure*  
22           *that such regulations take effect beginning with*  
23           *the first open enrollment period beginning 12*  
24           *months after the date of the enactment of this*  
25           *subsection.*



1           “(C) *CONSULTATION.*—*In establishing re-*  
2           *quirements under this subsection, the NAIC or*  
3           *Secretary (as the case may be) shall consult with*  
4           *a working group composed of representatives of*  
5           *Medicare Advantage organizations and PDP*  
6           *sponsors, consumer groups, and other qualified*  
7           *individuals. Such representatives shall be selected*  
8           *in a manner so as to insure balanced representa-*  
9           *tion among the interested groups.*

10           “(3) *STATE REPORTING OF VIOLATIONS OF*  
11           *STANDARDIZED MARKETING REQUIREMENTS.*—*The*  
12           *Secretary shall request that States report any viola-*  
13           *tions of the standardized marketing requirements*  
14           *under the regulations under subparagraph (A) or (B)*  
15           *of paragraph (2) to national and regional offices of*  
16           *the Centers for Medicare & Medicaid Services.*

17           “(4) *REPORT.*—*The Secretary shall submit an*  
18           *annual report to Congress on the enforcement of the*  
19           *standardized marketing requirements under the regu-*  
20           *lations under subparagraph (A) or (B) of paragraph*  
21           *(2), together with such recommendations as the Sec-*  
22           *retary determines appropriate. Such report shall in-*  
23           *clude—*

24                   “(A) *a list of any alleged violations of such*  
25           *requirements reported to the Secretary by a*

1           *State, a Medicare Advantage organization, or a*  
2           *PDP sponsor; and*

3                   “(B) *the disposition of such reported viola-*  
4                   *tions.*”.

5           (2) *STATE AUTHORITY TO ENFORCE STANDARD-*  
6           *IZED MARKETING REQUIREMENTS.—*

7                   (A) *IN GENERAL.—Section 1856(b)(3) of the*  
8                   *Social Security Act (42 U.S.C. 1395w–26(b)(3))*  
9                   *is amended—*

10                           (i) *by striking “or State” and insert-*  
11                           *ing “, State”; and*

12                           (ii) *by inserting “, or State laws or*  
13                           *regulations enacting the standardized mar-*  
14                           *keting requirements under subsection (c)”*  
15                           *after “plan solvency”.*

16                   (B) *NO PREEMPTION OF STATE SANC-*  
17                   *TIONS.—Nothing in title XVIII of the Social Se-*  
18                   *curity Act or the provisions of, or amendments*  
19                   *made by, this Act, shall be construed to prohibit*  
20                   *a State from conducting a market conduct exam-*  
21                   *ination or from imposing sanctions against*  
22                   *Medicare Advantage organizations, PDP spon-*  
23                   *sors, or agents or brokers of such organizations*  
24                   *or sponsors for violations of the standardized*  
25                   *marketing requirements under subsection (c) of*

1           *section 1856 of the Social Security Act (as added*  
2           *by paragraph (1)) as enacted by that State.*

3           (3)       *CONFORMING        AMENDMENT.—Section*  
4           *1851(h)(4) of the Social Security Act (42 U.S.C.*  
5           *1395w–21(h)(4)) is amended by adding at the end the*  
6           *following flush sentence:*

7           *“Beginning on the effective date of the implementa-*  
8           *tion of the regulations under subparagraph (A) or (B)*  
9           *of section 1856(c)(2), each Medicare Advantage orga-*  
10          *nization with respect to a Medicare Advantage plan*  
11          *offered by the organization (and agents of such orga-*  
12          *nization) shall comply with the standardized mar-*  
13          *keting requirements under section 1856(c).”.*

14          (b) *MEDICARE PRESCRIPTION DRUG PROGRAM.—Sec-*  
15          *tion 1860D–4 of the Social Security Act (42 U.S.C. 1395w–*  
16          *104) is amended by adding at the end the following new*  
17          *subsection:*

18          *“(m) STANDARDIZED MARKETING REQUIREMENTS.—*  
19          *A PDP sponsor with respect to a prescription drug plan*  
20          *offered by the sponsor (and agents of such sponsor) shall*  
21          *comply with the standardized marketing requirements*  
22          *under section 1856(c).”.*

1 **SEC. 1907. NAIC RECOMMENDATIONS ON THE ESTABLISH-**  
2 **MENT OF STANDARDIZED BENEFIT PACKAGES**  
3 **FOR MEDICARE ADVANTAGE PLANS AND PRE-**  
4 **SCRIPTION DRUG PLANS.**

5 *Not later than 30 days after the date of the enactment*  
6 *of this Act, the Secretary of Health and Human Services*  
7 *shall request the National Association of Insurance Com-*  
8 *missioners to establish a committee to study and make rec-*  
9 *ommendations to the Secretary and Congress on—*

10 *(1) the establishment of standardized benefit*  
11 *packages for Medicare Advantage plans under part C*  
12 *of title XVIII of the Social Security Act and for pre-*  
13 *scription drug plans under part D of such Act; and*

14 *(2) the regulation of such plans.*

15 **SEC. 1908. APPLICATION OF EMERGENCY SERVICES LAWS.**

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

21 **SEC. 1909. NATIONWIDE PROGRAM FOR NATIONAL AND**  
22 **STATE BACKGROUND CHECKS ON DIRECT PA-**  
23 **TIENT ACCESS EMPLOYEES OF LONG-TERM**  
24 **CARE FACILITIES AND PROVIDERS.**

25 *(a) IN GENERAL.—The Secretary of Health and*  
26 *Human Services (in this section referred to as the “Sec-*

1 *retary”), shall establish a program to identify efficient, ef-*  
2 *fective, and economical procedures for long term care facili-*  
3 *ties or providers to conduct background checks on prospec-*  
4 *tive direct patient access employees on a nationwide basis*  
5 *(in this subsection, such program shall be referred to as the*  
6 *“nationwide program”). Except for the following modifica-*  
7 *tions, the Secretary shall carry out the nationwide program*  
8 *under similar terms and conditions as the pilot program*  
9 *under section 307 of the Medicare Prescription Drug, Im-*  
10 *provement, and Modernization Act of 2003 (Public Law*  
11 *108–173; 117 Stat. 2257), including the prohibition on hir-*  
12 *ing abusive workers and the authorization of the imposition*  
13 *of penalties by a participating State under subsections*  
14 *(b)(3)(A) and (b)(6), respectively, of such section 307:*

15           (1) *AGREEMENTS.—*

16                   (A) *NEWLY PARTICIPATING STATES.—The*  
17                   *Secretary shall enter into agreements with each*  
18                   *State—*

19                           (i) *that the Secretary has not entered*  
20                           *into an agreement with under subsection*  
21                           *(c)(1) of such section 307;*

22                           (ii) *that agrees to conduct background*  
23                           *checks under the nationwide program on a*  
24                           *Statewide basis; and*

1                   (iii) that submits an application to the  
2                   Secretary containing such information and  
3                   at such time as the Secretary may specify.

4                   (B) CERTAIN PREVIOUSLY PARTICIPATING  
5                   STATES.—The Secretary shall enter into agree-  
6                   ments with each State—

7                   (i) that the Secretary has entered into  
8                   an agreement with under such subsection  
9                   (c)(1), but only in the case where such  
10                  agreement did not require the State to con-  
11                  duct background checks under the program  
12                  established under subsection (a) of such sec-  
13                  tion 307 on a Statewide basis;

14                  (ii) that agrees to conduct background  
15                  checks under the nationwide program on a  
16                  Statewide basis; and

17                  (iii) that submits an application to the  
18                  Secretary containing such information and  
19                  at such time as the Secretary may specify.

20                  (2) NONAPPLICATION OF SELECTION CRITERIA.—  
21                  The selection criteria required under subsection  
22                  (c)(3)(B) of such section 307 shall not apply.

23                  (3) REQUIRED FINGERPRINT CHECK AS PART OF  
24                  CRIMINAL HISTORY BACKGROUND CHECK.—The proce-

1        *dures established under subsection (b)(1) of such sec-*  
2        *tion 307 shall—*

3                *(A) require that the long-term care facility*  
4                *or provider (or the designated agent of the long-*  
5                *term care facility or provider) obtain State and*  
6                *national criminal history background checks on*  
7                *the prospective employee through such means as*  
8                *the Secretary determines appropriate that utilize*  
9                *a search of State-based abuse and neglect reg-*  
10               *istries and databases, including the abuse and*  
11               *neglect registries of another State in the case*  
12               *where a prospective employee previously resided*  
13               *in that State, State criminal history records, the*  
14               *records of any proceedings in the State that may*  
15               *contain disqualifying information about prospec-*  
16               *tive employees (such as proceedings conducted by*  
17               *State professional licensing and disciplinary*  
18               *boards and State Medicaid Fraud Control*  
19               *Units), and Federal criminal history records, in-*  
20               *cluding a fingerprint check using the Integrated*  
21               *Automated Fingerprint Identification System of*  
22               *the Federal Bureau of Investigation; and*

23               *(B) require States to describe and test meth-*  
24               *ods that reduce duplicative fingerprinting, in-*  
25               *cluding providing for the development of “rap*

1           *back” capability by the State such that, if a di-*  
2           *rect patient access employee of a long-term care*  
3           *facility or provider is convicted of a crime fol-*  
4           *lowing the initial criminal history background*  
5           *check conducted with respect to such employee,*  
6           *and the employee’s fingerprints match the prints*  
7           *on file with the State law enforcement depart-*  
8           *ment, the department will immediately inform*  
9           *the State and the State will immediately inform*  
10          *the long-term care facility or provider which em-*  
11          *ployes the direct patient access employee of such*  
12          *conviction.*

13           (4) *STATE REQUIREMENTS.*—*An agreement en-*  
14          *tered into under paragraph (1) shall require that a*  
15          *participating State—*

16                   (A) *be responsible for monitoring compli-*  
17                   *ance with the requirements of the nationwide*  
18                   *program;*

19                   (B) *have procedures in place to—*

20                           (i) *conduct screening and criminal his-*  
21                           *tory background checks under the nation-*  
22                           *wide program in accordance with the re-*  
23                           *quirements of this section;*

24                           (ii) *monitor compliance by long-term*  
25                           *care facilities and providers with the proce-*



1           *dures and requirements of the nationwide*  
2           *program;*

3                     *(iii) as appropriate, provide for a pro-*  
4                     *visional period of employment by a long-*  
5                     *term care facility or provider of a direct*  
6                     *patient access employee, not to exceed 30*  
7                     *days, pending completion of the required*  
8                     *criminal history background check and, in*  
9                     *the case where the employee has appealed*  
10                    *the results of such background check, pend-*  
11                    *ing completion of the appeals process, dur-*  
12                    *ing which the employee shall be subject to*  
13                    *direct on-site supervision (in accordance*  
14                    *with procedures established by the State to*  
15                    *ensure that a long-term care facility or pro-*  
16                    *vider furnishes such direct on-site super-*  
17                    *vision);*

18                    *(iv) provide an independent process by*  
19                    *which a provisional employee or an em-*  
20                    *ployee may appeal or dispute the accuracy*  
21                    *of the information obtained in a back-*  
22                    *ground check performed under the nation-*  
23                    *wide program, including the specification of*  
24                    *criteria for appeals for direct patient access*  
25                    *employees found to have disqualifying infor-*

1                    *mation which shall include consideration of*  
2                    *the passage of time, extenuating cir-*  
3                    *cumstances, demonstration of rehabilitation,*  
4                    *and relevancy of the particular disquali-*  
5                    *fying information with respect to the cur-*  
6                    *rent employment of the individual;*

7                    *(v) provide for the designation of a*  
8                    *single State agency as responsible for—*

9                    *(I) overseeing the coordination of*  
10                    *any State and national criminal his-*  
11                    *tory background checks requested by a*  
12                    *long-term care facility or provider (or*  
13                    *the designated agent of the long-term*  
14                    *care facility or provider) utilizing a*  
15                    *search of State and Federal criminal*  
16                    *history records, including a fingerprint*  
17                    *check of such records;*

18                    *(II) overseeing the design of ap-*  
19                    *propriate privacy and security safe-*  
20                    *guards for use in the review of the re-*  
21                    *sults of any State or national criminal*  
22                    *history background checks conducted*  
23                    *regarding a prospective direct patient*  
24                    *access employee to determine whether*

1           the employee has any conviction for a  
2           relevant crime;

3                   (III) immediately reporting to the  
4           long-term care facility or provider that  
5           requested the criminal history back-  
6           ground check the results of such review;  
7           and

8                   (IV) in the case of an employee  
9           with a conviction for a relevant crime  
10          that is subject to reporting under sec-  
11          tion 1128E of the Social Security Act  
12          (42 U.S.C. 1320a-7e), reporting the ex-  
13          istence of such conviction to the data-  
14          base established under that section;

15                  (vi) determine which individuals are  
16          direct patient access employees (as defined  
17          in paragraph (6)(B)) for purposes of the  
18          nationwide program;

19                  (vii) as appropriate, specify offenses,  
20          including convictions for violent crimes, for  
21          purposes of the nationwide program; and

22                  (viii) describe and test methods that re-  
23          duce duplicative fingerprinting, including  
24          providing for the development of “rap back”  
25          capability such that, if a direct patient ac-

1            *cess employee of a long-term care facility or*  
2            *provider is convicted of a crime following*  
3            *the initial criminal history background*  
4            *check conducted with respect to such em-*  
5            *ployee, and the employee's fingerprints*  
6            *match the prints on file with the State law*  
7            *enforcement department—*

8                    *(I) the department will imme-*  
9                    *diately inform the State agency des-*  
10                   *ignated under clause (v) and such*  
11                   *agency will immediately inform the fa-*  
12                   *cility or provider which employs the*  
13                   *direct patient access employee of such*  
14                   *conviction; and*

15                   *(II) the State will provide, or will*  
16                   *require the facility to provide, to the*  
17                   *employee a copy of the results of the*  
18                   *criminal history background check con-*  
19                   *ducted with respect to the employee at*  
20                   *no charge in the case where the indi-*  
21                   *vidual requests such a copy.*

22            *(5) PAYMENTS.—*

23                    *(A) NEWLY PARTICIPATING STATES.—*

24                    *(i) IN GENERAL.—As part of the appli-*  
25                    *cation submitted by a State under para-*

1           *graph (1)(A)(iii), the State shall guarantee,*  
2           *with respect to the costs to be incurred by*  
3           *the State in carrying out the nationwide*  
4           *program, that the State will make available*  
5           *(directly or through donations from public*  
6           *or private entities) a particular amount of*  
7           *non-Federal contributions, as a condition of*  
8           *receiving the Federal match under clause*  
9           *(ii).*

10           *(ii) FEDERAL MATCH.—The payment*  
11           *amount to each State that the Secretary en-*  
12           *ters into an agreement with under para-*  
13           *graph (1)(A) shall be 3 times the amount*  
14           *that the State guarantees to make available*  
15           *under clause (i), except that in no case may*  
16           *the payment amount exceed \$3,000,000.*

17           *(B) PREVIOUSLY PARTICIPATING STATES.—*

18           *(i) IN GENERAL.—As part of the appli-*  
19           *cation submitted by a State under para-*  
20           *graph (1)(B)(iii), the State shall guarantee,*  
21           *with respect to the costs to be incurred by*  
22           *the State in carrying out the nationwide*  
23           *program, that the State will make available*  
24           *(directly or through donations from public*  
25           *or private entities) a particular amount of*

1           *non-Federal contributions, as a condition of*  
2           *receiving the Federal match under clause*  
3           *(ii).*

4           *(ii) FEDERAL MATCH.—The payment*  
5           *amount to each State that the Secretary en-*  
6           *ters into an agreement with under para-*  
7           *graph (1)(B) shall be 3 times the amount*  
8           *that the State guarantees to make available*  
9           *under clause (i), except that in no case may*  
10          *the payment amount exceed \$1,500,000.*

11          (6) *DEFINITIONS.—Under the nationwide pro-*  
12          *gram:*

13           (A) *LONG-TERM CARE FACILITY OR PRO-*  
14           *VIDER.—The term “long-term care facility or*  
15           *provider” means the following facilities or pro-*  
16           *viders which receive payment for services under*  
17           *title XVIII or XIX of the Social Security Act:*

18           (i) *A skilled nursing facility (as de-*  
19           *fined in section 1819(a) of the Social Secu-*  
20           *rity Act (42 U.S.C. 1395i–3(a))).*

21           (ii) *A nursing facility (as defined in*  
22           *section 1919(a) of such Act (42 U.S.C.*  
23           *1396r(a))).*

24           (iii) *A home health agency.*

1           (iv) A provider of hospice care (as de-  
2           fined in section 1861(dd)(1) of such Act (42  
3           U.S.C. 1395x(dd)(1))).

4           (v) A long-term care hospital (as de-  
5           scribed in section 1886(d)(1)(B)(iv) of such  
6           Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

7           (vi) A provider of personal care serv-  
8           ices.

9           (vii) A provider of adult day care.

10          (viii) A residential care provider that  
11          arranges for, or directly provides, long-term  
12          care services, including an assisted living  
13          facility that provides a level of care estab-  
14          lished by the Secretary.

15          (ix) An intermediate care facility for  
16          the mentally retarded (as defined in section  
17          1905(d) of such Act (42 U.S.C. 1396d(d))).

18          (x) Any other facility or provider of  
19          long-term care services under such titles as  
20          the participating State determines appro-  
21          priate.

22          (B) *DIRECT PATIENT ACCESS EMPLOYEE*.—

23          The term “direct patient access employee” means  
24          any individual who has access to a patient or  
25          resident of a long-term care facility or provider

1           *through employment or through a contract with*  
2           *such facility or provider and has duties that in-*  
3           *volve (or may involve) one-on-one contact with a*  
4           *patient or resident of the facility or provider, as*  
5           *determined by the State for purposes of the na-*  
6           *tionwide program. Such term does not include a*  
7           *volunteer unless the volunteer has duties that are*  
8           *equivalent to the duties of a direct patient access*  
9           *employee and those duties involve (or may in-*  
10          *volve) one-on-one contact with a patient or resi-*  
11          *dent of the long-term care facility or provider.*

12          (7) *EVALUATION AND REPORT.—*

13                 (A) *EVALUATION.—The Inspector General of*  
14                 *the Department of Health and Human Services*  
15                 *shall conduct an evaluation of the nationwide*  
16                 *program.*

17                 (B) *REPORT.—Not later than 180 days*  
18                 *after the completion of the nationwide program,*  
19                 *the Inspector General of the Department of*  
20                 *Health and Human Services shall submit a re-*  
21                 *port to Congress containing the results of the*  
22                 *evaluation conducted under subparagraph (A).*

23          (b) *FUNDING.—*

24                 (1) *NOTIFICATION.—The Secretary of Health and*  
25                 *Human Services shall notify the Secretary of the*



1       *Treasury of the amount necessary to carry out the na-*  
 2       *tionwide program under this section for the period of*  
 3       *fiscal years 2010 through 2012, except that in no case*  
 4       *shall such amount exceed \$160,000,000.*

5               (2) *TRANSFER OF FUNDS.—Out of any funds in*  
 6       *the Treasury not otherwise appropriated, the Sec-*  
 7       *retary of the Treasury shall provide for the transfer*  
 8       *to the Secretary of Health and Human Services of the*  
 9       *amount specified as necessary to carry out the na-*  
 10       *tionwide program under paragraph (1). Such amount*  
 11       *shall remain available until expended.*

12 **SEC. 1910. ESTABLISHMENT OF CENTER FOR MEDICARE**  
 13                       **AND MEDICAID PAYMENT INNOVATION WITH-**  
 14                       **IN CMS.**

15       (a) *IN GENERAL.—Title XI of the Social Security Act*  
 16       *is amended by inserting after section 1115 the following*  
 17       *new section:*

18               “*CENTER FOR MEDICARE AND MEDICAID PAYMENT*  
 19   *INNOVATION*

20               “*SEC. 1115A. (a) CENTER FOR MEDICARE AND MED-*  
 21       *ICAID PAYMENT INNOVATION ESTABLISHED.—*

22                       “*(1) IN GENERAL.—There is created within the*  
 23       *Centers for Medicare & Medicaid Services a Center*  
 24       *for Medicare and Medicaid Payment Innovation (in*  
 25       *this section referred to as the ‘CMPI’) to carry out the*  
 26       *duties described in paragraph (4).*

1           “(2) *DIRECTOR.*—*The CMPI shall be headed by*  
2           *a Director who shall report directly to the Adminis-*  
3           *trator of the Centers for Medicare & Medicaid Serv-*  
4           *ices.*

5           “(3) *DEADLINE.*—*The Secretary shall ensure*  
6           *that the CMPI is carrying out the duties described in*  
7           *paragraph (4) by not later than January 1, 2011.*

8           “(4) *DUTIES.*—*The duties described in this*  
9           *paragraph are the following:*

10           “(A) *To carry out the duties described in*  
11           *this section.*

12           “(B) *Such other duties as the Secretary*  
13           *may specify.*

14           “(5) *CONSULTATION.*—*In carrying out the duties*  
15           *under paragraph (4), the CMPI shall consult rep-*  
16           *resentatives of relevant Federal agencies and outside*  
17           *clinical and analytical experts with expertise in med-*  
18           *icine and health care management. The CMPI shall*  
19           *use open door forums or other mechanisms to seek*  
20           *input from interested parties.*

21           “(b) *TESTING OF MODELS (PHASE I).*—

22           “(1) *IN GENERAL.*—*The CMPI shall test pay-*  
23           *ment models in accordance with selection criteria*  
24           *under paragraph (2) to determine the effect of apply-*  
25           *ing such models under title XVIII, title XIX, or both*

1 *titles on program expenditures under such titles and*  
2 *the quality of care received by individuals receiving*  
3 *benefits under such titles.*

4 “(2) *SELECTION OF MODELS TO BE TESTED.*—

5 “(A) *IN GENERAL.*—*The Secretary shall*  
6 *give preference to testing models for which, as de-*  
7 *termined by the professional staff at the Centers*  
8 *for Medicare & Medicaid Services and using*  
9 *such input from outside the Centers as the Sec-*  
10 *retary determines appropriate, there is evidence*  
11 *that the model addresses a defined population for*  
12 *which there are deficits in care leading to poor*  
13 *clinical outcomes or potentially avoidable ex-*  
14 *penditures. The Secretary shall focus on models*  
15 *expected to reduce program costs under title*  
16 *XVIII, title XIX, or both titles while preserving*  
17 *or enhancing the quality of care received by in-*  
18 *dividuals receiving benefits under such titles.*

19 “(B) *APPLICATION TO OTHER DEMONSTRA-*  
20 *TIONS.*—*The Secretary shall operate the dem-*  
21 *onstration programs under sections 1222 and*  
22 *1236 of the America’s Affordable Health Choices*  
23 *Act of 2009 through the CMPI in accordance*  
24 *with the rules applicable under this section, in-*

1           *cluding those relating to evaluations, termi-*  
2           *nations, and expansions.*

3           “(3) *BUDGET NEUTRALITY.*—

4                   “(A) *INITIAL PERIOD.*—*The Secretary shall*  
5           *not require as a condition for testing a model*  
6           *under paragraph (1) that the design of the model*  
7           *ensure that the model is budget neutral initially*  
8           *with respect to expenditures under titles XVIII*  
9           *and XIX.*

10                   “(B) *TERMINATION.*—*The Secretary shall*  
11           *terminate or modify the design and implementa-*  
12           *tion of a model unless the Secretary determines*  
13           *(and the Chief Actuary of the Centers for Medi-*  
14           *care & Medicaid Services, with respect to spend-*  
15           *ing under such titles, certifies), after testing has*  
16           *begun, that the model is expected to—*

17                           “(i) *improve the quality of patient*  
18                           *care (as determined by the Administrator of*  
19                           *the Centers for Medicare & Medicaid Serv-*  
20                           *ices) without increasing spending under*  
21                           *such titles;*

22                           “(ii) *reduce spending under such titles*  
23                           *without reducing the quality of patient*  
24                           *care; or*

25                           “(iii) *do both.*

1           *Such termination may occur at any time after*  
2           *such testing has begun and before completion of*  
3           *the testing.*

4           “(4) *EVALUATION.*—*The Secretary shall conduct*  
5           *an evaluation of each model tested under this sub-*  
6           *section. Such evaluation shall include an analysis*  
7           *of—*

8                   “(A) *the quality of patient care furnished*  
9                   *under the model, including through the use of*  
10                  *patient-level outcomes measures; and*

11                   “(B) *the changes in spending under titles*  
12                  *XVIII and XIX by reason of the model.*

13           *The Secretary shall make the results of each evalua-*  
14           *tion under this paragraph available to the public in*  
15           *a timely fashion.*

16           “(c) *EXPANSION OF MODELS (PHASE II).*—*The Sec-*  
17           *retary may expand the duration and the scope of a model*  
18           *that is being tested under subsection (b) (including imple-*  
19           *mentation on a nationwide basis), to the extent determined*  
20           *appropriate by the Secretary, if—*

21                   “(1) *the Secretary determines that such expan-*  
22                   *sion is expected—*

23                           “(A) *to improve the quality of patient care*  
24                           *without increasing spending under titles XVIII*  
25                           *and XIX;*

1           “(B) to reduce spending under such titles  
2           without reducing the quality of patient care; or

3           “(C) to do both; and

4           “(2) the Chief Actuary of the Centers for Medi-  
5           care & Medicaid Services certifies that such expan-  
6           sion would reduce (or not result in any increase in)  
7           net program spending under such titles.

8           “(d) IMPLEMENTATION.—

9           “(1) WAIVER AUTHORITY.—The Secretary may  
10          waive such requirements of title XVIII and of sections  
11          1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as  
12          may be necessary solely for purposes of carrying out  
13          this section with respect to testing models described in  
14          subsection (b).

15          “(2) LIMITATIONS ON REVIEW.—There shall be  
16          no administrative or judicial review under section  
17          1869, section 1878, or otherwise of—

18                  “(A) the selection of models for testing or  
19                  expansion under this section;

20                  “(B) the elements, parameters, scope, and  
21                  duration of such models for testing or dissemina-  
22                  tion;

23                  “(C) the termination or modification of the  
24                  design and implementation of a model under  
25                  subsection (b)(3)(B); and

1           “(D) determinations about expansion of the  
2           duration and scope of a model under subsection  
3           (c) including the determination that a model is  
4           not expected to meet criteria described in para-  
5           graphs (1) or (2) of such subsection.

6           “(3) ADMINISTRATION.—Chapter 35 of title 44,  
7           United States Code shall not apply to this section and  
8           testing and evaluation of models or expansion of such  
9           models under this section.

10           “(4) FUNDING FOR TESTING ITEMS AND SERV-  
11           ICES AND ADMINISTRATIVE COSTS.—There shall be  
12           available from the Federal Supplementary Medical  
13           Insurance Trust Fund for payments for designing,  
14           conducting, and evaluating payment models, as well  
15           as for additional benefits for items and services under  
16           models tested under subsection (b) not otherwise cov-  
17           ered under this title and the evaluation of such mod-  
18           els, \$350,000,000 for fiscal year 2010 and, for a sub-  
19           sequent fiscal year, the amount determined under this  
20           sentence for the preceding fiscal year increased by the  
21           annual percentage rate of increase in total expendi-  
22           tures under this title for the previous fiscal year.  
23           There are also appropriated, from any amounts in  
24           the Treasury not otherwise appropriated, \$25,000,000  
25           for each fiscal year (beginning with fiscal year 2010)

1       *for administrative costs of administering this section*  
2       *with respect to the Medicaid program under title XIX*  
3       *of the Social Security Act.*

4       “(e) *REPORT TO CONGRESS.*—*Beginning in 2012, and*  
5       *not less than once every other year thereafter, the Secretary*  
6       *shall submit to Congress a report on activities under this*  
7       *section. Each such report shall describe the payment models*  
8       *tested under subsection (b), any models chosen for expansion*  
9       *under subsection (c), and the results from evaluations under*  
10       *subsection (b)(4). In addition, each such report shall pro-*  
11       *vide such recommendations as the Secretary believes are ap-*  
12       *propriate for legislative action to facilitate the development*  
13       *and expansion of successful payment models.”.*

14       (b) *MEDICAID CONFORMING AMENDMENT.*—*Section*  
15       *1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),*  
16       *as amended by sections 1631(b), 1703(a), 1729, 1753,*  
17       *1757(a), and 1759(a), is amended—*

18               (1) *in paragraph (78), by striking “and” at the*  
19       *end;*

20               (2) *in paragraph (79), by striking the period at*  
21       *the end and inserting “; and”; and*

22               (3) *by inserting after paragraph (79) the fol-*  
23       *lowing new paragraph:*

24               “(80) *provide for implementation of the payment*  
25       *models specified by the Secretary under section*



1        *1115A(c) for implementation on a nationwide basis*  
 2        *unless the State demonstrates to the satisfaction of the*  
 3        *Secretary that implementation would not be adminis-*  
 4        *tratively feasible or appropriate to the health care de-*  
 5        *livery system of the State.”.*

6        ***DIVISION C—PUBLIC HEALTH***  
 7        ***AND WORKFORCE DEVELOP-***  
 8        ***MENT***

9        ***SEC. 2001. TABLE OF CONTENTS; REFERENCES.***

10        *(a) TABLE OF CONTENTS.—The table of contents of*  
 11        *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***

***PART 1—NATIONAL HEALTH SERVICE CORPS***

*Sec. 2201. National Health Service Corps.*

*Sec. 2202. Authorizations of appropriations.*

***PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY***

*Sec. 2211. Frontline health providers.*

*Sec. 2212. Primary care student loan funds.*

*Sec. 2213. Training in family medicine, general internal medicine, general pedi-*  
*atrics, geriatrics, and physician assistants.*

*Sec. 2214. Training of medical residents in community-based settings.*

*Sec. 2215. Training for general, pediatric, and public health dentists and dental*  
*hygienists.*

*Sec. 2216. Authorization of appropriations.*

*Sec. 2217. Study on effectiveness of scholarships and loan repayments.*

***Subtitle B—Nursing Workforce***

*Sec. 2221. Amendments to Public Health Service Act.*

*Subtitle C—Public Health Workforce*

- Sec. 2231. Public Health Workforce Corps.*  
*Sec. 2232. Enhancing the public health workforce.*  
*Sec. 2233. Public health training centers.*  
*Sec. 2234. Preventive medicine and public health training grant program.*  
*Sec. 2235. Authorization of appropriations.*

*Subtitle D—Adapting Workforce to Evolving Health System Needs**PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY*

- Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds.*  
*Sec. 2242. Nursing workforce diversity grants.*  
*Sec. 2243. Coordination of diversity and cultural competency programs.*

*PART 2—INTERDISCIPLINARY TRAINING PROGRAMS*

- Sec. 2251. Cultural and linguistic competency training for health professionals.*  
*Sec. 2252. Innovations in interdisciplinary care training.*

*PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT*

- Sec. 2261. Health workforce evaluation and assessment.*

*PART 4—HEALTH WORKFORCE ASSESSMENT*

- Sec. 2271. Health workforce assessment.*

*PART 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 prevention and wellness research grants.*

*“Subtitle E—Delivery of Community Prevention and Wellness Services**“Sec. 3151. Community prevention and wellness services grants.**“Subtitle F—Core Public Health Infrastructure**“Sec. 3161. Core public health infrastructure for State, local, and tribal 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.**Sec. 2402. Assistant Secretary for Health Information.**Sec. 2403. Authorization of appropriations.**TITLE V—OTHER PROVISIONS**Subtitle A—Drug Discount for Rural and Other Hospitals**Sec. 2501. Expanded participation in 340B program.**Sec. 2502. Extension of discounts to inpatient drugs.**Sec. 2503. Effective date.**Subtitle B—Programs**PART 1—GRANTS FOR CLINICS AND CENTERS**Sec. 2511. School-based health clinics.**Sec. 2512. Nurse-managed health centers.**Sec. 2513. Federally qualified behavioral health centers.**PART 2—OTHER GRANT PROGRAMS**Sec. 2521. Comprehensive programs to provide education to nurses and create a pipeline to nursing.**Sec. 2522. Mental and behavioral health training.**Sec. 2523. Programs to increase awareness of advance care planning issues.**Sec. 2524. Reauthorization of telehealth and telemedicine grant programs.**Sec. 2525. No child left unimmunized against influenza: demonstration program using elementary and secondary schools as influenza vaccination centers.**Sec. 2526. Extension of Wisewoman Program.**Sec. 2527. Healthy teen initiative to prevent teen pregnancy.**Sec. 2528. National training initiative on autism supplemental grants and technical assistance.**Sec. 2529. Implementation of medication management services in treatment of chronic diseases.**Sec. 2530. Postpartum depression.**Sec. 2531. Grants to promote positive health behaviors and outcomes.**PART 3—EMERGENCY CARE-RELATED PROGRAMS**Sec. 2541. Trauma care centers.**Sec. 2542. Emergency care coordination.*

- Sec. 2543. Pilot programs to improve emergency medical care.*  
*Sec. 2544. Assisting veterans with military emergency medical training to become State-licensed or certified emergency medical technicians (EMTs).*  
*Sec. 2545. Dental emergency responders: public health and medical response.*  
*Sec. 2546. Dental emergency responders: homeland security.*

*PART 4—PAIN CARE AND MANAGEMENT PROGRAMS*

- Sec. 2551. Institute of Medicine Conference on Pain.*  
*Sec. 2552. Pain research at National Institutes of Health.*  
*Sec. 2553. Public awareness campaign on pain management.*

*Subtitle C—Food and Drug Administration*

*PART 1—IN GENERAL*

- Sec. 2561. National medical device registry.*  
*Sec. 2562. Nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines.*  
*Sec. 2563. Protecting consumer access to generic drugs.*

*PART 2—BIOSIMILARS*

- Sec. 2565. Licensure pathway for biosimilar biological products.*  
*Sec. 2566. Fees relating to biosimilar biological products.*

*Subtitle D—Community Living Assistance Services and Supports*

- Sec. 2571. Establishment of national voluntary insurance program for purchasing community living assistance services and supports.*

*Subtitle E—Miscellaneous*

- Sec. 2581. States failing to adhere to certain employment obligations.*  
*Sec. 2582. Study, report, and termination of duplicative grant programs.*  
*Sec. 2583. Health centers under Public Health Service Act; liability protections for volunteer practitioners.*  
*Sec. 2584. Report to Congress on the current state of parasitic diseases that have been overlooked among the poorest Americans.*  
*Sec. 2585. Study of impact of optometrists on access to health care and on availability of support under Federal health programs for optometry.*

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, the*  
 4 *reference shall be considered to be made to a section or other*  
 5 *provision of the Public Health Service Act (42 U.S.C. 201*  
 6 *et seq.).*

1 **SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.**

2 (a) *ESTABLISHMENT OF FUNDS.—*

3 (1) *IN GENERAL.—There is established a fund to*  
4 *be known as the Public Health Investment Fund (re-*  
5 *ferred 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 *\$4,600,000,000;*

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 *\$7,800,000,000; and*

17 (v) *for fiscal year 2014,*  
18 *\$9,000,000,000.*

19 (B) *Amounts deposited into the Fund shall*  
20 *be derived from general revenues of the Treasury.*

21 (b) *AUTHORIZATION OF APPROPRIATIONS FROM THE*  
22 *FUND.—*

23 (1) *NEW FUNDING.—*

24 (A) *IN GENERAL.—Amounts in the Fund*  
25 *are authorized to be appropriated by the Com-*  
26 *mittees on Appropriations of the House of Rep-*

1            *representatives and the Senate for carrying out ac-*  
2            *tivities under designated public health provi-*  
3            *sions.*

4            (B) *DESIGNATED PROVISIONS.*—*For pur-*  
5            *poses of this paragraph, the term “designated*  
6            *public health provisions” means the provisions*  
7            *for which amounts are authorized to be appro-*  
8            *priated under section 330(s), 338(c), 338H–1,*  
9            *799C, 872, or 3111 of the Public Health Service*  
10           *Act, as added by this division.*

11           (2) *BASELINE FUNDING.*—

12           (A) *IN GENERAL.*—*Amounts in the Fund*  
13           *are authorized to be appropriated (as described*  
14           *in paragraph (1)) for a fiscal year only if (ex-*  
15           *cluding any amounts in or appropriated from*  
16           *the Fund)—*

17           (i) *the amounts specified in subpara-*  
18           *graph (B) for the fiscal year involved are*  
19           *equal to or greater than the amounts speci-*  
20           *fied in subparagraph (B) for fiscal year*  
21           *2008; and*

22           (ii) *the amounts appropriated, out of*  
23           *the general fund of the Treasury, to the Pre-*  
24           *vention and Wellness Trust under section*  
25           *3111 of the Public Health Service Act, as*

1           *added by this division, for the fiscal year*  
2           *involved are equal to or greater than the*  
3           *funds—*

4                     *(I) appropriated under the head-*  
5                     *ing “Prevention and Wellness Fund”*  
6                     *in title VIII of division A of the Amer-*  
7                     *ican Recovery and Reinvestment Act of*  
8                     *2009 (Public Law 111–5); and*

9                     *(II) allocated by the second pro-*  
10                    *viso under such heading for evidence-*  
11                    *based clinical and community-based*  
12                    *prevention and wellness strategies.*

13           *(B) AMOUNTS SPECIFIED.—The amounts*  
14           *specified in this subparagraph, with respect to a*  
15           *fiscal year, are the amounts appropriated for the*  
16           *following:*

17                    *(i) Community health centers (includ-*  
18                    *ing funds appropriated under the authority*  
19                    *of section 330 of the Public Health Service*  
20                    *Act (42 U.S.C. 254b)).*

21                    *(ii) The National Health Service Corps*  
22                    *Program (including funds appropriated*  
23                    *under the authority of section 338 of such*  
24                    *Act (42 U.S.C. 254k)).*

1           (iii) *The National Health Service*  
2           *Corps Scholarship and Loan Repayment*  
3           *Programs (including funds appropriated*  
4           *under the authority of section 338H of such*  
5           *Act (42 U.S.C. 254q)).*

6           (iv) *Primary care education programs*  
7           *(including funds appropriated under the*  
8           *authority of sections 736, 740, 741, and 747*  
9           *of such Act (42 U.S.C. 293, 293d, and*  
10           *293k)).*

11           (v) *Sections 761 and 770 of such Act*  
12           *(42 U.S.C. 294n and 295e).*

13           (vi) *Nursing workforce development*  
14           *(including funds appropriated under the*  
15           *authority of title VIII of such Act (42*  
16           *U.S.C. 296 et seq.)).*

17           (vii) *The National Center for Health*  
18           *Statistics (including funds appropriated*  
19           *under the authority of sections 304, 306,*  
20           *307, and 308 of such Act (42 U.S.C. 242b,*  
21           *242k, 242l, and 242m)).*

22           (viii) *The Agency for Healthcare Re-*  
23           *search and Quality (including funds appro-*  
24           *priated under the authority of title IX of*  
25           *such Act (42 U.S.C. 299 et seq.)).*



1           (3) *BUDGETARY IMPLICATIONS.*—Amounts ap-  
2           propriated under this section, and outlays flowing  
3           from such appropriations, shall not be taken into ac-  
4           count for purposes of any budget enforcement proce-  
5           dures including allocations under section 302(a) and  
6           (b) of the Balanced Budget and Emergency Deficit  
7           Control Act and budget resolutions for fiscal years  
8           during which appropriations are made from the  
9           Fund.

10       **TITLE I—COMMUNITY HEALTH**  
11                                   **CENTERS**

12       **SEC. 2101. INCREASED FUNDING.**

13           Section 330 of the Public Health Service Act (42  
14       U.S.C. 254b) is amended—

15                   (1) in subsection (r)(1)—

16                           (A) in subparagraph (D), by striking “and”  
17                           at the end;

18                           (B) in subparagraph (E), by striking the  
19                           period at the end and inserting “; and”; and

20                           (C) by inserting at the end the following:

21                                   “(F) such sums as may be necessary for  
22                           each of fiscal years 2013 and 2014.”; and

23                   (2) by inserting after subsection (r) the fol-  
24           lowing:

1       “(s) *ADDITIONAL FUNDING.*—*For the purpose of car-*  
 2 *rying out this section, in addition to any other amounts*  
 3 *authorized to be appropriated for such purpose, there are*  
 4 *authorized to be appropriated, out of any monies in the*  
 5 *Public Health Investment Fund, the following:*

6               “(1) *For fiscal year 2010, \$1,000,000,000.*

7               “(2) *For fiscal year 2011, \$1,500,000,000.*

8               “(3) *For fiscal year 2012, \$2,500,000,000.*

9               “(4) *For fiscal year 2013, \$3,000,000,000.*

10              “(5) *For fiscal year 2014, \$4,000,000,000.*”.

11                               ***TITLE II—WORKFORCE***  
 12                               ***Subtitle A—Primary Care***  
 13                               ***Workforce***

14                   ***PART 1—NATIONAL HEALTH SERVICE CORPS***

15           ***SEC. 2201. NATIONAL HEALTH SERVICE CORPS.***

16           (a) *FULFILLMENT OF OBLIGATED SERVICE REQUIRE-*  
 17 *MENT THROUGH HALF-TIME SERVICE.*—

18                   (1) *WAIVERS.*—*Subsection (i) of section 331 (42*  
 19 *U.S.C. 254d) is amended—*

20                               (A) *in paragraph (1), by striking “In car-*  
 21 *rying out subpart III” and all that follows*  
 22 *through the period and inserting “In carrying*  
 23 *out subpart III, the Secretary may, in accord-*  
 24 *ance with this subsection, issue waivers to indi-*  
 25 *viduals who have entered into a contract for obli-*

1           gated service under the Scholarship Program or  
2           the Loan Repayment Program under which the  
3           individuals are authorized to satisfy the require-  
4           ment of obligated service through providing clin-  
5           ical practice that is half-time.”;

6           (B) in paragraph (2)—

7           (i) in subparagraphs (A)(ii) and (B),  
8           by striking “less than full time” each place  
9           it appears and inserting “half time”;

10          (ii) in subparagraphs (C) and (F), by  
11          striking “less than full-time service” each  
12          place it appears and inserting “half-time  
13          service”; and

14          (iii) by amending subparagraphs (D)  
15          and (E) to read as follows:

16          “(D) the entity and the Corps member agree in  
17          writing that the Corps member will perform half-time  
18          clinical practice;

19          “(E) the Corps member agrees in writing to ful-  
20          fill all of the service obligations under section 338C  
21          through half-time clinical practice and either—

22                  “(i) double the period of obligated service  
23                  that would otherwise be required; or

24                  “(ii) in the case of contracts entered into  
25                  under section 338B, accept a minimum service

1           *obligation of 2 years with an award amount*  
2           *equal to 50 percent of the amount that would*  
3           *otherwise be payable for full-time service; and”;*  
4           *and*

5           *(C) in paragraph (3), by striking “In eval-*  
6           *uating a demonstration project described in*  
7           *paragraph (1)” and inserting “In evaluating*  
8           *waivers issued under paragraph (1)”.*

9           (2) *DEFINITIONS.*—*Subsection (j) of section 331*  
10          *(42 U.S.C. 254d) is amended by adding at the end*  
11          *the following:*

12           *“(5) The terms ‘full time’ and ‘full-time’ mean a*  
13           *minimum of 40 hours per week in a clinical practice,*  
14           *for a minimum of 45 weeks per year.*

15           *“(6) The terms ‘half time’ and ‘half-time’ mean*  
16           *a minimum of 20 hours per week (not to exceed 39*  
17           *hours per week) in a clinical practice, for a min-*  
18           *imum of 45 weeks per year.”.*

19          (b) *REAPPOINTMENT TO NATIONAL ADVISORY COUN-*  
20          *CIL.*—*Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amended*  
21          *by striking “Members may not be reappointed to the Coun-*  
22          *cil.”.*

23          (c)    *LOAN        REPAYMENT        AMOUNT.*—*Section*  
24          *338B(g)(2)(A) (42 U.S.C. 254l-1(g)(2)(A)) is amended by*  
25          *striking “\$35,000” and inserting “\$50,000, plus, beginning*

1 *with fiscal year 2012, an amount determined by the Sec-*  
2 *retary on an annual basis to reflect inflation.”.*

3 *(d) TREATMENT OF TEACHING AS OBLIGATED SERV-*  
4 *ICE.—Subsection (a) of section 338C (42 U.S.C. 254m) is*  
5 *amended by adding at the end the following: “The Secretary*  
6 *may treat teaching as clinical practice for up to 20 percent*  
7 *of such period of obligated service.”.*

8 **SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.**

9 *(a) NATIONAL HEALTH SERVICE CORPS PROGRAM.—*  
10 *Section 338 (42 U.S.C. 254k) is amended—*

11 *(1) in subsection (a), by striking “2012” and in-*  
12 *serting “2014”; and*

13 *(2) by adding at the end the following:*

14 *“(c) For the purpose of carrying out this subpart, in*  
15 *addition to any other amounts authorized to be appro-*  
16 *priated for such purpose, there are authorized to be appro-*  
17 *priated, out of any monies in the Public Health Investment*  
18 *Fund, the following:*

19 *“(1) \$63,000,000 for fiscal year 2010.*

20 *“(2) \$66,000,000 for fiscal year 2011.*

21 *“(3) \$70,000,000 for fiscal year 2012.*

22 *“(4) \$73,000,000 for fiscal year 2013.*

23 *“(5) \$77,000,000 for fiscal year 2014.”.*

1           (b) *SCHOLARSHIP AND LOAN REPAYMENT PRO-*  
2 *GRAMS.*—*Subpart III of part D of title III of the Public*  
3 *Health Service Act (42 U.S.C. 254l et seq.) is amended—*

4                   (1) *in section 338H(a)—*

5                           (A) *in paragraph (4), by striking “and” at*  
6 *the end;*

7                           (B) *in paragraph (5), by striking the period*  
8 *at the end and inserting “; and”; and*

9                           (C) *by adding at the end the following:*

10                           “*(6) for fiscal years 2013 and 2014, such sums*  
11 *as may be necessary.”; and*

12                   (2) *by inserting after section 338H the following:*

13 **“SEC. 338H-1. ADDITIONAL FUNDING.**

14                   “*For the purpose of carrying out this subpart, in addi-*  
15 *tion to any other amounts authorized to be appropriated*  
16 *for such purpose, there are authorized to be appropriated,*  
17 *out of any monies in the Public Health Investment Fund,*  
18 *the following:*

19                           “*(1) \$254,000,000 for fiscal year 2010.*

20                           “*(2) \$266,000,000 for fiscal year 2011.*

21                           “*(3) \$278,000,000 for fiscal year 2012.*

22                           “*(4) \$292,000,000 for fiscal year 2013.*

23                           “*(5) \$306,000,000 for fiscal year 2014.”.*

1     **PART 2—PROMOTION OF PRIMARY CARE AND**  
2                                   **DENTISTRY**

3     **SEC. 2211. FRONTLINE HEALTH PROVIDERS.**

4             *Part D of title III (42 U.S.C. 254b et seq.) is amended*  
5 *by adding at the end the following:*

6             **“Subpart XI—Health Professional Needs Areas**

7             **“SEC. 340H. IN GENERAL.**

8             “(a) *PROGRAM.—The Secretary, acting through the*  
9 *Administrator of the Health Resources and Services Admin-*  
10 *istration, shall establish a program, to be known as the*  
11 *Frontline Health Providers Loan Repayment Program, to*  
12 *address unmet health care needs in health professional needs*  
13 *areas through loan repayments under section 340I.*

14             “(b) *DESIGNATION OF HEALTH PROFESSIONAL NEEDS*  
15 *AREAS.—*

16             “(1) *IN GENERAL.—In this subpart, the term*  
17 *‘health professional needs area’ means an area, popu-*  
18 *lation, or facility that is designated by the Secretary*  
19 *in accordance with paragraph (2).*

20             “(2) *DESIGNATION.—To be designated by the*  
21 *Secretary as a health professional needs area under*  
22 *this subpart:*

23             “(A) *In the case of an area, the area must*  
24 *be a rational area for the delivery of health serv-*  
25 *ices.*

1           “(B) *The area, population, or facility must*  
2           *have, in one or more health disciplines, special-*  
3           *ties, or subspecialties for the population served,*  
4           *as determined by the Secretary—*

5                     “(i) *insufficient capacity of health pro-*  
6                     *essionals; or*

7                     “(ii) *high needs for health services, in-*  
8                     *cluding services to address health dispari-*  
9                     *ties.*

10           “(C) *With respect to the delivery of primary*  
11           *health services, the area, population, or facility*  
12           *must not include a health professional shortage*  
13           *area (as designated under section 332), except*  
14           *that the area, population, or facility may in-*  
15           *clude such a health professional shortage area in*  
16           *which there is an unmet need for such services.*

17           “(c) *ELIGIBILITY.—To be eligible to participate in the*  
18           *Program, an individual shall—*

19                     “(1) *hold a degree in a course of study or pro-*  
20                     *gram (approved by the Secretary) from a school de-*  
21                     *fined in section 799B(1)(A) (other than a school of*  
22                     *public health);*

23                     “(2) *hold a degree in a course of study or pro-*  
24                     *gram (approved by the Secretary) from a school or*



1 program defined in subparagraph (C), (D), or (E)(4)  
2 of section 799B(1), as designated by the Secretary;

3 “(3) be enrolled as a full-time student—

4 “(A) in a school or program defined in sub-  
5 paragraph (C), (D), or (E)(4) of section  
6 799B(1), as designated by the Secretary, or a  
7 school described in paragraph (1); and

8 “(B) in the final year of a course of study  
9 or program, offered by such school or program  
10 and approved by the Secretary, leading to a de-  
11 gree in a discipline referred to in subparagraph  
12 (A) (other than a graduate degree in public  
13 health), (C), (D), or (E)(4) of section 799B(1);

14 “(4) be a practitioner described in section  
15 1842(b)(18)(C) or 1848(k)(3)(B)(iii) or (iv) of the So-  
16 cial Security Act; or

17 “(5) be a practitioner in the field of respiratory  
18 therapy, medical technology, or radiologic technology.

19 “(d) DEFINITIONS.—In this subpart:

20 “(1) The term ‘health disparities’ has the mean-  
21 ing given to the term in section 3171.

22 “(2) The term ‘primary health services’ has the  
23 meaning given to such term in section 331(a)(3)(D).

1 **“SEC. 340I. LOAN REPAYMENTS.**

2       “(a) *LOAN REPAYMENTS.*—*The Secretary, acting*  
3 *through the Administrator of the Health Resources and*  
4 *Services Administration, shall enter into contracts with in-*  
5 *dividuals under which—*

6               “(1) *the individual agrees—*

7                       “(A) *to serve as a full-time primary health*  
8 *services provider or as a full-time or part-time*  
9 *provider of other health services for a period of*  
10 *time equal to 2 years or such longer period as*  
11 *the individual may agree to;*

12                       “(B) *to serve in a health professional needs*  
13 *area in a health discipline, specialty, or a sub-*  
14 *specialty for which the area, population, or facil-*  
15 *ity is designated as a health professional needs*  
16 *area under section 340H; and*

17                       “(C) *in the case of an individual described*  
18 *in section 340H(c)(3) who is in the final year of*  
19 *study and who has accepted employment as a*  
20 *primary health services provider or provider of*  
21 *other health services in accordance with subpara-*  
22 *graphs (A) and (B), to complete the education or*  
23 *training and maintain an acceptable level of*  
24 *academic standing (as determined by the edu-*  
25 *cational institution offering the course of study*  
26 *or training); and*

1           “(2) the Secretary agrees to pay, for each year  
2           of such service, an amount on the principal and in-  
3           terest of the undergraduate or graduate educational  
4           loans (or both) of the individual that is not more  
5           than 50 percent of the average award made under the  
6           National Health Service Corps Loan Repayment Pro-  
7           gram under subpart III in that year.

8           “(b) *PRACTICE SETTING.*—A contract entered into  
9           under this section shall allow the individual receiving the  
10          loan repayment to satisfy the service requirement described  
11          in subsection (a)(1) through employment in a solo or group  
12          practice, a clinic, an accredited public or private nonprofit  
13          hospital, or any other health care entity, as deemed appro-  
14          priate by the Secretary.

15          “(c) *APPLICATION OF CERTAIN PROVISIONS.*—The pro-  
16          visions of subpart III of part D shall, except as inconsistent  
17          with this section, apply to the loan repayment program  
18          under this subpart in the same manner and to the same  
19          extent as such provisions apply to the National Health  
20          Service Corps Loan Repayment Program established under  
21          section 338B.

22          “(d) *INSUFFICIENT NUMBER OF APPLICANTS.*—If  
23          there are an insufficient number of applicants for loan re-  
24          payments under this section to obligate all appropriated  
25          funds, the Secretary shall transfer the unobligated funds to

1 *the National Health Service Corps for the purpose of re-*  
2 *cruting applicants and entering into contracts with indi-*  
3 *viduals so as to ensure a sufficient number of participants*  
4 *in the National Health Service Corps for the following year.*

5 **“SEC. 340J. REPORT.**

6 *“The Secretary shall submit to the Congress an annual*  
7 *report on the program carried out under this subpart.*

8 **“SEC. 340K. ALLOCATION.**

9 *“Of the amount of funds obligated under this subpart*  
10 *each fiscal year for loan repayments—*

11 *“(1) 90 percent shall be for physicians and other*  
12 *health professionals providing primary health serv-*  
13 *ices; and*

14 *“(2) 10 percent shall be for health professionals*  
15 *not described in paragraph (1).”.*

16 **SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.**

17 *(a) IN GENERAL.—Section 735 (42 U.S.C. 292y) is*  
18 *amended—*

19 *(1) by redesignating subsection (f) as subsection*  
20 *(g); and*

21 *(2) by inserting after subsection (e) the following:*

22 *“(f) DETERMINATION OF FINANCIAL NEED.—The Sec-*  
23 *retary—*

24 *“(1) may require, or authorize a school or other*  
25 *entity to require, the submission of financial informa-*

1        *tion to determine the financial resources available to*  
2        *any individual seeking assistance under this subpart;*  
3        *and*

4                *“(2) shall take into account the extent to which*  
5        *such individual is financially independent in deter-*  
6        *mining whether to require or authorize the submission*  
7        *of such information regarding such individual’s fam-*  
8        *ily members.”.*

9        *(b) REVISED GUIDELINES.—The Secretary of Health*  
10        *and Human Services shall—*

11                *(1) strike the second sentence of section 57.206(b)*  
12        *of title 42, Code of Federal Regulations; and*

13                *(2) make such other revisions to guidelines and*  
14        *regulations in effect as of the date of the enactment*  
15        *of this Act as may be necessary for consistency with*  
16        *the amendments made by paragraph (1).*

17        **SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL IN-**  
18                **TERNAL MEDICINE, GENERAL PEDIATRICS,**  
19                **GERIATRICS, AND PHYSICIAN ASSISTANTS.**

20        *Section 747 (42 U.S.C. 293k) is amended—*

21                *(1) by amending the section heading to read as*  
22        *follows: “**PRIMARY CARE TRAINING AND EN-***  
23        ***HANCEMENT**”;*

24                *(2) by redesignating subsection (e) as subsection*  
25        *(g); and*

1           (3) *by striking subsections (a) through (d) and*  
2           *inserting the following:*

3           “(a) *PROGRAM.—The Secretary shall establish a pri-*  
4           *mary care training and capacity building program con-*  
5           *sisting of awarding grants and contracts under subsections*  
6           *(b) and (c).*

7           “(b) *SUPPORT AND DEVELOPMENT OF PRIMARY CARE*  
8           *TRAINING PROGRAMS.—*

9           “(1) *IN GENERAL.—The Secretary shall make*  
10          *grants to, or enter into contracts with, eligible enti-*  
11          *ties—*

12                 “(A) *to plan, develop, operate, or partici-*  
13                 *pate in an accredited professional training pro-*  
14                 *gram, including an accredited residency or in-*  
15                 *ternship program, in the field of family medi-*  
16                 *cine, general internal medicine, general pediat-*  
17                 *rics, or geriatrics for medical students, interns,*  
18                 *residents, or practicing physicians;*

19                 “(B) *to provide financial assistance in the*  
20                 *form of traineeships and fellowships to medical*  
21                 *students, interns, residents, or practicing physi-*  
22                 *cians, who are participants in any such pro-*  
23                 *gram, and who plan to specialize or work in*  
24                 *family medicine, general internal medicine, gen-*  
25                 *eral pediatrics, or geriatrics;*

1           “(C) to plan, develop, operate, or partici-  
2           pate in an accredited program for the training  
3           of physicians who plan to teach in family medi-  
4           cine, general internal medicine, general pediat-  
5           rics, or geriatrics training programs including  
6           in community-based settings;

7           “(D) to provide financial assistance in the  
8           form of traineeships and fellowships to prac-  
9           ticing physicians who are participants in any  
10          such programs and who plan to teach in a fam-  
11          ily medicine, general internal medicine, general  
12          pediatrics, or geriatrics training program; and

13          “(E) to plan, develop, operate, or partici-  
14          pate in an accredited program for physician as-  
15          sistant education, and for the training of indi-  
16          viduals who plan to teach in programs to pro-  
17          vide such training.

18          “(2) *ELIGIBILITY*.—To be eligible for a grant or  
19          contract under paragraph (1), an entity shall be—

20                 “(A) an accredited school of medicine or os-  
21                 teopathic medicine, public or nonprofit private  
22                 hospital, or physician assistant training pro-  
23                 gram;

24                 “(B) a public or private nonprofit entity; or

1                   “(C) a consortium of 2 or more entities de-  
2                   scribed in subparagraphs (A) and (B).

3                   “(c) *CAPACITY BUILDING IN PRIMARY CARE.*—

4                   “(1) *IN GENERAL.*—The Secretary shall make  
5                   grants to or enter into contracts with eligible entities  
6                   to establish, maintain, or improve—

7                   “(A) academic administrative units (in-  
8                   cluding departments, divisions, or other appro-  
9                   priate units) in the specialties of family medi-  
10                  cine, general internal medicine, general pediat-  
11                  rics, or geriatrics; or

12                  “(B) programs that improve clinical teach-  
13                  ing in such specialties.

14                  “(2) *ELIGIBILITY.*—To be eligible for a grant or  
15                  contract under paragraph (1), an entity shall be an  
16                  accredited school of medicine or osteopathic medicine.

17                  “(d) *PREFERENCE.*—In awarding grants or contracts  
18                  under this section, the Secretary shall give preference to en-  
19                  tities that have a demonstrated record of the following:

20                  “(1) Training the greatest percentage, or signifi-  
21                  cantly improving the percentage, of health profes-  
22                  sionals who provide primary care.

23                  “(2) Training individuals who are from under-  
24                  represented minority groups or disadvantaged back-  
25                  grounds.



1           “(3) A high rate of placing graduates in practice  
2 settings having the principal focus of serving in un-  
3 derserved areas or populations experiencing health  
4 disparities (including serving patients eligible for  
5 medical assistance under title XIX of the Social Secu-  
6 rity Act or for child health assistance under title XXI  
7 of such Act or those with special health care needs).

8           “(4) Supporting teaching programs that address  
9 the health care needs of vulnerable populations.

10          “(e) REPORT.—The Secretary shall submit to the Con-  
11 gress an annual report on the program carried out under  
12 this section.

13          “(f) DEFINITION.—In this section, the term ‘health dis-  
14 parities’ has the meaning given the term in section 3171.”.

15 **SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN COMMU-**  
16 **NITY-BASED SETTINGS.**

17 Title VII (42 U.S.C. 292 et seq.) is amended—

18           (1) by redesignating section 748 as 749A; and

19           (2) by inserting after section 747 the following:

20 **“SEC. 748. TRAINING OF MEDICAL RESIDENTS IN COMMU-**  
21 **NITY-BASED SETTINGS.**

22          “(a) PROGRAM.—The Secretary shall establish a pro-  
23 gram for the training of medical residents in community-  
24 based settings consisting of awarding grants and contracts  
25 under this section.

1           “(b) *DEVELOPMENT AND OPERATION OF COMMUNITY-*  
2 *BASED PROGRAMS.*—*The Secretary shall make grants to,*  
3 *or enter into contracts with, eligible entities—*

4                   “(1) *to plan and develop a new primary care*  
5 *residency training program, which may include—*

6                           “(A) *planning and developing curricula;*

7                           “(B) *recruiting and training residents and*  
8 *faculty; and*

9                           “(C) *other activities designated to result in*  
10 *accreditation of such a program; or*

11                   “(2) *to operate or participate in an established*  
12 *primary care residency training program, which may*  
13 *include—*

14                           “(A) *planning and developing curricula;*

15                           “(B) *recruitment and training of residents;*  
16 *and*

17                           “(C) *retention of faculty.*

18           “(c) *ELIGIBLE ENTITY.*—*To be eligible to receive a*  
19 *grant or contract under subsection (b), an entity shall—*

20                   “(1) *be designated as a recipient of payment for*  
21 *the direct costs of medical education under section*  
22 *1886(k) of the Social Security Act;*

23                   “(2) *be designated as an approved teaching*  
24 *health center under section 1502(d) of the America’s*  
25 *Affordable Health Choices Act of 2009 and continuing*

1       to participate in the demonstration project under  
2       such section; or

3               “(3) be an applicant for designation described in  
4       paragraph (1) or (2) and have demonstrated to the  
5       Secretary appropriate involvement of an accredited  
6       teaching hospital to carry out the inpatient respon-  
7       sibilities associated with a primary care residency  
8       training program.

9       “(d) *PREFERENCES*.—In awarding grants and con-  
10      tracts under paragraph (1) or (2) of subsection (b), the Sec-  
11      retary shall give preference to entities that—

12               “(1) support teaching programs that address the  
13      health care needs of vulnerable populations; or

14               “(2) are a Federally qualified health center (as  
15      defined in section 1861(aa)(4) of the Social Security  
16      Act) or a rural health clinic (as defined in section  
17      1861(aa)(2) of such Act).

18       “(e) *ADDITIONAL PREFERENCES FOR ESTABLISHED*  
19      *PROGRAMS*.—In awarding grants and contracts under sub-  
20      section (b)(2), the Secretary shall give preference to entities  
21      that have a demonstrated record of training—

22               “(1) a high or significantly improved percentage  
23      of health professionals who provide primary care;

24               “(2) individuals who are from underrepresented  
25      minority groups or disadvantaged backgrounds; or

1           “(3) *individuals who practice in settings having*  
2           *the principal focus of serving underserved areas or*  
3           *populations experiencing health disparities (including*  
4           *servicing patients eligible for medical assistance under*  
5           *title XIX of the Social Security Act or for child health*  
6           *assistance under title XXI of such Act or those with*  
7           *special health care needs).*

8           “(f) *PERIOD OF AWARDS.—*

9           “(1) *IN GENERAL.—The period of a grant or*  
10           *contract under this section—*

11                   “(A) *shall not exceed 3 years for awards*  
12                   *under subsection (b)(1); and*

13                   “(B) *shall not exceed 5 years for awards*  
14                   *under subsection (b)(2).*

15           “(2) *SPECIAL RULES.—*

16                   “(A) *An award of a grant or contract under*  
17                   *subsection (b)(1) shall not be renewed.*

18                   “(B) *The period of a grant or contract*  
19                   *awarded to an entity under subsection (b)(2)*  
20                   *shall not overlap with the period of any grant or*  
21                   *contract awarded to the same entity under sub-*  
22                   *section (b)(1).*

23           “(g) *REPORT.—The Secretary shall submit to the Con-*  
24           *gress an annual report on the program carried out under*  
25           *this section.*

1 “(h) *DEFINITIONS.*—*In this section:*

2 “(1) *HEALTH DISPARITIES.*—*The term ‘health*  
3 *disparities’ has the meaning given the term in section*  
4 *3171.*

5 “(2) *PRIMARY CARE RESIDENT.*—*The term ‘pri-*  
6 *mary care resident’ has the meaning given the term*  
7 *in section 1886(h)(5)(H) of the Social Security Act.*

8 “(3) *PRIMARY CARE RESIDENCY TRAINING PRO-*  
9 *GRAM.*—*The term ‘primary care residency training*  
10 *program’ means an approved medical residency*  
11 *training program described in section 1886(h)(5)(A)*  
12 *of the Social Security Act for primary care residents*  
13 *that is—*

14 “(A) *in the case of entities seeking awards*  
15 *under subsection (b)(1), actively applying to be*  
16 *accredited by the Accreditation Council for*  
17 *Graduate Medical Education or the American*  
18 *Osteopathic Association; or*

19 “(B) *in the case of entities seeking awards*  
20 *under subsection (b)(2), so accredited.”.*

21 **SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUB-**  
22 **LIC HEALTH DENTISTS AND DENTAL HYGIEN-**  
23 **ISTS.**

24 *Title VII (42 U.S.C. 292 et seq.) is amended—*

1           (1) in section 791(a)(1), by striking “747 and  
2           750” and inserting “747, 749, and 750”; and

3           (2) by inserting after section 748, as added, the  
4           following:

5   **“SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUB-**  
6                   **LIC HEALTH DENTISTS AND DENTAL HYGIEN-**  
7                   **ISTS.**

8           “(a) PROGRAM.—The Secretary shall establish a train-  
9           ing program for oral professionals consisting of awarding  
10          grants and contracts under this section.

11          “(b) SUPPORT AND DEVELOPMENT OF DENTAL TRAIN-  
12          ING PROGRAMS.—The Secretary shall make grants to, or  
13          enter into contracts with, eligible entities—

14               “(1) to plan, develop, operate, or participate in  
15               an accredited professional training program for oral  
16               health professionals;

17               “(2) to provide financial assistance to oral  
18               health professionals who are in need thereof, who are  
19               participants in any such program, and who plan to  
20               work in general, pediatric, or public health dentistry,  
21               or dental hygiene;

22               “(3) to plan, develop, operate, or participate in  
23               a program for the training of oral health profes-  
24               sionals who plan to teach in general, pediatric, or  
25               public health dentistry, or dental hygiene;

1           “(4) to provide financial assistance in the form  
2 of traineeships and fellowships to oral health profes-  
3 sionals who plan to teach in general, pediatric, or  
4 public health dentistry or dental hygiene;

5           “(5) to establish, maintain, or improve—

6           “(A) academic administrative units (in-  
7 cluding departments, divisions, or other appro-  
8 priate units) in the specialties of general, pedi-  
9 atric, or public health dentistry; or

10           “(B) programs that improve clinical teach-  
11 ing in such specialties;

12           “(6) to plan, develop, operate, or participate in  
13 predoctoral and postdoctoral training in general, pe-  
14 diatric, or public health dentistry programs;

15           “(7) to plan, develop, operate, or participate in  
16 a loan repayment program for full-time faculty in a  
17 program of general, pediatric, or public health den-  
18 tistry; and

19           “(8) to provide technical assistance to pediatric  
20 dental training programs in developing and imple-  
21 menting instruction regarding the oral health status,  
22 dental care needs, and risk-based clinical disease  
23 management of all pediatric populations with an em-  
24 phasis on underserved children.

1       “(c) *ELIGIBILITY.*—*To be eligible for a grant or con-*  
2 *tract under subsection (a), an entity shall be—*

3               “(1) *an accredited school of dentistry, training*  
4 *program in dental hygiene, or public or nonprofit*  
5 *private hospital;*

6               “(2) *a training program in dental hygiene at an*  
7 *accredited institution of higher education;*

8               “(3) *a public or private nonprofit entity; or*

9               “(4) *a consortium of—*

10                   “(A) *1 or more of the entities described in*  
11 *paragraphs (1) through (3); and*

12                   “(B) *an accredited school of public health.*

13       “(d) *PREFERENCE.*—*In awarding grants or contracts*  
14 *under this section, the Secretary shall give preference to en-*  
15 *tities that have a demonstrated record of the following:*

16               “(1) *Training the greatest percentage, or signifi-*  
17 *cantly improving the percentage, of oral health profes-*  
18 *sionals who practice general, pediatric, or public*  
19 *health dentistry.*

20               “(2) *Training individuals who are from under-*  
21 *represented minority groups or disadvantaged back-*  
22 *grounds.*

23               “(3) *A high rate of placing graduates in practice*  
24 *settings having the principal focus of serving in un-*  
25 *derserved areas or populations experiencing health*



1        *disparities (including serving patients eligible for*  
2        *medical assistance under title XIX of the Social Secu-*  
3        *rity Act or for child health assistance under title XXI*  
4        *of such Act or those with special health care needs).*

5                *“(4) Supporting teaching programs that address*  
6        *the dental needs of vulnerable populations.*

7                *“(5) Providing instruction regarding the oral*  
8        *health status, dental care needs, and risk-based clin-*  
9        *ical disease management of all pediatric populations*  
10        *with an emphasis on underserved children.*

11                *“(e) REPORT.—The Secretary shall submit to the Con-*  
12        *gress an annual report on the program carried out under*  
13        *this section.*

14                *“(f) DEFINITIONS.—In this section:*

15                        *“(1) The term ‘health disparities’ has the mean-*  
16        *ing given the term in section 3171.*

17                        *“(2) The term ‘oral health professional’ means*  
18        *an individual training or practicing—*

19                                *“(A) in general dentistry, pediatric den-*  
20        *tistry, public health dentistry, or dental hygiene;*

21        *or*

22                                *“(B) another oral health specialty, as*  
23        *deemed appropriate by the Secretary.”.*

1 **SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.**

2       (a) *IN GENERAL.*—*Part F of title VII (42 U.S.C. 295j*  
3 *et seq.) is amended by adding at the end the following:*

4 **“SEC. 799C. FUNDING THROUGH PUBLIC HEALTH INVEST-**  
5 **MENT FUND.**

6       “(a) *PROMOTION OF PRIMARY CARE AND DEN-*  
7 *TISTRY.*—*For the purpose of carrying out subpart XI of*  
8 *part D of title III and sections 747, 748, and 749, in addi-*  
9 *tion to any other amounts authorized to be appropriated*  
10 *for such purpose, there are authorized to be appropriated,*  
11 *out of any monies in the Public Health Investment Fund,*  
12 *the following:*

13               “(1) \$240,000,000 for fiscal year 2010.

14               “(2) \$253,000,000 for fiscal year 2011.

15               “(3) \$265,000,000 for fiscal year 2012.

16               “(4) \$278,000,000 for fiscal year 2013.

17               “(5) \$292,000,000 for fiscal year 2014.”.

18       (b) *EXISTING AUTHORIZATION OF APPROPRIATIONS.*—  
19 *Subsection (g), as so redesignated, of section 747 (42 U.S.C.*  
20 *293k) is amended by striking “2002” and inserting “2014”.*

21 **SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS**  
22 **AND LOAN REPAYMENTS.**

23       *Not later than 18 months after the date of the enact-*  
24 *ment of this Act, the Comptroller General of the United*  
25 *States shall conduct a study to determine the effectiveness*  
26 *of scholarship and loan repayment programs under sub-*

1 *parts III and XI of part D of title III of the Public Health*  
 2 *Service Act, as amended or added by sections 2201 and*  
 3 *2211, including whether scholarships or loan repayments*  
 4 *are more effective in—*

5           (1) *incentivizing physicians, and other pro-*  
 6 *viders, to pursue careers in primary care specialties;*

7           (2) *retaining such primary care providers; and*

8           (3) *encouraging such primary care providers to*  
 9 *practice in underserved areas.*

## 10           ***Subtitle B—Nursing Workforce***

### 11           ***SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.***

12           (a) *DEFINITIONS.—Section 801 (42 U.S.C. 296 et seq.)*  
 13 *is amended—*

14           (1) *in paragraph (1), by inserting “nurse-man-*  
 15 *aged health centers,” after “nursing centers,”; and*

16           (2) *by adding at the end the following:*

17           “(16) *NURSE-MANAGED HEALTH CENTER.—The*  
 18 *term ‘nurse-managed health center’ means a nurse-*  
 19 *practice arrangement, managed by advanced practice*  
 20 *nurses, that provides primary care or wellness serv-*  
 21 *ices to underserved or vulnerable populations and is*  
 22 *associated with an accredited school of nursing, Fed-*  
 23 *erally qualified health center, or independent non-*  
 24 *profit health or social services agency.”.*

1       (b) *GRANTS FOR HEALTH PROFESSIONS EDU-*  
2 *CATION.—Title VIII (42 U.S.C. 296 et seq.) is amended by*  
3 *striking section 807.*

4       (c) *REPORTS.—Part A of title VIII (42 U.S.C. 296 et*  
5 *seq.) is amended by adding at the end the following:*

6       **“SEC. 809. REPORTS.**

7           *“The Secretary shall submit to the Congress a separate*  
8 *annual report on the activities carried out under each of*  
9 *sections 811, 821, 836, 846A, and 861.”.*

10       (d) *ADVANCED EDUCATION NURSING GRANTS.—Sec-*  
11 *tion 811(f) (42 U.S.C. 296j(f)) is amended—*

12           (1) *by striking paragraph (2);*

13           (2) *by redesignating paragraph (3) as para-*  
14 *graph (2); and*

15           (3) *in paragraph (2), as so redesignated, by*  
16 *striking “that agrees” and all that follows through the*  
17 *end and inserting: “that agrees to expend the*  
18 *award—*

19                   *“(A) to train advanced education nurses*  
20 *who will practice in health professional shortage*  
21 *areas designated under section 332; or*

22                   *“(B) to increase diversity among advanced*  
23 *education nurses.”.*

24       (e) *NURSE EDUCATION, PRACTICE, AND RETENTION*  
25 *GRANTS.—Section 831 (42 U.S.C. 296p) is amended—*

1           (1) *in subsection (b), by amending paragraph*  
2           (3) *to read as follows:*

3           “*(3) providing coordinated care, quality care,*  
4           *and other skills needed to practice nursing; or*”; and

5           (2) *by striking subsection (e) and redesignating*  
6           *subsections (f) through (h) as subsections (e) through*  
7           *(g), respectively.*

8           (f) *STUDENT LOANS.—Subsection (a) of section 836*  
9           *(42 U.S.C. 297b) is amended—*

10           (1) *by striking “\$2,500” and inserting “\$3,300”;*

11           (2) *by striking “\$4,000” and inserting “\$5,200”;*

12           (3) *by striking “\$13,000” and inserting*  
13           *“\$17,000”; and*

14           (4) *by adding at the end the following: “Begin-*  
15           *ning with fiscal year 2012, the dollar amounts speci-*  
16           *fied in this subsection shall be adjusted by an amount*  
17           *determined by the Secretary on an annual basis to re-*  
18           *fect inflation.”.*

19           (g) *LOAN REPAYMENT.—Section 846 (42 U.S.C. 297n)*  
20           *is amended—*

21           (1) *in subsection (a), by amending paragraph*  
22           (3) *to read as follows:*

23           “*(3) who enters into an agreement with the Sec-*  
24           *retary to serve for a period of not less than 2 years—*

1           “(A) as a nurse at a health care facility  
2           with a critical shortage of nurses; or

3           “(B) as a faculty member at an accredited  
4           school of nursing;” and

5           (2) in subsection (g)(1), by striking “to provide  
6           health services” each place it appears and inserting  
7           “to provide health services or serve as a faculty mem-  
8           ber”.

9           (h) NURSE FACULTY LOAN PROGRAM.—Paragraph (2)  
10          of section 846A(c) (42 U.S.C. 297n–1(c)) is amended by  
11          striking “\$30,000” and all that follows through the semi-  
12          colon and inserting “\$35,000, plus, beginning with fiscal  
13          year 2012, an amount determined by the Secretary on an  
14          annual basis to reflect inflation;”.

15          (i) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII  
16          (42 U.S.C. 296 et seq.) is amended by striking part H.

17          (j) TECHNICAL AND CONFORMING AMENDMENTS.—  
18          Title VIII (42 U.S.C. 296 et seq.) is amended—

19                 (1) by moving section 810 (relating to prohibi-  
20                 tion against discrimination by schools on the basis of  
21                 sex) so that it follows section 809, as added by sub-  
22                 section (c);

23                 (2) in sections 835, 836, 838, 840, and 842, by  
24                 striking the term “this subpart” each place it appears  
25                 and inserting “this part”;

1           (3) *in section 836(h), by striking the last sen-*  
2 *tence;*

3           (4) *in section 836, by redesignating subsection*  
4 *(l) as subsection (k);*

5           (5) *in section 839, by striking “839” and all*  
6 *that follows through “(a)” and inserting “839. (a)”;*

7           (6) *in section 835(b), by striking “841” each*  
8 *place it appears and inserting “871”;*

9           (7) *by redesignating section 841 as section 871,*  
10 *moving part F to the end of the title, and redesi-*  
11 *gnating such part as part H;*

12           (8) *in part G—*

13                 (A) *by redesignating section 845 as section*  
14 *851; and*

15                 (B) *by redesignating part G as part F; and*

16           (9) *in part I—*

17                 (A) *by redesignating section 855 as section*  
18 *861; and*

19                 (B) *by redesignating part I as part G.*

20           (k) *FUNDING.—*

21                 (1) *IN GENERAL.—Part H, as redesignated, of*  
22 *title VIII is amended by adding at the end the fol-*  
23 *lowing:*

1 **“SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVEST-**  
 2 **MENT FUND.**

3 *“For the purpose of carrying out this title, in addition*  
 4 *to any other amounts authorized to be appropriated for*  
 5 *such purpose, there are authorized to be appropriated, out*  
 6 *of any monies in the Public Health Investment Fund, the*  
 7 *following:*

8 *“(1) \$115,000,000 for fiscal year 2010.*

9 *“(2) \$122,000,000 for fiscal year 2011.*

10 *“(3) \$127,000,000 for fiscal year 2012.*

11 *“(4) \$134,000,000 for fiscal year 2013.*

12 *“(5) \$140,000,000 for fiscal year 2014.”.*

13 (2) *EXISTING AUTHORIZATIONS OF APPROPRIA-*  
 14 *TIONS.—*

15 (A) *SECTIONS 831, 846, 846A, AND 861.—Sec-*  
 16 *tions 831(g) (as so redesignated), 846(i)(1) (42*  
 17 *U.S.C. 297n(i)(1)), 846A(f) (42 U.S.C. 297n-*  
 18 *1(f)), and 861(e) (as so redesignated) are amend-*  
 19 *ed by striking “2007” each place it appears and*  
 20 *inserting “2014”.*

21 (B) *SECTION 871.—Section 871, as so redes-*  
 22 *ignated by subsection (j), is amended to read as*  
 23 *follows:*

24 **“SEC. 871. FUNDING.**

25 *“For the purpose of carrying out parts B, C, and D*  
 26 *(subject to section 845(g)), there are authorized to be appro-*



1 *priated such sums as may be necessary for each fiscal year*  
2 *through fiscal year 2014.”.*

3                   ***Subtitle C—Public Health***  
4                   ***Workforce***

5 ***SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.***

6           *Part D of title III (42 U.S.C. 254b et seq.), as amended*  
7 *by section 2211, is amended by adding at the end the fol-*  
8 *lowing:*

9                   ***“Subpart XII—Public Health Workforce***

10 ***“SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.***

11           *“(a) ESTABLISHMENT.—There is established, within*  
12 *the Service, the Public Health Workforce Corps (in this sub-*  
13 *part referred to as the ‘Corps’), for the purpose of ensuring*  
14 *an adequate supply of public health professionals through-*  
15 *out the Nation. The Corps shall consist of—*

16                   *“(1) such officers of the Regular and Reserve*  
17 *Corps of the Service as the Secretary may designate;*

18                   *“(2) such civilian employees of the United States*  
19 *as the Secretary may appoint; and*

20                   *“(3) such other individuals who are not employ-*  
21 *ees of the United States.*

22           *“(b) ADMINISTRATION.—Except as provided in sub-*  
23 *section (c), the Secretary shall carry out this subpart acting*  
24 *through the Administrator of the Health Resources and*  
25 *Services Administration.*

1           “(c) *PLACEMENT AND ASSIGNMENT.*—*The Secretary,*  
2 *acting through the Director of the Centers for Disease Con-*  
3 *trol and Prevention, shall develop a methodology for placing*  
4 *and assigning Corps participants as public health profes-*  
5 *sionals. Such methodology may allow for placing and as-*  
6 *signing such participants in State, local, and tribal health*  
7 *departments and Federally qualified health centers (as de-*  
8 *finied in section 1861(aa)(4) of the Social Security Act).*

9           “(d) *APPLICATION OF CERTAIN PROVISIONS.*—*The*  
10 *provisions of subpart II shall, except as inconsistent with*  
11 *this subpart, apply to the Public Health Workforce Corps*  
12 *in the same manner and to the same extent as such provi-*  
13 *sions apply to the National Health Service Corps estab-*  
14 *lished under section 331.*

15           “(e) *REPORT.*—*The Secretary shall submit to the Con-*  
16 *gress an annual report on the programs carried out under*  
17 *this subpart.*

18           **“SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP**  
19   **PROGRAM.**

20           “(a) *ESTABLISHMENT.*—*The Secretary shall establish*  
21 *the Public Health Workforce Scholarship Program (referred*  
22 *to in this section as the ‘Program’)* for the purpose described  
23 *in section 340L(a).*

24           “(b) *ELIGIBILITY.*—*To be eligible to participate in the*  
25 *Program, an individual shall—*

1           “(1)(A) be accepted for enrollment, or be en-  
2           rolled, as a full-time or part-time student in a course  
3           of study or program (approved by the Secretary) at  
4           an accredited graduate school or program of public  
5           health; or

6           “(B) have demonstrated expertise in public  
7           health and be accepted for enrollment, or be enrolled,  
8           as a full-time or part-time student in a course of  
9           study or program (approved by the Secretary) at—

10           “(i) an accredited graduate school or pro-  
11           gram of nursing; health administration, manage-  
12           ment, or policy; preventive medicine; laboratory  
13           science; veterinary medicine; or dental medicine;  
14           or

15           “(ii) another accredited graduate school or  
16           program, as deemed appropriate by Secretary;

17           “(2) be eligible for, or hold, an appointment as  
18           a commissioned officer in the Regular or Reserve  
19           Corps of the Service or be eligible for selection for ci-  
20           vilian service in the Corps; and

21           “(3) sign and submit to the Secretary a written  
22           contract (described in subsection (c)) to serve full-time  
23           as a public health professional, upon the completion  
24           of the course of study or program involved, for the pe-

1        *riod of obligated service described in subsection*  
2        *(c)(2)(E).*

3        “(c) *CONTRACT.—The written contract between the*  
4        *Secretary and an individual under subsection (b)(3) shall*  
5        *contain—*

6                “(1) *an agreement on the part of the Secretary*  
7        *that the Secretary will—*

8                        “(A) *provide the individual with a scholar-*  
9                        *ship for a period of years (not to exceed 4 aca-*  
10                        *ademic years) during which the individual shall*  
11                        *pursue an approved course of study or program*  
12                        *to prepare the individual to serve in the public*  
13                        *health workforce; and*

14                        “(B) *accept (subject to the availability of*  
15                        *appropriated funds) the individual into the*  
16                        *Corps;*

17                “(2) *an agreement on the part of the individual*  
18        *that the individual will—*

19                        “(A) *accept provision of such scholarship to*  
20                        *the individual;*

21                        “(B) *maintain full-time or part-time enroll-*  
22                        *ment in the approved course of study or program*  
23                        *described in subsection (b)(1) until the indi-*  
24                        *vidual completes that course of study or pro-*  
25                        *gram;*

1           “(C) while enrolled in the approved course  
2 of study or program, maintain an acceptable  
3 level of academic standing (as determined by the  
4 educational institution offering such course of  
5 study or program);

6           “(D) if applicable, complete a residency or  
7 internship; and

8           “(E) serve full-time as a public health pro-  
9 fessional for a period of time equal to the greater  
10 of—

11                 “(i) 1 year for each academic year for  
12 which the individual was provided a schol-  
13 arship under the Program; or

14                 “(ii) 2 years; and

15           “(3) an agreement by both parties as to the na-  
16 ture and extent of the scholarship assistance, which  
17 may include—

18                 “(A) payment of reasonable educational ex-  
19 penses of the individual, including tuition, fees,  
20 books, equipment, and laboratory expenses; and

21                 “(B) payment of a stipend of not more than  
22 \$1,269 (plus, beginning with fiscal year 2011,  
23 an amount determined by the Secretary on an  
24 annual basis to reflect inflation) per month for  
25 each month of the academic year involved, with

1           *the dollar amount of such a stipend determined*  
 2           *by the Secretary taking into consideration*  
 3           *whether the individual is enrolled full-time or*  
 4           *part-time.*

5           “(d) *APPLICATION OF CERTAIN PROVISIONS.—The*  
 6 *provisions of subpart III shall, except as inconsistent with*  
 7 *this subpart, apply to the scholarship program under this*  
 8 *section in the same manner and to the same extent as such*  
 9 *provisions apply to the National Health Service Corps*  
 10 *Scholarship Program established under section 338A.*

11       **“SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REPAY-**  
 12   **MENT PROGRAM.**

13           “(a) *ESTABLISHMENT.—The Secretary shall establish*  
 14 *the Public Health Workforce Loan Repayment Program (re-*  
 15 *ferred to in this section as the ‘Program’) for the purpose*  
 16 *described in section 340L(a).*

17           “(b) *ELIGIBILITY.—To be eligible to participate in the*  
 18 *Program, an individual shall—*

19                               “(1)(A) *have a graduate degree from an accred-*  
 20                               *ited school or program of public health;*

21                               “(B) *have demonstrated expertise in public*  
 22                               *health and have a graduate degree in a course of*  
 23                               *study or program (approved by the Secretary) from—*

24   “(i) *an accredited school or program of*  
 25   *nursing; health administration, management, or*

1           *policy; preventive medicine; laboratory science;*  
2           *veterinary medicine; or dental medicine; or*

3           “(i) *another accredited school or program*  
4           *approved by the Secretary; or*

5           “(C) *be enrolled as a full-time or part-time stu-*  
6           *dent in the final year of a course of study or program*  
7           *(approved by the Secretary) offered by a school or*  
8           *program described in subparagraph (A) or (B), lead-*  
9           *ing to a graduate degree;*

10          “(2) *be eligible for, or hold, an appointment as*  
11          *a commissioned officer in the Regular or Reserve*  
12          *Corps of the Service or be eligible for selection for ci-*  
13          *vilian service in the Corps;*

14          “(3) *if applicable, complete a residency or in-*  
15          *ternship; and*

16          “(4) *sign and submit to the Secretary a written*  
17          *contract (described in subsection (c)) to serve full-time*  
18          *as a public health professional for the period of obli-*  
19          *gated service described in subsection (c)(2).*

20          “(c) *CONTRACT.—The written contract between the*  
21          *Secretary and an individual under subsection (b)(4) shall*  
22          *contain—*

23                 “(1) *an agreement by the Secretary to repay on*  
24                 *behalf of the individual loans incurred by the indi-*  
25                 *vidual in the pursuit of the relevant public health*

1 *workforce educational degree in accordance with the*  
2 *terms of the contract;*

3 *“(2) an agreement by the individual to serve*  
4 *full-time as a public health professional for a period*  
5 *of time equal to 2 years or such longer period as the*  
6 *individual may agree to; and*

7 *“(3) in the case of an individual described in*  
8 *subsection (b)(1)(C) who is in the final year of study*  
9 *and who has accepted employment as a public health*  
10 *professional, in accordance with section 340L(c), an*  
11 *agreement on the part of the individual to complete*  
12 *the education or training, maintain an acceptable*  
13 *level of academic standing (as determined by the edu-*  
14 *cational institution offering the course of study or*  
15 *training), and serve the period of obligated service de-*  
16 *scribed in paragraph (2).*

17 *“(d) PAYMENTS.—*

18 *“(1) IN GENERAL.—A loan repayment provided*  
19 *for an individual under a written contract under the*  
20 *Program shall consist of payment, in accordance with*  
21 *paragraph (2), on behalf of the individual of the prin-*  
22 *cipal, interest, and related expenses on government*  
23 *and commercial loans received by the individual re-*  
24 *garding the undergraduate or graduate education of*  
25 *the individual (or both), which loans were made for*



1       *reasonable educational expenses, including tuition,*  
2       *fees, books, equipment, and laboratory expenses, in-*  
3       *curring by the individual.*

4               “(2) *PAYMENTS FOR YEARS SERVED.—*

5                       “(A) *IN GENERAL.—For each year of obli-*  
6                       *gated service that an individual contracts to*  
7                       *serve under subsection (c), the Secretary may*  
8                       *pay up to \$35,000 (plus, beginning with fiscal*  
9                       *year 2012, an amount determined by the Sec-*  
10                      *retary on an annual basis to reflect inflation) on*  
11                      *behalf of the individual for loans described in*  
12                      *paragraph (1).*

13                      “(B) *REPAYMENT SCHEDULE.—Any ar-*  
14                      *rangement made by the Secretary for the making*  
15                      *of loan repayments in accordance with this sub-*  
16                      *section shall provide that any repayments for a*  
17                      *year of obligated service shall be made no later*  
18                      *than the end of the fiscal year in which the indi-*  
19                      *vidual completes such year of service.*

20               “(e) *APPLICATION OF CERTAIN PROVISIONS.—The pro-*  
21               *visions of subpart III shall, except as inconsistent with this*  
22               *subpart, apply to the loan repayment program under this*  
23               *section in the same manner and to the same extent as such*  
24               *provisions apply to the National Health Service Corps*

1 *Loan Repayment Program established under section*  
2 *338B.”.*

3 **SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

4 *Section 765 (42 U.S.C. 295) is amended to read as*  
5 *follows:*

6 **“SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

7 *“(a) PROGRAM.—The Secretary, acting through the*  
8 *Administrator of the Health Resources and Services Admin-*  
9 *istration and in consultation with the Director of the Cen-*  
10 *ters for Disease Control and Prevention, shall establish a*  
11 *public health workforce training and enhancement program*  
12 *consisting of awarding grants and contracts under sub-*  
13 *section (b).*

14 *“(b) GRANTS AND CONTRACTS.—The Secretary shall*  
15 *award grants and contracts to eligible entities—*

16 *“(1) to plan, develop, operate, or participate in,*  
17 *an accredited professional training program in the*  
18 *field of public health (including such a program in*  
19 *nursing; health administration, management, or pol-*  
20 *icy; preventive medicine; laboratory science; veteri-*  
21 *nary medicine; or dental medicine) for members of*  
22 *the public health workforce including mid-career pro-*  
23 *fessionals;*

24 *“(2) to provide financial assistance in the form*  
25 *of traineeships and fellowships to students who are*

1 *participants in any such program and who plan to*  
2 *specialize or work in the field of public health;*

3 *“(3) to plan, develop, operate, or participate in*  
4 *a program for the training of public health profes-*  
5 *sionals who plan to teach in any program described*  
6 *in paragraph (1); and*

7 *“(4) to provide financial assistance in the form*  
8 *of traineeships and fellowships to public health profes-*  
9 *sionals who are participants in any program de-*  
10 *scribed in paragraph (1) and who plan to teach in*  
11 *the field of public health, including nursing; health*  
12 *administration, management, or policy; preventive*  
13 *medicine; laboratory science; veterinary medicine; or*  
14 *dental medicine.*

15 *“(c) ELIGIBILITY.—To be eligible for a grant or con-*  
16 *tract under subsection (a), an entity shall be—*

17 *“(1) an accredited health professions school, in-*  
18 *cluding an accredited school or program of public*  
19 *health; nursing; health administration, management,*  
20 *or policy; preventive medicine; laboratory science; vet-*  
21 *erinary medicine; or dental medicine;*

22 *“(2) a State, local, or tribal health department;*

23 *“(3) a public or private nonprofit entity; or*

24 *“(4) a consortium of 2 or more entities described*  
25 *in paragraphs (1) through (3).*

1       “(d) *PREFERENCE.*—*In awarding grants or contracts*  
2 *under this section, the Secretary shall give preference to en-*  
3 *tities that have a demonstrated record of the following:*

4               “(1) *Training the greatest percentage, or signifi-*  
5 *cantly improving the percentage, of public health pro-*  
6 *essionals who serve in underserved communities.*

7               “(2) *Training individuals who are from under-*  
8 *represented minority groups or disadvantaged back-*  
9 *grounds.*

10              “(3) *Training individuals in public health spe-*  
11 *cialties experiencing a significant shortage of public*  
12 *health professionals (as determined by the Secretary).*

13              “(4) *Training the greatest percentage, or signifi-*  
14 *cantly improving the percentage, of public health pro-*  
15 *essionals serving in the Federal Government or a*  
16 *State, local, or tribal government.*

17       “(e) *REPORT.*—*The Secretary shall submit to the Con-*  
18 *gress an annual report on the program carried out under*  
19 *this section.”.*

20 **SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.**

21       Section 766 (42 U.S.C. 295a) is amended—

22              (1) *in subsection (b)(1), by striking “in further-*  
23 *ance of the goals established by the Secretary for the*  
24 *year 2000” and inserting “in furtherance of the goals*

1       *established by the Secretary in the national preven-*  
2       *tion and wellness strategy under section 3121”; and*

3               *(2) by adding at the end the following:*

4       “(d) *REPORT.—The Secretary shall submit to the Con-*  
5       *gress an annual report on the program carried out under*  
6       *this section.”.*

7       **SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH**  
8               **TRAINING GRANT PROGRAM.**

9       *Section 768 (42 U.S.C. 295c) is amended to read as*  
10       *follows:*

11       **“SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH**  
12               **TRAINING GRANT PROGRAM.**

13       “(a) *GRANTS.—The Secretary, acting through the Ad-*  
14       *ministrator of the Health Resources and Services Adminis-*  
15       *tration and in consultation with the Director of the Centers*  
16       *for Disease Control and Prevention, shall award grants to,*  
17       *or enter into contracts with, eligible entities to provide*  
18       *training to graduate medical residents in preventive medi-*  
19       *cine specialties.*

20       “(b) *ELIGIBILITY.—To be eligible for a grant or con-*  
21       *tract under subsection (a), an entity shall be—*

22               “(1) *an accredited school of public health or*  
23       *school of medicine or osteopathic medicine;*

24               “(2) *an accredited public or private hospital;*

1           “(3) a State, local, or tribal health department;

2           or

3           “(4) a consortium of 2 or more entities described  
4           in paragraphs (1) through (3).

5           “(c) *USE OF FUNDS.*—Amounts received under a grant  
6           or contract under this section shall be used to—

7           “(1) plan, develop (including the development of  
8           curricula), operate, or participate in an accredited  
9           residency or internship program in preventive medi-  
10          cine or public health;

11          “(2) defray the costs of practicum experiences, as  
12          required in such a program; and

13          “(3) establish, maintain, or improve—

14                 “(A) academic administrative units (in-  
15                 cluding departments, divisions, or other appro-  
16                 priate units) in preventive medicine and public  
17                 health; or

18                 “(B) programs that improve clinical teach-  
19                 ing in preventive medicine and public health.

20          “(d) *REPORT.*—The Secretary shall submit to the Con-  
21          gress an annual report on the program carried out under  
22          this section.”.

1 **SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.**

2       (a) *IN GENERAL.*—Section 799C, as added by section  
3 2216 of this Act, is amended by adding at the end the fol-  
4 lowing:

5       “(b) *PUBLIC HEALTH WORKFORCE.*—For the purpose  
6 of carrying out subpart XII of part D of title III and sec-  
7 tions 765, 766, and 768, in addition to any other amounts  
8 authorized to be appropriated for such purpose, there are  
9 authorized to be appropriated, out of any monies in the  
10 *Public Health Investment Fund*, the following:

11               “(1) \$51,000,000 for fiscal year 2010.

12               “(2) \$54,000,000 for fiscal year 2011.

13               “(3) \$57,000,000 for fiscal year 2012.

14               “(4) \$59,000,000 for fiscal year 2013.

15               “(5) \$62,000,000 for fiscal year 2014.”.

16       (b) *EXISTING AUTHORIZATION OF APPROPRIATIONS.*—  
17 Subsection (a) of section 770 (42 U.S.C. 295e) is amended  
18 by striking “2002” and inserting “2014”.

1 ***Subtitle D—Adapting Workforce to***  
2 ***Evolving Health System Needs***

3 ***PART 1—HEALTH PROFESSIONS TRAINING FOR***  
4 ***DIVERSITY***

5 ***SEC. 2241. SCHOLARSHIPS FOR DISADVANTAGED STU-***  
6 ***DENTS, LOAN REPAYMENTS AND FELLOW-***  
7 ***SHIPS REGARDING FACULTY POSITIONS, AND***  
8 ***EDUCATIONAL ASSISTANCE IN THE HEALTH***  
9 ***PROFESSIONS REGARDING INDIVIDUALS***  
10 ***FROM DISADVANTAGED BACKGROUNDS.***

11 *Paragraph (1) of section 738(a) (42 U.S.C. 293b(a))*  
12 *is amended by striking “not more than \$20,000” and all*  
13 *that follows through the end of the paragraph and inserting:*  
14 *“not more than \$35,000 (plus, beginning with fiscal year*  
15 *2012, an amount determined by the Secretary on an annual*  
16 *basis to reflect inflation) of the principal and interest of*  
17 *the educational loans of such individuals.”*

18 ***SEC. 2242. NURSING WORKFORCE DIVERSITY GRANTS.***

19 *Subsection (b) of section 821 (42 U.S.C. 296m) is*  
20 *amended—*

21 *(1) in the heading, by striking “GUIDANCE” and*  
22 *inserting “CONSULTATION”; and*

23 *(2) by striking “shall take into consideration”*  
24 *and all that follows through “consult with nursing as-*



1       sociations” and inserting “shall, as appropriate, con-  
2       sult with nursing associations”.

3   **SEC. 2243. COORDINATION OF DIVERSITY AND CULTURAL**  
4                   **COMPETENCY PROGRAMS.**

5       (a) *IN GENERAL.*—Title VII (42 U.S.C. 292 et seq.)  
6   is amended by inserting after section 739 the following:

7   **“SEC. 739A. COORDINATION OF DIVERSITY AND CULTURAL**  
8                   **COMPETENCY PROGRAMS.**

9       “The Secretary shall, to the extent practicable, coordi-  
10   nate the activities carried out under this part and section  
11   821 in order to enhance the effectiveness of such activities  
12   and avoid duplication of effort.”.

13       (b) *REPORT.*—Section 736 (42 U.S.C. 293) is amend-  
14   ed—

15               (1) by redesignating subsection (h) as subsection  
16       (i); and

17               (2) by inserting after subsection (g) the fol-  
18       lowing:

19       “(h) *REPORT.*—The Secretary shall submit to the Con-  
20   gress an annual report on the activities carried out under  
21   this section.”.

1           **PART 2—INTERDISCIPLINARY TRAINING**

2                                   **PROGRAMS**

3 **SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY**

4                                   **TRAINING FOR HEALTH PROFESSIONALS.**

5           *Section 741 (42 U.S.C. 293e) is amended—*

6                   (1) *in the section heading, by striking “GRANTS*  
7 *FOR HEALTH PROFESSIONS EDUCATION” and*  
8 *inserting “CULTURAL AND LINGUISTIC COM-*  
9 *PETENCY TRAINING FOR HEALTH PROFES-*  
10 *SIONALS”;*

11                   (2) *by redesignating subsection (b) as subsection*  
12 *(h); and*

13                   (3) *by striking subsection (a) and inserting the*  
14 *following:*

15           “(a) PROGRAM.—*The Secretary shall establish a cul-*  
16 *tural and linguistic competency training program for*  
17 *health professionals, including nurse professionals, con-*  
18 *sisting of awarding grants and contracts under subsection*  
19 *(b).*

20           “(b) CULTURAL AND LINGUISTIC COMPETENCY TRAIN-

21 *ING.—The Secretary shall award grants and contracts to*  
22 *eligible entities—*

23                   (1) *to test, develop, and evaluate models of cul-*  
24 *tural and linguistic competency training (including*  
25 *continuing education) for health professionals; and*

1           “(2) to implement cultural and linguistic com-  
2           petency training programs for health professionals de-  
3           veloped under paragraph (1) or otherwise.

4           “(c) *ELIGIBILITY.*—To be eligible for a grant or con-  
5           tract under subsection (b), an entity shall be—

6           “(1) an accredited health professions school or  
7           program;

8           “(2) an academic health center;

9           “(3) a public or private nonprofit entity; or

10           “(4) a consortium of 2 or more entities described  
11           in paragraphs (1) through (3).

12           “(d) *PREFERENCE.*—In awarding grants and con-  
13           tracts under this section, the Secretary shall give preference  
14           to entities that have a demonstrated record of the following:

15           “(1) Addressing, or partnering with an entity  
16           with experience addressing, the cultural and lin-  
17           guistic competency needs of the population to be  
18           served through the grant or contract.

19           “(2) Addressing health disparities.

20           “(3) Placing health professionals in regions expe-  
21           riencing significant changes in the cultural and lin-  
22           guistic demographics of populations, including com-  
23           munities along the United States-Mexico border.

1           “(4) *Carrying out activities described in sub-*  
2           *section (b) with respect to more than one health pro-*  
3           *fession discipline, specialty, or subspecialty.*

4           “(e) *CONSULTATION.—The Secretary shall carry out*  
5           *this section in consultation with the heads of appropriate*  
6           *health agencies and offices in the Department of Health and*  
7           *Human Services, including the Office of Minority Health.*

8           “(f) *DEFINITION.—In this section, the term ‘health dis-*  
9           *parities’ has the meaning given to the term in section 3171.*

10          “(g) *REPORT.—The Secretary shall submit to the Con-*  
11          *gress an annual report on the program carried out under*  
12          *this section.”.*

13       ***SEC. 2252. INNOVATIONS IN INTERDISCIPLINARY CARE***  
14               ***TRAINING.***

15          *Part D of title VII (42 U.S.C. 294 et seq.) is amended*  
16          *by adding at the end the following:*

17       ***“SEC. 759. INNOVATIONS IN INTERDISCIPLINARY CARE***  
18               ***TRAINING.***

19          “(a) *PROGRAM.—The Secretary shall establish an in-*  
20          *novations in interdisciplinary care training program con-*  
21          *sisting of awarding grants and contracts under subsection*  
22          *(b).*

23          “(b) *TRAINING PROGRAMS.—The Secretary shall*  
24          *award grants to, or enter into contracts with, eligible enti-*  
25          *ties—*

1           “(1) to test, develop, and evaluate health profes-  
2           sional training programs (including continuing edu-  
3           cation) designed to promote—

4                   “(A) the delivery of health services through  
5                   interdisciplinary and team-based models, which  
6                   may include patient-centered medical home mod-  
7                   els, medication therapy management models, and  
8                   models integrating physical, mental, or oral  
9                   health services; and

10                   “(B) coordination of the delivery of health  
11                   care within and across settings, including health  
12                   care institutions, community-based settings, and  
13                   the patient’s home; and

14           “(2) to implement such training programs devel-  
15           oped under paragraph (1) or otherwise.

16           “(c) *ELIGIBILITY.*—To be eligible for a grant or con-  
17           tract under subsection (b), an entity shall be—

18                   “(1) an accredited health professions school or  
19                   program;

20                   “(2) an academic health center;

21                   “(3) a public or private nonprofit entity (includ-  
22                   ing an area health education center or a geriatric  
23                   education center); or

24                   “(4) a consortium of 2 or more entities described  
25                   in paragraphs (1) through (3).

1       “(d) *PREFERENCES.*—*In awarding grants and con-*  
 2 *tracts under this section, the Secretary shall give preference*  
 3 *to entities that have a demonstrated record of the following:*

4               “(1) *Training the greatest percentage, or signifi-*  
 5 *cantly increasing the percentage, of health profes-*  
 6 *sionals who serve in underserved communities.*

7               “(2) *Broad interdisciplinary team-based collabo-*  
 8 *rations.*

9               “(3) *Addressing health disparities.*

10       “(e) *REPORT.*—*The Secretary shall submit to the Con-*  
 11 *gress an annual report on the program carried out under*  
 12 *this section.*

13       “(f) *DEFINITIONS.*—*In this section:*

14               “(1) *The term ‘health disparities’ has the mean-*  
 15 *ing given the term in section 3171.*

16               “(2) *The term ‘interdisciplinary’ means collabo-*  
 17 *ration across health professions and specialties, which*  
 18 *may include public health, nursing, allied health, and*  
 19 *appropriate medical specialties.”.*

20       **PART 3—ADVISORY COMMITTEE ON HEALTH**

21       **WORKFORCE EVALUATION AND ASSESSMENT**

22       **SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESS-**  
 23       **MENT.**

24       *Subpart 1 of part E of title VII (42 U.S.C. 294n et*  
 25 *seq.) is amended by adding at the end the following:*

1 **“SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESS-**  
2 **MENT.**

3 “(a) *ADVISORY COMMITTEE.*—*The Secretary, acting*  
4 *through the Assistant Secretary for Health, shall establish*  
5 *a permanent advisory committee to be known as the Advi-*  
6 *sory Committee on Health Workforce Evaluation and As-*  
7 *essment (referred to in this section as the ‘Advisory Com-*  
8 *mittee’).*

9 “(b) *RESPONSIBILITIES.*—*The Advisory Committee*  
10 *shall—*

11 “(1) *not later than 1 year after the date of the*  
12 *establishment of the Advisory Committee, submit rec-*  
13 *ommendations to the Secretary on—*

14 “(A) *classifications of the health workforce*  
15 *to ensure consistency of data collection on the*  
16 *health workforce; and*

17 “(B) *based on such classifications, stand-*  
18 *ardized methodologies and procedures to enu-*  
19 *merate the health workforce;*

20 “(2) *not later than 2 years after the date of the*  
21 *establishment of the Advisory Committee, submit rec-*  
22 *ommendations to the Secretary on—*

23 “(A) *the supply, diversity, and geographic*  
24 *distribution of the health workforce;*

1           “(B) the retention of the health workforce to  
2           ensure quality and adequacy of such workforce;  
3           and

4           “(C) policies to carry out the recommenda-  
5           tions made pursuant to subparagraphs (A) and  
6           (B); and

7           “(3) not later than 4 years after the date of the  
8           establishment of the Advisory Committee, and every 2  
9           years thereafter, submit updated recommendations to  
10          the Secretary under paragraphs (1) and (2).

11          “(c) *ROLE OF AGENCY.*—The Secretary shall provide  
12          ongoing administrative, research, and technical support for  
13          the operations of the Advisory Committee, including coordi-  
14          nating and supporting the dissemination of the rec-  
15          ommendations of the Advisory Committee.

16          “(d) *MEMBERSHIP.*—

17                  “(1) *NUMBER; APPOINTMENT.*—The Secretary  
18                  shall appoint 15 members to serve on the Advisory  
19                  Committee.

20                  “(2) *TERMS.*—

21                          “(A) *IN GENERAL.*—The Secretary shall ap-  
22                          point members of the Advisory Committee for a  
23                          term of 3 years and may reappoint such mem-  
24                          bers, but the Secretary may not appoint any  
25                          member to serve more than a total of 6 years.



1           “(B) *STAGGERED TERMS.*—*Notwithstanding*  
2           *subparagraph (A), of the members first ap-*  
3           *pointed to the Advisory Committee under para-*  
4           *graph (1)—*

5                     “(i) *5 shall be appointed for a term of*  
6                     *1 year;*

7                     “(ii) *5 shall be appointed for a term of*  
8                     *2 years; and*

9                     “(iii) *5 shall be appointed for a term*  
10                    *of 3 years.*

11           “(3) *QUALIFICATIONS.*—*Members of the Advisory*  
12           *Committee shall be appointed from among individ-*  
13           *uals who possess expertise in at least one of the fol-*  
14           *lowing areas:*

15                    “(A) *Conducting and interpreting health*  
16                    *workforce market analysis, including health care*  
17                    *labor workforce analysis.*

18                    “(B) *Conducting and interpreting health fi-*  
19                    *nance and economics research.*

20                    “(C) *Delivering and administering health*  
21                    *care services.*

22                    “(D) *Delivering and administering health*  
23                    *workforce education and training.*

24           “(4) *REPRESENTATION.*—*In appointing members*  
25           *of the Advisory Committee, the Secretary shall—*

1           “(A) include no less than one representative  
2 of each of—

3           “(i) health professionals within the  
4 health workforce;

5           “(ii) health care patients and con-  
6 sumers;

7           “(iii) employers;

8           “(iv) labor unions; and

9           “(v) third-party health payors; and

10          “(B) ensure that—

11           “(i) all areas of expertise described in  
12 paragraph (3) are represented;

13           “(ii) the members of the Advisory Com-  
14 mittee include members who, collectively,  
15 have significant experience working with—

16           “(I) populations in urban and  
17 federally designated rural and non-  
18 metropolitan areas; and

19           “(II) populations who are under-  
20 represented in the health professions,  
21 including underrepresented minority  
22 groups; and

23           “(iii) individuals who are directly in-  
24 volved in health professions education or

1                   *practice do not constitute a majority of the*  
2                   *members of the Advisory Committee.*

3                   “(5) *DISCLOSURE AND CONFLICTS OF INTER-*  
4                   *EST.—Members of the Advisory Committee shall not*  
5                   *be considered employees of the Federal Government by*  
6                   *reason of service on the Advisory Committee, except*  
7                   *members of the Advisory Committee shall be consid-*  
8                   *ered to be special Government employees within the*  
9                   *meaning of section 107 of the Ethics in Government*  
10                  *Act of 1978 (5 U.S.C. App.) and section 208 of title*  
11                  *18, United States Code, for the purposes of disclosure*  
12                  *and management of conflicts of interest under those*  
13                  *sections.*

14                  “(6) *NO PAY; RECEIPT OF TRAVEL EXPENSES.—*  
15                  *Members of the Advisory Committee shall not receive*  
16                  *any pay for service on the Committee, but may re-*  
17                  *ceive travel expenses, including a per diem, in accord-*  
18                  *ance with applicable provisions of subchapter I of*  
19                  *chapter 57 of title 5, United States Code.*

20                  “(e) *CONSULTATION.—In carrying out this section, the*  
21                  *Secretary shall consult with the Secretary of Education and*  
22                  *the Secretary of Labor.*

23                  “(f) *COLLABORATION.—The Advisory Committee shall*  
24                  *collaborate with the advisory bodies at the Health Resources*  
25                  *and Services Administration, the National Advisory Coun-*

1 *cil (as authorized in section 337), the Advisory Committee*  
2 *on Training in Primary Care Medicine and Dentistry (as*  
3 *authorized in section 749A), the Advisory Committee on*  
4 *Interdisciplinary, Community-Based Linkages (as author-*  
5 *ized in section 756), the Advisory Council on Graduate*  
6 *Medical Education (as authorized in section 762), and the*  
7 *National Advisory Council on Nurse Education and Prac-*  
8 *tice (as authorized in section 851).*

9       “(g) *FACA.—The Federal Advisory Committee Act (5*  
10 *U.S.C. App.) except for section 14 of such Act shall apply*  
11 *to the Advisory Committee under this section only to the*  
12 *extent that the provisions of such Act do not conflict with*  
13 *the requirements of this section.*

14       “(h) *REPORT.—The Secretary shall submit to the Con-*  
15 *gress an annual report on the activities of the Advisory*  
16 *Committee.*

17       “(i) *DEFINITION.—In this section, the term ‘health*  
18 *workforce’ includes all health care providers with direct pa-*  
19 *tient care and support responsibilities, including physi-*  
20 *cians, nurses, physician assistants, pharmacists, oral health*  
21 *professionals (as defined in section 749(f)), allied health*  
22 *professionals, mental and behavioral health professionals,*  
23 *and public health professionals (including veterinarians en-*  
24 *gaged in public health practice).”.*

1       **PART 4—HEALTH WORKFORCE ASSESSMENT**

2       **SEC. 2271. HEALTH WORKFORCE ASSESSMENT.**

3       (a) *IN GENERAL.*—Section 761 (42 U.S.C. 294n) is  
4 amended—

5           (1) by redesignating subsection (c) as subsection  
6 (e); and

7           (2) by striking subsections (a) and (b) and in-  
8 serting the following:

9       “(a) *IN GENERAL.*—The Secretary shall, based upon  
10 the classifications and standardized methodologies and pro-  
11 cedures developed by the Advisory Committee on Health  
12 Workforce Evaluation and Assessment under section  
13 764(b)—

14           “(1) collect data on the health workforce (as de-  
15 fined in section 764(i)), disaggregated by field, dis-  
16 cipline, and specialty, with respect to—

17                   “(A) the supply (including retention) of  
18 health professionals relative to the demand for  
19 such professionals;

20                   “(B) the diversity of health professionals  
21 (including with respect to race, ethnic back-  
22 ground, and gender); and

23                   “(C) the geographic distribution of health  
24 professionals; and

25           “(2) collect such data on individuals partici-  
26 pating in the programs authorized by subtitles A, B,

1       *and C and part 1 of subtitle D of title II of division*  
2       *C of the America’s Affordable Health Choices Act of*  
3       *2009.*

4       “(b) *GRANTS AND CONTRACTS FOR HEALTH WORK-*  
5       *FORCE ANALYSIS.—*

6               “(1) *IN GENERAL.—The Secretary may award*  
7       *grants or contracts to eligible entities to carry out*  
8       *subsection (a).*

9               “(2) *ELIGIBILITY.—To be eligible for a grant or*  
10       *contract under this subsection, an entity shall be—*

11                       “(A) *an accredited health professions school*  
12       *or program;*

13                       “(B) *an academic health center;*

14                       “(C) *a State, local, or tribal government;*

15                       “(D) *a public or private entity; or*

16                       “(E) *a consortium of 2 or more entities de-*  
17       *scribed in subparagraphs (A) through (D).*

18       “(c) *COLLABORATION AND DATA SHARING.—The Sec-*  
19       *retary shall collaborate with Federal departments and agen-*  
20       *cies, health professions organizations (including health pro-*  
21       *fessions education organizations), and professional medical*  
22       *societies for the purpose of carrying out subsection (a).*

23       “(d) *REPORT.—The Secretary shall submit to the Con-*  
24       *gress an annual report on the data collected under sub-*  
25       *section (a).”.*

1           (b) *PERIOD BEFORE COMPLETION OF NATIONAL*  
2 *STRATEGY.*—Pending completion of the classifications and  
3 standardized methodologies and procedures developed by the  
4 Advisory Committee on Health Workforce Evaluation and  
5 Assessment under section 764(b) of the Public Health Serv-  
6 ice Act, as added by section 2261, the Secretary of Health  
7 and Human Services, acting through the Administrator of  
8 the Health Resources and Services Administration and in  
9 consultation with such Advisory Committee, may make a  
10 judgment about the classifications, methodologies, and pro-  
11 cedures to be used for collection of data under section 761(a)  
12 of the Public Health Service Act, as amended by this sec-  
13 tion.

14       **PART 5—AUTHORIZATION OF APPROPRIATIONS**

15       **SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.**

16           (a) *IN GENERAL.*—Section 799C, as added and  
17 amended, is further amended by adding at the end the fol-  
18 lowing:

19           “(c) *HEALTH PROFESSIONS TRAINING FOR DIVER-*  
20 *SITY.*—For the purpose of carrying out sections 736, 737,  
21 738, 739, and 739A, in addition to any other amounts au-  
22 thorized to be appropriated for such purpose, there are au-  
23 thorized to be appropriated, out of any monies in the Public  
24 Health Investment Fund, the following:

25                   “(1) \$90,000,000 for fiscal year 2010.

1           “(2) \$97,000,000 for fiscal year 2011.

2           “(3) \$100,000,000 for fiscal year 2012.

3           “(4) \$104,000,000 for fiscal year 2013.

4           “(5) \$110,000,000 for fiscal year 2014.

5           “(d) *INTERDISCIPLINARY TRAINING PROGRAMS, ADVI-*  
6 *SORY COMMITTEE ON HEALTH WORKFORCE EVALUATION*  
7 *AND ASSESSMENT, AND HEALTH WORKFORCE ASSESS-*  
8 *MENT.*—*For the purpose of carrying out sections 741, 759,*  
9 *761, and 764, in addition to any other amounts authorized*  
10 *to be appropriated for such purpose, there are authorized*  
11 *to be appropriated, out of any monies in the Public Health*  
12 *Investment Fund, the following:*

13           “(1) \$87,000,000 for fiscal year 2010.

14           “(2) \$97,000,000 for fiscal year 2011.

15           “(3) \$103,000,000 for fiscal year 2012.

16           “(4) \$105,000,000 for fiscal year 2013.

17           “(5) \$113,000,000 for fiscal year 2014.”.

18           (b) *EXISTING AUTHORIZATIONS OF APPROPRIA-*  
19 *TIONS.*—

20           (1) *SECTION 736.*—*Paragraph (1) of section*  
21 *736(i) (42 U.S.C. 293(h)), as redesignated, is amend-*  
22 *ed by striking “2002” and inserting “2014”.*

23           (2) *SECTIONS 737, 738, AND 739.*—*Subsections (a),*  
24 *(b), and (c) of section 740 are amended by striking*  
25 *“2002” each place it appears and inserting “2014”.*



1           (3) *SECTION 741.*—Subsection (h), as so redesignated, of section 741 is amended—

2                   (A) by striking “and” after “fiscal year  
3                   2003,”; and

4                   (B) by inserting “, and such sums as may  
5                   be necessary for subsequent fiscal years through  
6                   the end of fiscal year 2014” before the period at  
7                   the end.

8           (4) *SECTION 761.*—Subsection (e)(1), as so redesignated, of section 761 is amended by striking “2002”  
9                   and inserting “2014”.

10                   **TITLE III—PREVENTION AND**  
11                   **WELLNESS**

12                   **SEC. 2301. PREVENTION AND WELLNESS.**

13           (a) *IN GENERAL.*—The Public Health Service Act (42  
14           U.S.C. 201 et seq.) is amended by adding at the end the  
15           following:  
16           

17                   **“TITLE XXXI—PREVENTION AND**  
18                   **WELLNESS**

19                   **“Subtitle A—Prevention and**  
20                   **Wellness Trust**

21                   **“SEC. 3111. PREVENTION AND WELLNESS TRUST.**

22           (a) *DEPOSITS INTO TRUST.*—There is established a  
23           Prevention and Wellness Trust. There are authorized to be  
24           appropriated to the Trust—  
25

1           “(1) amounts described in section  
2           2002(b)(2)(A)(ii) of the America’s Affordable Health  
3           Choices Act of 2009 for each fiscal year; and

4           “(2) in addition, out of any monies in the Public  
5           Health Investment Fund—

6                   “(A) for fiscal year 2010, \$2,400,000,000;

7                   “(B) for fiscal year 2011, \$2,845,000,000;

8                   “(C) for fiscal year 2012, \$3,100,000,000;

9                   “(D) for fiscal year 2013, \$3,455,000,000;

10           and

11                   “(E) for fiscal year 2014, \$3,600,000,000.

12           “(b) AVAILABILITY OF FUNDS.—Amounts in the Pre-  
13           vention and Wellness Trust shall be available, as provided  
14           in advance in appropriation Acts, for carrying out this  
15           title.

16           “(c) ALLOCATION.—Of the amounts authorized to be  
17           appropriated in subsection (a)(2), there are authorized to  
18           be appropriated—

19                   “(1) for carrying out subtitle C (Prevention Task  
20           Forces), \$30,000,000 for each of fiscal years 2010  
21           through 2014;

22                   “(2) for carrying out subtitle D (Prevention and  
23           Wellness Research)—

24                   “(A) for fiscal year 2010, \$100,000,000;

25                   “(B) for fiscal year 2011, \$150,000,000;

1           “(C) for fiscal year 2012, \$200,000,000;

2           “(D) for fiscal year 2013, \$250,000,000;

3           *and*

4           “(E) for fiscal year 2014, \$300,000,000;

5           “(3) for carrying out subtitle E (Delivery of  
6           *Community Preventive and Wellness Services*)—

7           “(A) for fiscal year 2010, \$1,065,000,000;

8           “(B) for fiscal year 2011, \$1,260,000,000;

9           “(C) for fiscal year 2012, \$1,365,000,000;

10          “(D) for fiscal year 2013, \$1,570,000,000;

11          *and*

12          “(E) for fiscal year 2014, \$1,600,000,000;

13          “(4) for carrying out section 3161 (Core Public  
14          *Health Infrastructure for State, Local, and Tribal*  
15          *Health Departments*)—

16          “(A) for fiscal year 2010, \$800,000,000;

17          “(B) for fiscal year 2011, \$1,000,000,000;

18          “(C) for fiscal year 2012, \$1,100,000,000;

19          “(D) for fiscal year 2013, \$1,200,000,000;

20          *and*

21          “(E) for fiscal year 2014, \$1,265,000,000;

22          *and*

23          “(5) for carrying out section 3162 (Core Public  
24          *Health Infrastructure and Activities for CDC*),

1       \$350,000,000 for each of fiscal years 2010 through  
2       2014.

3       **“Subtitle B—National Prevention**  
4               **and Wellness Strategy**

5       **“SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRAT-**  
6               **EGY.**

7               “(a) *IN GENERAL.*—The Secretary shall submit to the  
8 Congress within one year after the date of the enactment  
9 of this section, and at least every 2 years thereafter, a na-  
10 tional strategy that is designed to improve the Nation’s  
11 health through evidence-based clinical and community pre-  
12 vention and wellness activities (in this section referred to  
13 as ‘prevention and wellness activities’), including core pub-  
14 lic health infrastructure improvement activities.

15              “(b) *CONTENTS.*—The strategy under subsection (a)  
16 shall include each of the following:

17                      “(1) *Identification of specific national goals and*  
18 *objectives in prevention and wellness activities that*  
19 *take into account appropriate public health measures*  
20 *and standards, including departmental measures and*  
21 *standards (including Healthy People and National*  
22 *Public Health Performance Standards).*

23                      “(2) *Establishment of national priorities for pre-*  
24 *vention and wellness, taking into account unmet pre-*  
25 *vention and wellness needs.*

1           “(3) *Establishment of national priorities for re-*  
2           *search on prevention and wellness, taking into ac-*  
3           *count unanswered research questions on prevention*  
4           *and wellness.*

5           “(4) *Identification of health disparities in pre-*  
6           *vention and wellness.*

7           “(5) *Review of prevention payment incentives,*  
8           *the prevention workforce, and prevention delivery sys-*  
9           *tem capacity.*

10          “(6) *A plan for addressing and implementing*  
11          *paragraphs (1) through (5).*

12          “(c) *CONSULTATION.—In developing or revising the*  
13          *strategy under subsection (a), the Secretary shall consult*  
14          *with the following:*

15               “(1) *The heads of appropriate health agencies*  
16               *and offices in the Department, including the Office of*  
17               *the Surgeon General of the Public Health Service, the*  
18               *Office of Minority Health, the Office on Women’s*  
19               *Health, and the Substance Abuse and Mental Health*  
20               *Services Administration.*

21               “(2) *As appropriate, the heads of other Federal*  
22               *departments and agencies whose programs have a sig-*  
23               *nificant impact upon health (as determined by the*  
24               *Secretary).*

1           “(3) *As appropriate, nonprofit and for-profit 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           “(5) *The Task Force on Community Preventive*  
7           *Services and the Task Force on Clinical Preventive*  
8           *Services.*

9           **“Subtitle C—Prevention Task**  
10           **Forces**

11       **“SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERV-**  
12           **ICES.**

13           “(a) *IN GENERAL.—The Secretary, acting through the*  
14           *Director of the Agency for Healthcare Research and Qual-*  
15           *ity, shall establish a permanent task force to be known as*  
16           *the Task Force on Clinical Preventive Services (in this sec-*  
17           *tion referred to as the ‘Task Force’).*

18           “(b) *RESPONSIBILITIES.—The Task Force shall—*

19           “(1) *identify clinical preventive services for re-*  
20           *view;*

21           “(2) *review the scientific evidence related to the*  
22           *benefits, effectiveness, appropriateness, and costs of*  
23           *clinical preventive services identified under para-*  
24           *graph (1) for the purpose of developing, updating,*

1       *publishing, and disseminating evidence-based rec-*  
2       *ommendations on the use of such services;*

3             “(3) *as appropriate, take into account health*  
4       *disparities in developing, updating, publishing, and*  
5       *disseminating evidence-based recommendations on the*  
6       *use of such services;*

7             “(4) *identify gaps in clinical preventive services*  
8       *research and evaluation and recommend priority*  
9       *areas for such research and evaluation;*

10            “(5) *as appropriate, consult with the clinical*  
11       *prevention stakeholders board in accordance with sub-*  
12       *section (f);*

13            “(6) *consult with the Task Force on Community*  
14       *Preventive Services established under section 3132;*  
15       *and*

16            “(7) *as appropriate, in carrying out this section,*  
17       *consider the national strategy under section 3121.*

18       “(c) *ROLE OF AGENCY.—The Secretary shall provide*  
19       *ongoing administrative, research, and technical support for*  
20       *the operations of the Task Force, including coordinating*  
21       *and supporting the dissemination of the recommendations*  
22       *of the Task Force.*

23       “(d) *MEMBERSHIP.—*

1           “(1) *NUMBER; APPOINTMENT.*—*The Task Force*  
2           *shall be composed of 30 members, appointed by the*  
3           *Secretary.*

4           “(2) *TERMS.*—

5                   “(A) *IN GENERAL.*—*The Secretary shall ap-*  
6                   *point members of the Task Force for a term of*  
7                   *6 years and may reappoint such members, but*  
8                   *the Secretary may not appoint any member to*  
9                   *serve more than a total of 12 years.*

10                   “(B) *STAGGERED TERMS.*—*Notwithstanding*  
11                   *subparagraph (A), of the members first ap-*  
12                   *pointed to serve on the Task Force after the en-*  
13                   *actment of this title—*

14                           “(i) *10 shall be appointed for a term*  
15                           *of 2 years;*

16                           “(ii) *10 shall be appointed for a term*  
17                           *of 4 years; and*

18                           “(iii) *10 shall be appointed for a term*  
19                           *of 6 years.*

20           “(3) *QUALIFICATIONS.*—*Members of the Task*  
21           *Force shall be appointed from among individuals who*  
22           *possess expertise in at least one of the following areas:*

23                   “(A) *Health promotion and disease preven-*  
24                   *tion.*



1           “(B) *Evaluation of research and systematic*  
2           *evidence reviews.*

3           “(C) *Application of systematic evidence re-*  
4           *views to clinical decisionmaking or health policy.*

5           “(D) *Clinical primary care in child and*  
6           *adolescent health.*

7           “(E) *Clinical primary care in adult health,*  
8           *including women’s health.*

9           “(F) *Clinical primary care in geriatrics.*

10          “(G) *Clinical counseling and behavioral*  
11          *services for primary care patients.*

12          “(4) *REPRESENTATION.—In appointing members*  
13          *of the Task Force, the Secretary shall ensure that—*

14                 “(A) *all areas of expertise described in*  
15                 *paragraph (3) are represented; and*

16                 “(B) *the members of the Task Force include*  
17                 *individuals with expertise in health disparities.*

18          “(e) *SUBGROUPS.—As appropriate to maximize effi-*  
19          *ciency, the Task Force may delegate authority for con-*  
20          *ducting reviews and making recommendations to subgroups*  
21          *consisting of Task Force members, subject to final approval*  
22          *by the Task Force.*

23          “(f) *CLINICAL PREVENTION STAKEHOLDERS BOARD.—*

24                 “(1) *IN GENERAL.—The Task Force shall con-*  
25                 *vene a clinical prevention stakeholders board com-*

1        *posed of representatives of appropriate public and*  
2        *private entities with an interest in clinical preventive*  
3        *services to advise the Task Force on developing, up-*  
4        *dating, publishing, and disseminating evidence-based*  
5        *recommendations on the use of clinical preventive*  
6        *services.*

7                *“(2) MEMBERSHIP.—The members of the clinical*  
8        *prevention stakeholders board shall include represent-*  
9        *atives of the following:*

10                *“(A) Health care consumers and patient*  
11                *groups.*

12                *“(B) Providers of clinical preventive serv-*  
13                *ices, including community-based providers.*

14                *“(C) Federal departments and agencies, in-*  
15                *cluding—*

16                        *“(i) appropriate health agencies and*  
17                        *offices in the Department, including the Of-*  
18                        *fice of the Surgeon General of the Public*  
19                        *Health Service, the Office of Minority*  
20                        *Health, the National Center on Minority*  
21                        *Health and Health Disparities, and the Of-*  
22                        *fice on Women’s Health; and*

23                        *“(ii) as appropriate, other Federal de-*  
24                        *partments and agencies whose programs*

1                   *have a significant impact upon health (as*  
2                   *determined by the Secretary).*

3                   “(D) *Private health care payors.*

4                   “(3) *RESPONSIBILITIES.—In accordance with*  
5                   *subsection (b)(5), the clinical prevention stakeholders*  
6                   *board shall—*

7                   “(A) *recommend clinical preventive services*  
8                   *for review by the Task Force;*

9                   “(B) *suggest scientific evidence for consider-*  
10                  *ation by the Task Force related to reviews under-*  
11                  *taken by the Task Force;*

12                  “(C) *provide feedback regarding draft rec-*  
13                  *ommendations by the Task Force; and*

14                  “(D) *assist with efforts regarding dissemi-*  
15                  *nation of recommendations by the Director of the*  
16                  *Agency for Healthcare Research and Quality.*

17                  “(g) *DISCLOSURE AND CONFLICTS OF INTEREST.—*  
18                  *Members of the Task Force or the clinical prevention stake-*  
19                  *holders board shall not be considered employees of the Fed-*  
20                  *eral Government by reason of service on the Task Force or*  
21                  *the clinical prevention stakeholders board, except members*  
22                  *of the Task Force or the clinical prevention stakeholders*  
23                  *board shall be considered to be special Government employ-*  
24                  *ees within the meaning of section 107 of the Ethics in Gov-*  
25                  *ernment Act of 1978 (5 U.S.C. App.) and section 208 of*

1 *title 18, United States Code, for the purposes of disclosure*  
2 *and management of conflicts of interest under those sec-*  
3 *tions.*

4       “(h) *NO PAY; RECEIPT OF TRAVEL EXPENSES.*—*Mem-*  
5 *bers of the Task Force or the clinical prevention stakeholders*  
6 *board shall not receive any pay for service on the Task*  
7 *Force, but may receive travel expenses, including a per*  
8 *diem, in accordance with applicable provisions of sub-*  
9 *chapter I of chapter 57 of title 5, United States Code.*

10       “(i) *APPLICATION OF FACA.*—*The Federal Advisory*  
11 *Committee Act (5 U.S.C. App.) except for section 14 of such*  
12 *Act shall apply to the Task Force to the extent that the*  
13 *provisions of such Act do not conflict with the provisions*  
14 *of this title.*

15       “(j) *REPORT.*—*The Secretary shall submit to the Con-*  
16 *gress an annual report on the Task Force, including with*  
17 *respect to gaps identified and recommendations made under*  
18 *subsection (b)(4).*

19       “(k) *DEFINITION.*—*In this section, the term ‘health*  
20 *disparities’ has the meaning given the term in section 3171.*

21 **“SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE**  
22 **SERVICES.**

23       “(a) *IN GENERAL.*—*The Secretary, acting through the*  
24 *Director of the Centers for Disease Control and Prevention,*  
25 *shall establish a permanent task force to be known as the*

1 *Task Force on Community Preventive Services (in this sec-*  
2 *tion referred to as the ‘Task Force’).*

3 “(b) *RESPONSIBILITIES.—The Task Force shall—*

4 “(1) *identify community preventive services for*  
5 *review;*

6 “(2) *review the scientific evidence related to the*  
7 *benefits, effectiveness, appropriateness, and costs of*  
8 *community preventive services identified under para-*  
9 *graph (1) for the purpose of developing, updating,*  
10 *publishing, and disseminating evidence-based rec-*  
11 *ommendations on the use of such services;*

12 “(3) *as appropriate, take into account health*  
13 *disparities in developing, updating, publishing, and*  
14 *disseminating evidence-based recommendations on the*  
15 *use of such services;*

16 “(4) *identify gaps in community preventive serv-*  
17 *ices research and evaluation and recommend priority*  
18 *areas for such research and evaluation;*

19 “(5) *as appropriate, consult with the community*  
20 *prevention stakeholders board in accordance with sub-*  
21 *section (f);*

22 “(6) *consult with the Task Force on Clinical*  
23 *Preventive Services established under section 3131;*  
24 *and*

1           “(7) as appropriate, in carrying out this section,  
2           consider the national strategy under section 3121.

3           “(c) *ROLE OF AGENCY.*—The Secretary shall provide  
4 ongoing administrative, research, and technical support for  
5 the operations of the Task Force, including coordinating  
6 and supporting the dissemination of the recommendations  
7 of the Task Force.

8           “(d) *MEMBERSHIP.*—

9           “(1) *NUMBER; APPOINTMENT.*—The Task Force  
10 shall be composed of 30 members, appointed by the  
11 Secretary.

12           “(2) *TERMS.*—

13           “(A) *IN GENERAL.*—The Secretary shall ap-  
14 point members of the Task Force for a term of  
15 6 years and may reappoint such members, but  
16 the Secretary may not appoint any member to  
17 serve more than a total of 12 years.

18           “(B) *STAGGERED TERMS.*—Notwithstanding  
19 subparagraph (A), of the members first ap-  
20 pointed to serve on the Task Force after the en-  
21 actment of this section—

22           “(i) 10 shall be appointed for a term  
23 of 2 years;

24           “(ii) 10 shall be appointed for a term  
25 of 4 years; and

1                   “(iii) 10 shall be appointed for a term  
2                   of 6 years.

3                   “(3) *QUALIFICATIONS.*—Members of the Task  
4                   Force shall be appointed from among individuals who  
5                   possess expertise in at least one of the following areas:

6                   “(A) *Public health.*

7                   “(B) *Evaluation of research and systematic*  
8                   *evidence reviews.*

9                   “(C) *Disciplines relevant to community pre-*  
10                   *ventive services, including health promotion; dis-*  
11                   *ease prevention; chronic disease; worksite health;*  
12                   *qualitative and quantitative analysis; and health*  
13                   *economics, policy, law, and statistics.*

14                   “(4) *REPRESENTATION.*—In appointing members  
15                   of the Task Force, the Secretary—

16                   “(A) shall ensure that all areas of expertise  
17                   described in paragraph (3) are represented;

18                   “(B) shall ensure that such members include  
19                   sufficient representatives of each of—

20                   “(i) *State health officers;*

21                   “(ii) *local health officers;*

22                   “(iii) *health care practitioners; and*

23                   “(iv) *public health practitioners; and*

24                   “(C) shall appoint individuals who have ex-  
25                   pertise in health disparities.

1       “(e) *SUBGROUPS.*—As appropriate to maximize effi-  
2       *ciency, the Task Force may delegate authority for con-*  
3       *ducting reviews and making recommendations to subgroups*  
4       *consisting of Task Force members, subject to final approval*  
5       *by the Task Force.*

6       “(f) *COMMUNITY PREVENTION STAKEHOLDERS*  
7       *BOARD.*—

8               “(1) *IN GENERAL.*—The Task Force shall con-  
9       *vene a community prevention stakeholders board com-*  
10       *posed of representatives of appropriate public and*  
11       *private entities with an interest in community pre-*  
12       *ventive services to advise the Task Force on devel-*  
13       *oping, updating, publishing, and disseminating evi-*  
14       *dence-based recommendations on the use of commu-*  
15       *nity preventive services.*

16               “(2) *MEMBERSHIP.*—The members of the com-  
17       *munity prevention stakeholders board shall include*  
18       *representatives of the following:*

19                       “(A) *Health care consumers and patient*  
20       *groups.*

21                       “(B) *Providers of community preventive*  
22       *services, including community-based providers.*

23                       “(C) *Federal departments and agencies, in-*  
24       *cluding—*



1           “(i) appropriate health agencies and  
2           offices in the Department, including the Of-  
3           fice of the Surgeon General of the Public  
4           Health Service, the Office of Minority  
5           Health, the National Center on Minority  
6           Health and Health Disparities, and the Of-  
7           fice on Women’s Health; and

8           “(ii) as appropriate, other Federal de-  
9           partments and agencies whose programs  
10          have a significant impact upon health (as  
11          determined by the Secretary).

12          “(D) Private health care payors.

13          “(3) RESPONSIBILITIES.—In accordance with  
14          subsection (b)(5), the community prevention stake-  
15          holders board shall—

16               “(A) recommend community preventive  
17               services for review by the Task Force;

18               “(B) suggest scientific evidence for consider-  
19               ation by the Task Force related to reviews under-  
20               taken by the Task Force;

21               “(C) provide feedback regarding draft rec-  
22               ommendations by the Task Force; and

23               “(D) assist with efforts regarding dissemi-  
24               nation of recommendations by the Director of the  
25               Centers for Disease Control and Prevention.

1           “(g) *DISCLOSURE AND CONFLICTS OF INTEREST.*—  
2 *Members of the Task Force or the community prevention*  
3 *stakeholders board shall not be considered employees of the*  
4 *Federal Government by reason of service on the Task Force*  
5 *or the community prevention stakeholders board, except*  
6 *members of the Task Force or the community prevention*  
7 *stakeholders board shall be considered to be special Govern-*  
8 *ment employees within the meaning of section 107 of the*  
9 *Ethics in Government Act of 1978 (5 U.S.C. App.) and sec-*  
10 *tion 208 of title 18, United States Code, for the purposes*  
11 *of disclosure and management of conflicts of interest under*  
12 *those sections.*

13           “(h) *NO PAY; RECEIPT OF TRAVEL EXPENSES.*—*Mem-*  
14 *bers of the Task Force or the community prevention stake-*  
15 *holders board shall not receive any pay for service on the*  
16 *Task Force, but may receive travel expenses, including a*  
17 *per diem, in accordance with applicable provisions of sub-*  
18 *chapter I of chapter 57 of title 5, United States Code.*

19           “(i) *APPLICATION OF FACA.*—*The Federal Advisory*  
20 *Committee Act (5 U.S.C. App.) except for section 14 of such*  
21 *Act shall apply to the Task Force to the extent that the*  
22 *provisions of such Act do not conflict with the provisions*  
23 *of this title.*

24           “(j) *REPORT.*—*The Secretary shall submit to the Con-*  
25 *gress an annual report on the Task Force, including with*

1 *respect to gaps identified and recommendations made under*  
2 *subsection (b)(4).*

3 “(k) *DEFINITION.*—*In this section, the term ‘health*  
4 *disparities’ has the meaning given the term in section 3171.*

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 Control*  
11 *and Prevention, the Director of the National Institutes of*  
12 *Health, and the heads of other agencies within the Depart-*  
13 *ment of Health and Human Services conducting or sup-*  
14 *porting such research, shall take into consideration the na-*  
15 *tional strategy under section 3121 and the recommenda-*  
16 *tions of the Task Force on Clinical Preventive Services*  
17 *under section 3131 and the Task Force on Community Pre-*  
18 *ventive Services under section 3132.*

19 **“SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RE-**  
20 **SEARCH GRANTS.**

21 “(a) *IN GENERAL.*—*The Secretary, acting through the*  
22 *Director of the Centers for Disease Control and Prevention,*  
23 *shall conduct, or award grants to eligible entities to con-*  
24 *duct, research in priority areas identified by the Secretary*  
25 *in the national strategy under section 3121 or by the Task*

1 *Force on Community Preventive Services as required by*  
2 *section 3132.*

3 “(b) *ELIGIBILITY.*—*To be eligible for a grant under*  
4 *this section, an entity shall be—*

5 “(1) *a State, local, or tribal department of*  
6 *health;*

7 “(2) *a public or private nonprofit entity; or*

8 “(3) *a consortium of 2 or more entities described*  
9 *in paragraphs (1) and (2).*

10 “(c) *REPORT.*—*The Secretary shall submit to the Con-*  
11 *gress an annual report on the program of research under*  
12 *this section.*

13 **“Subtitle E—Delivery of Community**  
14 **Prevention and Wellness Services**

15 **“SEC. 3151. COMMUNITY PREVENTION AND WELLNESS**  
16 **SERVICES GRANTS.**

17 “(a) *IN GENERAL.*—*The Secretary, acting through the*  
18 *Director of the Centers for Disease Control and Prevention,*  
19 *shall establish a program for the delivery of community pre-*  
20 *vention and wellness services consisting of awarding grants*  
21 *to eligible entities—*

22 “(1) *to provide evidence-based, community pre-*  
23 *vention and wellness services in priority areas identi-*  
24 *fied by the Secretary in the national strategy under*  
25 *section 3121; or*

1           “(2) to plan such services.

2           “(b) *ELIGIBILITY.*—

3           “(1) *DEFINITION.*—To be eligible for a grant  
4 under this section, an entity shall be—

5           “(A) a State, local, or tribal department of  
6 health;

7           “(B) a public or private entity; or

8           “(C) a consortium of—

9           “(i) 2 or more entities described in  
10 subparagraph (A) or (B); and

11           “(ii) a community partnership rep-  
12 resenting a Health Empowerment Zone.

13           “(2) *HEALTH EMPOWERMENT ZONE.*—In this  
14 subsection, the term ‘Health Empowerment Zone’  
15 means an area—

16           “(A) in which multiple community preven-  
17 tion and wellness services are implemented in  
18 order to address one or more health disparities,  
19 including those identified by the Secretary in the  
20 national strategy under section 3121; and

21           “(B) which is represented by a community  
22 partnership that demonstrates community sup-  
23 port and coordination with State, local, or tribal  
24 health departments and includes—

1                   “(i) a broad cross section of stake-  
2                   holders;

3                   “(ii) residents of the community; and

4                   “(iii) representatives of entities that  
5                   have a history of working within and serv-  
6                   ing the community.

7                   “(c) *PREFERENCES.*—In awarding grants under this  
8                   section, the Secretary shall give preference to entities that—

9                   “(1) will address one or more goals or objectives  
10                  identified by the Secretary in the national strategy  
11                  under section 3121;

12                  “(2) will address significant health disparities,  
13                  including those identified by the Secretary in the na-  
14                  tional strategy under section 3121;

15                  “(3) will address unmet community prevention  
16                  and wellness needs and avoids duplication of effort;

17                  “(4) have been demonstrated to be effective in  
18                  communities comparable to the proposed target com-  
19                  munity;

20                  “(5) will contribute to the evidence base for com-  
21                  munity prevention and wellness services;

22                  “(6) demonstrate that the community prevention  
23                  and wellness services to be funded will be sustainable;  
24                  and

1           “(7) *demonstrate coordination or collaboration*  
2           *across governmental and nongovernmental partners.*

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 community prevention and wellness services whose*  
7           *primary purpose is to achieve a measurable reduction in*  
8           *one or more health disparities, including those identified*  
9           *by the Secretary in the national strategy under section*  
10          *3121.*

11          “(e) *EMPHASIS ON RECOMMENDED SERVICES.—For*  
12          *fiscal year 2013 and subsequent fiscal years, the Secretary*  
13          *shall award grants under this section only for planning or*  
14          *implementing services recommended by the Task Force on*  
15          *Community Preventive Services under section 3122 or*  
16          *deemed effective based on a review of comparable rigor (as*  
17          *determined by the Director of the Centers for Disease Con-*  
18          *trol and Prevention).*

19          “(f) *PROHIBITED USES OF FUNDS.—An entity that re-*  
20          *ceives a grant under this section may not use funds pro-*  
21          *vided through the grant—*

22                 “(1) *to build or acquire real property or for con-*  
23                 *struction; or*

1           “(2) for services or planning to the extent that  
2           payment has been made, or can reasonably be ex-  
3           pected to be made—

4                   “(A) under any insurance policy;

5                   “(B) under any Federal or State health ben-  
6           efits program (including titles XIX and XXI of  
7           the Social Security Act); or

8                   “(C) by an entity which provides health  
9           services on a prepaid basis.

10          “(g) REPORT.—The Secretary shall submit to the Con-  
11       gress an annual report on the program of grants awarded  
12       under this section.

13          “(h) DEFINITIONS.—In this section, the term ‘evi-  
14       dence-based’ means that methodologically sound research  
15       has demonstrated a beneficial health effect, in the judgment  
16       of the Director of the Centers for Disease Control and Pre-  
17       vention.

18           **“Subtitle F—Core Public Health**  
19                   **Infrastructure**

20       **“SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR**  
21                   **STATE, LOCAL, AND TRIBAL HEALTH DEPART-**  
22                   **MENTS.**

23          “(a) PROGRAM.—The Secretary, acting through the  
24       Director of the Centers for Disease Control and Prevention



1 *shall establish a core public health infrastructure program*  
2 *consisting of awarding grants under subsection (b).*

3 “(b) *GRANTS.*—

4 “(1) *AWARD.*—*For the purpose of addressing*  
5 *core public health infrastructure needs, the Sec-*  
6 *retary—*

7 “(A) *shall award a grant to each State*  
8 *health department; and*

9 “(B) *may award grants on a competitive*  
10 *basis to State, local, or tribal health depart-*  
11 *ments.*

12 “(2) *ALLOCATION.*—*Of the total amount of funds*  
13 *awarded as grants under this subsection for a fiscal*  
14 *year—*

15 “(A) *not less than 50 percent shall be for*  
16 *grants to State health departments under para-*  
17 *graph (1)(A); and*

18 “(B) *not less than 30 percent shall be for*  
19 *grants to State, local, or tribal health depart-*  
20 *ments under paragraph (1)(B).*

21 “(c) *USE OF FUNDS.*—*The Secretary may award a*  
22 *grant to an entity under subsection (b)(1) only if the entity*  
23 *agrees to use the grant to address core public health infra-*  
24 *structure needs, including those identified in the accredita-*  
25 *tion process under subsection (g).*

1       “(d) *FORMULA GRANTS TO STATE HEALTH DEPART-*  
2 *MENTS.—In making grants under subsection (b)(1)(A), the*  
3 *Secretary shall award funds to each State health depart-*  
4 *ment in accordance with—*

5               “(1) *a formula based on population size; burden*  
6 *of preventable disease and disability; and core public*  
7 *health infrastructure gaps, including those identified*  
8 *in the accreditation process under subsection (g); and*

9               “(2) *application requirements established by the*  
10 *Secretary, including a requirement that the State*  
11 *submit a plan that demonstrates to the satisfaction of*  
12 *the Secretary that the State’s health department*  
13 *will—*

14                       “(A) *address its highest priority core public*  
15 *health infrastructure needs; and*

16                       “(B) *as appropriate, allocate funds to local*  
17 *health departments within the State.*

18       “(e) *COMPETITIVE GRANTS TO STATE, LOCAL, AND*  
19 *TRIBAL HEALTH DEPARTMENTS.—In making grants under*  
20 *subsection (b)(1)(B), the Secretary shall give priority to ap-*  
21 *plicants demonstrating core public health infrastructure*  
22 *needs identified in the accreditation process under sub-*  
23 *section (g).*

24       “(f) *MAINTENANCE OF EFFORT.—The Secretary may*  
25 *award a grant to an entity under subsection (b) only if*

1 *the entity demonstrates to the satisfaction of the Secretary*  
2 *that—*

3           “(1) *funds received through the grant will be ex-*  
4 *pended only to supplement, and not supplant, non-*  
5 *Federal and Federal funds otherwise available to the*  
6 *entity for the purpose of addressing core public health*  
7 *infrastructure needs; and*

8           “(2) *with respect to activities for which the grant*  
9 *is awarded, the entity will maintain expenditures of*  
10 *non-Federal amounts for such activities at a level not*  
11 *less than the level of such expenditures maintained by*  
12 *the entity for the fiscal year preceding the fiscal year*  
13 *for which the entity receives the grant.*

14           “(g) *ESTABLISHMENT OF A PUBLIC HEALTH ACCREDI-*  
15 *TATION PROGRAM.—*

16           “(1) *IN GENERAL.—The Secretary, acting*  
17 *through the Director of the Centers for Disease Con-*  
18 *trol and Prevention, shall—*

19           “(A) *develop, and periodically review and*  
20 *update, standards for voluntary accreditation of*  
21 *State, local, or tribal health departments and*  
22 *public health laboratories for the purpose of ad-*  
23 *vancing the quality and performance of such de-*  
24 *partments and laboratories; and*

1           “(B) *implement a program to accredit such*  
2           *health departments and laboratories in accord-*  
3           *ance with such standards.*

4           “(2) *COOPERATIVE AGREEMENT.—The Secretary*  
5           *may enter into a cooperative agreement with a pri-*  
6           *vate nonprofit entity to carry out paragraph (1).*

7           “(h) *REPORT.—The Secretary shall submit to the Con-*  
8           *gress an annual report on progress being made to accredit*  
9           *entities under subsection (g), including—*

10           “(1) *a strategy, including goals and objectives,*  
11           *for accrediting entities under subsection (g) and*  
12           *achieving the purpose described in subsection (g)(1);*  
13           *and*

14           “(2) *identification of gaps in research related to*  
15           *core public health infrastructure and recommenda-*  
16           *tions of priority areas for such research.*

17           **“SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND**  
18           **ACTIVITIES FOR CDC.**

19           “(a) *IN GENERAL.—The Secretary, acting through the*  
20           *Director of the Centers for Disease Control and Prevention,*  
21           *shall expand and improve the core public health infrastruc-*  
22           *ture and activities of the Centers for Disease Control and*  
23           *Prevention to address unmet and emerging public health*  
24           *needs.*

1       “(b) *REPORT.*—*The Secretary shall submit to the Con-*  
2 *gress an annual report on the activities funded through this*  
3 *section.*

## 4       **“Subtitle G—General Provisions**

### 5       **“SEC. 3171. DEFINITIONS.**

6       *“In this title:*

7               “(1) *The term ‘core public health infrastructure’*  
8 *includes workforce capacity and competency; labora-*  
9 *tory systems; health information, health information*  
10 *systems, and health information analysis; commu-*  
11 *nications; financing; other relevant components of or-*  
12 *ganizational capacity; and other related activities.*

13               “(2) *The terms ‘Department’ and ‘departmental’*  
14 *refer to the Department of Health and Human Serv-*  
15 *ices.*

16               “(3) *The term ‘health disparities’ includes health*  
17 *and health care disparities and means population-*  
18 *specific differences in the presence of disease, health*  
19 *outcomes, or access to health care. For purposes of the*  
20 *preceding sentence, a population may be delineated*  
21 *by race, ethnicity, geographic setting, and other popu-*  
22 *lations or subpopulations determined by the Secretary*  
23 *to experience significant gaps in disease, health out-*  
24 *comes, or access to health care.*

1           “(4) *The term ‘tribal’ refers to an Indian tribe,*  
2           *a Tribal organization, or an Urban Indian organiza-*  
3           *tion, as such terms are defined in section 4 of the In-*  
4           *dian Health Care Improvement Act.’”.*

5           **(b) TRANSITION PROVISIONS APPLICABLE TO TASK**  
6           **FORCES.—**

7           **(1) FUNCTIONS, PERSONNEL, ASSETS, LIABIL-**  
8           **ITIES, AND ADMINISTRATIVE ACTIONS.—***All functions,*  
9           *personnel, assets, and liabilities of, and administra-*  
10           *tive actions applicable to, the Preventive Services*  
11           *Task Force convened under section 915(a) of the Pub-*  
12           *lic Health Service Act and the Task Force on Com-*  
13           *munity Preventive Services (as such section and Task*  
14           *Forces were in existence on the day before the date of*  
15           *the enactment of this Act) shall be transferred to the*  
16           *Task Force on Clinical Preventive Services and the*  
17           *Task Force on Community Preventive Services, re-*  
18           *spectively, established under sections 3121 and 3122*  
19           *of the Public Health Service Act, as added by sub-*  
20           *section (a).*

21           **(2) RECOMMENDATIONS.—***All recommendations*  
22           *of the Preventive Services Task Force and the Task*  
23           *Force on Community Preventive Services, as in exist-*  
24           *ence on the day before the date of the enactment of*  
25           *this Act, shall be considered to be recommendations of*

1 *the Task Force on Clinical Preventive Services and*  
2 *the Task Force on Community Preventive Services,*  
3 *respectively, established under sections 3121 and 3122*  
4 *of the Public Health Service Act, as added by sub-*  
5 *section (a).*

6 (3) *MEMBERS ALREADY SERVING.—*

7 (A) *INITIAL MEMBERS.—The Secretary of*  
8 *Health and Human Services may select those in-*  
9 *dividuals already serving on the Preventive*  
10 *Services Task Force and the Task Force on Com-*  
11 *munity Preventive Services, as in existence on*  
12 *the day before the date of the enactment of this*  
13 *Act, to be among the first members appointed to*  
14 *the Task Force on Clinical Preventive Services*  
15 *and the Task Force on Community Preventive*  
16 *Services, respectively, under sections 3121 and*  
17 *3122 of the Public Health Service Act, as added*  
18 *by subsection (a).*

19 (B) *CALCULATION OF TOTAL SERVICE.—In*  
20 *calculating the total years of service of a member*  
21 *of a task force for purposes of section*  
22 *3131(d)(2)(A) or 3132(d)(2)(A) of the Public*  
23 *Health Service Act, as added by subsection (a),*  
24 *the Secretary of Health and Human Services*  
25 *shall not include any period of service by the*

1           *member on the Preventive Services Task Force or*  
2           *the Task Force on Community Preventive Serv-*  
3           *ices, respectively, as in existence on the day be-*  
4           *fore the date of the enactment of this Act.*

5           (c) *PERIOD BEFORE COMPLETION OF NATIONAL*  
6           *STRATEGY.—Pending completion of the national strategy*  
7           *under section 3121 of the Public Health Service Act, as*  
8           *added by subsection (a), the Secretary of Health and*  
9           *Human Services, acting through the relevant agency head,*  
10          *may make a judgment about how the strategy will address*  
11          *an issue and rely on such judgment in carrying out any*  
12          *provision of subtitle C, D, E, or F of title XXXI of such*  
13          *Act, as added by subsection (a), that requires the Sec-*  
14          *retary—*

15                 (1) *to take into consideration such strategy;*

16                 (2) *to conduct or support research or provide*  
17                 *services in priority areas identified in such strategy;*  
18                 *or*

19                 (3) *to take any other action in reliance on such*  
20                 *strategy.*

21           (d) *CONFORMING AMENDMENTS.—*

22                 (1) *Paragraph (61) of section 3(b) of the Indian*  
23                 *Health Care Improvement Act (25 U.S.C. 1602) is*  
24                 *amended by striking “United States Preventive Serv-*



1        *ices Task Force” and inserting “Task Force on Clin-*  
2        *ical Preventive Services”.*

3            (2) *Section 126 of the Medicare, Medicaid, and*  
4        *SCHIP Benefits Improvement and Protection Act of*  
5        *2000 (Appendix F of Public Law 106–554) is amend-*  
6        *ed by striking “United States Preventive Services*  
7        *Task Force” each place it appears and inserting*  
8        *“Task Force on Clinical Preventive Services”.*

9            (3) *Paragraph (7) of section 317D(a) of the Pub-*  
10       *lic Health Service Act (42 U.S.C. 247b–5(a)) is*  
11       *amended by striking “United States Preventive Serv-*  
12       *ices Task Force” and inserting “Task Force on Clin-*  
13       *ical Preventive Services”.*

14           (4) *Section 915 of the Public Health Service Act*  
15       *(42 U.S.C. 299b–4) is amended by striking subsection*  
16       *(a).*

17           (5) *Subsections (s)(2)(AA)(iii)(II), (xx)(1), and*  
18       *(ddd)(1)(B) of section 1861 of the Social Security Act*  
19       *(42 U.S.C. 1395x) are amended by striking “United*  
20       *States Preventive Services Task Force” each place it*  
21       *appears and inserting “Task Force on Clinical Pre-*  
22       *ventive Services”.*

1                   **TITLE IV—QUALITY AND**  
2                   **SURVEILLANCE**

3   **SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE**  
4                   **DELIVERY OF HEALTH CARE.**

5           (a) *IN GENERAL.*—*Title IX of the Public Health Serv-*  
6   *ice Act (42 U.S.C. 299 et seq.) is amended—*

7                   (1) *by redesignating part D as part E;*

8                   (2) *by redesignating sections 931 through 938 as*  
9   *sections 941 through 948, respectively;*

10                  (3) *in section 948(1), as redesignated, by strik-*  
11   *ing “931” and inserting “941”; and*

12                  (4) *by inserting after part C the following:*

13   **“PART D—IMPLEMENTATION OF BEST PRACTICES**  
14                   **IN THE DELIVERY OF HEALTH CARE**

15   **“SEC. 931. CENTER FOR QUALITY IMPROVEMENT.**

16           “(a) *IN GENERAL.*—*There is established the Center for*  
17   *Quality Improvement (referred to in this part as the ‘Cen-*  
18   *ter’), to be headed by the Director.*

19           “(b) *PRIORITIZATION.*—

20                  “(1) *IN GENERAL.*—*The Director shall prioritize*  
21   *areas for the identification, development, evaluation,*  
22   *and implementation of best practices (including inno-*  
23   *vative methodologies and strategies) for quality im-*  
24   *provement activities in the delivery of health care*  
25   *services (in this section referred to as ‘best practices’).*

1           “(2) *CONSIDERATIONS.—In prioritizing areas*  
2           *under paragraph (1), the Director shall consider—*

3                   “(A) *the priorities established under section*  
4                   *1191 of the Social Security Act; and*

5                   “(B) *the key health indicators identified by*  
6                   *the Assistant Secretary for Health Information*  
7                   *under section 1709.*

8           “(3) *LIMITATIONS.—In conducting its duties*  
9           *under this subsection, the Center for Quality Improve-*  
10           *ment shall not develop quality-adjusted life year*  
11           *measures or any other methodologies that can be used*  
12           *to deny benefits to a beneficiary against the bene-*  
13           *ficiary’s wishes on the basis of the beneficiary’s age,*  
14           *life expectancy, present or predicted disability, or ex-*  
15           *pected quality of life.*

16           “(c) *OTHER RESPONSIBILITIES.—The Director, acting*  
17           *directly or by awarding a grant or contract to an eligible*  
18           *entity, shall—*

19                   “(1) *identify existing best practices under sub-*  
20                   *section (e);*

21                   “(2) *develop new best practices under subsection*  
22                   *(f);*

23                   “(3) *evaluate best practices under subsection (g);*

24                   “(4) *implement best practices under subsection*  
25                   *(h);*

1           “(5) ensure that best practices are identified, de-  
2           veloped, evaluated, and implemented under this sec-  
3           tion consistent with standards adopted by the Sec-  
4           retary under section 3004 for health information tech-  
5           nology used in the collection and reporting of quality  
6           information (including for purposes of the demonstra-  
7           tion of meaningful use of certified electronic health  
8           record (EHR) technology by physicians and hospitals  
9           under the Medicare program (under sections  
10          1848(o)(2) and 1886(n)(3), respectively, of the Social  
11          Security Act)); and

12           “(6) provide for dissemination of information  
13          and reporting under subsections (i) and (j).

14          “(d) *ELIGIBILITY.*—To be eligible for a grant or con-  
15          tract under subsection (c), an entity shall—

16           “(1) be a nonprofit entity;

17           “(2) agree to work with a variety of institutional  
18          health care providers, physicians, nurses, and other  
19          health care practitioners; and

20           “(3) if the entity is not the organization holding  
21          a contract under section 1153 of the Social Security  
22          Act for the area to be served, agree to cooperate with  
23          and avoid duplication of the activities of such organi-  
24          zation.

1       “(e) *IDENTIFYING EXISTING BEST PRACTICES.*—The  
2 Secretary shall identify best practices that are—

3               “(1) *currently utilized by health care providers*  
4 *(including hospitals, physician and other clinician*  
5 *practices, community cooperatives, and other health*  
6 *care entities) that deliver consistently high-quality, ef-*  
7 *ficient health care services; and*

8               “(2) *easily adapted for use by other health care*  
9 *providers and for use across a variety of health care*  
10 *settings.*

11       “(f) *DEVELOPING NEW BEST PRACTICES.*—The Sec-  
12 retary shall develop best practices that are—

13               “(1) *based on a review of existing scientific evi-*  
14 *dence;*

15               “(2) *sufficiently detailed for implementation and*  
16 *incorporation into the workflow of health care pro-*  
17 *viders; and*

18               “(3) *designed to be easily adapted for use by*  
19 *health care providers across a variety of health care*  
20 *settings.*

21       “(g) *EVALUATION OF BEST PRACTICES.*—The Director  
22 shall evaluate best practices identified or developed under  
23 this section. Such evaluation—

24               “(1) *shall include determinations of which best*  
25 *practices—*

1           “(A) most reliably and effectively achieve  
2           significant progress in improving the quality of  
3           patient care; and

4           “(B) are easily adapted for use by health  
5           care providers across a variety of health care set-  
6           tings;

7           “(2) shall include regular review, updating, and  
8           improvement of such best practices; and

9           “(3) may include in-depth case studies or empir-  
10          ical assessments of health care providers (including  
11          hospitals, physician and other clinician practices,  
12          community cooperatives, and other health care enti-  
13          ties) and simulations of such best practices for deter-  
14          minations under paragraph (1).

15          “(h) IMPLEMENTATION OF BEST PRACTICES.—

16                 “(1) IN GENERAL.—The Director shall enter into  
17                 arrangements with entities in a State or region to  
18                 implement best practices identified or developed under  
19                 this section. Such implementation—

20                         “(A) may include forming collaborative  
21                         multi-institutional teams; and

22                         “(B) shall include an evaluation of the best  
23                         practices being implemented, including the meas-  
24                         urement of patient outcomes before, during, and  
25                         after implementation of such best practices.

1           “(2) *PREFERENCES.*—*In carrying out this sub-*  
2           *section, the Director shall give priority to health care*  
3           *providers implementing best practices that—*

4                     “(A) *have the greatest impact on patient*  
5                     *outcomes and satisfaction;*

6                     “(B) *are the most easily adapted for use by*  
7                     *health care providers across a variety of health*  
8                     *care settings;*

9                     “(C) *promote coordination of health care*  
10                    *practitioners across the continuum of care; and*

11                    “(D) *engage patients and their families in*  
12                    *improving patient care and outcomes.*

13           “(i) *PUBLIC DISSEMINATION OF INFORMATION.*—*The*  
14           *Director shall provide for the public dissemination of infor-*  
15           *mation with respect to best practices and activities under*  
16           *this section. Such information shall be made available in*  
17           *appropriate formats and languages to reflect the varying*  
18           *needs of consumers and diverse levels of health literacy.*

19           “(j) *REPORT.*—

20                     “(1) *IN GENERAL.*—*The Director shall submit an*  
21                     *annual report to the Congress and the Secretary on*  
22                     *activities under this section.*

23                     “(2) *CONTENT.*—*Each report under paragraph*  
24                     *(1) shall include—*

1           “(A) information on activities conducted  
2           pursuant to grants and contracts awarded;

3           “(B) summary data on patient outcomes be-  
4           fore, during, and after implementation of best  
5           practices; and

6           “(C) recommendations on the adaptability  
7           of best practices for use by health providers.”.

8           (b) *INITIAL QUALITY IMPROVEMENT ACTIVITIES AND*  
9           *INITIATIVES TO BE IMPLEMENTED.*—Until the Director of  
10          the Agency for Healthcare Research and Quality has estab-  
11          lished initial priorities under section 931(b) of the Public  
12          Health Service Act, as added by subsection (a), the Director  
13          shall, for purposes of such section, prioritize the following:

14               (1) *HEALTH CARE-ASSOCIATED INFECTIONS.*—  
15               Reducing health care-associated infections, including  
16               infections in nursing homes and outpatient settings.

17               (2) *SURGERY.*—Increasing hospital and out-  
18               patient perioperative patient safety, including reduc-  
19               ing surgical-site infections and surgical errors (such  
20               as wrong-site surgery and retained foreign bodies).

21               (3) *EMERGENCY ROOM.*—Improving care in hos-  
22               pital emergency rooms, including through the use of  
23               principles of efficiency of design and delivery to im-  
24               prove patient flow.



1 (4) *OBSTETRICS.*—Improving the provision of  
2 obstetrical and neonatal care, including the identi-  
3 fication of interventions that are effective in reducing  
4 the risk of preterm and premature labor and the im-  
5 plementation of best practices for labor and delivery  
6 care.

7 (5) *PEDIATRICS.*—Improving the provision of  
8 preventive and developmental child health services,  
9 including interventions that can reduce child health  
10 disparities and reduce the risk of developing chronic  
11 health-threatening conditions that affect an individ-  
12 ual's life course development.

13 (c) *REPORT.*—Not later than 18 months after the date  
14 of the enactment of this Act, the Director of the Agency for  
15 Healthcare Research and Quality shall submit a report to  
16 the Congress on the impact of the nurse-to-patient ratio on  
17 the quality of care and patient outcomes, including rec-  
18 ommendations for further integration into quality measure-  
19 ment and quality improvement activities.

20 **SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMA-**  
21 **TION.**

22 (a) *ESTABLISHMENT.*—Title XVII (42 U.S.C. 300u et  
23 seq.) is amended—

24 (1) by redesignating sections 1709 and 1710 as  
25 sections 1710 and 1711, respectively; and

1           (2) by inserting after section 1708 the following:

2   **“SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMA-**  
3                           **TION.**

4           “(a) *IN GENERAL.*—There is established within the De-  
5   partment an Assistant Secretary for Health Information  
6   (in this section referred to as the ‘Assistant Secretary’), to  
7   be appointed by the Secretary.

8           “(b) *RESPONSIBILITIES.*—The Assistant Secretary  
9   shall—

10           “(1) ensure the collection, collation, reporting,  
11   and publishing of information (including full and  
12   complete statistics) on key health indicators regarding  
13   the Nation’s health and the performance of the Na-  
14   tion’s health care;

15           “(2) facilitate and coordinate the collection, col-  
16   lation, reporting, and publishing of information re-  
17   garding the Nation’s health and the performance of  
18   the Nation’s health care (other than information de-  
19   scribed in paragraph (1));

20           “(3)(A) develop standards for the collection of  
21   data regarding the Nation’s health and the perform-  
22   ance of the Nation’s health care; and

23           “(B) in carrying out subparagraph (A)—

1           “(i) ensure appropriate specificity and  
2           standardization for data collection at the na-  
3           tional, regional, State, and local levels;

4           “(ii) include standards, as appropriate, for  
5           the collection of accurate data on health and  
6           health care by race, ethnicity, primary language,  
7           sex, sexual orientation, gender identity, dis-  
8           ability, socioeconomic status, rural, urban, or  
9           other geographic setting, and any other popu-  
10          lation or subpopulation determined appropriate  
11          by the Secretary;

12          “(iii) ensure, with respect to data on race  
13          and ethnicity, consistency with the 1997 Office of  
14          Management and Budget Standards for Main-  
15          taining, Collecting and Presenting Federal Data  
16          on Race and Ethnicity (or any successor stand-  
17          ards); and

18          “(iv) in consultation with the Director of  
19          the Office of Minority Health, and the Director  
20          of the Office of Civil Rights, of the Department,  
21          develop standards for the collection of data on  
22          health and health care with respect to primary  
23          language;

24          “(4) provide support to Federal departments and  
25          agencies whose programs have a significant impact

1       upon health (as determined by the Secretary) for the  
2       collection and collation of information described in  
3       paragraphs (1) and (2);

4               “(5) ensure the sharing of information described  
5       in paragraphs (1) and (2) among the agencies of the  
6       Department;

7               “(6) facilitate the sharing of information de-  
8       scribed in paragraphs (1) and (2) by Federal depart-  
9       ments and agencies whose programs have a signifi-  
10      cant impact upon health (as determined by the Sec-  
11      retary);

12              “(7) identify gaps in information described in  
13      paragraphs (1) and (2) and the appropriate agency  
14      or entity to address such gaps;

15              “(8) facilitate and coordinate identification and  
16      monitoring by the agencies of the Department of  
17      health disparities to inform program and policy ef-  
18      forts to reduce such disparities, including facilitating  
19      and funding analyses conducted in cooperation with  
20      the Social Security Administration, the Bureau of the  
21      Census, and other appropriate agencies and entities;

22              “(9) consistent with privacy, proprietary, and  
23      other appropriate safeguards, facilitate public accessi-  
24      bility of datasets (such as de-identified Medicare

1 *datasets or publicly available data on key health indi-*  
2 *cators) by means of the Internet; and*

3 *“(10) award grants or contracts for the collection*  
4 *and collation of information described in paragraphs*  
5 *(1) and (2) (including through statewide surveys that*  
6 *provide standardized information).*

7 *“(c) KEY HEALTH INDICATORS.—*

8 *“(1) IN GENERAL.—In carrying out subsection*  
9 *(b)(1), the Assistant Secretary shall—*

10 *“(A) identify, and reassess at least once*  
11 *every 3 years, key health indicators described in*  
12 *such subsection;*

13 *“(B) publish statistics on such key health*  
14 *indicators for the public—*

15 *“(i) not less than annually; and*

16 *“(ii) on a supplemental basis whenever*  
17 *warranted by—*

18 *“(I) the rate of change for a key*  
19 *health indicator; or*

20 *“(II) the need to inform policy re-*  
21 *garding the Nation’s health and the*  
22 *performance of the Nation’s health*  
23 *care; and*

24 *“(C) ensure consistency with the national*  
25 *strategy developed by the Secretary under section*

1           3121 and consideration of the indicators speci-  
2           fied in the reports under sections 308, 903(a)(6),  
3           and 913(b)(2).

4           “(2) *RELEASE OF KEY HEALTH INDICATORS.*—  
5           *The regulations, rules, processes, and procedures of the*  
6           *Office of Management and Budget governing the re-*  
7           *view, release, and dissemination of key health indica-*  
8           *tors shall be the same as the regulations, rules, proc-*  
9           *esses, and procedures of the Office of Management and*  
10          *Budget governing the review, release, and dissemina-*  
11          *tion of Principal Federal Economic Indicators (or*  
12          *equivalent statistical data) by the Bureau of Labor*  
13          *Statistics.*

14          “(d) *COORDINATION.*—*In carrying out this section, the*  
15          *Assistant Secretary shall coordinate with—*

16                  “(1) *public and private entities that collect and*  
17                  *disseminate information on health and health care,*  
18                  *including foundations; and*

19                  “(2) *the head of the Office of the National Coor-*  
20                  *dinator for Health Information Technology to ensure*  
21                  *optimal use of health information technology.*

22          “(e) *REQUEST FOR INFORMATION FROM OTHER DE-*  
23          *PARTMENTS AND AGENCIES.*—*Consistent with applicable*  
24          *law, the Assistant Secretary may secure directly from any*

1 *Federal department or agency information necessary to en-*  
2 *able the Assistant Secretary to carry out this section.*

3 “(f) *REPORT.*—

4 “(1) *SUBMISSION.*—*The Assistant Secretary*  
5 *shall submit to the Secretary and the Congress an an-*  
6 *nual report containing—*

7 “(A) *a description of national, regional, or*  
8 *State changes in health or health care, as re-*  
9 *flected by the key health indicators identified*  
10 *under subsection (c)(1);*

11 “(B) *a description of gaps in the collection,*  
12 *collation, reporting, and publishing of informa-*  
13 *tion regarding the Nation’s health and the per-*  
14 *formance of the Nation’s health care;*

15 “(C) *recommendations for addressing such*  
16 *gaps and identification of the appropriate agen-*  
17 *cy within the Department or other entity to ad-*  
18 *dress such gaps;*

19 “(D) *a description of analyses of health dis-*  
20 *parities, including the results of completed anal-*  
21 *yses, the status of ongoing longitudinal studies,*  
22 *and proposed or planned research; and*

23 “(E) *a plan for actions to be taken by the*  
24 *Assistant Secretary to address gaps described in*  
25 *subparagraph (B).*

1           “(2) *CONSIDERATION.*—*In preparing a report*  
2 *under paragraph (1), the Assistant Secretary shall*  
3 *take into consideration the findings and conclusions*  
4 *in the reports under sections 308, 903(a)(6), and*  
5 *913(b)(2).*

6           “(g) *PROPRIETARY AND PRIVACY PROTECTIONS.*—  
7 *Nothing in this section shall be construed to affect applica-*  
8 *ble proprietary or privacy protections.*

9           “(h) *CONSULTATION.*—*In carrying out this section, the*  
10 *Assistant Secretary shall consult with—*

11           “(1) *the heads of appropriate health agencies*  
12 *and offices in the Department, including the Office of*  
13 *the Surgeon General of the Public Health Service, the*  
14 *Office of Minority Health, and the Office on Women’s*  
15 *Health; and*

16           “(2) *as appropriate, the heads of other Federal*  
17 *departments and agencies whose programs have a sig-*  
18 *nificant impact upon health (as determined by the*  
19 *Secretary).*

20           “(i) *DEFINITION.*—*In this section:*

21           “(1) *The terms ‘agency’ and ‘agencies’ include*  
22 *an epidemiology center established under section 214*  
23 *of the Indian Health Care Improvement Act.*

24           “(2) *The term ‘Department’ means the Depart-*  
25 *ment of Health and Human Services.*



1           “(3) *The term ‘health disparities’ has the mean-*  
2           *ing given to such term in section 3171.’*”

3           ***(b) OTHER COORDINATION RESPONSIBILITIES.—Title***  
4           ***III (42 U.S.C. 241 et seq.) is amended—***

5                   *(1) in paragraphs (1) and (2) of section 304(c)*  
6                   *(42 U.S.C. 242b(c)), by inserting “, acting through*  
7                   *the Assistant Secretary for Health Information,” after*  
8                   *“The Secretary” each place it appears; and*

9                   *(2) in section 306(j) (42 U.S.C. 242k(j)), by in-*  
10                  *serting “, acting through the Assistant Secretary for*  
11                  *Health Information,” after “of this section, the Sec-*  
12                  *retary”.*

13           ***SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.***

14           *Section 799C, as added and amended, is further*  
15           *amended by adding at the end the following:*

16                   ***“(e) QUALITY AND SURVEILLANCE.—For the purpose***  
17                   *of carrying out part D of title IX and section 1709, in addi-*  
18                   *tion to any other amounts authorized to be appropriated*  
19                   *for such purpose, there are authorized to be appropriated,*  
20                   *out of any monies in the Public Health Investment Fund,*  
21                   *\$300,000,000 for each of fiscal years 2010 through 2014.”.*

1     **TITLE V—OTHER PROVISIONS**  
2             **Subtitle A—Drug Discount for**  
3             **Rural and Other Hospitals**

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                     “(M) A children’s hospital excluded from the  
9             Medicare prospective payment system pursuant  
10            to section 1886(d)(1)(B)(iii) of the Social Secu-  
11            rity Act which would meet the requirements of  
12            subparagraph (L), including the dispropor-  
13            tionate share adjustment percentage requirement  
14            under subparagraph (L)(ii), if the hospital were  
15            a subsection (d) hospital as defined in section  
16            1886(d)(1)(B) of the Social Security Act.

17                    “(N) An entity that is a critical access hos-  
18            pital (as determined under section 1820(c)(2) of  
19            the Social Security Act).

20                    “(O) An entity receiving funds under title  
21            V of the Social Security Act (relating to mater-  
22            nal and child health) for the provision of health  
23            services.

24                    “(P) An entity receiving funds under sub-  
25            part I of part B of title XIX of the Public Health

1           *Service Act (relating to comprehensive mental*  
 2           *health services) for the provision of community*  
 3           *mental health services.*

4           “(Q) *An entity receiving funds under sub-*  
 5           *part II of such part B (relating to the prevention*  
 6           *and treatment of substance abuse) for the provi-*  
 7           *sion of treatment services for substance abuse.*

8           “(R) *An entity that is a Medicare-depend-*  
 9           *ent, small rural hospital (as defined in section*  
 10           *1886(d)(5)(G)(iv) of the Social Security Act).*

11           “(S) *An entity that is a sole community*  
 12           *hospital (as defined in section 1886(d)(5)(D)(iii)*  
 13           *of the Social Security Act).*

14           “(T) *An entity that is classified as a rural*  
 15           *referral center under section 1886(d)(5)(C) of the*  
 16           *Social Security Act.”.*

17           **(b) PROHIBITION ON GROUP PURCHASING ARRANGE-**  
 18           **MENTS.—***Section 340B(a) (42 U.S.C. 256b(a)) is amend-*  
 19           *ed—*

20           (1) *in paragraph (4)(L)—*

21           (A) *by adding “and” at the end of clause*  
 22           (i);

23           (B) *by striking “; and” at the end of clause*  
 24           (ii) *and inserting a period; and*

25           (C) *by striking clause (iii); and*

1           (2) *in paragraph (5), by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E),*  
2           *respectively, and by inserting after subparagraph (B)*  
3           *the following:*

4                           “(C) *PROHIBITING USE OF GROUP PUR-*  
5                           *CHASING ARRANGEMENTS.—*

6   “(i) *A hospital described in subpara-*  
7   *graph (L), (M), (N), (R), (S), or (T) of*  
8   *paragraph (4) shall not obtain covered out-*  
9   *patient drugs through a group purchasing*  
10   *organization or other group purchasing ar-*  
11   *rangement, except as permitted or provided*  
12   *pursuant to clause (ii).*

13   “(ii) *The Secretary shall establish rea-*  
14   *sonable exceptions to the requirement of*  
15   *clause (i)—*

16   “(I) *with respect to a covered out-*  
17   *patient drug that is unavailable to be*  
18   *purchased through the program under*  
19   *this section due to a drug shortage*  
20   *problem, manufacturer noncompliance,*  
21   *or any other reason beyond the hos-*  
22   *pital’s control;*

23   “(II) *to facilitate generic substi-*  
24   *tution when a generic covered out-*  
25

1                    *patient drug is available at a lower*  
 2                    *price; and*

3                    “(III) to reduce in other ways the  
 4                    *administrative burdens of managing*  
 5                    *both inventories of drugs obtained*  
 6                    *under this section and not under this*  
 7                    *section, if such exception does not cre-*  
 8                    *ate a duplicate discount problem in*  
 9                    *violation of subparagraph (A) or a di-*  
 10                    *version problem in violation of sub-*  
 11                    *paragraph (B).”.*

12 **SEC. 2502. EXTENSION OF DISCOUNTS TO INPATIENT**  
 13                    **DRUGS.**

14                    (a) *IN GENERAL.*—Section 340B (42 U.S.C. 256b) is  
 15 *amended—*

16                    (1) *in subsection (b)—*

17                    (A) *by striking “In this section, the terms”*  
 18                    *and inserting the following: “In this section:*

19                    “(1) *IN GENERAL.*—*The terms”; and*

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

22                    “(2) *COVERED DRUG.*—*The term ‘covered*  
 23                    *drug’—*

1           “(A) means a covered outpatient drug (as  
2           defined in section 1927(k)(2) of the Social Secu-  
3           rity Act); and

4           “(B) includes, notwithstanding the section  
5           1927(k)(3)(A) of such Act, a drug used in con-  
6           nection with an inpatient or outpatient service  
7           provided by a hospital described in subpara-  
8           graph (L), (M), (N), (R), (S), or (T) of sub-  
9           section (a)(4) that is enrolled to participate in  
10          the drug discount program under this section.”;  
11          and

12          (2) in paragraphs (5) (other than subparagraph  
13          (C)), (7), and (9) of subsection (a), by striking “out-  
14          patient” each place it appears.

15          (b) *MEDICAID CREDITS ON INPATIENT DRUGS.*—Sub-  
16          section (c) of section 340B (42 U.S.C. 256b(c)) is amended  
17          to read as follows:

18          “(c) *MEDICAID CREDITS ON INPATIENT DRUGS.*—

19                 “(1) *IN GENERAL.*—For the cost reporting period  
20                 covered by the most recently filed Medicare cost report  
21                 under title XVIII of the Social Security Act, a hos-  
22                 pital described in subparagraph (L), (M), (N), (R),  
23                 (S), or (T) of subsection (a)(4) and enrolled to par-  
24                 ticipate in the drug discount program under this sec-

1        *tion shall provide to each State under its plan under*  
2        *title XIX of such Act—*

3                *“(A) a credit on the estimated annual costs*  
4                *to such hospital of single source and innovator*  
5                *multiple source drugs provided to Medicaid bene-*  
6                *ficiaries for inpatient use; and*

7                *“(B) a credit on the estimated annual costs*  
8                *to such hospital of noninnovator multiple source*  
9                *drugs provided to Medicaid beneficiaries for in-*  
10               *patient use.*

11               *“(2) AMOUNT OF CREDITS.—*

12               *“(A) SINGLE SOURCE AND INNOVATOR MUL-*  
13               *TIPLE SOURCE DRUGS.—For purposes of para-*  
14               *graph (1)(A)—*

15               *“(i) the credit under such paragraph*  
16               *shall be equal to the product of—*

17               *“(I) the annual value of single*  
18               *source and innovator multiple source*  
19               *drugs purchased under this section by*  
20               *the hospital based on the drugs’ aver-*  
21               *age manufacturer price;*

22               *“(II) the estimated percentage of*  
23               *the hospital’s drug purchases attrib-*  
24               *utable to Medicaid beneficiaries for in-*  
25               *patient use; and*

1           “(III) the minimum rebate per-  
2           centage described in section  
3           1927(c)(1)(B) of the Social Security  
4           Act;

5           “(ii) the reference in clause (i)(I) to  
6           the annual value of single source and inno-  
7           vator multiple source drugs purchased  
8           under this section by the hospital based on  
9           the drugs’ average manufacturer price shall  
10          be equal to the sum of—

11           “(I) the annual quantity of each  
12           single source and innovator multiple  
13           source drug purchased during the cost  
14           reporting period, multiplied by

15           “(II) the average manufacturer  
16           price for that drug;

17           “(iii) the reference in clause (i)(II) to  
18           the estimated percentage of the hospital’s  
19           drug purchases attributable to Medicaid  
20           beneficiaries for inpatient use shall be equal  
21          to—

22           “(I) the Medicaid inpatient drug  
23           charges as reported on the hospital’s  
24           most recently filed Medicare cost re-  
25          port, divided by



1                   “(II) total drug charges reported  
2                   on the cost report; and

3                   “(iv) the terms ‘single source drug’ and  
4                   ‘innovator multiple source drug’ have the  
5                   meanings given such terms in section  
6                   1927(k)(7) of the Social Security Act.

7                   “(B) NONINNOVATOR MULTIPLE SOURCE  
8                   DRUGS.—For purposes of paragraph (1)(B)—

9                   “(i) the credit under such paragraph  
10                  shall be equal to the product of—

11                  “(I) the annual value of noninno-  
12                  vator multiple source drugs purchased  
13                  under this section by the hospital based  
14                  on the drugs’ average manufacturer  
15                  price;

16                  “(II) the estimated percentage of  
17                  the hospital’s drug purchases attrib-  
18                  utable to Medicaid beneficiaries for in-  
19                  patient use; and

20                  “(III) the applicable percentage as  
21                  defined in section 1927(c)(3)(B) of the  
22                  Social Security Act;

23                  “(ii) the reference in clause (i)(I) to  
24                  the annual value of noninnovator multiple  
25                  source drugs purchased under this section

1           *by the hospital based on the drugs' average*  
2           *manufacturer price shall be equal to the*  
3           *sum of—*

4                     *“(I) the annual quantity of each*  
5                     *noninnovator multiple source drug*  
6                     *purchased during the cost reporting pe-*  
7                     *riod, multiplied by*

8                     *“(II) the average manufacturer*  
9                     *price for that drug;*

10                    *“(iii) the reference in clause (i)(II) to*  
11                    *the estimated percentage of the hospital's*  
12                    *drug purchases attributable to Medicaid*  
13                    *beneficiaries for inpatient use shall be equal*  
14                    *to—*

15                    *“(I) the Medicaid inpatient drug*  
16                    *charges as reported on the hospital's*  
17                    *most recently filed Medicare cost re-*  
18                    *port, divided by*

19                    *“(II) total drug charges reported*  
20                    *on the cost report; and*

21                    *“(iv) the term ‘noninnovator multiple*  
22                    *source drug’ has the meaning given such*  
23                    *term in section 1927(k)(7) of the Social Se-*  
24                    *curity Act.*

25                    *“(3) CALCULATION OF CREDITS.—*

1           “(A) *IN GENERAL.*—*Each State calculates*  
2           *credits under paragraph (1) and informs hos-*  
3           *pitals of amount under section 1927(a)(5)(D) of*  
4           *the Social Security Act.*

5           “(B) *HOSPITAL PROVISION OF INFORMA-*  
6           *TION.*—*Not later than 30 days after the date of*  
7           *the filing of the hospital’s most recently filed*  
8           *Medicare cost report, the hospital shall provide*  
9           *the State with the information described in*  
10           *paragraphs (2)(A)(ii) and (2)(B)(ii). With re-*  
11           *spect to each drug purchased during the cost re-*  
12           *porting period, the hospital shall provide the dos-*  
13           *age form, strength, package size, date of pur-*  
14           *chase, and the number of units purchased.*

15           “(4) *PAYMENT DEADLINE.*—*The credits provided*  
16           *by a hospital under paragraph (1) shall be paid with-*  
17           *in 60 days after receiving the information specified in*  
18           *paragraph (3)(A).*

19           “(5) *OPT OUT.*—*A hospital shall not be required*  
20           *to provide the Medicaid credit required under para-*  
21           *graph (1) if it can demonstrate to the State that it*  
22           *will lose reimbursement under the State plan result-*  
23           *ing from the extension of discounts to inpatient drugs*  
24           *under subsection (b)(2) and that the loss of reimburse-*

1        *ment will exceed the amount of the credit otherwise*  
2        *owed by the hospital.*

3            “(6) *OFFSET AGAINST MEDICAL ASSISTANCE.—*  
4        *Amounts received by a State under this subsection in*  
5        *any quarter shall be considered to be a reduction in*  
6        *the amount expended under the State plan in the*  
7        *quarter for medical assistance for purposes of section*  
8        *1903(a)(1) of the Social Security Act.”.*

9        (c) *CONFORMING AMENDMENTS.—Section 1927 of the*  
10       *Social Security Act (42 U.S.C. 1396r–8) is amended—*

11            (1) *in subsection (a)(5)(A), by striking “covered*  
12        *outpatient drugs” and inserting “covered drugs (as*  
13        *defined in section 340B(b)(2) of the Public Health*  
14        *Service Act)”;*

15            (2) *in subsection (a)(5), by striking subpara-*  
16        *graph (D) and inserting the following:*

17            “(D) *STATE RESPONSIBILITY FOR CALCU-*  
18        *LATING HOSPITAL CREDITS.—The State shall*  
19        *calculate the credits owed by the hospital under*  
20        *paragraph (1) of section 340B(c) of the Public*  
21        *Health Service Act and provide the hospital with*  
22        *both the amounts and an explanation of how it*  
23        *calculated the credits. In performing the calcula-*  
24        *tions specified in paragraphs (2)(A)(ii) and*  
25        *(2)(B)(ii) of such section, the State shall use the*

1           *average manufacturer price applicable to the cal-*  
2           *endar quarter in which the drug was purchased*  
3           *by the hospital.”; and*

4           *(3) in subsection (k)(1)—*

5                     *(A) in subparagraph (A), by striking “sub-*  
6                     *paragraph (B)” and inserting “subparagraphs*  
7                     *(B) and (D)”;* and

8                     *(B) by adding at the end the following:*

9                     *“(D) CALCULATION FOR COVERED DRUGS.—*

10                    *With respect to a covered drug (as defined in sec-*  
11                    *tion 340B(b)(2) of the Public Health Service*  
12                    *Act), the average manufacturer price shall be de-*  
13                    *termined in accordance with subparagraph (A)*  
14                    *except that, in the event a covered drug is not*  
15                    *distributed to the retail pharmacy class of trade,*  
16                    *it shall mean the average price paid to the man-*  
17                    *ufacturer for the drug in the United States by*  
18                    *wholesalers for drugs distributed to the acute*  
19                    *care class of trade, after deducting customary*  
20                    *prompt pay discounts.”.*

21   **SEC. 2503. EFFECTIVE DATE.**

22            *(a) IN GENERAL.—The amendments made by this sub-*  
23            *title shall take effect on July 1, 2010, and shall apply to*  
24            *drugs dispensed on or after such date.*

1       (b) *EFFECTIVENESS.*—*The amendments made by this*  
 2 *subtitle shall be effective, and shall be taken into account*  
 3 *in determining whether a manufacturer is deemed to meet*  
 4 *the requirements of section 340B(a) of the Public Health*  
 5 *Service Act (42 U.S.C. 256b(a)) and of section 1927(a)(5)*  
 6 *of the Social Security Act (42 U.S.C. 1396r–8(a)(5)), not-*  
 7 *withstanding any other provision of law.*

## 8                                   **Subtitle B—Programs**

### 9       **PART 1—GRANTS FOR CLINICS AND CENTERS**

#### 10   **SEC. 2511. SCHOOL-BASED HEALTH CLINICS.**

11       (a) *IN GENERAL.*—*Part Q of title III (42 U.S.C. 280h*  
 12 *et seq.) is amended by adding at the end the following:*

#### 13   **“SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.**

14       “(a) *PROGRAM.*—*The Secretary shall establish a*  
 15 *school-based health clinic program consisting of awarding*  
 16 *grants to eligible entities to support the operation of school-*  
 17 *based health clinics (referred to in this section as ‘SBHCs’).*

18       “(b) *ELIGIBILITY.*—*To be eligible for a grant under*  
 19 *this section, an entity shall—*

20               “(1) *be an SBHC (as defined in subsection*  
 21 *(l)(4)); and*

22               “(2) *submit an application at such time, in such*  
 23 *manner, and containing such information as the Sec-*  
 24 *retary may require, including at a minimum—*

1           “(A) evidence that the applicant meets all  
2 criteria necessary to be designated as an SBHC;

3           “(B) evidence of local need for the services  
4 to be provided by the SBHC;

5           “(C) an assurance that—

6                 “(i) SBHC services will be provided in  
7 accordance with Federal, State, and local  
8 laws;

9                 “(ii) the SBHC has established and  
10 maintains collaborative relationships with  
11 other health care providers in the catchment  
12 area of the SBHC;

13                 “(iii) the SBHC will provide onsite ac-  
14 cess during the academic day when school is  
15 in session and has an established network of  
16 support and access to services with backup  
17 health providers when the school or SBHC  
18 is closed;

19                 “(iv) the SBHC will be integrated into  
20 the school environment and will coordinate  
21 health services with appropriate school per-  
22 sonnel and other community providers co-  
23 located at the school; and

1                   “(v) *the SBHC sponsoring facility as-*  
2                   *sumes all responsibility for the SBHC ad-*  
3                   *ministration, operations, and oversight; and*

4                   “(D) *such other information as the Sec-*  
5                   *retary may require.*

6                   “(c) *USE OF FUNDS.—Funds awarded under a grant*  
7                   *under this section—*

8                   “(1) *may be used for—*

9                   “(A) *providing training related to the pro-*  
10                   *vision of comprehensive primary health services*  
11                   *and additional health services;*

12                   “(B) *the management and operation of*  
13                   *SBHC programs;*

14                   “(C) *the payment of salaries for health pro-*  
15                   *essionals and other appropriate SBHC per-*  
16                   *sonnel; and*

17                   “(2) *may not be used to provide abortions.*

18                   “(d) *CONSIDERATION OF NEED.—In determining the*  
19                   *amount of a grant under this section, the Secretary shall*  
20                   *take into consideration—*

21                   “(1) *the financial need of the SBHC;*

22                   “(2) *State, local, or other sources of funding pro-*  
23                   *vided to the SBHC; and*

24                   “(3) *other factors as determined appropriate by*  
25                   *the Secretary.*



1       “(e) *PREFERENCES.*—*In awarding grants under this*  
2 *section, the Secretary shall give preference to SBHCs that*  
3 *have a demonstrated record of service to the following:*

4               “(1) *A high percentage of medically underserved*  
5 *children and adolescents.*

6               “(2) *Communities or populations in which chil-*  
7 *dren and adolescents have difficulty accessing health*  
8 *and mental health services.*

9               “(3) *Communities with high percentages of chil-*  
10 *dren and adolescents who are uninsured, under-*  
11 *insured, or eligible for medical assistance under Fed-*  
12 *eral or State health benefits programs (including ti-*  
13 *ties XIX and XXI of the Social Security Act).*

14       “(f) *MATCHING REQUIREMENT.*—*The Secretary may*  
15 *award a grant to an SBHC under this section only if the*  
16 *SBHC agrees to provide, from non-Federal sources, an*  
17 *amount equal to 20 percent of the amount of the grant*  
18 *(which may be provided in cash or in kind) to carry out*  
19 *the activities supported by the grant.*

20       “(g) *SUPPLEMENT, NOT SUPPLANT.*—*The Secretary*  
21 *may award a grant to an SBHC under this section only*  
22 *if the SBHC demonstrates to the satisfaction of the Sec-*  
23 *retary that funds received through the grant will be ex-*  
24 *pendent only to supplement, and not supplant, non-Federal*  
25 *and Federal funds otherwise available to the SBHC for op-*

1 *eration of the SBHC (including each activity described in*  
2 *paragraph (1) or (2) of subsection (c)).*

3       “(h) *PAYOR OF LAST RESORT.*—*The Secretary may*  
4 *award a grant to an SBHC under this section only if the*  
5 *SBHC demonstrates to the satisfaction of the Secretary that*  
6 *funds received through the grant will not be expended for*  
7 *any activity to the extent that payment has been made, or*  
8 *can reasonably be expected to be made—*

9               “(1) *under any insurance policy;*

10              “(2) *under any Federal or State health benefits*  
11 *program (including titles XIX and XXI of the Social*  
12 *Security Act); or*

13              “(3) *by an entity which provides health services*  
14 *on a prepaid basis.*

15       “(i) *REGULATIONS REGARDING REIMBURSEMENT FOR*  
16 *HEALTH SERVICES.*—*The Secretary shall issue regulations*  
17 *regarding the reimbursement for health services provided by*  
18 *SBHCs to individuals eligible to receive such services*  
19 *through the program under this section, including reim-*  
20 *bursement under any insurance policy or any Federal or*  
21 *State health benefits program (including titles XIX and*  
22 *XXI of the Social Security Act).*

23       “(j) *TECHNICAL ASSISTANCE.*—*The Secretary shall*  
24 *provide (either directly or by grant or contract) technical*  
25 *and other assistance to SBHCs to assist such SBHCs to*

1 *meet the requirements of this section. Such assistance may*  
2 *include fiscal and program management assistance, train-*  
3 *ing in fiscal and program management, operational and*  
4 *administrative support, and the provision of information*  
5 *to the SBHCs of the variety of resources available under*  
6 *this title and how those resources can be best used to meet*  
7 *the health needs of the communities served by the SBHCs.*

8 *“(k) EVALUATION; REPORT.—The Secretary shall—*

9 *“(1) develop and implement a plan for evalu-*  
10 *ating SBHCs and monitoring quality performances*  
11 *under the awards made under this section; and*

12 *“(2) submit to the Congress on an annual basis*  
13 *a report on the program under this section.*

14 *“(l) DEFINITIONS.—In this section:*

15 *“(1) COMPREHENSIVE PRIMARY HEALTH SERV-*  
16 *ICES.—The term ‘comprehensive primary health serv-*  
17 *ices’ means the core services offered by SBHCs, which*  
18 *shall include the following:*

19 *“(A) PHYSICAL.—Comprehensive health as-*  
20 *sessments, diagnosis, and treatment of minor,*  
21 *acute, and chronic medical conditions and refer-*  
22 *als to, and followup for, specialty care.*

23 *“(B) MENTAL HEALTH.—Mental health as-*  
24 *sessments, crisis intervention, counseling, treat-*  
25 *ment, and referral to a continuum of services in-*

1           *cluding emergency psychiatric care, community*  
2           *support programs, inpatient care, and out-*  
3           *patient programs.*

4           “(C) *OPTIONAL SERVICES.—Additional*  
5           *services, which may include oral health, social,*  
6           *and age-appropriate health education services,*  
7           *including nutritional counseling.*

8           “(2) *MEDICALLY UNDERSERVED CHILDREN AND*  
9           *ADOLESCENTS.—The term ‘medically underserved*  
10           *children and adolescents’ means a population of chil-*  
11           *dren and adolescents who are residents of an area des-*  
12           *ignated by the Secretary as an area with a shortage*  
13           *of personal health services and health infrastructure*  
14           *for such children and adolescents.*

15           “(3) *SCHOOL-BASED HEALTH CLINIC.—The term*  
16           *‘school-based health clinic’ means a health clinic*  
17           *that—*

18                   “(A) *is located in, or is adjacent to, a school*  
19                   *facility of a local educational agency;*

20                   “(B) *is organized through school, commu-*  
21                   *nity, and health provider relationships;*

22                   “(C) *is administered by a sponsoring facil-*  
23                   *ity;*

24                   “(D) *provides, at a minimum, comprehen-*  
25                   *sive primary health services during school hours*

1           to children and adolescents by health profes-  
2           sionals in accordance with State and local laws  
3           and regulations, established standards, and com-  
4           munity practice; and

5                   “(E) does not perform abortion services.

6           “(4) *SPONSORING FACILITY.*—The term ‘spon-  
7           soring facility’ is—

8                   “(A) a hospital;

9                   “(B) a public health department;

10                  “(C) a community health center;

11                  “(D) a nonprofit health care agency;

12                  “(E) a local educational agency; or

13                  “(F) a program administered by the Indian  
14           Health Service or the Bureau of Indian Affairs  
15           or operated by an Indian tribe or a tribal orga-  
16           nization under the Indian Self-Determination  
17           and Education Assistance Act, a Native Hawai-  
18           ian entity, or an urban Indian program under  
19           title V of the Indian Health Care Improvement  
20           Act.

21           “(m) *AUTHORIZATION OF APPROPRIATIONS.*—For  
22           purposes of carrying out this section, there are authorized  
23           to be appropriated \$50,000,000 for fiscal year 2010 and  
24           such sums as may be necessary for each of the fiscal years  
25           2011 through 2014.”.

1           (b) *EFFECTIVE DATE.*—*The Secretary of Health and*  
2 *Human Services shall begin awarding grants under section*  
3 *399Z–1 of the Public Health Service Act, as added by sub-*  
4 *section (a), not later than July 1, 2010, without regard to*  
5 *whether or not final regulations have been issued under sec-*  
6 *tion 399Z–1(i) of such Act.*

7 **SEC. 2512. NURSE-MANAGED HEALTH CENTERS.**

8           *Title III (42 U.S.C. 241 et seq.) is amended by adding*  
9 *at the end the following:*

10       **“PART S—NURSE-MANAGED HEALTH CENTERS**

11       **“SEC. 399GG. NURSE-MANAGED HEALTH CENTERS.**

12           “(a) *PROGRAM.*—*The Secretary, acting through the*  
13 *Administrator of the Health Resources and Services Admin-*  
14 *istration, shall establish a nurse-managed health center pro-*  
15 *gram consisting of awarding grants to entities under sub-*  
16 *section (b).*

17           “(b) *GRANT.*—*The Secretary shall award grants to en-*  
18 *tities—*

19                   “(1) *to plan and develop a nurse-managed health*  
20 *center; or*

21                   “(2) *to operate a nurse-managed health center.*

22           “(c) *USE OF FUNDS.*—*Amounts received as a grant*  
23 *under subsection (b) may be used for activities including*  
24 *the following:*

25                   “(1) *Purchasing or leasing equipment.*

1           “(2) *Training and technical assistance related to*  
2 *the provision of comprehensive primary care services*  
3 *and wellness services.*

4           “(3) *Other activities for planning, developing, or*  
5 *operating, as applicable, a nurse-managed health cen-*  
6 *ter.*

7           “(d) *ASSURANCES APPLICABLE TO BOTH PLANNING*  
8 *AND OPERATION GRANTS.—*

9           “(1) *IN GENERAL.—The Secretary may award a*  
10 *grant under this section to an entity only if the entity*  
11 *demonstrates to the Secretary’s satisfaction that—*

12                   “(A) *nurses, in addition to managing the*  
13 *center, will be adequately represented as pro-*  
14 *viders at the center; and*

15                   “(B) *not later than 90 days after receiving*  
16 *the grant, the entity will establish a community*  
17 *advisory committee composed of individuals, a*  
18 *majority of whom are being served by the center,*  
19 *to provide input into the nurse-managed health*  
20 *center’s operations.*

21           “(2) *MATCHING REQUIREMENT.—The Secretary*  
22 *may award a grant under this section to an entity*  
23 *only if the entity agrees to provide, from non-Federal*  
24 *sources, an amount equal to 20 percent of the amount*  
25 *of the grant (which may be provided in cash or in*

1       *kind) to carry out the activities supported by the*  
2       *grant.*

3               “(3) *PAYOR OF LAST RESORT.*—*The Secretary*  
4       *may award a grant under this section to an entity*  
5       *only if the entity demonstrates to the satisfaction of*  
6       *the Secretary that funds received through the grant*  
7       *will not be expended for any activity to the extent*  
8       *that payment has been made, or can reasonably be ex-*  
9       *pected to be made—*

10               “(A) *under any insurance policy;*

11               “(B) *under any Federal or State health ben-*  
12       *efits program (including titles XIX and XXI of*  
13       *the Social Security Act); or*

14               “(C) *by an entity which provides health*  
15       *services on a prepaid basis.*

16               “(4) *MAINTENANCE OF EFFORT.*—*The Secretary*  
17       *may award a grant under this section to an entity*  
18       *only if the entity demonstrates to the satisfaction of*  
19       *the Secretary that—*

20               “(A) *funds received through the grant will*  
21       *be expended only to supplement, and not sup-*  
22       *plant, non-Federal and Federal funds otherwise*  
23       *available to the entity for the activities to be*  
24       *funded through the grant; and*



1           “(B) with respect to such activities, the en-  
2           tity will maintain expenditures of non-Federal  
3           amounts for such activities at a level not less  
4           than the lesser of such expenditures maintained  
5           by the entity for the fiscal year preceding the fis-  
6           cal year for which the entity receives the grant.

7           “(e) *ADDITIONAL ASSURANCE FOR PLANNING*  
8 *GRANTS.*—The Secretary may award a grant under sub-  
9 section (b)(1) to an entity only if the entity agrees—

10           “(1) to assess the needs of the medically under-  
11           served populations proposed to be served by the nurse-  
12           managed health center; and

13           “(2) to design services and operations of the  
14           nurse-managed health center for such populations  
15           based on such assessment.

16           “(f) *ADDITIONAL ASSURANCES FOR OPERATION*  
17 *GRANTS.*—The Secretary may award a grant under sub-  
18 section (b)(2) to an entity only if the entity assures that  
19 the nurse-managed health center will provide—

20           “(1) comprehensive primary care services,  
21           wellness services, and other health care services  
22           deemed appropriate by the Secretary;

23           “(2) care without respect to insurance status or  
24           income of the patient; and

1           “(3) *direct access to client-centered services of-*  
2           *fered by advanced practice nurses, other nurses, phy-*  
3           *sicians, physician assistants, or other qualified health*  
4           *professionals.*

5           “(g) *TECHNICAL ASSISTANCE.—The Secretary shall*  
6           *provide (either directly or by grant or contract) technical*  
7           *and other assistance to nurse-managed health centers to as-*  
8           *sist such centers in meeting the requirements of this section.*  
9           *Such assistance may include fiscal and program manage-*  
10          *ment assistance, training in fiscal and program manage-*  
11          *ment, operational and administrative support, and the pro-*  
12          *vision of information to nurse-managed health centers re-*  
13          *garding the various resources available under this section*  
14          *and how those resources can best be used to meet the health*  
15          *needs of the communities served by nurse-managed health*  
16          *centers.*

17          “(h) *REPORT.—The Secretary shall submit to the Con-*  
18          *gress an annual report on the program under this section.*

19          “(i) *DEFINITIONS.—*

20                 “(1) *COMPREHENSIVE PRIMARY CARE SERV-*  
21                 *ICES.—The term ‘comprehensive primary care serv-*  
22                 *ices’ has the meaning given to the term ‘required pri-*  
23                 *mary health services’ in section 330(b)(1).*

1           “(2) *MEDICALLY UNDERSERVED POPULATION*.—  
2           *The term ‘medically underserved population’ has the*  
3           *meaning given to such term in section 330(b)(3).*

4           “(3) *NURSE-MANAGED HEALTH CENTER*.—*The*  
5           *term ‘nurse-managed health center’ has the meaning*  
6           *given to such term in section 801.*

7           “(4) *WELLNESS SERVICES*.—*The term ‘wellness*  
8           *services’ means any health-related service or interven-*  
9           *tion, not including primary care, which is designed*  
10           *to reduce identifiable health risks and increase*  
11           *healthy behaviors intended to prevent the onset of dis-*  
12           *ease or lessen the impact of existing chronic condi-*  
13           *tions by teaching more effective management tech-*  
14           *niques that focus on individual self-care and patient-*  
15           *driven decisionmaking.’.*

16 **SEC. 2513. FEDERALLY QUALIFIED BEHAVIORAL HEALTH**  
17 **CENTERS.**

18           (a) *BLOCK GRANTS REGARDING MENTAL HEALTH*  
19 *AND SUBSTANCE ABUSE*.—*Section 1913 (42 U.S.C. 300x-*  
20 *3) is amended—*

21           (1) *in subsection (a)(2)(A), by striking “commu-*  
22           *nity mental health services” and inserting “behav-*  
23           *ioral health services”;*

24           (2) *in subsection (b)—*

1           (A) by striking paragraph (1) and inserting  
2           the following:

3           “(1) services under the plan will be provided  
4           only through appropriate, qualified community pro-  
5           grams (which may include federally qualified behav-  
6           ioral health centers, child mental health programs,  
7           psychosocial rehabilitation programs, mental health  
8           peer-support programs, and mental health primary  
9           consumer-directed programs); and”;

10           (B) in paragraph (2), by striking “commu-  
11           nity mental health centers” and inserting “feder-  
12           ally qualified behavioral health centers”;

13           (3) by striking subsection (c) and inserting the  
14           following:

15           “(c) *CRITERIA FOR FEDERALLY QUALIFIED BEHAV-*  
16           *IORAL HEALTH CENTERS.—*

17           “(1) *IN GENERAL.—*The Administrator shall cer-  
18           tify, and recertify at least every 5 years, federally  
19           qualified behavioral health centers as meeting the cri-  
20           teria specified in this subsection.

21           “(2) *REGULATIONS.—*Not later than 18 months  
22           after the date of the enactment of the America’s Af-  
23           fordable Health Choices Act of 2009, the Adminis-  
24           trator shall issue final regulations for certifying cen-  
25           ters under paragraph (1).

1           “(3) *CRITERIA.*—*The criteria referred to in sub-*  
2           *section (b)(2) are that the center performs each of the*  
3           *following:*

4                   “(A) *Provide services in locations that en-*  
5                   *sure services will be available and accessible*  
6                   *promptly and in a manner which preserves*  
7                   *human dignity and assures continuity of care.*

8                   “(B) *Provide services in a mode of service*  
9                   *delivery appropriate for the target population.*

10                   “(C) *Provide individuals with a choice of*  
11                   *service options where there is more than one effi-*  
12                   *acious treatment.*

13                   “(D) *Employ a core staff of clinical staff*  
14                   *that is multidisciplinary and culturally and lin-*  
15                   *guistically competent.*

16                   “(E) *Provide services, within the limits of*  
17                   *the capacities of the center, to any individual re-*  
18                   *siding or employed in the service area of the cen-*  
19                   *ter.*

20                   “(F) *Provide, directly or through contract,*  
21                   *to the extent covered for adults in the State Med-*  
22                   *icaid plan and for children in accordance with*  
23                   *section 1905(r) of the Social Security Act re-*  
24                   *garding early and periodic screening, diagnosis,*  
25                   *and treatment, each of the following services:*

1           “(i) Screening, assessment, and diag-  
2           nosis, including risk assessment.

3           “(ii) Person-centered treatment plan-  
4           ning or similar processes, including risk as-  
5           sessment and crisis planning.

6           “(iii) Outpatient clinic mental health  
7           services, including screening, assessment, di-  
8           agnosis, psychotherapy, substance abuse  
9           counseling, medication management, and  
10          integrated treatment for mental illness and  
11          substance abuse which shall be evidence-  
12          based (including cognitive behavioral ther-  
13          apy, dialectical behavioral therapy, motiva-  
14          tional interviewing, and other such thera-  
15          pies which are evidence-based).

16          “(iv) Outpatient clinic primary care  
17          services, including screening and moni-  
18          toring of key health indicators and health  
19          risk (including screening for diabetes, hy-  
20          pertension, and cardiovascular disease and  
21          monitoring of weight, height, body mass  
22          index (BMI), blood pressure, blood glucose  
23          or HbA1C, and lipid profile).

24          “(v) Crisis mental health services, in-  
25          cluding 24-hour mobile crisis teams, emer-

1            *gency crisis intervention services, and crisis*  
2            *stabilization.*

3            “(vi) *Targeted case management (serv-*  
4            *ices to assist individuals gaining access to*  
5            *needed medical, social, educational, and*  
6            *other services and applying for income secu-*  
7            *rity and other benefits to which they may*  
8            *be entitled).*

9            “(vii) *Psychiatric rehabilitation serv-*  
10           *ices including skills training, assertive com-*  
11           *munity treatment, family psychoeducation,*  
12           *disability self-management, supported em-*  
13           *ployment, supported housing services, thera-*  
14           *peutic foster care services, multisystemic*  
15           *therapy, and such other evidence-based*  
16           *practices as the Secretary may require.*

17           “(viii) *Peer support and counselor*  
18           *services and family supports.*

19           “(G) *Maintain linkages, and where possible*  
20           *enter into formal contracts with, inpatient psy-*  
21           *chiatric facilities and substance abuse detoxifica-*  
22           *tion and residential programs.*

23           “(H) *Make available to individuals served*  
24           *by the center, directly, through contract, or*

1           *through linkages with other programs, each of*  
2           *the following:*

3                   “(i) *Adult and youth peer support and*  
4                   *counselor services.*”

5                   “(ii) *Family support services for fami-*  
6                   *lies of children with serious mental dis-*  
7                   *orders.*”

8                   “(iii) *Other community or regional*  
9                   *services, supports, and providers, including*  
10                   *schools, child welfare agencies, juvenile and*  
11                   *criminal justice agencies and facilities,*  
12                   *housing agencies and programs, employers,*  
13                   *and other social services.*”

14                   “(iv) *Onsite or offsite access to pri-*  
15                   *mary care services.*”

16                   “(v) *Enabling services, including out-*  
17                   *reach, transportation, and translation.*”

18                   “(vi) *Health and wellness services, in-*  
19                   *cluding services for tobacco cessation.*”.

20           (b) *CONFORMING AMENDMENTS.*—

21                   (1) *BLOCK GRANTS FOR BEHAVIORAL HEALTH*  
22                   *SERVICES.*—*Subpart I of part B of title XIX (42*  
23                   *U.S.C. 300x–1 et seq.) is amended—*

24                           (A) *in the subpart heading, by striking*

25                                   **“Community Mental Health Services”**



1           and inserting “**Behavioral Mental Health**  
2           **Services**”;

3                   (B) in the heading of section 1912, by strik-  
4           ing “**COMMUNITY MENTAL HEALTH SERV-**  
5           **ICES**” and inserting “**BEHAVIORAL MENTAL**  
6           **HEALTH SERVICES**”; and

7                   (C) in sections 1912(a)(1), 1912(b),  
8           1915(b)(1), and 1918(a)(8), by striking the term  
9           “community mental health services” each place  
10          it appears and inserting “behavioral mental  
11          health services”.

12                  (2) *CENTER FOR MENTAL HEALTH SERVICES.*—  
13          Paragraph (13) of section 520(b) (42 U.S.C. 290bb–  
14          31) is amended by striking “community mental  
15          health centers” and inserting “federally qualified be-  
16          havioral health centers”.

17                  (3) *GRANTS FOR EMERGENCY MENTAL HEALTH*  
18          *CENTERS.*—Subsection (b) of section 520F (42 U.S.C.  
19          290bb–37) is amended by striking “community men-  
20          tal health centers” and inserting “federally qualified  
21          behavioral health centers”.

**PART 2—OTHER GRANT PROGRAMS****SEC. 2521. COMPREHENSIVE PROGRAMS TO PROVIDE EDUCATION TO NURSES AND CREATE A PIPELINE TO NURSING.**

(a) *PURPOSES.*—It is the purpose of this section to authorize grants to—

(1) *address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses) for incumbent ancillary health care workers;*

(2) *increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and*

(3) *provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.*

(b) *GRANTS.*—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (referred

1 to in this section as the “Secretary”) shall establish a part-  
2 nership grant program to award grants to eligible entities  
3 to carry out comprehensive programs to provide education  
4 to nurses and create a pipeline to nursing for incumbent  
5 ancillary health care workers who wish to advance their ca-  
6 reers, and to otherwise carry out the purposes of this sec-  
7 tion.

8 (c) *ELIGIBILITY.*—To be eligible for a grant under this  
9 section, an entity shall be—

10 (1) a health care entity that is jointly adminis-  
11 tered by a health care employer and a labor union  
12 representing the health care employees of the employer  
13 and that carries out activities using labor manage-  
14 ment training funds as provided for under section  
15 302(c)(6) of the Labor Management Relations Act,  
16 1947 (29 U.S.C. 186(c)(6));

17 (2) an entity that operates a training program  
18 that is jointly administered by—

19 (A) one or more health care providers or fa-  
20 cilities, or a trade association of health care pro-  
21 viders; and

22 (B) one or more organizations which rep-  
23 resent the interests of direct care health care  
24 workers or staff nurses and in which the direct  
25 care health care workers or staff nurses have di-

1           *rect input as to the leadership of the organiza-*  
2           *tion;*

3           *(3) a State training partnership program that*  
4           *consists of nonprofit organizations that include equal*  
5           *participation from industry, including public or pri-*  
6           *vate employers, and labor organizations including*  
7           *joint labor-management training programs, and*  
8           *which may include representatives from local govern-*  
9           *ments, worker investment agency one-stop career cen-*  
10          *ters, community-based organizations, community col-*  
11          *leges, and accredited schools of nursing; or*

12          *(4) a school of nursing (as defined in section 801*  
13          *of the Public Health Service Act (42 U.S.C. 296)).*

14          *(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE*  
15          *EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible*  
16          *for a grant under this section, a health care employer de-*  
17          *scribed in subsection (c) shall demonstrate that it—*

18                 *(1) has an established program within its facil-*  
19                 *ity to encourage the retention of existing nurses;*

20                 *(2) provides wages and benefits to its nurses that*  
21                 *are competitive for its market or that have been col-*  
22                 *lectively bargained with a labor organization; and*

23                 *(3) supports programs funded under this section*  
24                 *through 1 or more of the following:*

1           (A) *The provision of paid leave time and*  
2 *continued health coverage to incumbent health*  
3 *care workers to allow their participation in*  
4 *nursing career ladder programs, including cer-*  
5 *tified nurse assistants, licensed practical nurses,*  
6 *licensed vocational nurses, and registered nurses.*

7           (B) *Contributions to a joint labor-manage-*  
8 *ment training fund which administers the pro-*  
9 *gram involved.*

10          (C) *The provision of paid release time, in-*  
11 *centive compensation, or continued health cov-*  
12 *erage to staff nurses who desire to work full- or*  
13 *part-time in a faculty position.*

14          (D) *The provision of paid release time for*  
15 *staff nurses to enable them to obtain a bachelor*  
16 *of science in nursing degree, other advanced*  
17 *nursing degrees, specialty training, or certifi-*  
18 *cation program.*

19          (E) *The payment of tuition assistance*  
20 *which is managed by a joint labor-management*  
21 *training fund or other jointly administered pro-*  
22 *gram.*

23       (e) *OTHER REQUIREMENTS.—*

24           (1) *MATCHING REQUIREMENT.—*

1           (A) *IN GENERAL.*—*The Secretary may not*  
2           *make a grant under this section unless the appli-*  
3           *cant involved agrees, with respect to the costs to*  
4           *be incurred by the applicant in carrying out the*  
5           *program under the grant, to make available non-*  
6           *Federal contributions (in cash or in kind under*  
7           *subparagraph (B)) toward such costs in an*  
8           *amount equal to not less than \$1 for each \$1 of*  
9           *Federal funds provided in the grant. Such con-*  
10          *tributions may be made directly or through do-*  
11          *nations from public or private entities, or may*  
12          *be provided through the cash equivalent of paid*  
13          *release time provided to incumbent worker stu-*  
14          *dents.*

15           (B) *DETERMINATION OF AMOUNT OF NON-*  
16          *FEDERAL CONTRIBUTION.*—*Non-Federal con-*  
17          *tributions required in subparagraph (A) may be*  
18          *in cash or in kind (including paid release time),*  
19          *fairly evaluated, including equipment or services*  
20          *(and excluding indirect or overhead costs).*  
21          *Amounts provided by the Federal Government,*  
22          *or services assisted or subsidized to any signifi-*  
23          *cant extent by the Federal Government, may not*  
24          *be included in determining the amount of such*  
25          *non-Federal contributions.*

1           (2) *REQUIRED COLLABORATION.*—*Entities car-*  
2           *rying out or overseeing programs carried out with as-*  
3           *stance provided under this section shall demonstrate*  
4           *collaboration with accredited schools of nursing which*  
5           *may include community colleges and other academic*  
6           *institutions providing associate, bachelor's, or ad-*  
7           *vanced nursing degree programs or specialty training*  
8           *or certification programs.*

9           (f) *USE OF FUNDS.*—*Amounts awarded to an entity*  
10          *under a grant under this section shall be used for the fol-*  
11          *lowing:*

12               (1) *To carry out programs that provide edu-*  
13               *cation and training to establish nursing career lad-*  
14               *ders to educate incumbent health care workers to be-*  
15               *come nurses (including certified nurse assistants, li-*  
16               *icensed practical nurses, licensed vocational nurses,*  
17               *and registered nurses). Such programs shall include*  
18               *one or more of the following:*

19                       (A) *Preparing incumbent workers to return*  
20                       *to the classroom through English-as-a-second*  
21                       *language education, GED education, precollege*  
22                       *counseling, college preparation classes, and sup-*  
23                       *port with entry level college classes that are a*  
24                       *prerequisite to nursing.*

1           (B) *Providing tuition assistance with pref-*  
2           *erence for dedicated cohort classes in community*  
3           *colleges, universities, and accredited schools of*  
4           *nursing with supportive services including tutor-*  
5           *ing and counseling.*

6           (C) *Providing assistance in preparing for*  
7           *and meeting all nursing licensure tests and re-*  
8           *quirements.*

9           (D) *Carrying out orientation and*  
10          *mentorship programs that assist newly grad-*  
11          *uated nurses in adjusting to working at the bed-*  
12          *side to ensure their retention postgraduation,*  
13          *and ongoing programs to support nurse reten-*  
14          *tion.*

15          (E) *Providing stipends for release time and*  
16          *continued health care coverage to enable incum-*  
17          *bent health care workers to participate in these*  
18          *programs.*

19          (2) *To carry out programs that assist nurses in*  
20          *obtaining advanced degrees and completing specialty*  
21          *training or certification programs and to establish*  
22          *incentives for nurses to assume nurse faculty positions*  
23          *on a part-time or full-time basis. Such programs*  
24          *shall include one or more of the following:*



1           (A) *Increasing the pool of nurses with ad-*  
2           *vanced degrees who are interested in teaching by*  
3           *funding programs that enable incumbent nurses*  
4           *to return to school.*

5           (B) *Establishing incentives for advanced de-*  
6           *gree bedside nurses who wish to teach in nursing*  
7           *programs so they can obtain a leave from their*  
8           *bedside position to assume a full- or part-time*  
9           *position as adjunct or full-time faculty without*  
10          *the loss of salary or benefits.*

11          (C) *Collaboration with accredited schools of*  
12          *nursing which may include community colleges*  
13          *and other academic institutions providing asso-*  
14          *ciate, bachelor's, or advanced nursing degree pro-*  
15          *grams, or specialty training or certification pro-*  
16          *grams, for nurses to carry out innovative nurs-*  
17          *ing programs which meet the needs of bedside*  
18          *nursing and health care providers.*

19          (g) *PREFERENCE.—In awarding grants under this sec-*  
20          *tion the Secretary shall give preference to programs that—*

21                 (1) *provide for improving nurse retention;*

22                 (2) *provide for improving the diversity of the*  
23                 *new nurse graduates to reflect changes in the demo-*  
24                 *graphics of the patient population;*

1           (3) *provide for improving the quality of nursing*  
2 *education to improve patient care and safety;*

3           (4) *have demonstrated success in upgrading in-*  
4 *cumbent health care workers to become nurses or*  
5 *which have established effective programs or pilots to*  
6 *increase nurse faculty; or*

7           (5) *are modeled after or affiliated with such pro-*  
8 *grams described in paragraph (4).*

9       (h) *EVALUATION.*—

10           (1) *PROGRAM EVALUATIONS.*—*An entity that re-*  
11 *ceives a grant under this section shall annually evalu-*  
12 *ate, and submit to the Secretary a report on, the ac-*  
13 *tivities carried out under the grant and the outcomes*  
14 *of such activities. Such outcomes may include—*

15                   (A) *an increased number of incumbent*  
16 *workers entering an accredited school of nursing*  
17 *and in the pipeline for nursing programs;*

18                   (B) *an increasing number of graduating*  
19 *nurses and improved nurse graduation and li-*  
20 *cence rates;*

21                   (C) *improved nurse retention;*

22                   (D) *an increase in the number of staff*  
23 *nurses at the health care facility involved;*

24                   (E) *an increase in the number of nurses*  
25 *with advanced degrees in nursing;*

1           (F) an increase in the number of nurse fac-  
2           ulty;

3           (G) improved measures of patient quality  
4           (which may include staffing ratios of nurses, pa-  
5           tient satisfaction rates, and patient safety meas-  
6           ures); and

7           (H) an increase in the diversity of new  
8           nurse graduates relative to the patient popu-  
9           lation.

10          (2) *GENERAL REPORT.*—Not later than 2 years  
11          after the date of the enactment of this Act, and annu-  
12          ally thereafter, the Secretary of Labor shall, using  
13          data and information from the reports received under  
14          paragraph (1), submit to the Congress a report con-  
15          cerning the overall effectiveness of the grant program  
16          carried out under this section.

17          (i) *AUTHORIZATION OF APPROPRIATIONS.*—There are  
18          authorized to be appropriated to carry out this section such  
19          sums as may be necessary.

20          **SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.**

21          Part E of title VII (42 U.S.C. 294n et seq.) is amended  
22          by adding at the end the following:

1 **“Subpart 3—Mental and Behavioral Health Training**

2 **“SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING**  
3 **PROGRAM.**

4 “(a) *PROGRAM.—The Secretary shall establish an*  
5 *interdisciplinary mental and behavioral health training*  
6 *program consisting of awarding grants and contracts under*  
7 *subsection (b).*

8 “(b) *SUPPORT AND DEVELOPMENT OF MENTAL AND*  
9 *BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Sec-*  
10 *retary shall make grants to, or enter into contracts with,*  
11 *eligible entities—*

12 “(1) *to plan, develop, operate, or participate in*  
13 *an accredited professional training program for men-*  
14 *tal and behavioral health professionals to promote—*

15 “(A) *interdisciplinary training; and*

16 “(B) *coordination of the delivery of health*  
17 *care within and across settings, including health*  
18 *care institutions, community-based settings, and*  
19 *the patient’s home;*

20 “(2) *to provide financial assistance to mental*  
21 *and behavioral health professionals, who are partici-*  
22 *pants in any such program, and who plan to work*  
23 *in the field of mental and behavioral health;*

24 “(3) *to plan, develop, operate, or participate in*  
25 *an accredited program for the training of mental and*

1 *behavioral health professionals who plan to teach in*  
2 *the field of mental and behavioral health; and*

3 *“(4) to provide financial assistance in the form*  
4 *of traineeships and fellowships to mental and behav-*  
5 *ioral health professionals who are participants in any*  
6 *such program and who plan to teach in the field of*  
7 *mental and behavioral health.*

8 *“(c) ELIGIBILITY.—To be eligible for a grant or con-*  
9 *tract under subsection (b), an entity shall be—*

10 *“(1) an accredited health professions school, in-*  
11 *cluding an accredited school or program of psy-*  
12 *chology, psychiatry, social work, marriage and family*  
13 *therapy, professional mental health and substance*  
14 *abuse counseling, or addiction medicine;*

15 *“(2) an accredited public or nonprofit private*  
16 *hospital;*

17 *“(3) a public or private nonprofit entity; or*

18 *“(4) a consortium of 2 or more entities described*  
19 *in paragraphs (1) through (3).*

20 *“(d) PREFERENCE.—In awarding grants or contracts*  
21 *under this section, the Secretary shall give preference to en-*  
22 *tities that have a demonstrated record of the following:*

23 *“(1) Training the greatest percentage, or signifi-*  
24 *cantly improving the percentage, of health profes-*  
25 *sionals who serve in underserved communities.*

1           “(2) *Supporting teaching programs that address*  
2           *the health care needs of vulnerable populations.*

3           “(3) *Training individuals who are from under-*  
4           *represented minority groups or disadvantaged back-*  
5           *grounds.*

6           “(4) *Training individuals who serve geriatric*  
7           *populations with an emphasis on underserved elderly.*

8           “(5) *Training individuals who serve pediatric*  
9           *populations with an emphasis on underserved chil-*  
10          *dren.*

11          “(e) *REPORT.—The Secretary shall submit to the Con-*  
12          *gress an annual report on the program under this section.*

13          “(f) *DEFINITION.—In this section:*

14                 “(1) *The term ‘health disparities’ has the mean-*  
15                 *ing given the term in section 3171.*

16                 “(2) *The term ‘mental and behavioral health*  
17                 *professional’ means an individual training or prac-*  
18                 *ticing—*

19                         “(A) *in psychology; general, geriatric, child*  
20                         *or adolescent psychiatry; social work; marriage*  
21                         *and family therapy; professional mental health*  
22                         *and substance abuse counseling; or addiction*  
23                         *medicine; or*

1           “(B) another mental and behavioral health  
2 specialty, as deemed appropriate by the Sec-  
3 retary.

4           “(3) The term ‘interdisciplinary’ means collabo-  
5 ration across health professions, specialties, and sub-  
6 specialties, which may include public health, nursing,  
7 allied health, and appropriate medical specialties.

8           “(g) *AUTHORIZATION OF APPROPRIATIONS.*—To carry  
9 out this section, there is authorized to be appropriated  
10 \$60,000,000 for each of fiscal years 2010 through 2014. Of  
11 the amounts appropriated to carry out this section for a  
12 fiscal year, not less than 15 percent shall be used for train-  
13 ing programs in psychology.”.

14 **SEC. 2523. PROGRAMS TO INCREASE AWARENESS OF AD-**  
15 **VANCE CARE PLANNING ISSUES.**

16           *Title III (42 U.S.C. 241 et seq.), as amended, is*  
17 *amended by adding at the end the following:*

18 **“PART T—PROGRAMS TO INCREASE AWARENESS**  
19 **OF ADVANCE CARE PLANNING ISSUES**  
20 **“SEC. 399HH. ADVANCE CARE PLANNING EDUCATION CAM-**  
21 **PAIGNS AND INFORMATION PHONE LINE AND**  
22 **CLEARINGHOUSE.**

23           “(a) *ADVANCE CARE PLANNING EDUCATION CAM-*  
24 *PAIGN.*—The Secretary shall, directly or through grants

1 *awarded under subsection (c), conduct a national public*  
2 *education campaign—*

3           “(1) *to raise public awareness of the importance*  
4 *of planning for care near the end of life;*

5           “(2) *to improve the public’s understanding of the*  
6 *various situations in which individuals may find*  
7 *themselves if they become unable to express their*  
8 *health care wishes;*

9           “(3) *to explain the need for readily available*  
10 *legal documents that express an individual’s wishes*  
11 *through—*

12                 “(A) *advance directives (including living*  
13 *wills, comfort care orders, and durable powers of*  
14 *attorney for health care); and*

15                 “(B) *other planning tools, such as a physi-*  
16 *cian’s orders for life-sustaining treatment*  
17 *(POLST); and*

18           “(4) *to educate the public about the availability*  
19 *of hospice care and palliative care.*

20           “(b) *INFORMATION PHONE LINE AND CLEARING-*  
21 *HOUSE.—The Secretary, directly or through grants award-*  
22 *ed under subsection (c), shall provide for the establishment*  
23 *of a national, toll-free, information telephone line and a*  
24 *clearinghouse that the public and health professionals may*



1 *access to find out about State-specific and other informa-*  
2 *tion regarding advance directive and end-of-life decisions.*

3 “(c) *GRANTS.*—

4 “(1) *IN GENERAL.*—*The Secretary shall use*  
5 *funds appropriated under subsection (d) for the pur-*  
6 *pose of awarding grants to public or nonprofit pri-*  
7 *vate entities (including States or political subdivi-*  
8 *sions of a State), or a consortium of any of such enti-*  
9 *ties, for the purpose of conducting education cam-*  
10 *paigns under subsection (a).*

11 “(2) *LIMITATION ON ELIGIBILITY.*—*Any grant*  
12 *awarded under this Act shall not go to any govern-*  
13 *mental or nongovernmental organization that pro-*  
14 *motes suicide, assisted suicide, or the active hastening*  
15 *of death. Nothing in the previous clause shall be con-*  
16 *strued to prohibit palliative or hospice care.*

17 “(3) *PERIOD.*—*Any grant awarded under para-*  
18 *graph (1) shall be for a period of 3 years.*

19 “(d) *AUTHORIZATION OF APPROPRIATIONS.*—*There*  
20 *are authorized to be appropriated—*

21 “(1) *for purposes of carrying out subsection (b),*  
22 *\$5,000,000 for fiscal year 2010 and each subsequent*  
23 *year; and*

1           “(2) for purposes of making grants under sub-  
2           section (c), \$10,000,000 for fiscal year 2010, to re-  
3           main available until expended.”.

4 **SEC. 2524. REAUTHORIZATION OF TELEHEALTH AND TELE-**  
5 **MEDICINE GRANT PROGRAMS.**

6           (a) *TELEHEALTH NETWORK AND TELEHEALTH RE-*  
7 *SOURCE CENTERS GRANT PROGRAMS.*—Section 330I (42  
8 *U.S.C. 254c–14*) is amended—

9           (1) in subsection (a)—

10                   (A) by striking paragraph (3) (relating to  
11                   frontier communities); and

12                   (B) by inserting after paragraph (2) the fol-  
13                   lowing:

14                   “(3) *HEALTH DISPARITIES.*—The term ‘health  
15                   disparities’ has the meaning given such term in sec-  
16                   tion 3171.”;

17           (2) in subsection (d)(1)—

18                   (A) in subparagraph (B), by striking “and”  
19                   at the end;

20                   (B) in subparagraph (C), by striking the  
21                   period at the end and inserting “; and”; and

22                   (C) by adding at the end the following:

23                   “(D) reduce health disparities.”;

24           (3) in subsection (f)(1)(B)(iii)—

1           (A) in subclause (VII), by inserting “, in-  
2           cluding skilled nursing facilities” before the pe-  
3           riod at the end;

4           (B) in subclause (IX), by inserting “, in-  
5           cluding county mental health and public mental  
6           health facilities” before the period at the end;  
7           and

8           (C) by adding at the end the following:

9                           “(XIII) Renal dialysis facilities.”;

10          (4) by amending subsection (i) to read as fol-  
11          lows:

12          “(i) PREFERENCES.—

13                   “(1) TELEHEALTH NETWORKS.—In awarding  
14                   grants under subsection (d)(1) for projects involving  
15                   telehealth networks, the Secretary shall give preference  
16                   to eligible entities meeting the following:

17                           “(A) NETWORK.—The eligible entity is a  
18                           health care provider in, or proposing to form, a  
19                           health care network that furnishes services in a  
20                           medically underserved area or a health profes-  
21                           sional shortage area.

22                           “(B) BROAD GEOGRAPHIC COVERAGE.—The  
23                           eligible entity demonstrates broad geographic  
24                           coverage in the rural or medically underserved

1           *areas of the State or States in which the entity*  
2           *is located.*

3           “(C) *HEALTH DISPARITIES.*—*The eligible*  
4           *entity demonstrates how the project to be funded*  
5           *through the grant will address health disparities.*

6           “(D) *LINKAGES.*—*The eligible entity agrees*  
7           *to use the grant to establish or develop plans for*  
8           *telehealth systems that will link rural hospitals*  
9           *and rural health care providers to other hos-*  
10          *pitals, health care providers, and patients.*

11          “(E) *EFFICIENCY.*—*The eligible entity*  
12          *agrees to use the grant to promote greater effi-*  
13          *ciency in the use of health care resources.*

14          “(F) *VIABILITY.*—*The eligible entity dem-*  
15          *onstrates the long-term viability of projects*  
16          *through—*

17                  “(i) *availability of non-Federal fund-*  
18                  *ing sources; or*

19                  “(ii) *institutional and community sup-*  
20                  *port for the telehealth network.*

21          “(G) *SERVICES.*—*The eligible entity pro-*  
22          *vides a plan for coordinating system use by eli-*  
23          *gible entities and prioritizes use of grant funds*  
24          *for health care services over nonclinical uses.*

1           “(2) *TELEHEALTH RESOURCE CENTERS.*—*In*  
2           *awarding grants under subsection (d)(2) for projects*  
3           *involving telehealth resource centers, the Secretary*  
4           *shall give preference to eligible entities meeting the*  
5           *following:*

6                   “(A) *PROVISION OF A BROAD RANGE OF*  
7                   *SERVICES.*—*The eligible entity has a record of*  
8                   *success in the provision of a broad range of tele-*  
9                   *health services to medically underserved areas or*  
10                   *populations.*

11                   “(B) *PROVISION OF TELEHEALTH TECH-*  
12                   *NICAL ASSISTANCE.*—*The eligible entity has a*  
13                   *record of success in the provision of technical as-*  
14                   *sistance to providers serving medically under-*  
15                   *served communities or populations in the estab-*  
16                   *lishment and implementation of telehealth serv-*  
17                   *ices.*

18                   “(C) *COLLABORATION AND SHARING OF EX-*  
19                   *PERTISE.*—*The eligible entity has a dem-*  
20                   *onstrated record of collaborating and sharing ex-*  
21                   *pertise with providers of telehealth services at the*  
22                   *national, regional, State, and local levels.”;*

23                   (5) *in subsection (j)(2)(B), by striking “such*  
24                   *projects for fiscal year 2001” and all that follows*

1 through the period and inserting “such project for fis-  
2 cal year 2009.”;

3 (6) in subsection (k)(1)—

4 (A) in subparagraph (E)(i), by striking  
5 “transmission of medical data” and inserting  
6 “transmission and electronic archival of medical  
7 data”; and

8 (B) by amending subparagraph (F) to read  
9 as follows:

10 “(F) developing projects to use telehealth  
11 technology—

12 “(i) to facilitate collaboration between  
13 health care providers;

14 “(ii) to promote telenursing services; or

15 “(iii) to promote patient under-  
16 standing and adherence to national guide-  
17 lines for chronic disease and self-manage-  
18 ment of such conditions;”;

19 (7) in subsection (q), by striking “Not later than  
20 September 30, 2005” and inserting “Not later than 1  
21 year after the date of the enactment of the America’s  
22 Affordable Health Choices Act of 2009, and annually  
23 thereafter”;

24 (8) by striking subsection (r);

1           (9) by redesignating subsection (s) as subsection  
2           (r); and

3           (10) in subsection (r) (as so redesignated)—

4           (A) in paragraph (1)—

5                 (i) by striking “and” before “such  
6                 sums”; and

7                 (ii) by inserting “, \$10,000,000 for fis-  
8                 cal year 2010, and such sums as may be  
9                 necessary for each of fiscal years 2011  
10                through 2014” before the semicolon; and

11           (B) in paragraph (2)—

12                 (i) by striking “and” before “such  
13                 sums”; and

14                 (ii) by inserting “, \$10,000,000 for fis-  
15                 cal year 2010, and such sums as may be  
16                 necessary for each of fiscal years 2011  
17                 through 2014” before the period.

18           (b) *TELEMEDICINE; INCENTIVE GRANTS REGARDING*  
19 *COORDINATION AMONG STATES.*—Subsection (b) of section  
20 330L (42 U.S.C. 254c–18) is amended by inserting “,  
21 \$10,000,000 for fiscal year 2010, and such sums as may  
22 be necessary for each of fiscal years 2011 through 2014”  
23 before the period at the end.

1 **SEC. 2525. NO CHILD LEFT UNIMMUNIZED AGAINST INFLU-**  
2 **ENZA: DEMONSTRATION PROGRAM USING EL-**  
3 **EMENTARY AND SECONDARY SCHOOLS AS IN-**  
4 **FLUENZA VACCINATION CENTERS.**

5 (a) *PURPOSE.*—*The Secretary of Health and Human*  
6 *Services, in consultation with the Secretary of Education*  
7 *and the Secretary of Labor, shall award grants to eligible*  
8 *partnerships to carry out demonstration programs designed*  
9 *to test the feasibility of using the Nation’s elementary*  
10 *schools and secondary schools as influenza vaccination cen-*  
11 *ters.*

12 (b) *IN GENERAL.*—*The Secretary shall coordinate with*  
13 *the Secretary of Labor, the Secretary of Education, State*  
14 *Medicaid agencies, State insurance agencies, and private*  
15 *insurers to carry out a program consisting of awarding*  
16 *grants under subsection (c) to ensure that children have cov-*  
17 *erage for all reasonable and customary expenses related to*  
18 *influenza vaccinations, including the costs of purchasing*  
19 *and administering the vaccine incurred when influenza*  
20 *vaccine is administered outside of the physician’s office in*  
21 *a school or other related setting.*

22 (c) *PROGRAM DESCRIPTION.*—

23 (1) *GRANTS.*—*From amounts appropriated pur-*  
24 *suant to subsection (l), the Secretary shall award*  
25 *grants to eligible partnerships to be used to provide*  
26 *influenza vaccinations to children in elementary and*



1        *secondary schools, in coordination with school nurses,*  
2        *school health care programs, community health care*  
3        *providers, State insurance agencies, or private insur-*  
4        *ers.*

5            (2) *ACIP RECOMMENDATIONS.*—*The program*  
6        *under this section shall be designed to administer vac-*  
7        *cines consistent with the recommendations of the Cen-*  
8        *ters for Disease Control and Prevention’s Advisory*  
9        *Committee on Immunization Practices (ACIP) for the*  
10       *annual vaccination of all children 5 through 19 years*  
11       *of age.*

12           (3) *PARTICIPATION VOLUNTARY.*—*Participation*  
13       *by a school or an individual shall be voluntary.*

14           (d) *USE OF FUNDS.*—*Eligible partnerships receiving*  
15       *a grant under this section shall ensure the maximum num-*  
16       *ber of children access influenza vaccinations as follows:*

17           (1) *COVERED CHILDREN.*—*To the extent to which*  
18       *payment of the costs of purchasing and administering*  
19       *the influenza vaccine for children is not covered*  
20       *through other federally funded programs or through*  
21       *private insurance, eligible partnerships receiving a*  
22       *grant shall use funds to purchase and administer in-*  
23       *fluenza vaccinations.*

24           (2) *CHILDREN COVERED BY OTHER FEDERAL*  
25       *PROGRAMS.*—*For children who are eligible under*

1        *other federally funded programs for payment of the*  
2        *costs of purchasing and administering the influenza*  
3        *vaccine, eligible partnerships receiving a grant shall*  
4        *not use funds provided under this section for such*  
5        *costs.*

6                (3) *CHILDREN COVERED BY PRIVATE HEALTH IN-*  
7        *SURANCE.—For children who have private insurance,*  
8        *eligible partnerships receiving a grant shall offer as-*  
9        *sistance in accessing coverage for vaccinations admin-*  
10        *istered through the program under this section.*

11              (e) *PRIVACY.—The Secretary shall ensure that the pro-*  
12        *gram under this section adheres to confidentiality and pri-*  
13        *vacy requirements of section 264 of the Health Insurance*  
14        *Portability and Accountability Act of 1996 (42 U.S.C.*  
15        *1320d–2 note) and section 444 of the General Education*  
16        *Provisions Act (20 U.S.C. 1232g; commonly referred to as*  
17        *the “Family Educational Rights and Privacy Act of*  
18        *1974”).*

19              (f) *APPLICATION.—An eligible partnership desiring a*  
20        *grant under this section shall submit an application to the*  
21        *Secretary at such time, in such manner, and containing*  
22        *such information as the Secretary may require.*

23              (g) *DURATION.—Eligible partnerships receiving a*  
24        *grant shall administer a demonstration program funded*

1 *through this section over a period of 2 consecutive school*  
2 *years.*

3       (h) *CHOICE OF VACCINE.*—*The program under this*  
4 *section shall not restrict the discretion of a health care pro-*  
5 *vider to administer any influenza vaccine approved by the*  
6 *Food and Drug Administration for use in pediatric popu-*  
7 *lations.*

8       (i) *AWARDS.*—*The Secretary shall award—*

9           (1) *a minimum of 10 grants in 10 different*  
10 *States to eligible partnerships that each include one*  
11 *or more public schools serving primarily low-income*  
12 *students; and*

13           (2) *a minimum of 5 grants in 5 different States*  
14 *to eligible partnerships that each include one or more*  
15 *public schools located in a rural local education agen-*  
16 *cy.*

17       (j) *REPORT.*—*Not later than 90 days following the*  
18 *completion of the program under this section, the Secretary*  
19 *shall submit to the Committees on Education and Labor,*  
20 *Energy and Commerce, and Appropriations of the House*  
21 *of Representatives and to the Committees on Health, Edu-*  
22 *cation, Labor, and Pensions and Appropriations of the Sen-*  
23 *ate a report on the results of the program. The report shall*  
24 *include—*

1           (1) *an assessment of the influenza vaccination*  
2 *rates of school-age children in localities where the pro-*  
3 *gram is implemented, compared to the national aver-*  
4 *age influenza vaccination rates for school-aged chil-*  
5 *dren, including whether school-based vaccination as-*  
6 *sists in achieving the recommendations of the Advi-*  
7 *sory Committee on Immunization Practices for an-*  
8 *annual influenza vaccination of all children 6 months*  
9 *to 18 years of age;*

10           (2) *an assessment of the utility of employing ele-*  
11 *mentary schools and secondary schools as a part of a*  
12 *multistate, community-based pandemic response pro-*  
13 *gram that is consistent with existing Federal and*  
14 *State pandemic response plans;*

15           (3) *an assessment of the feasibility of using exist-*  
16 *ing Federal and private insurance funding in estab-*  
17 *lishing a multistate, school-based vaccination pro-*  
18 *gram for seasonal influenza vaccination;*

19           (4) *an assessment of the number of education*  
20 *days gained by students as a result of seasonal vac-*  
21 *cinations based on absenteeism rates;*

22           (5) *a determination of whether the program*  
23 *under this section—*

24                   (A) *increased vaccination rates in the par-*  
25 *ticipating localities; and*

1                   (B) was implemented for sufficient time for  
2                   gathering enough valid data; and

3                   (6) a recommendation on whether the program  
4                   should be continued, expanded, or terminated.

5                   (k) DEFINITIONS.—In this section:

6                   (1) ELIGIBLE PARTNERSHIP.—The term “eligible  
7                   partnership” means a local public health department,  
8                   or another health organization defined by the Sec-  
9                   retary as eligible to submit an application, and one  
10                  or more elementary and secondary schools.

11                  (2) ELEMENTARY SCHOOL.—The terms “elemen-  
12                  tary school” and “secondary school” have the mean-  
13                  ings given such terms in section 9101 of the Elemen-  
14                  tary and Secondary Education Act of 1965 (20  
15                  U.S.C. 7801).

16                  (3) LOW-INCOME.—The term “low-income”  
17                  means a student, age 5 through 19, eligible for free or  
18                  reduced-price lunch under the National School Lunch  
19                  Act (42 U.S.C. 1751 et seq.).

20                  (4) RURAL LOCAL EDUCATIONAL AGENCY.—The  
21                  term “rural local educational agency” means an eligi-  
22                  ble local educational agency described in section  
23                  6211(b)(1) of the Elementary and Secondary Edu-  
24                  cation Act of 1965 (20 U.S.C. 7345(b)(1)).

1           (5) *SECRETARY*.—*Except as otherwise specified,*  
2           *the term “Secretary” means the Secretary of Health*  
3           *and Human Services.*

4           (1) *AUTHORIZATION OF APPROPRIATIONS*.—*To carry*  
5           *out this section, there are authorized to be appropriated*  
6           *such sums as may be necessary.*

7           **SEC. 2526. EXTENSION OF WISEWOMAN PROGRAM.**

8           *Section 1509 of the Public Health Service Act (42*  
9           *U.S.C. 300n-4a) is amended—*

10           (1) *in subsection (a)—*

11                   (A) *by striking the heading and inserting*  
12                   *“IN GENERAL.—”; and*

13                   (B) *in the matter preceding paragraph (1),*  
14                   *by striking “may make grants” and all that fol-*  
15                   *lows through “purpose” and inserting the fol-*  
16                   *lowing: “may make grants to such States for the*  
17                   *purpose”; and*

18           (2) *in subsection (d)(1), by striking “there are*  
19           *authorized” and all that follows through the period*  
20           *and inserting “there are authorized to be appro-*  
21           *priated \$70,000,000 for fiscal year 2010, \$73,500,000*  
22           *for fiscal year 2011, \$77,000,000 for fiscal year 2012,*  
23           *\$81,000,000 for fiscal year 2013, and \$85,000,000 for*  
24           *fiscal year 2014.”.*

1 **SEC. 2527. HEALTHY TEEN INITIATIVE TO PREVENT TEEN**  
2 **PREGNANCY.**

3 *Part B of title III (42 U.S.C. 243 et seq.) is amended*  
4 *by inserting after section 317T the following:*

5 **“SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN**  
6 **PREGNANCY.**

7 *“(a) PROGRAM.—To the extent and in the amount of*  
8 *appropriations made in advance in appropriations Acts,*  
9 *the Secretary, acting through the Director of the Centers*  
10 *for Disease Control and Prevention, shall establish a pro-*  
11 *gram consisting of making grants, in amounts determined*  
12 *under subsection (c), to each State that submits an applica-*  
13 *tion in accordance with subsection (d) for an evidence-based*  
14 *education program described in subsection (b).*

15 *“(b) USE OF FUNDS.—Amounts received by a State*  
16 *under this section shall be used to conduct or support evi-*  
17 *dence-based education programs (directly or through grants*  
18 *or contracts to public or private nonprofit entities, includ-*  
19 *ing schools and community-based and faith-based organiza-*  
20 *tions) to reduce teen pregnancy or sexually transmitted dis-*  
21 *eases.*

22 *“(c) DISTRIBUTION OF FUNDS.—The Director shall,*  
23 *for fiscal year 2010 and each subsequent fiscal year, make*  
24 *a grant to each State described in subsection (a) in an*  
25 *amount equal to the product of—*

1           “(1) the amount appropriated to carry out this  
2 section for the fiscal year; and

3           “(2) the percentage determined for the State  
4 under section 502(c)(1)(B)(ii) of the Social Security  
5 Act.

6           “(d) *APPLICATION.*—To seek a grant under this sec-  
7 tion, a State shall submit an application at such time, in  
8 such manner, and containing such information and assur-  
9 ance of compliance with this section as the Secretary may  
10 require. At a minimum, an application shall to the satisfac-  
11 tion of the Secretary—

12           “(1) describe how the State’s proposal will ad-  
13 dress the needs of at-risk teens in the State;

14           “(2) identify the evidence-based education pro-  
15 gram or programs selected from the registry developed  
16 under subsection (g) that will be used to address risks  
17 in priority populations;

18           “(3) describe how the program or programs will  
19 be implemented and any adaptations to the evidence-  
20 based model that will be made;

21           “(4) list any private and public entities with  
22 whom the State proposes to work, including schools  
23 and community-based and faith-based organizations,  
24 and demonstrate their capacity to implement the pro-  
25 posed program or programs; and



1           “(5) *identify an independent entity that will*  
2 *evaluate the impact of the program or programs.*

3           “(e) *EVALUATION.—*

4           “(1) *REQUIREMENT.—As a condition on receipt*  
5 *of a grant under this section, a State shall agree—*

6           “(A) *to arrange for an independent evalua-*  
7 *tion of the impact of the programs to be con-*  
8 *ducted or supported through the grant; and*

9           “(B) *submit reports to the Secretary on*  
10 *such programs and the results of evaluation of*  
11 *such programs.*

12           “(2) *FUNDING LIMITATION.—Of the amounts*  
13 *made available to a State through a grant under this*  
14 *section for any fiscal year, not more than 10 percent*  
15 *may be used for such evaluation.*

16           “(f) *RULE OF CONSTRUCTION.—This section shall not*  
17 *be construed to preempt or limit any State law regarding*  
18 *parental involvement and decisionmaking in children’s*  
19 *education.*

20           “(g) *REGISTRY OF ELIGIBLE PROGRAMS.—The Sec-*  
21 *retary shall develop not later than 180 days after the date*  
22 *of the enactment of the America’s Affordable Health Choices*  
23 *Act of 2009, and periodically update thereafter, a publicly*  
24 *available registry of programs described in subsection (b)*  
25 *that, as determined by the Secretary—*

1           “(1) meet the definition of the term ‘evidence-  
2           based’ in subsection (i);

3           “(2) are medically and scientifically accurate;  
4           and

5           “(3) provide age-appropriate information.

6           “(h) *MATCHING FUNDS.*—The Secretary may award  
7 a grant to a State under this section for a fiscal year only  
8 if the State agrees to provide, from non-Federal sources, an  
9 amount equal to \$1 (in cash or in kind) for each \$4 pro-  
10 vided through the grant to carry out the activities supported  
11 by the grant.

12          “(i) *DEFINITION.*—In this section, the term ‘evidence-  
13 based’ means based on a model that has been found, in  
14 methodologically sound research—

15           “(1) to delay initiation of sex;

16           “(2) to decrease number of partners;

17           “(3) to reduce teen pregnancy;

18           “(4) to reduce sexually transmitted infection  
19 rates; or

20           “(5) to improve rates of contraceptive use.

21          “(j) *APPROPRIATIONS.*—To carry out this section,  
22 there is authorized to be appropriated \$50,000,000 for each  
23 of the fiscal years 2010 through 2014.”.

1 **SEC. 2528. NATIONAL TRAINING INITIATIVE ON AUTISM**  
2 **SUPPLEMENTAL GRANTS AND TECHNICAL AS-**  
3 **SISTANCE.**

4 *Part R of title III (42 U.S.C. 280i et seq.) is amend-*  
5 *ed—*

6 *(1) by inserting after the header for part R the*  
7 *following:*

8 **“Subpart 1—Surveillance and Research Program;**  
9 **Education, Early Detection, and Intervention;**  
10 **and Reporting”;**

11 *(2) in section 399AA(d), by striking “part” and*  
12 *inserting “subpart”; and*

13 *(3) by adding at the end the following:*

14 **“Subpart 2—National Training Initiative**

15 **“SEC. 399FF. NATIONAL TRAINING INITIATIVE.**

16 *“(a) NATIONAL TRAINING INITIATIVE SUPPLEMENTAL*  
17 *GRANTS AND TECHNICAL ASSISTANCE.—*

18 *“(1) SUPPLEMENTAL GRANTS.—*

19 *“(A) IN GENERAL.—The Secretary shall*  
20 *award, in consultation with the Interagency Au-*  
21 *tism Coordinating Committee, multiyear na-*  
22 *tional training initiative supplemental grants to*  
23 *University Centers for Excellence in Develop-*  
24 *mental Disabilities authorized by the Develop-*  
25 *mental Disabilities Assistance and Bill of Rights*  
26 *Act of 2000, public or private nonprofit entities,*

1           *and other comparable interdisciplinary service,*  
2           *training, and academic entities to provide inter-*  
3           *disciplinary training, continuing education ini-*  
4           *tiatives, technical assistance, dissemination, and*  
5           *services to address the unmet needs of children*  
6           *and adults with autism spectrum disorders and*  
7           *related developmental disabilities, and their fam-*  
8           *ilies.*

9           “(B) *REQUIREMENTS.—A University Cen-*  
10          *ter for Excellence in Developmental Disabilities*  
11          *that desires to receive a grant under this para-*  
12          *graph shall submit to the Secretary an applica-*  
13          *tion containing such agreements and informa-*  
14          *tion as the Secretary may require, including*  
15          *agreements that the training program shall—*

16                “(i) *provide trainees with an appro-*  
17                *priate balance of interdisciplinary aca-*  
18                *demie and community-based experiences;*

19                “(ii) *have a demonstrated capacity to*  
20                *provide training and technical assistance in*  
21                *evidence-based practices to evaluate, and*  
22                *provide effective interventions, treatment,*  
23                *services, and supports to children and*  
24                *adults with autism and related develop-*  
25                *mental disabilities, and their families;*

1           “(iii) have a demonstrated capacity to  
2 include persons with autism spectrum dis-  
3 orders, parents, and family members as  
4 part of the training program to ensure that  
5 a person and family-centered approach is  
6 used;

7           “(iv) provide to the Secretary, in the  
8 manner prescribed by the Secretary, data  
9 regarding the number of persons who have  
10 benefitted and outcomes of the provision of  
11 training and technical assistance;

12           “(v) demonstrate a capacity to share  
13 and disseminate materials and practices  
14 that are developed and evaluated to be effec-  
15 tive in the provision of training and tech-  
16 nical assistance;

17           “(vi) provide assurances that training,  
18 technical assistance, dissemination, and  
19 services performed under grants made pur-  
20 suant to this paragraph shall be consistent  
21 with the goals of the Developmental Disabil-  
22 ities Act of 1984, the Americans with Dis-  
23 abilities Act of 1990, the Individuals with  
24 Disabilities Education Act, and the No  
25 Child Left Behind Act of 2001 and con-

1           *ducted in coordination with other relevant*  
2           *State agencies, other institutions of higher*  
3           *education, and service providers; and*

4           *“(vii) have a demonstrated capacity to*  
5           *provide training, technical assistance, sup-*  
6           *ports, and services under this section state-*  
7           *wide.*

8           *“(C) ACTIVITIES.—A University Center for*  
9           *Excellence in Developmental Disabilities, or*  
10          *other eligible entity that receives a grant under*  
11          *this paragraph shall expand and develop inter-*  
12          *disciplinary training and continuing education*  
13          *initiatives for parents, health, allied health, vo-*  
14          *ccational, educational, and other professionals*  
15          *and develop model services and supports that*  
16          *demonstrate evidence-based practices, by engag-*  
17          *ing in the following activities:*

18          *“(i) Training health, allied health, vo-*  
19          *ccational, and educational professionals to*  
20          *identify, evaluate the needs, and develop*  
21          *treatments, interventions, services, and sup-*  
22          *ports for children and adults with, autism*  
23          *spectrum disorder and related develop-*  
24          *mental disabilities.*

1           “(ii) *Developing systems and products*  
2           *that allow for the interventions, services and*  
3           *supports to be evaluated for fidelity of im-*  
4           *plementation.*

5           “(iii) *Working to expand the avail-*  
6           *ability of evidence-based, lifelong interven-*  
7           *tions, educational, employment, and transi-*  
8           *tion services, and community supports.*

9           “(iv) *Providing statewide technical as-*  
10          *istance in collaboration with relevant State*  
11          *agencies, other institutions of higher edu-*  
12          *cation, autism spectrum disorder advocacy*  
13          *groups, and community-based service pro-*  
14          *viders.*

15          “(v) *Working to develop comprehensive*  
16          *systems of supports and services for individ-*  
17          *uals with autism and related developmental*  
18          *disabilities and their families, including*  
19          *seamless transitions between educational*  
20          *and health systems across the lifespan.*

21          “(vi) *Promoting training, technical as-*  
22          *istance, dissemination, supports, and serv-*  
23          *ices.*

24          “(vii) *Developing mechanisms to pro-*  
25          *vide training and technical assistance, in-*

1            *cluding for-credit courses, intensive summer*  
2            *institutes, continuing education programs,*  
3            *distance based programs, and Web-based in-*  
4            *formation dissemination strategies.*

5            *“(viii) Promoting activities that sup-*  
6            *port community-based family and indi-*  
7            *vidual services and enable individuals with*  
8            *autism and related developmental disabil-*  
9            *ities to fully participate in society and*  
10           *achieve good quality of life outcomes.*

11           *“(ix) Collecting data on the outcomes*  
12           *of training and technical assistance pro-*  
13           *grams to meet statewide needs for the ex-*  
14           *pansion of services to children and adults*  
15           *with autism spectrum disorders and related*  
16           *developmental disabilities.*

17           *“(2) TECHNICAL ASSISTANCE.—The Secretary*  
18           *shall reserve 2 percent of the appropriated funds to*  
19           *make a grant to a national organization with dem-*  
20           *onstrated capacity for proving training and technical*  
21           *assistance to University Centers for Excellence in De-*  
22           *velopmental Disabilities to—*

23           *“(A) assist in national dissemination of*  
24           *specific information, including evidence-based*  
25           *best practices, from interdisciplinary training*



1            *programs, and when appropriate, other entities*  
2            *whose findings would inform the work performed*  
3            *by entities awarded grants;*

4            *“(B) compile and disseminate strategies*  
5            *and materials that prove to be effective in the*  
6            *provision of training and technical assistance so*  
7            *that the entire network can benefit from the mod-*  
8            *els, materials, and practices developed in indi-*  
9            *vidual centers;*

10           *“(C) assist in the coordination of activities*  
11           *of grantees under this section;*

12           *“(D) develop a Web portal that will provide*  
13           *linkages to each of the individual training ini-*  
14           *tiatives and provide access to training modules,*  
15           *promising training, and technical assistance*  
16           *practices and other materials developed by*  
17           *grantees;*

18           *“(E) serve as a research-based resource for*  
19           *Federal and State policymakers on information*  
20           *concerning the provision of training and tech-*  
21           *nical assistance for the assessment, and provision*  
22           *of supports and services for children and adults*  
23           *with autism spectrum disorders and related de-*  
24           *velopmental disabilities;*

1           “(F) convene experts from multiple inter-  
2           disciplinary training programs, individuals  
3           with autism spectrum disorders, and their fami-  
4           lies to discuss and make recommendations with  
5           regard to training issues related to the assess-  
6           ment, and treatment, interventions, supports,  
7           and services for children and adults with autism  
8           spectrum disorders and related developmental  
9           disorders; and

10           “(G) undertake any other functions that the  
11           Secretary determines to be appropriate.

12           “(3) AUTHORIZATION OF APPROPRIATIONS.—

13           “(A) IN GENERAL.—Subject to subpara-  
14           graph (B), there is authorized to be appropriated  
15           to carry out this subsection \$17,000,000 for fiscal  
16           year 2011 to be equally divided among existing  
17           University Centers for Excellence in Develop-  
18           mental Disabilities and such sums for fiscal  
19           years 2012 through 2015 in the case of Univer-  
20           sity Centers for Excellence in Developmental  
21           Disabilities located in American Samoa or the  
22           Commonwealth of the Northern Mariana Islands,  
23           supplemental grants of not less than \$100,000.

24           “(B) APPROPRIATIONS LESS THAN  
25           \$17,000,000.—With respect to any fiscal year in

1           *which the amount appropriated under subsection*  
2           *(A) to carry out this section is less than*  
3           *\$17,000,000, the Secretary shall make competi-*  
4           *tive grants from such amount to individual Uni-*  
5           *versity Centers for Excellence in Developmental*  
6           *Disabilities but would not be less than \$250,000*  
7           *per individual grant, in the case of University*  
8           *Centers for Excellence for Developmental Disabil-*  
9           *ities located in American Samoa or the Com-*  
10          *monwealth of the Northern Mariana Islands,*  
11          *supplemental grants of not less than \$100,000.*

12           “(C) *RESERVATION.*—*Not more than 2 per-*  
13          *cent of the amount appropriated under subpara-*  
14          *graphs (A) or (B) shall be reserved to carry out*  
15          *paragraph (2).*

16          “(b) *EXPANSION OF THE NUMBER OF UNIVERSITY*  
17          *CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABIL-*  
18          *ITIES RESEARCH, EDUCATION, AND SERVICES.*—

19           “(1) *PURPOSE.*—*The Secretary shall award up*  
20          *to four additional grants for the University Centers*  
21          *for Excellence in Developmental Disabilities for the*  
22          *purpose of expanding the capacity of existing na-*  
23          *tional network and enhance the number of training*  
24          *facilities serving minority institutions with a pri-*

1 *mary focus on autism spectrum disorder and related*  
2 *developmental disabilities. Such centers shall—*

3 *“(A) train health, allied health, and edu-*  
4 *cational professionals to identify, diagnose, treat,*  
5 *and provide services for individuals with autism*  
6 *spectrum disorders;*

7 *“(B) provide services, including early iden-*  
8 *tification, diagnosis, and intervention for indi-*  
9 *viduals with autism spectrum disorders; and*

10 *“(C) provide other training and technical*  
11 *assistance, as necessary.*

12 *“(2) PRIORITY.—The Secretary shall give pri-*  
13 *ority to establishing such centers in—*

14 *“(A) minority-serving institutions that have*  
15 *demonstrated capacity to meet the requirements*  
16 *to qualify as a University Center for Excellence*  
17 *in Developmental Disabilities and provide serv-*  
18 *ices to individuals with autism spectrum dis-*  
19 *orders; or*

20 *“(B) States with underserved populations.*

21 *“(3) AUTHORIZATION OF APPROPRIATIONS.—*  
22 *There is authorized to be appropriated to carry out*  
23 *this subsection \$2,000,000 for each of the fiscal years*  
24 *2011 through 2015.”.*

1 **SEC. 2529. IMPLEMENTATION OF MEDICATION MANAGE-**  
2 **MENT SERVICES IN TREATMENT OF CHRONIC**  
3 **DISEASES.**

4 (a) *IN GENERAL.*—*The Secretary of Health and*  
5 *Human Services (referred to in this section as the “Sec-*  
6 *retary”), acting through the Director of the Agency for*  
7 *Health Care Research and Quality, shall establish a pro-*  
8 *gram to provide grants to eligible entities to implement*  
9 *medication management services (referred to in this section*  
10 *as “MTM services”) provided by licensed pharmacists, as*  
11 *a part of a collaborative, multidisciplinary, interprofes-*  
12 *sional approach to the treatment of chronic diseases for tar-*  
13 *geted individuals, to improve the quality of care and reduce*  
14 *overall cost in the treatment of such diseases. The Secretary*  
15 *shall commence the grant program not later than May 1,*  
16 *2010.*

17 (b) *ELIGIBLE ENTITIES.*—*To be eligible to receive a*  
18 *grant under subsection (a), an entity shall—*

19 (1) *provide a setting appropriate for MTM serv-*  
20 *ices, as recommended by the experts described in sub-*  
21 *section (e);*

22 (2) *submit to the Secretary a plan for achieving*  
23 *long-term financial sustainability;*

24 (3) *where applicable, submit a plan for coordi-*  
25 *nating MTM services with other local providers and*  
26 *where applicable, through or in collaboration with the*

1        *Medicare Medical Home Pilot program as established*  
2        *by section 1866F of the Social Security Act, as added*  
3        *by section 1302(a) of this Act;*

4            *(4) submit a plan for meeting the requirements*  
5        *under subsection (c); and*

6            *(5) submit to the Secretary such other informa-*  
7        *tion as the Secretary may require.*

8        *(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The*  
9        *MTM services provided with the assistance of a grant*  
10       *awarded under subsection (a) shall, as allowed by State law*  
11       *(including applicable collaborative pharmacy practice*  
12       *agreements), include—*

13            *(1) performing or obtaining necessary assess-*  
14        *ments of the health and functional status of each pa-*  
15        *tient receiving such MTM services;*

16            *(2) formulating a medication treatment plan ac-*  
17        *cording to therapeutic goals agreed upon by the pre-*  
18        *scriber and the patient or caregiver or authorized rep-*  
19        *resentative of the patient;*

20            *(3) selecting, initiating, modifying, recom-*  
21        *mending changes to, or administering medication*  
22        *therapy;*

23            *(4) monitoring, which may include access to, or-*  
24        *dering, or performing laboratory assessments, and*

1 *evaluating the response of the patient to therapy, in-*  
2 *cluding safety and effectiveness;*

3 *(5) performing an initial comprehensive medica-*  
4 *tion review to identify, resolve, and prevent medica-*  
5 *tion-related problems, including adverse drug events,*  
6 *quarterly targeted medication reviews for ongoing*  
7 *monitoring, and additional follow-up interventions*  
8 *on a schedule developed collaboratively with the pre-*  
9 *scriber;*

10 *(6) documenting the care delivered and commu-*  
11 *nicating essential information about such care (in-*  
12 *cluding a summary of the medication review) and the*  
13 *recommendations of the pharmacist to other appro-*  
14 *priate health care providers of the patient in a timely*  
15 *fashion;*

16 *(7) providing education and training designed to*  
17 *enhance the understanding and appropriate use of the*  
18 *medications by the patient, caregiver, and other au-*  
19 *thorized representative;*

20 *(8) providing information, support services, and*  
21 *resources and strategies designed to enhance patient*  
22 *adherence with therapeutic regimens;*

23 *(9) coordinating and integrating MTM services*  
24 *within the broader health care management services*  
25 *provided to the patient; and*

1           (10) such other patient care services as are al-  
2           lowed under the scopes of practice for pharmacists for  
3           purposes of other Federal programs.

4           (d) *TARGETED INDIVIDUALS*.—*MTM services provided*  
5 *by licensed pharmacists under a grant awarded under sub-*  
6 *section (a) shall be offered to targeted individuals who—*

7           (1) take 4 or more prescribed medications (in-  
8           cluding over-the-counter and dietary supplements);

9           (2) take any high-risk medications;

10          (3) have 2 or more chronic diseases, as identified  
11          by the Secretary; or

12          (4) have undergone a transition of care, or other  
13          factors, as determined by the Secretary, that are like-  
14          ly to create a high risk of medication-related prob-  
15          lems.

16          (e) *CONSULTATION WITH EXPERTS*.—*In designing*  
17 *and implementing MTM services provided under grants*  
18 *awarded under subsection (a), the Secretary shall consult*  
19 *with Federal, State, private, public-private, and academic*  
20 *entities, pharmacy and pharmacist organizations, health*  
21 *care organizations, consumer advocates, chronic disease*  
22 *groups, and other stakeholders involved with the research,*  
23 *dissemination, and implementation of pharmacist-delivered*  
24 *MTM services, as the Secretary determines appropriate. The*  
25 *Secretary, in collaboration with this group, shall determine*



1 *whether it is possible to incorporate rapid cycle process im-*  
2 *provement concepts in use in other Federal programs that*  
3 *have implemented MTM services.*

4 (f) *REPORTING TO THE SECRETARY.*—*An entity that*  
5 *receives a grant under subsection (a) shall submit to the*  
6 *Secretary a report that describes and evaluates, as requested*  
7 *by the Secretary, the activities carried out under subsection*  
8 *(c), including quality measures, as determined by the Sec-*  
9 *retary.*

10 (g) *EVALUATION AND REPORT.*—*The Secretary shall*  
11 *submit to the relevant committees of Congress a report*  
12 *which shall—*

13 (1) *assess the clinical effectiveness of pharmacist-*  
14 *provided services under the MTM services program, as*  
15 *compared to usual care, including an evaluation of*  
16 *whether enrollees maintained better health with fewer*  
17 *hospitalizations and emergency room visits than*  
18 *similar patients not enrolled in the program;*

19 (2) *assess changes in overall health care resource*  
20 *of targeted individuals;*

21 (3) *assess patient and prescriber satisfaction*  
22 *with MTM services;*

23 (4) *assess the impact of patient-cost-sharing re-*  
24 *quirements on medication adherence and rec-*  
25 *ommendations for modifications;*

1           (5) *identify and evaluate other factors that may*  
2           *impact clinical and economic outcomes, including de-*  
3           *mographic characteristics, clinical characteristics,*  
4           *and health services use of the patient, as well as char-*  
5           *acteristics of the regimen, pharmacy benefit, and*  
6           *MTM services provided; and*

7           (6) *evaluate the extent to which participating*  
8           *pharmacists who maintain a dispensing role have a*  
9           *conflict of interest in the provision of MTM services,*  
10          *and if such conflict is found, provide recommenda-*  
11          *tions on how such a conflict might be appropriately*  
12          *addressed.*

13          (h) *GRANT TO FUND DEVELOPMENT OF PERFORM-*  
14          *ANCE MEASURES.—The Secretary may award grants or*  
15          *contracts to eligible entities for the purpose of funding the*  
16          *development of performance measures that assess the use*  
17          *and effectiveness of medication therapy management serv-*  
18          *ices.*

19          **SEC. 2530. POSTPARTUM DEPRESSION.**

20          (a) *EXPANSION AND INTENSIFICATION OF ACTIVI-*  
21          *TIES.—*

22                  (1) *CONTINUATION OF ACTIVITIES.—The Sec-*  
23                  *retary is encouraged to expand and intensify activi-*  
24                  *ties on postpartum conditions.*

1           (2) *PROGRAMS FOR POSTPARTUM CONDITIONS.—*

2           *In carrying out paragraph (1), the Secretary is en-*  
3           *couraged to continue research to expand the under-*  
4           *standing of the causes of, and treatments for,*  
5           *postpartum conditions, including conducting and*  
6           *supporting the following:*

7                   (A) *Basic research concerning the etiology*  
8                   *and causes of the conditions.*

9                   (B) *Epidemiological studies to address the*  
10                  *frequency and natural history of the conditions*  
11                  *and the differences among racial and ethnic*  
12                  *groups with respect to the conditions.*

13                  (C) *The development of improved screening*  
14                  *and diagnostic techniques.*

15                  (D) *Clinical research for the development*  
16                  *and evaluation of new treatments.*

17                  (E) *Information and education programs*  
18                  *for health professionals and the public, which*  
19                  *may include a coordinated national campaign*  
20                  *that—*

21                          (i) *is designed to increase the aware-*  
22                          *ness and knowledge of postpartum condi-*  
23                          *tions;*

1           (ii) may include public service an-  
2           nouncements through television, radio, and  
3           other means; and

4           (iii) may focus on—

5                 (I) raising awareness about  
6                 screening;

7                 (II) educating new mothers and  
8                 their families about postpartum condi-  
9                 tions to promote earlier diagnosis and  
10                treatment; and

11                (III) ensuring that such education  
12                includes complete information con-  
13                cerning postpartum conditions, includ-  
14                ing its symptoms, methods of coping  
15                with the illness, and treatment re-  
16                sources.

17       (b) *REPORT BY THE SECRETARY.*—

18               (1) *STUDY.*—The Secretary shall conduct a study  
19               on the benefits of screening for postpartum conditions.

20               (2) *REPORT.*—Not later than 2 years after the  
21               date of the enactment of this Act, the Secretary shall  
22               complete the study required by paragraph (1) and  
23               submit a report to the Congress on the results of such  
24               study.

1           (c) *SENSE OF CONGRESS REGARDING LONGITUDINAL*  
2 *STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES*  
3 *FOR WOMEN OF RESOLVING A PREGNANCY.*—

4           (1) *SENSE OF CONGRESS.*—*It is the sense of the*  
5 *Congress that the Director of the National Institute of*  
6 *Mental Health may conduct a nationally representa-*  
7 *tive longitudinal study (during the period of fiscal*  
8 *years 2009 through 2018) on the relative mental*  
9 *health consequences for women of resolving a preg-*  
10 *nancy (intended and unintended) in various ways,*  
11 *including carrying the pregnancy to term and par-*  
12 *enting the child, carrying the pregnancy to term and*  
13 *placing the child for adoption, miscarriage, and hav-*  
14 *ing an abortion. This study may assess the incidence,*  
15 *timing, magnitude, and duration of the immediate*  
16 *and long-term mental health consequences (positive or*  
17 *negative) of these pregnancy outcomes.*

18           (2) *REPORT.*—*Beginning not later than 3 years*  
19 *after the date of the enactment of this Act, and peri-*  
20 *odically thereafter for the duration of the study, such*  
21 *Director may prepare and submit to the Congress re-*  
22 *ports on the findings of the study.*

23           (d) *DEFINITIONS.*—*In this section:*

24           (1) *The term “postpartum condition” means*  
25 *postpartum depression or postpartum psychosis.*

1           (2) *The term “Secretary” means the Secretary of*  
2           *Health and Human Services.*

3           (e) *AUTHORIZATION OF APPROPRIATIONS.—For the*  
4           *purpose of carrying out this section, in addition to any*  
5           *other amounts authorized to be appropriated for such pur-*  
6           *pose, there are authorized to be appropriated such sums as*  
7           *may be necessary for fiscal years 2010 through 2012.*

8           **SEC. 2531. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**  
9           **IORS AND OUTCOMES.**

10          *Part P of title III (42 U.S.C. 280g et seq.) is amended*  
11          *by adding at the end the following:*

12          **“SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BE-**  
13          **HAVIORS AND OUTCOMES.**

14          *“(a) GRANTS AUTHORIZED.—The Secretary, in col-*  
15          *laboration with the Director of the Centers for Disease Con-*  
16          *trol and Prevention and other Federal officials determined*  
17          *appropriate by the Secretary, is authorized to award grants*  
18          *to eligible entities to promote positive health behaviors for*  
19          *populations in medically underserved communities through*  
20          *the use of community health workers.*

21          *“(b) USE OF FUNDS.—Grants awarded under sub-*  
22          *section (a) shall be used to support community health work-*  
23          *ers—*

24                  *“(1) to educate, guide, and provide outreach in*  
25          *a community setting regarding health problems prev-*

1        *alent in medically underserved communities, espe-*  
2        *cially racial and ethnic minority populations;*

3                *“(2) to educate, guide, and provide experiential*  
4        *learning opportunities that target behavioral risk fac-*  
5        *tors including—*

6                        *“(A) poor nutrition;*

7                        *“(B) physical inactivity;*

8                        *“(C) being overweight or obese;*

9                        *“(D) tobacco use;*

10                      *“(E) alcohol and substance use;*

11                      *“(F) injury and violence;*

12                      *“(G) risky sexual behavior;*

13                      *“(H) untreated mental health problems;*

14                      *“(I) untreated dental and oral health prob-*  
15        *lems; and*

16                      *“(J) understanding informed consent;*

17                *“(3) to educate and provide guidance regarding*  
18        *effective strategies to promote positive health behav-*  
19        *iors within the family;*

20                *“(4) to educate and provide outreach regarding*  
21        *enrollment in health insurance including the State*  
22        *Children’s Health Insurance Program under title XXI*  
23        *of the Social Security Act, Medicare under title XVIII*  
24        *of such Act, and Medicaid under title XIX of such*  
25        *Act;*

1           “(5) to educate and refer underserved popu-  
2           lations to appropriate health care agencies and com-  
3           munity-based programs and organizations in order to  
4           increase access to quality health care services, includ-  
5           ing preventive health services, and to eliminate dupli-  
6           cative care; or

7           “(6) to educate, guide, and provide home visita-  
8           tion services regarding maternal health and prenatal  
9           care.

10          “(c) APPLICATION.—

11           “(1) IN GENERAL.—Each eligible entity that de-  
12           sires to receive a grant under subsection (a) shall sub-  
13           mit an application to the Secretary, at such time, in  
14           such manner, and accompanied by such information  
15           as the Secretary may require.

16           “(2) CONTENTS.—Each application submitted  
17           pursuant to paragraph (1) shall—

18           “(A) describe the activities for which assist-  
19           ance is sought under this section;

20           “(B) contain an assurance that, with re-  
21           spect to each community health worker program  
22           receiving funds under the grant, such program  
23           will provide training and supervision to commu-  
24           nity health workers to enable such workers to  
25           provide authorized program services;



1           “(C) contain an assurance that the appli-  
2 cant will evaluate the effectiveness of community  
3 health worker programs receiving funds under  
4 the grant;

5           “(D) contain an assurance that each com-  
6 munity health worker program receiving funds  
7 under the grant will provide services in the cul-  
8 tural context most appropriate for the individ-  
9 uals served by the program;

10          “(E) contain a plan to document and dis-  
11 seminate project descriptions and results to other  
12 States and organizations as identified by the  
13 Secretary; and

14          “(F) describe plans to enhance the capacity  
15 of individuals to utilize health services and  
16 health-related social services under Federal,  
17 State, and local programs by—

18               “(i) assisting individuals in estab-  
19 lishing eligibility under the programs and  
20 in receiving the services or other benefits of  
21 the programs; and

22               “(ii) providing other services as the  
23 Secretary determines to be appropriate, that  
24 may include transportation and translation  
25 services.

1       “(d) *PRIORITY.*—*In awarding grants under subsection*  
2 *(a), the Secretary shall give priority to applicants that—*  
3           “(1) *propose to target geographic areas—*  
4               “(A) *with a high percentage of residents*  
5 *who are eligible for health insurance but are un-*  
6 *insured or underinsured;*  
7               “(B) *with a high percentage of residents*  
8 *who suffer from chronic diseases including pul-*  
9 *monary conditions, hypertension, heart disease,*  
10 *mental disorders, diabetes, and asthma; and*  
11               “(C) *with a high infant mortality rate;*  
12           “(2) *have experience in providing health or*  
13 *health-related social services to individuals who are*  
14 *underserved with respect to such services; and*  
15           “(3) *have documented community activity and*  
16 *experience with community health workers.*  
17       “(e) *COLLABORATION WITH ACADEMIC INSTITU-*  
18 *TIONS.*—*The Secretary shall encourage community health*  
19 *worker programs receiving funds under this section to col-*  
20 *laborate with academic institutions, especially those that*  
21 *graduate a disproportionate number of health and health*  
22 *care students from underrepresented racial and ethnic mi-*  
23 *nority backgrounds. Nothing in this section shall be con-*  
24 *strued to require such collaboration.*

1           “(f) *EVIDENCE-BASED INTERVENTIONS.*—*The Sec-*  
2 *retary shall encourage community health worker programs*  
3 *receiving funding under this section to implement an out-*  
4 *come-based payment system that rewards community health*  
5 *workers for connecting underserved populations with the*  
6 *most appropriate services at the most appropriate time.*  
7 *Nothing in this section shall be construed to require such*  
8 *payment.*

9           “(g) *QUALITY ASSURANCE AND COST EFFECTIVE-*  
10 *NESS.*—*The Secretary shall establish guidelines for assuring*  
11 *the quality of the training and supervision of community*  
12 *health workers under the programs funded under this sec-*  
13 *tion and for assuring the cost-effectiveness of such programs.*

14           “(h) *MONITORING.*—*The Secretary shall monitor com-*  
15 *munity health worker programs identified in approved ap-*  
16 *plications under this section and shall determine whether*  
17 *such programs are in compliance with the guidelines estab-*  
18 *lished under subsection (g).*

19           “(i) *TECHNICAL ASSISTANCE.*—*The Secretary may*  
20 *provide technical assistance to community health worker*  
21 *programs identified in approved applications under this*  
22 *section with respect to planning, developing, and operating*  
23 *programs under the grant.*

24           “(j) *REPORT TO CONGRESS.*—

1           “(1) *IN GENERAL.*—Not later than 4 years after  
2           the date on which the Secretary first awards grants  
3           under subsection (a), the Secretary shall submit to  
4           Congress a report regarding the grant project.

5           “(2) *CONTENTS.*—The report required under  
6           paragraph (1) shall include the following:

7                   “(A) A description of the programs for  
8                   which grant funds were used.

9                   “(B) The number of individuals served  
10                  under such programs.

11                  “(C) An evaluation of—

12                           “(i) the effectiveness of such programs;

13                           “(ii) the cost of such programs; and

14                           “(iii) the impact of the programs on  
15                   the health outcomes of the community resi-  
16                   dents.

17                  “(D) Recommendations for sustaining the  
18                  community health worker programs developed or  
19                  assisted under this section.

20                  “(E) Recommendations regarding training  
21                  to enhance career opportunities for community  
22                  health workers.

23           “(k) *DEFINITIONS.*—In this section:

24                   “(1) *COMMUNITY HEALTH WORKER.*—The term  
25                  ‘community health worker’ means an individual who

1 *promotes health or nutrition within the community*  
2 *in which the individual resides—*

3 *“(A) by serving as a liaison between com-*  
4 *munities and health care agencies;*

5 *“(B) by providing guidance and social as-*  
6 *sistance to community residents;*

7 *“(C) by enhancing community residents’*  
8 *ability to effectively communicate with health*  
9 *care providers;*

10 *“(D) by providing culturally and linguis-*  
11 *tically appropriate health or nutrition edu-*  
12 *cation;*

13 *“(E) by advocating for individual and com-*  
14 *munity health, including oral and mental, or*  
15 *nutrition needs; and*

16 *“(F) by providing referral and followup*  
17 *services or otherwise coordinating care.*

18 *“(2) COMMUNITY SETTING.—The term ‘commu-*  
19 *nity setting’ means a home or a community organiza-*  
20 *tion located in the neighborhood in which a partici-*  
21 *pant resides.*

22 *“(3) MEDICALLY UNDERSERVED COMMUNITY.—*  
23 *The term ‘medically underserved community’ means a*  
24 *community identified by a State, United States terri-*

1        *tory or possession, or federally recognized Indian*  
2        *tribe—*

3                *“(A) that has a substantial number of indi-*  
4                *viduals who are members of a medically under-*  
5                *served population, as defined by section*  
6                *330(b)(3); and*

7                *“(B) a significant portion of which is a*  
8                *health professional shortage area as designated*  
9                *under section 332.*

10                *“(4) SUPPORT.—The term ‘support’ means the*  
11                *provision of training, supervision, and materials*  
12                *needed to effectively deliver the services described in*  
13                *subsection (b), reimbursement for services, and other*  
14                *benefits.*

15                *“(5) ELIGIBLE ENTITY.—The term ‘eligible enti-*  
16                *ty’ means a public or nonprofit private entity (in-*  
17                *cluding a State or public subdivision of a State, a*  
18                *public health department, or a federally qualified*  
19                *health center), or a consortium of any of such entities,*  
20                *located in the United States or territory thereof.*

21                *“(l) AUTHORIZATION OF APPROPRIATIONS.—There is*  
22                *authorized to be appropriated to carry out this section*  
23                *\$30,000,000 for each of fiscal years 2010, 2011, 2012, 2013,*  
24                *and 2014.”.*

1 **PART 3—EMERGENCY CARE-RELATED PROGRAMS**

2 **SEC. 2541. TRAUMA CARE CENTERS.**

3 (a) *GRANTS FOR TRAUMA CARE CENTERS.*—Section  
4 1241 (42 U.S.C. 300d–41) is amended to read as follows:

5 **“SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.**

6 “(a) *IN GENERAL.*—The Secretary shall establish a  
7 trauma center program consisting of awarding grants  
8 under section (b).

9 “(b) *GRANTS.*—The Secretary shall award grants as  
10 follows:

11 “(1) *EXISTING CENTERS.*—Grants to public, pri-  
12 vate nonprofit, Indian Health Service, Indian tribal,  
13 and urban Indian trauma centers—

14 “(A) to further the core missions of such  
15 centers; or

16 “(B) to provide emergency relief to ensure  
17 the continued and future availability of trauma  
18 services by trauma centers—

19 “(i) at risk of closing or operating in  
20 an area where a closing has occurred within  
21 their primary service area; or

22 “(ii) in need of financial assistance  
23 following a natural disaster or other cata-  
24 strophic event, such as a terrorist attack.

25 “(2) *NEW CENTERS.*—Grants to local govern-  
26 ments and public or private nonprofit entities to es-

1       *tablish new trauma centers in urban areas with a*  
2       *substantial degree of trauma resulting from violent*  
3       *crimes.*

4       “(c) *MINIMUM QUALIFICATIONS OF TRAUMA CEN-*  
5       *TERS.—*

6               “(1) *PARTICIPATION IN TRAUMA CARE SYSTEM*  
7       *OPERATING UNDER CERTAIN PROFESSIONAL GUIDE-*  
8       *LINES.—*

9                       “(A) *LIMITATION.—Subject to subparagraph*  
10                      *(B), the Secretary may not award a grant to an*  
11                      *existing trauma center under this section unless*  
12                      *the center is a participant in a trauma care sys-*  
13                      *tem that substantially complies with section*  
14                      *1213.*

15                      “(B) *EXEMPTION.—Subparagraph (A) shall*  
16                      *not apply to trauma centers that are located in*  
17                      *States with no existing trauma care system.*

18               “(2) *DESIGNATION.—The Secretary may not*  
19       *award a grant under this section to an existing trau-*  
20       *ma center unless the center is—*

21                      “(A) *verified as a trauma center by the*  
22                      *American College of Surgeons; or*

23                      “(B) *designated as a trauma center by the*  
24                      *applicable State health or emergency medical*  
25                      *services authority.”.*



1       (b) *CONSIDERATIONS IN MAKING GRANTS.*—Section  
2 1242 (42 U.S.C. 300d–42) is amended to read as follows:

3 **“SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.**

4       “(a) *CORE MISSION AWARDS.*—

5               “(1) *IN GENERAL.*—In awarding grants under  
6 section 1241(b)(1)(A), the Secretary shall—

7                       “(A) reserve a minimum of 25 percent of  
8 the amount allocated for such grants for level III  
9 and level IV trauma centers in rural or under-  
10 served areas;

11                      “(B) reserve a minimum of 25 percent of  
12 the amount allocated for such grants for level I  
13 and level II trauma centers in urban areas; and

14                      “(C) give preference to any application  
15 made by a trauma center—

16                               “(i) in a geographic area where growth  
17 in demand for trauma services exceeds ca-  
18 pacity;

19                               “(ii) that demonstrates the financial  
20 support of the State or political subdivision  
21 involved;

22                               “(iii) that has at least 1 graduate med-  
23 ical education fellowship in trauma or  
24 trauma-related specialties, including neuro-  
25 logical surgery, surgical critical care, vas-

1           *cular surgery, and spinal cord injury, for*  
2           *which demand is exceeding supply; or*

3                   *“(iv) that demonstrates a substantial*  
4                   *commitment to serving vulnerable popu-*  
5                   *lations.*

6           *“(2) FINANCIAL SUPPORT.—For purposes of*  
7           *paragraph (1)(C)(ii), financial support may be dem-*  
8           *onstrated by State or political subdivision funding for*  
9           *the trauma center’s capital or operating expenses (in-*  
10           *cluding through State trauma regional advisory co-*  
11           *ordination activities, Medicaid funding designated for*  
12           *trauma services, or other governmental funding).*  
13           *State funding derived from Federal support shall not*  
14           *constitute State or local financial support for pur-*  
15           *poses of preferential treatment under this subsection.*

16           *“(3) USE OF FUNDS.—The recipient of a grant*  
17           *under section 1241(b)(1)(A) shall carry out, con-*  
18           *sistent with furthering the core missions of the center,*  
19           *one or more of the following activities:*

20                   *“(A) Providing 24-hour-a-day, 7-day-a-week*  
21                   *trauma care availability.*

22                   *“(B) Reducing overcrowding related to*  
23                   *throughput of trauma patients.*

24                   *“(C) Enhancing trauma surge capacity.*

1           “(D) *Ensuring physician and essential per-*  
2           *sonnel availability.*

3           “(E) *Trauma education and outreach.*

4           “(F) *Coordination with local and regional*  
5           *trauma care systems.*

6           “(G) *Such other activities as the Secretary*  
7           *may deem appropriate.*

8           “(b) *EMERGENCY AWARDS; NEW CENTERS.—In*  
9           *awarding grants under paragraphs (1)(B) and (2) of sec-*  
10          *tion 1241(b), the Secretary shall—*

11           “(1) *give preference to any application submitted*  
12          *by an applicant that demonstrates the financial sup-*  
13          *port (in accordance with subsection (a)(2)) of the*  
14          *State or political subdivision involved for the activi-*  
15          *ties to be funded through the grant for each fiscal year*  
16          *during which payments are made to the center under*  
17          *the grant; and*

18           “(2) *give preference to any application submitted*  
19          *for a trauma center that—*

20           “(A) *is providing or will provide trauma*  
21          *care in a geographic area in which the avail-*  
22          *ability of trauma care has either significantly*  
23          *decreased as a result of a trauma center in the*  
24          *area permanently ceasing participation in a sys-*  
25          *tem described in section 1241(c)(1) as of a date*

1           *occurring during the 2-year period preceding the*  
2           *fiscal year for which the trauma center is apply-*  
3           *ing to receive a grant, or in geographic areas*  
4           *where growth in demand for trauma services ex-*  
5           *ceeds capacity;*

6           *“(B) will, in providing trauma care during*  
7           *the 1-year period beginning on the date on which*  
8           *the application for the grant is submitted, incur*  
9           *substantial uncompensated care costs in an*  
10          *amount that renders the center unable to con-*  
11          *tinue participation in such system and results in*  
12          *a significant decrease in the availability of trau-*  
13          *ma care in the geographic area;*

14          *“(C) operates or will operate in rural areas*  
15          *where trauma care availability will significantly*  
16          *decrease if the center is forced to close or down-*  
17          *grade service and substantial costs are contrib-*  
18          *uting to a likelihood of such closure or*  
19          *downgradation;*

20          *“(D) is in a geographic location substan-*  
21          *tially affected by a natural disaster or other cat-*  
22          *astrophic event such as a terrorist attack; or*

23          *“(E) will establish a new trauma service in*  
24          *an urban area with a substantial degree of trau-*  
25          *ma resulting from violent crimes.*

1           “(c) *DESIGNATIONS OF LEVELS OF TRAUMA CENTERS*  
2 *IN CERTAIN STATES.*—*In the case of a State which has not*  
3 *designated 4 levels of trauma centers, any reference in this*  
4 *section to—*

5                   “(1) *a level I or level II trauma center is deemed*  
6 *to be a reference to a trauma center within the highest*  
7 *2 levels of trauma centers designated under State*  
8 *guidelines; and*

9                   “(2) *a level III or IV trauma center is deemed*  
10 *to be a reference to a trauma center not within such*  
11 *highest 2 levels.”.*

12           (c) *CERTAIN AGREEMENTS.*—*Section 1243 (42 U.S.C.*  
13 *300d-43) is amended to read as follows:*

14           **“SEC. 1243. CERTAIN AGREEMENTS.**

15                   “(a) *COMMITMENT REGARDING CONTINUED PARTICI-*  
16 *PATION IN TRAUMA CARE SYSTEM.*—*The Secretary may*  
17 *not award a grant to an applicant under section 1241(b)*  
18 *unless the applicant agrees that—*

19                           “(1) *the trauma center involved will continue*  
20 *participation, or in the case of a new center will par-*  
21 *ticipate, in the system described in section 1241(c)(1),*  
22 *except as provided in section 1241(c)(1)(B), through-*  
23 *out the grant period beginning on the date that the*  
24 *center first receives payments under the grant; and*

1           “(2) if the agreement made pursuant to para-  
2           graph (1) is violated by the center, the center will be  
3           liable to the United States for an amount equal to the  
4           sum of—

5                     “(A) the amount of assistance provided to  
6                     the center under section 1241; and

7                     “(B) an amount representing interest on the  
8                     amount specified in subparagraph (A).

9           “(b) *MAINTENANCE OF FINANCIAL SUPPORT.*—With  
10          respect to activities for which funds awarded through a  
11          grant under section 1241 are authorized to be expended, the  
12          Secretary may not award such a grant unless the applicant  
13          agrees that, during the period in which the trauma center  
14          involved is receiving payments under the grant, the center  
15          will maintain access to trauma services at levels not less  
16          than the levels for the prior year, taking into account—

17                     “(1) reasonable volume fluctuation that is not  
18                     caused by intentional trauma boundary reduction;

19                     “(2) downgrading of the level of services; and

20                     “(3) whether such center diverts its incoming pa-  
21          tients away from such center 5 percent or more of the  
22          time during which the center is in operation over the  
23          course of the year.

1       “(c) *TRAUMA CARE REGISTRY.*—*The Secretary may*  
2 *not award a grant to a trauma center under section*  
3 *1241(b)(1) unless the center agrees that—*

4               “(1) *not later than 6 months after the date on*  
5 *which the center submits a grant application to the*  
6 *Secretary, the center will establish and operate a reg-*  
7 *istry of trauma cases in accordance with guidelines*  
8 *developed by the American College of Surgeons; and*

9               “(2) *in carrying out paragraph (1), the center*  
10 *will maintain information on the number of trauma*  
11 *cases treated by the center and, for each such case, the*  
12 *extent to which the center incurs uncompensated costs*  
13 *in providing trauma care.”.*

14       “(d) *GENERAL PROVISIONS.*—*Section 1244 (42 U.S.C.*  
15 *300d–44) is amended to read as follows:*

16       **“SEC. 1244. GENERAL PROVISIONS.**

17       “(a) *LIMITATION ON DURATION OF SUPPORT.*—*The*  
18 *period during which a trauma center receives payments*  
19 *under a grant under section 1241(b)(1) shall be for 3 fiscal*  
20 *years, except that the Secretary may waive such require-*  
21 *ment for the center and authorize the center to receive such*  
22 *payments for 1 additional fiscal year.*

23       “(b) *ELIGIBILITY.*—*The acquisition of, or eligibility*  
24 *for, a grant under section 1241(b) shall not preclude a trau-*

1 *ma center's eligibility for another grant described in such*  
2 *section.*

3 “(c) *FUNDING DISTRIBUTION.*—*Of the total amount*  
4 *appropriated for a fiscal year under section 1245—*

5 “(1) *90 percent shall be used for grants under*  
6 *paragraph (1)(A) of section 1241(b); and*

7 “(2) *10 percent shall be used for grants under*  
8 *paragraphs (1)(B) and (2) of section 1241(b).*

9 “(d) *REPORT.*—*Beginning 2 years after the date of the*  
10 *enactment of the America's Affordable Health Choices Act*  
11 *of 2009, and every 2 years thereafter, the Secretary shall*  
12 *biennially—*

13 “(1) *report to Congress on the status of the*  
14 *grants made pursuant to section 1241;*

15 “(2) *evaluate and report to Congress on the over-*  
16 *all financial stability of trauma centers in the United*  
17 *States;*

18 “(3) *report on the populations using trauma*  
19 *care centers and include aggregate patient data on*  
20 *income, race, ethnicity, and geography; and*

21 “(4) *evaluate the effectiveness and efficiency of*  
22 *trauma care center activities using standard public*  
23 *health measures and evaluation methodologies.”.*

24 (e) *AUTHORIZATION OF APPROPRIATIONS.*—*Section*  
25 *1245 (42 U.S.C. 300d–45) is amended to read as follows:*



1 **“SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.**

2       “(a) *IN GENERAL.*—*For the purpose of carrying out*  
3 *this part, there are authorized to be appropriated*  
4 *\$100,000,000 for fiscal year 2010, and such sums as may*  
5 *be necessary for each of fiscal years 2011 through 2015.*  
6 *Such authorization of appropriations is in addition to any*  
7 *other authorization of appropriations or amounts that are*  
8 *available for such purpose.*

9       “(b) *REALLOCATION.*—*The Secretary shall reallocate*  
10 *for grants under section 1241(b)(1)(A) any funds appro-*  
11 *priated for grants under paragraph (1)(B) or (2) of section*  
12 *1241(b), but not obligated due to insufficient applications*  
13 *eligible for funding.”.*

14 **SEC. 2542. EMERGENCY CARE COORDINATION.**

15       “(a) *IN GENERAL.*—*Subtitle B of title XXVIII (42*  
16 *U.S.C. 300hh–10 et seq.) is amended by adding at the end*  
17 *the following:*

18 **“SEC. 2816. EMERGENCY CARE COORDINATION.**

19       “(a) *EMERGENCY CARE COORDINATION CENTER.*—

20               “(1) *ESTABLISHMENT.*—*The Secretary shall es-*  
21 *tablish, within the Office of the Assistant Secretary*  
22 *for Preparedness and Response, an Emergency Care*  
23 *Coordination Center (in this section referred to as the*  
24 *‘Center’), to be headed by a director.*

25               “(2) *DUTIES.*—*The Secretary, acting through the*  
26 *Director of the Center, in coordination with the Fed-*

1 *eral Interagency Committee on Emergency Medical*  
2 *Services, shall—*

3 *“(A) promote and fund research in emer-*  
4 *gency medicine and trauma health care;*

5 *“(B) promote regional partnerships and*  
6 *more effective emergency medical systems in*  
7 *order to enhance appropriate triage, distribu-*  
8 *tion, and care of routine community patients;*  
9 *and*

10 *“(C) promote local, regional, and State*  
11 *emergency medical systems’ preparedness for and*  
12 *response to public health events.*

13 *“(b) COUNCIL OF EMERGENCY CARE.—*

14 *“(1) ESTABLISHMENT.—The Secretary, acting*  
15 *through the Director of the Center, shall establish a*  
16 *Council of Emergency Care to provide advice and rec-*  
17 *ommendations to the Director on carrying out this*  
18 *section.*

19 *“(2) COMPOSITION.—The Council shall be com-*  
20 *prised of employees of the departments and agencies*  
21 *of the Federal Government who are experts in emer-*  
22 *gency care and management.*

23 *“(c) REPORT.—*

24 *“(1) SUBMISSION.—Not later than 12 months*  
25 *after the date of the enactment of the America’s Af-*

1        *fordable Health Choices Act of 2009, the Secretary*  
2        *shall submit to the Congress an annual report on the*  
3        *activities carried out under this section.*

4                *“(2) CONSIDERATIONS.—In preparing a report*  
5        *under paragraph (1), the Secretary shall consider fac-*  
6        *tors including—*

7                        *“(A) emergency department crowding and*  
8                        *boarding; and*

9                        *“(B) delays in care following presentation.*

10                *“(d) AUTHORIZATION OF APPROPRIATIONS.—To carry*  
11        *out this section, there are authorized to be appropriated*  
12        *such sums as may be necessary for fiscal years 2010 through*  
13        *2014.”.*

14                *(b) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES,*  
15        *AND ADMINISTRATIVE ACTIONS.—All functions, personnel,*  
16        *assets, and liabilities of, and administrative actions appli-*  
17        *cable to, the Emergency Care Coordination Center, as in*  
18        *existence on the day before the date of the enactment of this*  
19        *Act, shall be transferred to the Emergency Care Coordina-*  
20        *tion Center established under section 2816(a) of the Public*  
21        *Health Service Act, as added by subsection (a).*

22        **SEC. 2543. PILOT PROGRAMS TO IMPROVE EMERGENCY**  
23                        **MEDICAL CARE.**

24                *Part B of title III (42 U.S.C. 243 et seq.) is amended*  
25        *by inserting after section 314 the following:*

1 **“SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR**  
2 **EMERGENCY CARE RESPONSE.**

3 “(a) *IN GENERAL.*—*The Secretary, acting through the*  
4 *Assistant Secretary for Preparedness and Response, shall*  
5 *award not fewer than 4 multiyear contracts or competitive*  
6 *grants to eligible entities to support demonstration pro-*  
7 *grams that design, implement, and evaluate innovative*  
8 *models of regionalized, comprehensive, and accountable*  
9 *emergency care systems.*

10 “(b) *ELIGIBLE ENTITY; REGION.*—

11 “(1) *ELIGIBLE ENTITY.*—*In this section, the*  
12 *term ‘eligible entity’ means a State or a partnership*  
13 *of 1 or more States and 1 or more local governments.*

14 “(2) *REGION.*—*In this section, the term ‘region’*  
15 *means an area within a State, an area that lies with-*  
16 *in multiple States, or a similar area (such as a*  
17 *multicounty area), as determined by the Secretary.*

18 “(c) *DEMONSTRATION PROGRAM.*—*The Secretary shall*  
19 *award a contract or grant under subsection (a) to an eligi-*  
20 *ble entity that proposes a demonstration program to design,*  
21 *implement, and evaluate an emergency medical system*  
22 *that—*

23 “(1) *coordinates with public safety services, pub-*  
24 *lic health services, emergency medical services, med-*  
25 *ical facilities, and other entities within a region;*

1           “(2) coordinates an approach to emergency med-  
2           ical system access throughout the region, including 9-  
3           1-1 public safety answering points and emergency  
4           medical dispatch;

5           “(3) includes a mechanism, such as a regional  
6           medical direction or transport communications sys-  
7           tem, that operates throughout the region to ensure  
8           that the correct patient is taken to the medically ap-  
9           propriate facility (whether an initial facility or a  
10          higher level facility) in a timely fashion;

11          “(4) allows for the tracking of prehospital and  
12          hospital resources, including inpatient bed capacity,  
13          emergency department capacity, on-call specialist cov-  
14          erage, ambulance diversion status, and the coordina-  
15          tion of such tracking with regional communications  
16          and hospital destination decisions; and

17          “(5) includes a consistent regionwide  
18          prehospital, hospital, and interfacility data manage-  
19          ment system that—

20                  “(A) complies with the National EMS In-  
21                  formation System, the National Trauma Data  
22                  Bank, and others;

23                  “(B) reports data to appropriate Federal  
24                  and State databanks and registries; and

1           “(C) contains information sufficient to  
2           evaluate key elements of prehospital care, hos-  
3           pital destination decisions, including initial hos-  
4           pital and interfacility decisions, and relevant  
5           outcomes of hospital care.

6           “(d) APPLICATION.—

7           “(1) IN GENERAL.—An eligible entity that seeks  
8           a contract or grant described in subsection (a) shall  
9           submit to the Secretary an application at such time  
10          and in such manner as the Secretary may require.

11          “(2) APPLICATION INFORMATION.—Each appli-  
12          cation shall include—

13                 “(A) an assurance from the eligible entity  
14                 that the proposed system—

15                         “(i) has been coordinated with the ap-  
16                         plicable State office of emergency medical  
17                         services (or equivalent State office);

18                         “(ii) is compatible with the applicable  
19                         State emergency medical services system;

20                         “(iii) includes consistent indirect and  
21                         direct medical oversight of prehospital, hos-  
22                         pital, and interfacility transport throughout  
23                         the region;

1           “(iv) coordinates prehospital treatment  
2           and triage, hospital destination, and inter-  
3           facility transport throughout the region;

4           “(v) includes a categorization or des-  
5           ignation system for special medical facili-  
6           ties throughout the region that is—

7                   “(I) consistent with State laws  
8                   and regulations; and

9                   “(II) integrated with the protocols  
10                  for transport and destination through-  
11                  out the region; and

12           “(vi) includes a regional medical direc-  
13           tion system, a patient tracking system, and  
14           a resource allocation system that—

15                   “(I) support day-to-day emer-  
16                   gency care system operation;

17                   “(II) can manage surge capacity  
18                   during a major event or disaster; and

19                   “(III) are integrated with other  
20                  components of the national and State  
21                  emergency preparedness system;

22           “(B) an agreement to make available non-  
23           Federal contributions in accordance with sub-  
24           section (e); and

1           “(C) *such other information as the Sec-*  
2           *retary may require.*

3           “(e) *MATCHING FUNDS.—*

4           “(1) *IN GENERAL.—With respect to the costs of*  
5           *the activities to be carried out each year with a con-*  
6           *tract or grant under subsection (a), a condition for*  
7           *the receipt of the contract or grant is that the eligible*  
8           *entity involved agrees to make available (directly or*  
9           *through donations from public or private entities)*  
10          *non-Federal contributions toward such costs in an*  
11          *amount that is not less than 25 percent of such costs.*

12          “(2) *DETERMINATION OF AMOUNT CONTRIB-*  
13          *UTED.—Non-Federal contributions required in para-*  
14          *graph (1) may be in cash or in kind, fairly evaluated,*  
15          *including plant, equipment, or services. Amounts pro-*  
16          *vided by the Federal Government, or services assisted*  
17          *or subsidized to any significant extent by the Federal*  
18          *Government, may not be included in determining the*  
19          *amount of such non-Federal contributions.*

20          “(f) *PRIORITY.—The Secretary shall give priority for*  
21          *the award of the contracts or grants described in subsection*  
22          *(a) to any eligible entity that serves a medically under-*  
23          *served population (as defined in section 330(b)(3)).*

24          “(g) *REPORT.—Not later than 90 days after the com-*  
25          *pletion of a demonstration program under subsection (a),*



1 *the recipient of such contract or grant described in such*  
2 *subsection shall submit to the Secretary a report containing*  
3 *the results of an evaluation of the program, including an*  
4 *identification of—*

5           “(1) *the impact of the regional, accountable*  
6 *emergency care system on patient outcomes for var-*  
7 *ious critical care categories, such as trauma, stroke,*  
8 *cardiac emergencies, and pediatric emergencies;*

9           “(2) *the system characteristics that contribute to*  
10 *the effectiveness and efficiency of the program (or lack*  
11 *thereof);*

12           “(3) *methods of assuring the long-term financial*  
13 *sustainability of the emergency care system;*

14           “(4) *the State and local legislation necessary to*  
15 *implement and to maintain the system; and*

16           “(5) *the barriers to developing regionalized, ac-*  
17 *countable emergency care systems, as well as the*  
18 *methods to overcome such barriers.*

19           “(h) *EVALUATION.—The Secretary, acting through the*  
20 *Assistant Secretary for Preparedness and Response, shall*  
21 *enter into a contract with an academic institution or other*  
22 *entity to conduct an independent evaluation of the dem-*  
23 *onstration programs funded under subsection (a), including*  
24 *an evaluation of—*

1           “(1) the performance of the eligible entities re-  
2           ceiving the funds; and

3           “(2) the impact of the demonstration programs.

4           “(i) *DISSEMINATION OF FINDINGS.*—The Secretary  
5 shall, as appropriate, disseminate to the public and to the  
6 appropriate committees of the Congress, the information  
7 contained in a report made under subsection (h).

8           “(j) *AUTHORIZATION OF APPROPRIATIONS.*—

9           “(1) *IN GENERAL.*—There is authorized to be ap-  
10 propriated to carry out this section \$12,000,000 for  
11 each of fiscal years 2010 through 2015.

12           “(2) *RESERVATION.*—Of the amount appro-  
13 priated to carry out this section for a fiscal year, the  
14 Secretary shall reserve 3 percent of such amount to  
15 carry out subsection (h) (relating to an independent  
16 evaluation).”.

17 **SEC. 2544. ASSISTING VETERANS WITH MILITARY EMER-**  
18 **GENCY MEDICAL TRAINING TO BECOME**  
19 **STATE-LICENSED OR CERTIFIED EMERGENCY**  
20 **MEDICAL TECHNICIANS (EMTS).**

21           (a) *IN GENERAL.*—Part B of title III (42 U.S.C. 243  
22 et seq.), as amended, is amended by inserting after section  
23 315 the following:

1 **“SEC. 315A. ASSISTING VETERANS WITH MILITARY EMER-**  
2 **GENCY MEDICAL TRAINING TO BECOME**  
3 **STATE-LICENSED OR CERTIFIED EMERGENCY**  
4 **MEDICAL TECHNICIANS (EMTS).**

5 “(a) *PROGRAM.*—*The Secretary shall establish a pro-*  
6 *gram consisting of awarding grants to States to assist vet-*  
7 *erans who received and completed military emergency med-*  
8 *ical training while serving in the Armed Forces of the*  
9 *United States to become, upon their discharge or release*  
10 *from active duty service, State-licensed or certified emer-*  
11 *gency medical technicians.*

12 “(b) *USE OF FUNDS.*—*Amounts received as a grant*  
13 *under this section may be used to assist veterans described*  
14 *in subsection (a) to become State-licensed or certified emer-*  
15 *gency medical technicians as follows:*

16 “(1) *Providing training.*

17 “(2) *Providing reimbursement for costs associ-*  
18 *ated with—*

19 “(A) *training; or*

20 “(B) *applying for licensure or certification.*

21 “(3) *Expediting the licensing or certification*  
22 *process.*

23 “(c) *ELIGIBILITY.*—*To be eligible for a grant under*  
24 *this section, a State shall demonstrate to the Secretary’s sat-*  
25 *isfaction that the State has a shortage of emergency medical*  
26 *technicians.*

1       “(d) *REPORT.*—*The Secretary shall submit to the Con-*  
2 *gress an annual report on the program under this section.*

3       “(e) *AUTHORIZATION OF APPROPRIATIONS.*—*To carry*  
4 *out this section, there are authorized to be appropriated*  
5 *such sums as may be necessary for fiscal years 2010 through*  
6 *2014.”.*

7       “(b) *GAO STUDY AND REPORT.*—*The Comptroller Gen-*  
8 *eral of the United States shall—*

9           (1) *conduct a study on the barriers experienced*  
10 *by veterans who received training as medical per-*  
11 *sonnel while serving in the Armed Forces of the*  
12 *United States and, upon their discharge or release*  
13 *from active duty service, seek to become licensed or*  
14 *certified in a State as civilian health professionals;*  
15 *and*

16           (2) *not later than 2 years after the date of the*  
17 *enactment of this Act, submit to the Congress a report*  
18 *on the results of such study, including recommenda-*  
19 *tions on whether the program established under sec-*  
20 *tion 315A of the Public Health Service Act, as added*  
21 *by subsection (a), should be expanded to assist vet-*  
22 *erans seeking to become licensed or certified in a*  
23 *State as health providers other than emergency med-*  
24 *ical technicians.*

1 **SEC. 2545. DENTAL EMERGENCY RESPONDERS: PUBLIC**  
2 **HEALTH AND MEDICAL RESPONSE.**

3 (a) *NATIONAL HEALTH SECURITY STRATEGY*.—Section  
4 *2802(b)(3)* (42 U.S.C. 300hh–1(b)(3)) is amended—

5 (1) *in the matter preceding subparagraph (A),*  
6 *by inserting “dental and” before “mental health fa-*  
7 *cilities”; and*

8 (2) *in subparagraph (D), by inserting “and den-*  
9 *tal” after “medical”.*

10 (b) *ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RE-*  
11 *SPONSE CURRICULA AND TRAINING*.—Section  
12 *319F(a)(5)(B)* (42 U.S.C. 247d–6(a)(5)(B)) is amended by  
13 *striking “public health or medical” and inserting “public*  
14 *health, medical, or dental”.*

15 **SEC. 2546. DENTAL EMERGENCY RESPONDERS: HOMELAND**  
16 **SECURITY.**

17 (a) *NATIONAL RESPONSE FRAMEWORK*.—Paragraph  
18 (6) of section 2 of the *Homeland Security Act of 2002* (6  
19 U.S.C. 101) is amended by inserting “and dental” after  
20 “emergency medical”.

21 (b) *NATIONAL PREPAREDNESS SYSTEM*.—Subpara-  
22 *graph (B) of section 653(b)(4) of the Post-Katrina Emer-*  
23 *gency Management Reform Act of 2006* (6 U.S.C. 753(b)(4))  
24 *is amended by striking “public health and medical” and*  
25 *inserting “public health, medical, and dental”.*

1           (c) *CHIEF MEDICAL OFFICER.*—Paragraph (5) of sec-  
2 *tion 516(c) of the Homeland Security Act of 2002 (6 U.S.C.*  
3 *321e(c)) is amended by striking “medical community” and*  
4 *inserting “medical and dental communities”.*

5                   **PART 4—PAIN CARE AND MANAGEMENT**  
6                                   **PROGRAMS**

7 **SEC. 2551. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.**

8           (a) *CONVENING.*—Not later than June 30, 2010, the  
9 *Secretary of Health and Human Services shall seek to enter*  
10 *into an agreement with the Institute of Medicine of the Na-*  
11 *tional Academies to convene a Conference on Pain (in this*  
12 *section referred to as “the Conference”).*

13           (b) *PURPOSES.*—The purposes of the Conference shall  
14 *be to—*

15                   (1) *increase the recognition of pain as a signifi-*  
16 *cant public health problem in the United States;*

17                   (2) *evaluate the adequacy of assessment, diag-*  
18 *nosis, treatment, and management of acute and*  
19 *chronic pain in the general population, and in iden-*  
20 *tified racial, ethnic, gender, age, and other demo-*  
21 *graphic groups that may be disproportionately af-*  
22 *ected by inadequacies in the assessment, diagnosis,*  
23 *treatment, and management of pain;*

24                   (3) *identify barriers to appropriate pain care,*  
25 *including—*

1           (A) *lack of understanding and education*  
2           *among employers, patients, health care pro-*  
3           *viders, regulators, and third-party payors;*

4           (B) *barriers to access to care at the pri-*  
5           *mary, specialty, and tertiary care levels, includ-*  
6           *ing barriers—*

7                   (i) *specific to those populations that*  
8                   *are disproportionately undertreated for*  
9                   *pain;*

10                   (ii) *related to physician concerns over*  
11                   *regulatory and law enforcement policies ap-*  
12                   *plicable to some pain therapies; and*

13                   (iii) *attributable to benefit, coverage,*  
14                   *and payment policies in both the public and*  
15                   *private sectors; and*

16           (C) *gaps in basic and clinical research on*  
17           *the symptoms and causes of pain, and potential*  
18           *assessment methods and new treatments to im-*  
19           *prove pain care; and*

20           (4) *establish an agenda for action in both the*  
21           *public and private sectors that will reduce such bar-*  
22           *riers and significantly improve the state of pain care*  
23           *research, education, and clinical care in the United*  
24           *States.*

1           (c) *OTHER APPROPRIATE ENTITY.*—If the Institute of  
2 *Medicine declines to enter into an agreement under sub-*  
3 *section (a), the Secretary of Health and Human Services*  
4 *may enter into such agreement with another appropriate*  
5 *entity.*

6           (d) *REPORT.*—A report summarizing the Conference’s  
7 *findings and recommendations shall be submitted to the*  
8 *Congress not later than June 30, 2011.*

9           (e) *AUTHORIZATION OF APPROPRIATIONS.*—For the  
10 *purpose of carrying out this section, there is authorized to*  
11 *be appropriated \$500,000 for each of fiscal years 2010 and*  
12 *2011.*

13 **SEC. 2552. PAIN RESEARCH AT NATIONAL INSTITUTES OF**  
14 **HEALTH.**

15           *Part B of title IV (42 U.S.C. 284 et seq.) is amended*  
16 *by adding at the end the following:*

17 **“SEC. 409J. PAIN RESEARCH.**

18           “(a) *RESEARCH INITIATIVES.*—

19                   “(1) *IN GENERAL.*—The Director of NIH is en-  
20 *couraged to continue and expand, through the Pain*  
21 *Consortium, an aggressive program of basic and clin-*  
22 *ical research on the causes of and potential treatments*  
23 *for pain.*

24                   “(2) *ANNUAL RECOMMENDATIONS.*—Not less than  
25 *annually, the Pain Consortium, in consultation with*



1 *the Division of Program Coordination, Planning, and*  
2 *Strategic Initiatives, shall develop and submit to the*  
3 *Director of NIH recommendations on appropriate*  
4 *pain research initiatives that could be undertaken*  
5 *with funds reserved under section 402A(c)(1) for the*  
6 *Common Fund or otherwise available for such initia-*  
7 *tives.*

8 “(3) *DEFINITION.*—*In this subsection, the term*  
9 *‘Pain Consortium’ means the Pain Consortium of the*  
10 *National Institutes of Health or a similar trans-Na-*  
11 *tional Institutes of Health coordinating entity des-*  
12 *ignated by the Secretary for purposes of this sub-*  
13 *section.*

14 “(b) *INTERAGENCY PAIN RESEARCH COORDINATING*  
15 *COMMITTEE.*—

16 “(1) *ESTABLISHMENT.*—*The Secretary shall es-*  
17 *tablish not later than 1 year after the date of the en-*  
18 *actment of this section and as necessary maintain a*  
19 *committee, to be known as the Interagency Pain Re-*  
20 *search Coordinating Committee (in this section re-*  
21 *ferred to as the ‘Committee’), to coordinate all efforts*  
22 *within the Department of Health and Human Serv-*  
23 *ices and other Federal agencies that relate to pain re-*  
24 *search.*

25 “(2) *MEMBERSHIP.*—

1                   “(A) *IN GENERAL.*—*The Committee shall be*  
2                   *composed of the following voting members:*

3                   “(i) *Not more than 7 voting Federal*  
4                   *representatives as follows:*

5                   “(I) *The Director of the Centers*  
6                   *for Disease Control and Prevention.*

7                   “(II) *The Director of the National*  
8                   *Institutes of Health and the directors*  
9                   *of such national research institutes and*  
10                   *national centers as the Secretary deter-*  
11                   *mines appropriate.*

12                   “(III) *The heads of such other*  
13                   *agencies of the Department of Health*  
14                   *and Human Services as the Secretary*  
15                   *determines appropriate.*

16                   “(IV) *Representatives of other*  
17                   *Federal agencies that conduct or sup-*  
18                   *port pain care research and treatment,*  
19                   *including the Department of Defense*  
20                   *and the Department of Veterans Af-*  
21                   *airs.*

22                   “(ii) *12 additional voting members ap-*  
23                   *pointed under subparagraph (B).*

1           “(B) *ADDITIONAL MEMBERS.*—*The Com-*  
2           *mittee shall include additional voting members*  
3           *appointed by the Secretary as follows:*

4                   “(i) *6 members shall be appointed from*  
5                   *among scientists, physicians, and other*  
6                   *health professionals, who—*

7                           “(I) *are not officers or employees*  
8                           *of the United States;*

9                           “(II) *represent multiple dis-*  
10                          *ciplines, including clinical, basic, and*  
11                          *public health sciences;*

12                          “(III) *represent different geo-*  
13                          *graphical regions of the United States;*  
14                          *and*

15                          “(IV) *are from practice settings,*  
16                          *academia, manufacturers, or other re-*  
17                          *search settings; and*

18                          “(ii) *6 members shall be appointed*  
19                          *from members of the general public, who are*  
20                          *representatives of leading research, advo-*  
21                          *cacy, and service organizations for individ-*  
22                          *uals with pain-related conditions.*

23           “(C) *NONVOTING MEMBERS.*—*The Com-*  
24           *mittee shall include such nonvoting members as*  
25           *the Secretary determines to be appropriate.*

1           “(3) *CHAIRPERSON.*—*The voting members of the*  
2           *Committee shall select a chairperson from among such*  
3           *members. The selection of a chairperson shall be sub-*  
4           *ject to the approval of the Director of NIH.*

5           “(4) *MEETINGS.*—*The Committee shall meet at*  
6           *the call of the chairperson of the Committee or upon*  
7           *the request of the Director of NIH, but in no case less*  
8           *often than once each year.*

9           “(5) *DUTIES.*—*The Committee shall—*

10           “(A) *develop a summary of advances in*  
11           *pain care research supported or conducted by the*  
12           *Federal agencies relevant to the diagnosis, pre-*  
13           *vention, and treatment of pain and diseases and*  
14           *disorders associated with pain;*

15           “(B) *identify critical gaps in basic and*  
16           *clinical research on the symptoms and causes of*  
17           *pain;*

18           “(C) *make recommendations to ensure that*  
19           *the activities of the National Institutes of Health*  
20           *and other Federal agencies, including the De-*  
21           *partment of Defense and the Department of Vet-*  
22           *eran Affairs, are free of unnecessary duplication*  
23           *of effort;*

24           “(D) *make recommendations on how best to*  
25           *disseminate information on pain care; and*

1           “(E) make recommendations on how to ex-  
2           pand partnerships between public entities, in-  
3           cluding Federal agencies, and private entities to  
4           expand collaborative, cross-cutting research.

5           “(6) REVIEW.—The Secretary shall review the  
6           necessity of the Committee at least once every 2  
7           years.”.

8   **SEC. 2553. PUBLIC AWARENESS CAMPAIGN ON PAIN MAN-**  
9                                   **AGEMENT.**

10          Part B of title II (42 U.S.C. 238 et seq.) is amended  
11          by adding at the end the following:

12   **“SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARE-**  
13                                   **NESS CAMPAIGN ON PAIN MANAGEMENT.**

14          “(a) ESTABLISHMENT.—Not later than June 30, 2010,  
15          the Secretary shall establish and implement a national pain  
16          care education outreach and awareness campaign described  
17          in subsection (b).

18          “(b) REQUIREMENTS.—The Secretary shall design the  
19          public awareness campaign under this section to educate  
20          consumers, patients, their families, and other caregivers  
21          with respect to—

22                  “(1) the incidence and importance of pain as a  
23                  national public health problem;

24                  “(2) the adverse physical, psychological, emo-  
25                  tional, societal, and financial consequences that can

1       *result if pain is not appropriately assessed, diag-*  
2       *nosed, treated, or managed;*

3             *“(3) the availability, benefits, and risks of all*  
4       *pain treatment and management options;*

5             *“(4) having pain promptly assessed, appro-*  
6       *priately diagnosed, treated, and managed, and regu-*  
7       *larly reassessed with treatment adjusted as needed;*

8             *“(5) the role of credentialed pain management*  
9       *specialists and subspecialists, and of comprehensive*  
10       *interdisciplinary centers of treatment expertise;*

11            *“(6) the availability in the public, nonprofit,*  
12       *and private sectors of pain management-related infor-*  
13       *mation, services, and resources for consumers, em-*  
14       *ployers, third-party payors, patients, their families,*  
15       *and caregivers, including information on—*

16                *“(A) appropriate assessment, diagnosis,*  
17                *treatment, and management options for all types*  
18                *of pain and pain-related symptoms; and*

19                *“(B) conditions for which no treatment op-*  
20                *tions are yet recognized; and*

21                *“(7) other issues the Secretary deems appro-*  
22       *priate.*

23                *“(c) CONSULTATION.—In designing and implementing*  
24       *the public awareness campaign required by this section, the*  
25       *Secretary shall consult with organizations representing pa-*

1 *tients in pain and other consumers, employers, physicians*  
2 *including physicians specializing in pain care, other pain*  
3 *management professionals, medical device manufacturers,*  
4 *and pharmaceutical companies.*

5 “(d) *COORDINATION.*—

6 “(1) *LEAD OFFICIAL.*—*The Secretary shall des-*  
7 *ignate one official in the Department of Health and*  
8 *Human Services to oversee the campaign established*  
9 *under this section.*

10 “(2) *AGENCY COORDINATION.*—*The Secretary*  
11 *shall ensure the involvement in the public awareness*  
12 *campaign under this section of the Surgeon General*  
13 *of the Public Health Service, the Director of the Cen-*  
14 *ters for Disease Control and Prevention, and such*  
15 *other representatives of offices and agencies of the De-*  
16 *partment of Health and Human Services as the Sec-*  
17 *retary determines appropriate.*

18 “(e) *UNDERSERVED AREAS AND POPULATIONS.*—*In*  
19 *designing the public awareness campaign under this sec-*  
20 *tion, the Secretary shall—*

21 “(1) *take into account the special needs of geo-*  
22 *graphic areas and racial, ethnic, gender, age, and*  
23 *other demographic groups that are currently under-*  
24 *served; and*

1           “(2) *provide resources that will reduce dispari-*  
2           *ties in access to appropriate diagnosis, assessment,*  
3           *and treatment.*

4           “(f) *GRANTS AND CONTRACTS.—The Secretary may*  
5           *make awards of grants, cooperative agreements, and con-*  
6           *tracts to public agencies and private nonprofit organiza-*  
7           *tions to assist with the development and implementation*  
8           *of the public awareness campaign under this section.*

9           “(g) *EVALUATION AND REPORT.—Not later than the*  
10           *end of fiscal year 2012, the Secretary shall prepare and*  
11           *submit to the Congress a report evaluating the effectiveness*  
12           *of the public awareness campaign under this section in edu-*  
13           *cating the general public with respect to the matters de-*  
14           *scribed in subsection (b).*

15           “(h) *AUTHORIZATION OF APPROPRIATIONS.—For pur-*  
16           *poses of carrying out this section, there are authorized to*  
17           *be appropriated \$2,000,000 for fiscal year 2010 and*  
18           *\$4,000,000 for each of fiscal years 2011 and 2012.”.*

19           ***Subtitle C—Food and Drug***  
20           ***Administration***

21           ***PART 1—IN GENERAL***

22           ***SEC. 2561. NATIONAL MEDICAL DEVICE REGISTRY.***

23           ***(a) REGISTRY.—***



1           (1) *IN GENERAL.*—Section 519 of the Federal  
2     *Food, Drug, and Cosmetic Act (21 U.S.C. 360i)* is  
3     *amended—*

4           (A) *by redesignating subsection (g) as sub-*  
5     *section (h); and*

6           (B) *by inserting after subsection (f) the fol-*  
7     *lowing:*

8           “*National Medical Device Registry*

9           “(g)(1) *The Secretary shall establish a national med-*  
10    *ical device registry (in this subsection referred to as the ‘reg-*  
11    *istry’) to facilitate analysis of postmarket safety and out-*  
12    *comes data on each device that—*

13           “(A) *is or has been used in or on a patient; and*

14           “(B) *is—*

15           “(i) *a class III device; or*

16           “(ii) *a class II device that is implantable,*  
17    *life-supporting, or life-sustaining.*

18           “(2) *In developing the registry, the Secretary shall, in*  
19    *consultation with the Commissioner of Food and Drugs, the*  
20    *Administrator of the Centers for Medicare & Medicaid Serv-*  
21    *ices, the head of the Office of the National Coordinator for*  
22    *Health Information Technology, and the Secretary of Vet-*  
23    *erans Affairs, determine the best methods for—*

24           “(A) *including in the registry, in a manner con-*  
25    *sistent with subsection (f), appropriate information to*

1 *identify each device described in paragraph (1) by*  
2 *type, model, and serial number or other unique iden-*  
3 *tifier;*

4 *“(B) validating methods for analyzing patient*  
5 *safety and outcomes data from multiple sources and*  
6 *for linking such data with the information included*  
7 *in the registry as described in subparagraph (A), in-*  
8 *cluding, to the extent feasible, use of—*

9 *“(i) data provided to the Secretary under*  
10 *other provisions of this chapter; and*

11 *“(ii) information from public and private*  
12 *sources identified under paragraph (3);*

13 *“(C) integrating the activities described in this*  
14 *subsection with—*

15 *“(i) activities under paragraph (3) of sec-*  
16 *tion 505(k) (relating to active postmarket risk*  
17 *identification);*

18 *“(ii) activities under paragraph (4) of sec-*  
19 *tion 505(k) (relating to advanced analysis of*  
20 *drug safety data); and*

21 *“(iii) other postmarket device surveillance*  
22 *activities of the Secretary authorized by this*  
23 *chapter; and*

24 *“(D) providing public access to the data and*  
25 *analysis collected or developed through the registry in*

1       *a manner and form that protects patient privacy and*  
2       *proprietary information and is comprehensive, useful,*  
3       *and not misleading to patients, physicians, and sci-*  
4       *entists.*

5       “(3)(A) *To facilitate analyses of postmarket safety and*  
6       *patient outcomes for devices described in paragraph (1), the*  
7       *Secretary shall, in collaboration with public, academic, and*  
8       *private entities, develop methods to—*

9               “(i) *obtain access to disparate sources of patient*  
10       *safety and outcomes data, including—*

11                       “(I) *Federal health-related electronic data*  
12                       *(such as data from the Medicare program under*  
13                       *title XVIII of the Social Security Act or from the*  
14                       *health systems of the Department of Veterans Af-*  
15                       *fairs);*

16                       “(II) *private sector health-related electronic*  
17                       *data (such as pharmaceutical purchase data and*  
18                       *health insurance claims data); and*

19                       “(III) *other data as the Secretary deems*  
20                       *necessary to permit postmarket assessment of de-*  
21                       *vice safety and effectiveness; and*

22               “(ii) *link data obtained under clause (i) with in-*  
23       *formation in the registry.*

24       “(B) *In this paragraph, the term ‘data’ refers to infor-*  
25       *mation respecting a device described in paragraph (1), in-*

1 *cluding claims data, patient survey data, standardized*  
2 *analytic files that allow for the pooling and analysis of data*  
3 *from disparate data environments, electronic health records,*  
4 *and any other data deemed appropriate by the Secretary.*

5       “(4) *Not later than 36 months after the date of the*  
6 *enactment of this subsection, the Secretary shall promulgate*  
7 *regulations for establishment and operation of the registry*  
8 *under paragraph (1). Such regulations—*

9               “(A)(i) *in the case of devices that are described*  
10 *in paragraph (1) and sold on or after the date of the*  
11 *enactment of this subsection, shall require manufac-*  
12 *turers of such devices to submit information to the*  
13 *registry, including, for each such device, the type,*  
14 *model, and serial number or, if required under sub-*  
15 *section (f), other unique device identifier; and*

16               “(ii) *in the case of devices that are described in*  
17 *paragraph (1) and sold before such date, may require*  
18 *manufacturers of such devices to submit such infor-*  
19 *mation to the registry, if deemed necessary by the*  
20 *Secretary to protect the public health;*

21               “(B) *shall establish procedures—*

22                       “(i) *to permit linkage of information sub-*  
23 *mitted pursuant to subparagraph (A) with pa-*  
24 *tient safety and outcomes data obtained under*  
25 *paragraph (3); and*

1                   “(ii) to permit analyses of linked data;

2                   “(C) may require device manufacturers to sub-  
3                   mit such other information as is necessary to facili-  
4                   tate postmarket assessments of device safety and effec-  
5                   tiveness and notification of device risks;

6                   “(D) shall establish requirements for regular and  
7                   timely reports to the Secretary, which shall be in-  
8                   cluded in the registry, concerning adverse event  
9                   trends, adverse event patterns, incidence and preva-  
10                  lence of adverse events, and other information the Sec-  
11                  retary determines appropriate, which may include  
12                  data on comparative safety and outcomes trends; and

13                  “(E) shall establish procedures to permit public  
14                  access to the information in the registry in a manner  
15                  and form that protects patient privacy and propri-  
16                  etary information and is comprehensive, useful, and  
17                  not misleading to patients, physicians, and scientists.

18                  “(5) To carry out this subsection, there are authorized  
19                  to be appropriated such sums as may be necessary for fiscal  
20                  years 2010 and 2011.”.

21                  (2) *EFFECTIVE DATE.*—The Secretary of Health  
22                  and Human Services shall establish and begin imple-  
23                  mentation of the registry under section 519(g) of the  
24                  Federal Food, Drug, and Cosmetic Act, as added by  
25                  paragraph (1), by not later than the date that is 36

1 months after the date of the enactment of this Act,  
2 without regard to whether or not final regulations to  
3 establish and operate the registry have been promul-  
4 gated by such date.

5 (3) CONFORMING AMENDMENT.—Section  
6 303(f)(1)(B)(ii) of the Federal Food, Drug, and Cos-  
7 metic Act (21 U.S.C. 333(f)(1)(B)(ii)) is amended by  
8 striking “519(g)” and inserting “519(h)”.

9 (b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED  
10 ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDEN-  
11 TIFIERS.—

12 (1) RECOMMENDATIONS.—The HIT Policy Com-  
13 mittee established under section 3002 of the Public  
14 Health Service Act (42 U.S.C. 300jj–12) shall rec-  
15 ommend to the head of the Office of the National Co-  
16 ordinator for Health Information Technology stand-  
17 ards, implementation specifications, and certification  
18 criteria for the electronic exchange and use in cer-  
19 tified electronic health records of a unique device  
20 identifier for each device described in section  
21 519(g)(1) of the Federal Food, Drug, and Cosmetic  
22 Act, as added by subsection (a).

23 (2) STANDARDS, IMPLEMENTATION CRITERIA,  
24 AND CERTIFICATION CRITERIA.—The Secretary of the  
25 Health Human Services, acting through the head of

1        *the Office of the National Coordinator for Health In-*  
 2        *formation Technology, shall adopt standards, imple-*  
 3        *mentation specifications, and certification criteria for*  
 4        *the electronic exchange and use in certified electronic*  
 5        *health records of a unique device identifier for each*  
 6        *device described in paragraph (1), if such an identi-*  
 7        *fier is required by section 519(f) of the Federal Food,*  
 8        *Drug, and Cosmetic Act (21 U.S.C. 360i(f)) for the*  
 9        *device.*

10    **SEC. 2562. NUTRITION LABELING OF STANDARD MENU**  
 11                                    **ITEMS AT CHAIN RESTAURANTS AND OF ARTI-**  
 12                                    **CLES OF FOOD SOLD FROM VENDING MA-**  
 13                                    **CHINES.**

14        *(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A)*  
 15        *of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.*  
 16        *343(q)(5)(A)) is amended—*

17                    *(1) in subclause (i), by inserting “except as pro-*  
 18                    *vided in clause (H)(ii)(III),” after “(i)” ; and*

19                    *(2) in subclause (ii), by inserting “except as pro-*  
 20                    *vided in clause (H)(ii)(III),” after “(ii)”.*

21        *(b) LABELING REQUIREMENTS.—Section 403(q)(5) of*  
 22        *the Federal Food, Drug, and Cosmetic Act (21 U.S.C.*  
 23        *343(q)(5)) is amended by adding at the end the following:*

24                    *“(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS,*  
 25        *AND VENDING MACHINES.—*

1           “(i) *GENERAL REQUIREMENTS FOR RES-*  
2           *TAURANTS AND SIMILAR RETAIL FOOD ESTABLISH-*  
3           *MENTS.—Except for food described in subclause (vii),*  
4           *in the case of food that is a standard menu item that*  
5           *is offered for sale in a restaurant or similar retail*  
6           *food establishment that is part of a chain with 20 or*  
7           *more locations doing business under the same name*  
8           *(regardless of the type of ownership of the locations)*  
9           *and offering for sale substantially the same menu*  
10           *items, the restaurant or similar retail food establish-*  
11           *ment shall disclose the information described in sub-*  
12           *clauses (ii) and (iii).*

13           “(ii) *INFORMATION REQUIRED TO BE DISCLOSED*  
14           *BY RESTAURANTS AND RETAIL FOOD ESTABLISH-*  
15           *MENTS.—Except as provided in subclause (vii), the*  
16           *restaurant or similar retail food establishment shall*  
17           *disclose in a clear and conspicuous manner—*

18                   “(I)(aa) *in a nutrient content disclosure*  
19                   *statement adjacent to the name of the standard*  
20                   *menu item, so as to be clearly associated with the*  
21                   *standard menu item, on the menu listing the*  
22                   *item for sale, the number of calories contained in*  
23                   *the standard menu item, as usually prepared*  
24                   *and offered for sale; and*



1           “(bb) a succinct statement concerning sug-  
2           gested daily caloric intake, as specified by the  
3           Secretary by regulation and posted prominently  
4           on the menu and designed to enable the public  
5           to understand, in the context of a total daily  
6           diet, the significance of the caloric information  
7           that is provided on the menu;

8           “(II)(aa) in a nutrient content disclosure  
9           statement adjacent to the name of the standard  
10          menu item, so as to be clearly associated with the  
11          standard menu item, on the menu board, includ-  
12          ing a drive-through menu board, the number of  
13          calories contained in the standard menu item, as  
14          usually prepared and offered for sale; and

15          “(bb) a succinct statement concerning sug-  
16          gested daily caloric intake, as specified by the  
17          Secretary by regulation and posted prominently  
18          on the menu board, designed to enable the public  
19          to understand, in the context of a total daily  
20          diet, the significance of the nutrition informa-  
21          tion that is provided on the menu board;

22          “(III) in a written form, available on the  
23          premises of the restaurant or similar retail es-  
24          tablishment and to the consumer upon request,

1           *the nutrition information required under clauses*  
2           *(C) and (D) of subparagraph (1); and*

3           *“(IV) on the menu or menu board, a promi-*  
4           *nent, clear, and conspicuous statement regarding*  
5           *the availability of the information described in*  
6           *item (III).*

7           *“(iii) SELF-SERVICE FOOD AND FOOD ON DIS-*  
8           *PLAY.—Except as provided in subclause (vii), in the*  
9           *case of food sold at a salad bar, buffet line, cafeteria*  
10          *line, or similar self-service facility, and for self-service*  
11          *beverages or food that is on display and that is visible*  
12          *to customers, a restaurant or similar retail food es-*  
13          *tablishment shall place adjacent to each food offered*  
14          *a sign that lists calories per displayed food item or*  
15          *per serving.*

16          *“(iv) REASONABLE BASIS.—For the purposes of*  
17          *this clause, a restaurant or similar retail food estab-*  
18          *lishment shall have a reasonable basis for its nutrient*  
19          *content disclosures, including nutrient databases,*  
20          *cookbooks, laboratory analyses, and other reasonable*  
21          *means, as described in section 101.10 of title 21, Code*  
22          *of Federal Regulations (or any successor regulation)*  
23          *or in a related guidance of the Food and Drug Ad-*  
24          *ministration.*

1           “(v) *MENU VARIABILITY AND COMBINATION*  
2 *MEALS.*—*The Secretary shall establish by regulation*  
3 *standards for determining and disclosing the nutrient*  
4 *content for standard menu items that come in dif-*  
5 *ferent flavors, varieties, or combinations, but which*  
6 *are listed as a single menu item, such as soft drinks,*  
7 *ice cream, pizza, doughnuts, or children’s combina-*  
8 *tion meals, through means determined by the Sec-*  
9 *retary, including ranges, averages, or other methods.*

10           “(vi) *ADDITIONAL INFORMATION.*—*If the Sec-*  
11 *retary determines that a nutrient, other than a nutri-*  
12 *ent required under subclause (i)(III), should be dis-*  
13 *closed for the purpose of providing information to as-*  
14 *assist consumers in maintaining healthy dietary prac-*  
15 *tices, the Secretary may require, by regulation, disclo-*  
16 *sure of such nutrient in the written form required*  
17 *under subclause (i)(III).*

18           “(vii) *NONAPPLICABILITY TO CERTAIN FOOD.*—

19           “(I) *IN GENERAL.*—*Subclauses (i) through*  
20 *(vi) do not apply to—*

21           “(aa) *items that are not listed on a*  
22 *menu or menu board (such as condiments*  
23 *and other items placed on the table or*  
24 *counter for general use);*

1           “(bb) *daily specials, temporary menu*  
2           *items appearing on the menu for less than*  
3           *60 days per calendar year, or custom or-*  
4           *ders; or*

5           “(cc) *such other food that is part of a*  
6           *customary market test appearing on the*  
7           *menu for less than 90 days, under terms*  
8           *and conditions established by the Secretary.*

9           “(II) *WRITTEN FORMS.—Clause (C) shall*  
10          *apply to any regulations promulgated under sub-*  
11          *clauses (ii)(III) and (vi).*

12          “(viii) *VENDING MACHINES.—In the case of an*  
13          *article of food sold from a vending machine that—*

14                 “(I) *does not permit a prospective pur-*  
15                 *chaser to examine the Nutrition Facts Panel be-*  
16                 *fore purchasing the article or does not otherwise*  
17                 *provide visible nutrition information at the*  
18                 *point of purchase; and*

19                 “(II) *is operated by a person who is en-*  
20                 *gaged in the business of owning or operating 20*  
21                 *or more vending machines,*

22          *the vending machine operator shall provide a sign in*  
23          *close proximity to each article of food or the selection*  
24          *button that includes a clear and conspicuous state-*

1        *ment disclosing the number of calories contained in*  
2        *the article.*

3                *“(ix) VOLUNTARY PROVISION OF NUTRITION IN-*  
4        *FORMATION.—*

5                *“(I) IN GENERAL.—An authorized official of*  
6        *any restaurant or similar retail food establish-*  
7        *ment or vending machine operator not subject to*  
8        *the requirements of this clause may elect to be*  
9        *subject to the requirements of such clause, by reg-*  
10       *istering biannually the name and address of*  
11       *such restaurant or similar retail food establish-*  
12       *ment or vending machine operator with the Sec-*  
13       *retary, as specified by the Secretary by regula-*  
14       *tion.*

15               *“(II) REGISTRATION.—Within 120 days of*  
16       *the enactment of this clause, the Secretary shall*  
17       *publish a notice in the Federal Register speci-*  
18       *fying the terms and conditions for implementa-*  
19       *tion of item (I), pending promulgation of regula-*  
20       *tions.*

21               *“(III) RULE OF CONSTRUCTION.—Nothing*  
22       *in this subclause shall be construed to authorize*  
23       *the Secretary to require an application, review,*  
24       *or licensing process for any entity to register*  
25       *with the Secretary, as described in such item.*

1           “(x) *REGULATIONS.*—

2                   “(I) *PROPOSED REGULATION.*—*Not later*  
3 *than 1 year after the date of the enactment of*  
4 *this clause, the Secretary shall promulgate pro-*  
5 *posed regulations to carry out this clause.*

6                   “(II) *CONTENTS.*—*In promulgating regula-*  
7 *tions, the Secretary shall—*

8                           “(aa) *consider standardization of rec-*  
9 *ipes and methods of preparation, reasonable*  
10 *variation in serving size and formulation of*  
11 *menu items, space on menus and menu*  
12 *boards, inadvertent human error, training*  
13 *of food service workers, variations in ingre-*  
14 *redients, and other factors, as the Secretary*  
15 *determines; and*

16                           “(bb) *specify the format and manner of*  
17 *the nutrient content disclosure requirements*  
18 *under this subclause.*

19                   “(III) *REPORTING.*—*The Secretary shall*  
20 *submit to the Committee on Health, Education,*  
21 *Labor, and Pensions of the Senate and the Com-*  
22 *mittee on Energy and Commerce of the House of*  
23 *Representatives a quarterly report that describes*  
24 *the Secretary’s progress toward promulgating*  
25 *final regulations under this subparagraph.*

1           “(xi) *DEFINITION.*—*In this clause, the term*  
2           *‘menu’ or ‘menu board’ means the primary writing of*  
3           *the restaurant or other similar retail food establish-*  
4           *ment from which a consumer makes an order selec-*  
5           *tion.*”.

6           (c) *NATIONAL UNIFORMITY.*—*Section 403A(a)(4) of*  
7           *the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343–*  
8           *1(a)(4)) is amended by striking “except a requirement for*  
9           *nutrition labeling of food which is exempt under subclause*  
10           *(i) or (ii) of section 403(q)(5)(A)” and inserting “except*  
11           *that this paragraph does not apply to food that is offered*  
12           *for sale in a restaurant or similar retail food establishment*  
13           *that is not part of a chain with 20 or more locations doing*  
14           *business under the same name (regardless of the type of*  
15           *ownership of the locations) and offering for sale substan-*  
16           *tially the same menu items unless such restaurant or simi-*  
17           *lar retail food establishment complies with the voluntary*  
18           *provision of nutrition information requirements under sec-*  
19           *tion 403(q)(5)(H)(ix).”.*

20           (d) *RULE OF CONSTRUCTION.*—*Nothing in the amend-*  
21           *ments made by this section shall be construed—*

22           (1) *to preempt any provision of State or local*  
23           *law, unless such provision establishes or continues*  
24           *into effect nutrient content disclosures of the type re-*  
25           *quired under section 403(q)(5)(H) of the Federal*

1 *Food, Drug, and Cosmetic Act (as added by sub-*  
2 *section (b)) and is expressly preempted under section*  
3 *403A(a)(4) of such Act;*

4 *(2) to apply to any State or local requirement*  
5 *respecting a statement in the labeling of food that*  
6 *provides for a warning concerning the safety of the*  
7 *food or component of the food; or*

8 *(3) except as provided in section*  
9 *403(q)(5)(H)(ix) of the Federal Food, Drug, and Cos-*  
10 *metic Act (as added by subsection (b)), to apply to*  
11 *any restaurant or similar retail food establishment*  
12 *other than a restaurant or similar retail food estab-*  
13 *lishment described in section 403(q)(5)(H)(i) of such*  
14 *Act.*

15 **SEC. 2563. PROTECTING CONSUMER ACCESS TO GENERIC**  
16 **DRUGS.**

17 *(a) IN GENERAL.—Section 505 of the Federal Food,*  
18 *Drug, and Cosmetic Act (21 U.S.C. 355) is amended by*  
19 *adding at the end the following:*

20 *“(w) PROTECTING CONSUMER ACCESS TO GENERIC*  
21 *DRUGS.—*

22 *“(1) UNFAIR AND DECEPTIVE ACTS AND PRAC-*  
23 *TICES RELATED TO NEW DRUG APPLICATIONS.—*

24 *“(A) CONDUCT PROHIBITED.—It shall be*  
25 *unlawful for any person to directly or indirectly*



1           *be a party to any agreement resolving or settling*  
2           *a patent infringement claim in which—*

3                   “(i) *an ANDA filer receives anything*  
4                   *of value; and*

5                   “(ii) *the ANDA filer agrees to limit or*  
6                   *forego research, development, manufac-*  
7                   *turing, marketing, or sales, for any period*  
8                   *of time, of the drug that is to be manufac-*  
9                   *tured under the ANDA involved and is the*  
10                  *subject of the patent infringement claim.*

11                  “(B) *EXCEPTIONS.—Notwithstanding sub-*  
12                  *paragraph (A)(i), subparagraph (A) does not*  
13                  *prohibit a resolution or settlement of a patent*  
14                  *infringement claim in which the value received*  
15                  *by the ANDA filer includes no more than—*

16                   “(i) *the right to market the drug that*  
17                   *is to be manufactured under the ANDA in-*  
18                   *volved and is the subject of the patent in-*  
19                   *fringement claim, before the expiration of—*

20                           “(I) *the patent that is the basis*  
21                           *for the patent infringement claim; or*

22                           “(II) *any other statutory exclu-*  
23                           *sivity that would prevent the mar-*  
24                           *keting of such drug; and*

1           “(ii) *the waiver of a patent infringement*  
2           *claim for damages based on prior*  
3           *marketing of such drug.*

4           “(C) *ENFORCEMENT.*—

5           “(i) *IN GENERAL.*—*A violation of sub-*  
6           *paragraph (A) shall be treated as an unfair*  
7           *and deceptive act or practice and an unfair*  
8           *method of competition in or affecting inter-*  
9           *state commerce prohibited under section 5 of*  
10           *the Federal Trade Commission Act and*  
11           *shall be enforced by the Federal Trade Com-*  
12           *mission in the same manner, by the same*  
13           *means, and with the same jurisdiction as*  
14           *though all applicable terms and provisions*  
15           *of the Federal Trade Commission Act were*  
16           *incorporated into and made a part of this*  
17           *subsection.*

18           “(ii) *INAPPLICABILITY.*—*Subchapter A*  
19           *of chapter VII shall not apply with respect*  
20           *to this subsection.*

21           “(D) *DEFINITIONS.*—*In this subsection:*

22           “(i) *AGREEMENT.*—*The term ‘agree-*  
23           *ment’ means anything that would constitute*  
24           *an agreement under section 5 of the Federal*  
25           *Trade Commission Act.*

1           “(ii) *AGREEMENT RESOLVING OR SET-*  
2           *TLING.—The term ‘agreement resolving or*  
3           *settling’, in reference to a patent infringe-*  
4           *ment claim, includes any agreement that is*  
5           *contingent upon, provides a contingent con-*  
6           *dition for, or is otherwise related to the res-*  
7           *olution or settlement of the claim.*

8           “(iii) *ANDA.—The term ‘ANDA’*  
9           *means an abbreviated new drug application*  
10           *for the approval of a new drug under sec-*  
11           *tion (j).*

12           “(iv) *ANDA FILER.—The term ‘ANDA*  
13           *filer’ means a party that has filed an*  
14           *ANDA with the Food and Drug Adminis-*  
15           *tration.*

16           “(v) *PATENT INFRINGEMENT.—The*  
17           *term ‘patent infringement’ means infringe-*  
18           *ment of any patent or of any filed patent*  
19           *application, extension, reissuance, renewal,*  
20           *division, continuation, continuation in*  
21           *part, reexamination, patent term restora-*  
22           *tion, patent of addition, or extension there-*  
23           *of.*

24           “(vi) *PATENT INFRINGEMENT CLAIM.—*  
25           *The term ‘patent infringement claim’ means*

1           *any allegation made to an ANDA filer,*  
2           *whether or not included in a complaint*  
3           *filed with a court of law, that its ANDA or*  
4           *drug to be manufactured under such ANDA*  
5           *may infringe any patent.*

6           “(2) *FTC RULEMAKING.—The Federal Trade*  
7           *Commission may, by rule promulgated under section*  
8           *553 of title 5, United States Code, exempt certain*  
9           *agreements described in paragraph (1) from the re-*  
10          *quirements of this subsection if the Commission finds*  
11          *such agreements to be in furtherance of market com-*  
12          *petition and for the benefit of consumers. Consistent*  
13          *with the authority of the Commission, such rules may*  
14          *include interpretive rules and general statements of*  
15          *policy with respect to the practices prohibited under*  
16          *paragraph (1).”.*

17          (b) *NOTICE AND CERTIFICATION OF AGREEMENTS.—*

18                 (1) *NOTICE OF ALL AGREEMENTS.—Section*  
19                 *1112(c)(2) of the Medicare Prescription Drug, Im-*  
20                 *provement, and Modernization Act of 2003 (21 U.S.C.*  
21                 *3155 note) is amended by—*

22                         (A) *striking “the Commission the” and in-*  
23                         *serting the following: “the Commission—*

24                                 *“(A) the”;*

1           (B) striking the period at the end and in-  
2           serting “; and”; and

3           (C) adding at the end the following:

4           “(B) any other agreement the parties enter  
5           into within 30 days of entering into an agree-  
6           ment covered by subsection (a) or (b).”.

7           (2) *CERTIFICATION OF AGREEMENTS.*—Section  
8           1112 of such Act is amended by adding at the end the  
9           following:

10          “(d) *CERTIFICATION.*—The chief executive officer or  
11          the company official responsible for negotiating any agree-  
12          ment required to be filed under subsection (a), (b), or (c)  
13          shall execute and file with the Assistant Attorney General  
14          and the Commission a certification as follows: ‘I declare  
15          under penalty of perjury that the following is true and cor-  
16          rect: The materials filed with the Federal Trade Commis-  
17          sion and the Department of Justice under section 1112 of  
18          subtitle B of title XI of the Medicare Prescription Drug,  
19          Improvement, and Modernization Act of 2003, with respect  
20          to the agreement referenced in this certification: (1) rep-  
21          resent the complete, final, and exclusive agreement between  
22          the parties; (2) include any ancillary agreements that are  
23          contingent upon, provide a contingent condition for, or are  
24          otherwise related to, the referenced agreement; and (3) in-  
25          clude written descriptions of any oral agreements, represen-

1 *tations, commitments, or promises between the parties that*  
2 *are responsive to subsection (a) or (b) of such section 1112*  
3 *and have not been reduced to writing.’’.*

4 *(c) GAO STUDY.—*

5 *(1) STUDY.—Beginning 2 years after the date of*  
6 *enactment of this Act, and each year for a period of*  
7 *4 years thereafter, the Comptroller General shall con-*  
8 *duct a study on the litigation in United States courts*  
9 *during the period beginning years prior to the date*  
10 *of enactment of this Act relating to patent infringe-*  
11 *ment claims involving generic drugs, the number of*  
12 *patent challenges initiated by manufacturers of ge-*  
13 *neric drugs, and the number of settlements of such*  
14 *litigation. The Comptroller General shall transmit to*  
15 *Congress a report of the findings of such a study and*  
16 *an analysis of the effect of the amendments made by*  
17 *subsections (a) and (b) on such litigation, whether*  
18 *such amendments have had an effect on the number*  
19 *and frequency of claims settled, and whether such*  
20 *amendments resulted in earlier or delayed entry of ge-*  
21 *neric drugs to market, including whether any harm*  
22 *or benefits to consumers has resulted.*

23 *(2) DISCLOSURE OF AGREEMENTS.—Notwith-*  
24 *standing any other law, agreements filed under sec-*  
25 *tion 1112 of the Medicare Prescription Drug, Im-*

1        *provement, and Modernization Act of 2003 (21 U.S.C.*  
2        *355 note), or unaggregated information from such*  
3        *agreements, shall be disclosed to the Comptroller Gen-*  
4        *eral for purposes of the study under paragraph (1)*  
5        *within 30 days of a request by the Comptroller Gen-*  
6        *eral.*

7                                **PART 2—BIOSIMILARS**

8        **SEC. 2565. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGI-**  
9                                **CAL PRODUCTS.**

10        *(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIO-*  
11        *SIMILAR OR INTERCHANGEABLE.—Section 351 of the Public*  
12        *Health Service Act (42 U.S.C. 262) is amended—*

13                                *(1) in subsection (a)(1)(A), by inserting “under*  
14        *this subsection or subsection (k)” after “biologics li-*  
15        *cence”; and*

16                                *(2) by adding at the end the following:*

17        *“(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIO-*  
18        *SIMILAR OR INTERCHANGEABLE.—*

19                                *“(1) IN GENERAL.—Any person may submit an*  
20        *application for licensure of a biological product under*  
21        *this subsection.*

22                                *“(2) CONTENT.—*

23                                *“(A) IN GENERAL.—*

24                                *“(i) REQUIRED INFORMATION.—An ap-*  
25        *plication submitted under this subsection*

1 shall include information demonstrating  
2 that—

3 “(I) the biological product is bio-  
4 similar to a reference product based  
5 upon data derived from—

6 “(aa) analytical studies that  
7 demonstrate that the biological  
8 product is highly similar to the  
9 reference product notwithstanding  
10 minor differences in clinically in-  
11 active components;

12 “(bb) animal studies (includ-  
13 ing the assessment of toxicity);  
14 and

15 “(cc) a clinical study or  
16 studies (including the assessment  
17 of immunogenicity and phar-  
18 macokinetics or  
19 pharmacodynamics) that are suf-  
20 ficient to demonstrate safety, pu-  
21 rity, and potency in 1 or more  
22 appropriate conditions of use for  
23 which the reference product is li-  
24 censed and intended to be used



1                    *and for which licensure is sought*  
2                    *for the biological product;*

3                    *“(II) the biological product and*  
4                    *reference product utilize the same*  
5                    *mechanism or mechanisms of action*  
6                    *for the condition or conditions of use*  
7                    *prescribed, recommended, or suggested*  
8                    *in the proposed labeling, but only to*  
9                    *the extent the mechanism or mecha-*  
10                   *nisms of action are known for the ref-*  
11                   *erence product;*

12                   *“(III) the condition or conditions*  
13                   *of use prescribed, recommended, or sug-*  
14                   *gested in the labeling proposed for the*  
15                   *biological product have been previously*  
16                   *approved for the reference product;*

17                   *“(IV) the route of administration,*  
18                   *the dosage form, and the strength of the*  
19                   *biological product are the same as*  
20                   *those of the reference product; and*

21                   *“(V) the facility in which the bio-*  
22                   *logical product is manufactured, proc-*  
23                   *essed, packed, or held meets standards*  
24                   *designed to assure that the biological*

1                   *product continues to be safe, pure, and*  
2                   *potent.*

3                   “(ii) *DETERMINATION BY SEC-*  
4                   *RETARY.—The Secretary may determine, in*  
5                   *the Secretary’s discretion, that an element*  
6                   *described in clause (i)(I) is unnecessary in*  
7                   *an application submitted under this sub-*  
8                   *section.*

9                   “(iii) *ADDITIONAL INFORMATION.—An*  
10                   *application submitted under this sub-*  
11                   *section—*

12                    “(I) *shall include publicly avail-*  
13                    *able information regarding the Sec-*  
14                    *retary’s previous determination that*  
15                    *the reference product is safe, pure, and*  
16                    *potent; and*

17                    “(II) *may include any additional*  
18                    *information in support of the applica-*  
19                    *tion, including publicly available in-*  
20                    *formation with respect to the reference*  
21                    *product or another biological product.*

22                   “(B) *INTERCHANGEABILITY.—An applica-*  
23                    *tion (or a supplement to an application) sub-*  
24                    *mitted under this subsection may include infor-*

1            *mation demonstrating that the biological product*  
2            *meets the standards described in paragraph (4).*

3            “(3) *EVALUATION BY SECRETARY.*—*Upon review*  
4            *of an application (or a supplement to an application)*  
5            *submitted under this subsection, the Secretary shall*  
6            *license the biological product under this subsection*  
7            *if—*

8                    “(A) *the Secretary determines that the in-*  
9                    *formation submitted in the application (or the*  
10                   *supplement) is sufficient to show that the biologi-*  
11                   *cal product—*

12                            “(i) *is biosimilar to the reference prod-*  
13                            *uct; or*

14                            “(ii) *meets the standards described in*  
15                            *paragraph (4), and therefore is interchange-*  
16                            *able with the reference product; and*

17                            “(B) *the applicant (or other appropriate*  
18                            *person) consents to the inspection of the facility*  
19                            *that is the subject of the application, in accord-*  
20                            *ance with subsection (c).*

21            “(4) *SAFETY STANDARDS FOR DETERMINING*  
22            *INTERCHANGEABILITY.*—*Upon review of an applica-*  
23            *tion submitted under this subsection or any supple-*  
24            *ment to such application, the Secretary shall deter-*  
25            *mine the biological product to be interchangeable with*

1 *the reference product if the Secretary determines that*  
2 *the information submitted in the application (or a*  
3 *supplement to such application) is sufficient to show*  
4 *that—*

5 *“(A) the biological product—*

6 *“(i) is biosimilar to the reference prod-*  
7 *uct; and*

8 *“(ii) can be expected to produce the*  
9 *same clinical result as the reference product*  
10 *in any given patient; and*

11 *“(B) for a biological product that is admin-*  
12 *istered more than once to an individual, the risk*  
13 *in terms of safety or diminished efficacy of alter-*  
14 *nating or switching between use of the biological*  
15 *product and the reference product is not greater*  
16 *than the risk of using the reference product with-*  
17 *out such alternation or switch.*

18 *“(5) GENERAL RULES.—*

19 *“(A) ONE REFERENCE PRODUCT PER APPLI-*  
20 *CATION.—A biological product, in an applica-*  
21 *tion submitted under this subsection, may not be*  
22 *evaluated against more than 1 reference product.*

23 *“(B) REVIEW.—An application submitted*  
24 *under this subsection shall be reviewed by the di-*  
25 *vision within the Food and Drug Administra-*

1            *tion that is responsible for the review and ap-*  
2            *proval of the application under which the ref-*  
3            *erence product is licensed.*

4            *“(C) RISK EVALUATION AND MITIGATION*  
5            *STRATEGIES.—The authority of the Secretary*  
6            *with respect to risk evaluation and mitigation*  
7            *strategies under the Federal Food, Drug, and*  
8            *Cosmetic Act shall apply to biological products*  
9            *licensed under this subsection in the same man-*  
10           *ner as such authority applies to biological prod-*  
11           *ucts licensed under subsection (a).*

12           *“(D) RESTRICTIONS ON BIOLOGICAL PROD-*  
13           *UCTS CONTAINING DANGEROUS INGREDIENTS.—If*  
14           *information in an application submitted under*  
15           *this subsection, in a supplement to such an ap-*  
16           *plication, or otherwise available to the Secretary*  
17           *shows that a biological product—*

18           *“(i) is, bears, or contains a select agent*  
19           *or toxin listed in section 73.3 or 73.4 of*  
20           *title 42, section 121.3 or 121.4 of title 9, or*  
21           *section 331.3 of title 7, Code of Federal Reg-*  
22           *ulations (or any successor regulations); or*

23           *“(ii) is, bears, or contains a controlled*  
24           *substance in schedule I or II of section 202*  
25           *of the Controlled Substances Act, as listed*

1           *in part 1308 of title 21, Code of Federal*  
2           *Regulations (or any successor regulations);*  
3           *the Secretary shall not license the biological*  
4           *product under this subsection unless the Sec-*  
5           *retary determines, after consultation with appro-*  
6           *priate national security and drug enforcement*  
7           *agencies, that there would be no increased risk to*  
8           *the security or health of the public from licensing*  
9           *such biological product under this subsection.*

10           “(6) *EXCLUSIVITY FOR FIRST INTERCHANGEABLE*  
11           *BIOLOGICAL PRODUCT.—Upon review of an applica-*  
12           *tion submitted under this subsection relying on the*  
13           *same reference product for which a prior biological*  
14           *product has received a determination of interchange-*  
15           *ability for any condition of use, the Secretary shall*  
16           *not make a determination under paragraph (4) that*  
17           *the second or subsequent biological product is inter-*  
18           *changeable for any condition of use until the earlier*  
19           *of—*

20                   “(A) *1 year after the first commercial mar-*  
21                   *keting of the first interchangeable biosimilar bio-*  
22                   *logical product to be approved as interchangeable*  
23                   *for that reference product;*

24                   “(B) *18 months after—*

1           “(i) a final court decision on all pat-  
2           ents in suit in an action instituted under  
3           subsection (l)(5) against the applicant that  
4           submitted the application for the first ap-  
5           proved interchangeable biosimilar biological  
6           product; or

7           “(ii) the dismissal with or without  
8           prejudice of an action instituted under sub-  
9           section (l)(5) against the applicant that  
10          submitted the application for the first ap-  
11          proved interchangeable biosimilar biological  
12          product; or

13          “(C)(i) 42 months after approval of the first  
14          interchangeable biosimilar biological product if  
15          the applicant that submitted such application  
16          has been sued under subsection (l)(5) and such  
17          litigation is still ongoing within such 42-month  
18          period; or

19          “(ii) 18 months after approval of the first  
20          interchangeable biosimilar biological product if  
21          the applicant that submitted such application  
22          has not been sued under subsection (l)(5).

23          For purposes of this paragraph, the term ‘final court  
24          decision’ means a final decision of a court from which  
25          no appeal (other than a petition to the United States

1 *Supreme Court for a writ of certiorari) has been or*  
2 *can be taken.*

3 “(7) *EXCLUSIVITY FOR REFERENCE PRODUCT.*—

4 “(A) *EFFECTIVE DATE OF BIOSIMILAR AP-*  
5 *PLICATION APPROVAL.*—*Approval of an applica-*  
6 *tion under this subsection may not be made ef-*  
7 *fective by the Secretary until the date that is 12*  
8 *years after the date on which the reference prod-*  
9 *uct was first licensed under subsection (a).*

10 “(B) *FILING PERIOD.*—*An application*  
11 *under this subsection may not be submitted to*  
12 *the Secretary until the date that is 4 years after*  
13 *the date on which the reference product was first*  
14 *licensed under subsection (a).*

15 “(C) *FIRST LICENSURE.*—*Subparagraphs*  
16 *(A) and (B) shall not apply to a license for or*  
17 *approval of—*

18 “(i) *a supplement for the biological*  
19 *product that is the reference product; or*

20 “(ii) *a subsequent application filed by*  
21 *the same sponsor or manufacturer of the bi-*  
22 *ological product that is the reference prod-*  
23 *uct (or a licensor, predecessor in interest, or*  
24 *other related entity) for—*



1                   “(I) a change (not including a  
2                   modification to the structure of the bio-  
3                   logical product) that results in a new  
4                   indication, route of administration,  
5                   dosing schedule, dosage form, delivery  
6                   system, delivery device, or strength; or

7                   “(II) a modification to the struc-  
8                   ture of the biological product that does  
9                   not result in a change in safety, pu-  
10                  rity, or potency.

11                  “(8) *PEDIATRIC STUDIES.*—

12                  “(A) *EXCLUSIVITY.*—If, before or after li-  
13                  censure of the reference product under subsection  
14                  (a) of this section, the Secretary determines that  
15                  information relating to the use of such product  
16                  in the pediatric population may produce health  
17                  benefits in that population, the Secretary makes  
18                  a written request for pediatric studies (which  
19                  shall include a timeframe for completing such  
20                  studies), the applicant or holder of the approved  
21                  application agrees to the request, such studies are  
22                  completed using appropriate formulations for  
23                  each age group for which the study is requested  
24                  within any such timeframe, and the reports  
25                  thereof are submitted and accepted in accordance

1           *with section 505A(d)(3) of the Federal Food,*  
2           *Drug, and Cosmetic Act the period referred to in*  
3           *paragraph (7)(A) of this subsection is deemed to*  
4           *be 12 years and 6 months rather than 12 years.*

5           “(B) *EXCEPTION.—The Secretary shall not*  
6           *extend the period referred to in subparagraph*  
7           *(A) of this paragraph if the determination under*  
8           *section 505A(d)(3) of the Federal Food, Drug,*  
9           *and Cosmetic Act is made later than 9 months*  
10          *prior to the expiration of such period.*

11          “(C) *APPLICATION OF CERTAIN PROVI-*  
12          *SIONS.—The provisions of subsections (a), (d),*  
13          *(e), (f), (h), (j), (k), and (l) of section 505A of*  
14          *the Federal Food, Drug, and Cosmetic Act shall*  
15          *apply with respect to the extension of a period*  
16          *under subparagraph (A) of this paragraph to the*  
17          *same extent and in the same manner as such*  
18          *provisions apply with respect to the extension of*  
19          *a period under subsection (b) or (c) of section*  
20          *505A of the Federal Food, Drug, and Cosmetic*  
21          *Act.*

22          “(9) *GUIDANCE DOCUMENTS.—*

23          “(A) *IN GENERAL.—The Secretary may,*  
24          *after opportunity for public comment, issue*  
25          *guidance in accordance, except as provided in*

1           subparagraph (B)(i), with section 701(h) of the  
2           Federal Food, Drug, and Cosmetic Act with re-  
3           spect to the licensure of a biological product  
4           under this subsection. Any such guidance may be  
5           general or specific.

6           “(B) PUBLIC COMMENT.—

7                   “(i) IN GENERAL.—The Secretary shall  
8                   provide the public an opportunity to com-  
9                   ment on any proposed guidance issued  
10                  under subparagraph (A) before issuing final  
11                  guidance.

12                  “(ii) INPUT REGARDING MOST VALU-  
13                  ABLE GUIDANCE.—The Secretary shall es-  
14                  tablish a process through which the public  
15                  may provide the Secretary with input re-  
16                  garding priorities for issuing guidance.

17           “(C) NO REQUIREMENT FOR APPLICATION  
18           CONSIDERATION.—The issuance (or non-  
19           issuance) of guidance under subparagraph (A)  
20           shall not preclude the review of, or action on, an  
21           application submitted under this subsection.

22           “(D) REQUIREMENT FOR PRODUCT CLASS-  
23           SPECIFIC GUIDANCE.—If the Secretary issues  
24           product class-specific guidance under subpara-

1 *graph (A), such guidance shall include a descrip-*  
2 *tion of—*

3 *“(i) the criteria that the Secretary will*  
4 *use to determine whether a biological prod-*  
5 *uct is highly similar to a reference product*  
6 *in such product class; and*

7 *“(ii) the criteria, if available, that the*  
8 *Secretary will use to determine whether a*  
9 *biological product meets the standards de-*  
10 *scribed in paragraph (4).*

11 *“(E) CERTAIN PRODUCT CLASSES.—*

12 *“(i) GUIDANCE.—The Secretary may*  
13 *indicate in a guidance document that the*  
14 *science and experience, as of the date of*  
15 *such guidance, with respect to a product or*  
16 *product class (not including any recom-*  
17 *binant protein) does not allow approval of*  
18 *an application for a license as provided*  
19 *under this subsection for such product or*  
20 *product class.*

21 *“(ii) MODIFICATION OR REVERSAL.—*  
22 *The Secretary may issue a subsequent guid-*  
23 *ance document under subparagraph (A) to*  
24 *modify or reverse a guidance document*  
25 *under clause (i).*

1                   “(iii) *NO EFFECT ON ABILITY TO DENY*  
2                   *LICENSE.*—*Clause (i) shall not be construed*  
3                   *to require the Secretary to approve a prod-*  
4                   *uct with respect to which the Secretary has*  
5                   *not indicated in a guidance document that*  
6                   *the science and experience, as described in*  
7                   *clause (i), does not allow approval of such*  
8                   *an application.*

9                   “(10) *NAMING.*—*The Secretary shall ensure that*  
10                  *the labeling and packaging of each biological product*  
11                  *licensed under this subsection bears a name that*  
12                  *uniquely identifies the biological product and distin-*  
13                  *guishes it from the reference product and any other*  
14                  *biological products licensed under this subsection fol-*  
15                  *lowing evaluation against such reference product.*

16                  “(l) *PATENT NOTICES; RELATIONSHIP TO FINAL AP-*  
17                  *PROVAL.*—

18                  “(1) *DEFINITIONS.*—*For the purposes of this*  
19                  *subsection, the term—*

20                         “(A) *‘biosimilar product’ means the biologi-*  
21                         *cal product that is the subject of the application*  
22                         *under subsection (k);*

23                         “(B) *‘relevant patent’ means a patent*  
24                         *that—*

1           “(i) expires after the date specified in  
2           subsection (k)(7)(A) that applies to the ref-  
3           erence product; and

4           “(ii) could reasonably be asserted  
5           against the applicant due to the unauthor-  
6           ized making, use, sale, or offer for sale with-  
7           in the United States, or the importation  
8           into the United States of the biosimilar  
9           product, or materials used in the manufac-  
10          ture of the biosimilar product, or due to a  
11          use of the biosimilar product in a method of  
12          treatment that is indicated in the applica-  
13          tion;

14          “(C) ‘reference product sponsor’ means the  
15          holder of an approved application or license for  
16          the reference product; and

17          “(D) ‘interested third party’ means a per-  
18          son other than the reference product sponsor that  
19          owns a relevant patent, or has the right to com-  
20          mence or participate in an action for infringe-  
21          ment of a relevant patent.

22          “(2) *HANDLING OF CONFIDENTIAL INFORMA-*  
23          *TION.*—Any entity receiving confidential information  
24          pursuant to this subsection shall designate one or  
25          more individuals to receive such information. Each

1       *individual so designated shall execute an agreement*  
2       *in accordance with regulations promulgated by the*  
3       *Secretary. The regulations shall require each such in-*  
4       *dividual to take reasonable steps to maintain the con-*  
5       *fidentiality of information received pursuant to this*  
6       *subsection and use the information solely for purposes*  
7       *authorized by this subsection. The obligations imposed*  
8       *on an individual who has received confidential infor-*  
9       *mation pursuant to this subsection shall continue*  
10       *until the individual returns or destroys the confiden-*  
11       *tial information, a court imposes a protective order*  
12       *that governs the use or handling of the confidential*  
13       *information, or the party providing the confidential*  
14       *information agrees to other terms or conditions re-*  
15       *garding the handling or use of the confidential infor-*  
16       *mation.*

17               “(3) *PUBLIC NOTICE BY SECRETARY.*—*Within 30*  
18       *days of acceptance by the Secretary of an application*  
19       *filed under subsection (k), the Secretary shall publish*  
20       *a notice identifying—*

21                       “(A) *the reference product identified in the*  
22                       *application; and*

23                       “(B) *the name and address of an agent des-*  
24                       *ignated by the applicant to receive notices pursu-*  
25                       *ant to paragraph (4)(B).*

1           “(4) *EXCHANGES CONCERNING PATENTS.*—

2                   “(A) *EXCHANGES WITH REFERENCE PROD-*  
3           *UCT SPONSOR.*—

4                           “(i) *Within 30 days of the date of ac-*  
5                           *ceptance of the application by the Sec-*  
6                           *retary, the applicant shall provide the ref-*  
7                           *erence product sponsor with a copy of the*  
8                           *application and information concerning the*  
9                           *biosimilar product and its production. This*  
10                           *information shall include a detailed de-*  
11                           *scription of the biosimilar product, its*  
12                           *method of manufacture, and the materials*  
13                           *used in the manufacture of the product.*

14                           “(ii) *Within 60 days of the date of re-*  
15                           *ceipt of the information required to be pro-*  
16                           *vided under clause (i), the reference product*  
17                           *sponsor shall provide to the applicant a list*  
18                           *of relevant patents owned by the reference*  
19                           *product sponsor, or in respect of which the*  
20                           *reference product sponsor has the right to*  
21                           *commence an action of infringement or oth-*  
22                           *erwise has an interest in the patent as such*  
23                           *patent concerns the biosimilar product.*

24                           “(iii) *If the reference product sponsor*  
25                           *is issued or acquires an interest in a rel-*



1            *evant patent after the date on which the ref-*  
2            *erence product sponsor provides the list re-*  
3            *quired by clause (i) to the applicant, the*  
4            *reference product sponsor shall identify that*  
5            *patent to the applicant within 30 days of*  
6            *the date of issue of the patent, or the date*  
7            *of acquisition of the interest in the patent,*  
8            *as applicable.*

9            *“(B) EXCHANGES WITH INTERESTED THIRD*  
10           *PARTIES.—*

11           *“(i) At any time after the date on*  
12           *which the Secretary publishes a notice for*  
13           *an application under paragraph (3), any*  
14           *interested third party may provide notice to*  
15           *the designated agent of the applicant that*  
16           *the interested third party owns or has*  
17           *rights under 1 or more patents that may be*  
18           *relevant patents. The notice shall identify at*  
19           *least 1 patent and shall designate an indi-*  
20           *vidual who has executed an agreement in*  
21           *accordance with paragraph (2) to receive*  
22           *confidential information from the appli-*  
23           *cant.*

24           *“(ii) Within 30 days of the date of re-*  
25           *ceiving notice pursuant to clause (i), the*

1            *applicant shall send to the individual des-*  
2            *ignated by the interested third party the in-*  
3            *formation specified in subparagraph (A)(i),*  
4            *unless the applicant and interested third*  
5            *party otherwise agree.*

6            *“(iii) Within 90 days of the date of re-*  
7            *ceiving information pursuant to clause (ii),*  
8            *the interested third party shall provide to*  
9            *the applicant a list of relevant patents*  
10           *which the interested third party owns, or in*  
11           *respect of which the interested third party*  
12           *has the right to commence or participate in*  
13           *an action for infringement.*

14           *“(iv) If the interested third party is*  
15           *issued or acquires an interest in a relevant*  
16           *patent after the date on which the interested*  
17           *third party provides the list required by*  
18           *clause (iii), the interested third party shall*  
19           *identify that patent within 30 days of the*  
20           *date of issue of the patent, or the date of ac-*  
21           *quisition of the interest in the patent, as*  
22           *applicable.*

23           *“(C) IDENTIFICATION OF BASIS FOR IN-*  
24           *FRINGEMENT.—For any patent identified under*  
25           *clause (ii) or (iii) of subparagraph (A) or under*

1           *clause (iii) or (iv) of subparagraph (B), the ref-*  
2           *erence product sponsor or the interested third*  
3           *party, as applicable—*

4                   *“(i) shall explain in writing why the*  
5                   *sponsor or the interested third party believes*  
6                   *the relevant patent would be infringed by*  
7                   *the making, use, sale, or offer for sale with-*  
8                   *in the United States, or importation into*  
9                   *the United States, of the biosimilar product*  
10                  *or by a use of the biosimilar product in*  
11                  *treatment that is indicated in the applica-*  
12                  *tion;*

13                   *“(ii) may specify whether the relevant*  
14                   *patent is available for licensing; and*

15                   *“(iii) shall specify the number and*  
16                   *date of expiration of the relevant patent.*

17           *“(D) CERTIFICATION BY APPLICANT CON-*  
18           *CERNING IDENTIFIED RELEVANT PATENTS.—Not*  
19           *later than 45 days after the date on which a pat-*  
20           *ent is identified under clause (ii) or (iii) of sub-*  
21           *paragraph (A) or under clause (iii) or (iv) of*  
22           *subparagraph (B), the applicant shall send a*  
23           *written statement regarding each identified pat-*  
24           *ent to the party that identified the patent. Such*  
25           *statement shall either—*

1           “(i) state that the applicant will not  
2           commence marketing of the biosimilar prod-  
3           uct and has requested the Secretary to not  
4           grant final approval of the application be-  
5           fore the date of expiration of the noticed  
6           patent; or

7           “(ii) provide a detailed written expla-  
8           nation setting forth the reasons why the ap-  
9           plicant believes—

10           “(I) the making, use, sale, or offer  
11           for sale within the United States, or  
12           the importation into the United States,  
13           of the biosimilar product, or the use of  
14           the biosimilar product in a treatment  
15           indicated in the application, would not  
16           infringe the patent; or

17           “(II) the patent is invalid or un-  
18           enforceable.

19           “(5) ACTION FOR INFRINGEMENT INVOLVING  
20           REFERENCE PRODUCT SPONSOR.—If an action for in-  
21           fringement concerning a relevant patent identified by  
22           the reference product sponsor under clause (ii) or (iii)  
23           of paragraph (4)(A), or by an interested third party  
24           under clause (iii) or (iv) of paragraph (4)(B), is  
25           brought within 60 days of the date of receipt of a

1 *statement under paragraph (4)(D)(ii), and the court*  
2 *in which such action has been commenced determines*  
3 *the patent is infringed prior to the date applicable*  
4 *under subsection (k)(7)(A) or (k)(8), the Secretary*  
5 *shall make approval of the application effective on the*  
6 *day after the date of expiration of the patent that has*  
7 *been found to be infringed. If more than one such pat-*  
8 *ent is found to be infringed by the court, the approval*  
9 *of the application shall be made effective on the day*  
10 *after the date that the last such patent expires.”.*

11 *(b) DEFINITIONS.—Section 351(i) of the Public Health*  
12 *Service Act (42 U.S.C. 262(i)) is amended—*

13 *(1) by striking “In this section, the term ‘biologi-*  
14 *cal product’ means” and inserting the following: “In*  
15 *this section:*

16 *“(1) The term ‘biological product’ means”;*

17 *(2) in paragraph (1), as so designated, by insert-*  
18 *ing “protein (except any chemically synthesized*  
19 *polypeptide),” after “allergenic product,”; and*

20 *(3) by adding at the end the following:*

21 *“(2) The term ‘biosimilar’ or ‘biosimilarity’, in*  
22 *reference to a biological product that is the subject of*  
23 *an application under subsection (k), means—*

24 *“(A) that the biological product is highly*  
25 *similar to the reference product notwithstanding*

1           *minor differences in clinically inactive compo-*  
2           *nents; and*

3                   “(B) *there are no clinically meaningful dif-*  
4           *ferences between the biological product and the*  
5           *reference product in terms of the safety, purity,*  
6           *and potency of the product.*

7                   “(3) *The term ‘interchangeable’ or ‘interchange-*  
8           *ability’, in reference to a biological product that is*  
9           *shown to meet the standards described in subsection*  
10          *(k)(4), means that the biological product may be sub-*  
11          *stituted for the reference product without the interven-*  
12          *tion of the health care provider who prescribed the*  
13          *reference product.*

14                   “(4) *The term ‘reference product’ means the sin-*  
15          *gle biological product licensed under subsection (a)*  
16          *against which a biological product is evaluated in an*  
17          *application submitted under subsection (k).”.*

18          (c) *PRODUCTS PREVIOUSLY APPROVED UNDER SEC-*  
19          *TION 505.—*

20                   (1) *REQUIREMENT TO FOLLOW SECTION 351.—*  
21          *Except as provided in paragraph (2), an application*  
22          *for a biological product shall be submitted under sec-*  
23          *tion 351 of the Public Health Service Act (42 U.S.C.*  
24          *262) (as amended by this Act).*

1           (2) *EXCEPTION.*—*An application for a biological*  
2 *product may be submitted under section 505 of the*  
3 *Federal Food, Drug, and Cosmetic Act (21 U.S.C.*  
4 *355) if—*

5                   (A) *such biological product is in a product*  
6 *class for which a biological product in such*  
7 *product class is the subject of an application ap-*  
8 *proved under such section 505 not later than the*  
9 *date of enactment of this Act; and*

10                   (B) *such application—*

11                           (i) *has been submitted to the Secretary*  
12 *of Health and Human Services (referred to*  
13 *in this Act as the “Secretary”) before the*  
14 *date of enactment of this Act; or*

15                           (ii) *is submitted to the Secretary not*  
16 *later than the date that is 10 years after the*  
17 *date of enactment of this Act.*

18           (3) *LIMITATION.*—*Notwithstanding paragraph*  
19 *(2), an application for a biological product may not*  
20 *be submitted under section 505 of the Federal Food,*  
21 *Drug, and Cosmetic Act (21 U.S.C. 355) if there is*  
22 *another biological product approved under subsection*  
23 *(a) of section 351 of the Public Health Service Act*  
24 *that could be a reference product with respect to such*  
25 *application (within the meaning of such section 351)*

1 *if such application were submitted under subsection*  
2 *(k) of such section 351.*

3 (4) *DEEMED APPROVED UNDER SECTION 351.—*  
4 *An approved application for a biological product*  
5 *under section 505 of the Federal Food, Drug, and*  
6 *Cosmetic Act (21 U.S.C. 355) shall be deemed to be*  
7 *a license for the biological product under such section*  
8 *351 on the date that is 10 years after the date of en-*  
9 *actment of this Act.*

10 (5) *DEFINITIONS.—For purposes of this sub-*  
11 *section, the term “biological product” has the mean-*  
12 *ing given such term under section 351 of the Public*  
13 *Health Service Act (42 U.S.C. 262) (as amended by*  
14 *this Act).*

15 **SEC. 2566. FEES RELATING TO BIOSIMILAR BIOLOGICAL**  
16 **PRODUCTS.**

17 *Subparagraph (B) of section 735(1) of the Federal*  
18 *Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is*  
19 *amended by inserting “, including licensure of a biological*  
20 *product under section 351(k) of such Act” before the period*  
21 *at the end.*



1           ***Subtitle D—Community Living***  
2           ***Assistance Services and Supports***

3   ***SEC. 2571. ESTABLISHMENT OF NATIONAL VOLUNTARY IN-***  
4                           ***SURANCE PROGRAM FOR PURCHASING COM-***  
5                           ***MUNITY LIVING ASSISTANCE SERVICES AND***  
6                           ***SUPPORTS.***

7           *(a) IN GENERAL.—The Public Health Service Act (42*  
8           *U.S.C. 201 et seq.), as amended, is amended by adding at*  
9           *the end the following:*

10           ***“TITLE XXXII—COMMUNITY LIV-***  
11                           ***ING ASSISTANCE SERVICES***  
12                           ***AND SUPPORTS***

13           ***“SEC. 3201. IN GENERAL.***

14           *“The Secretary shall establish a national voluntary in-*  
15           *surance program to be known as the CLASS Independence*  
16           *Benefit Plan for purchasing community living assistance*  
17           *services and supports. Such program shall—*

18                           *“(1) provide individuals who have functional*  
19                           *limitations with tools that will allow them—*

20   *“(A) to maintain their personal and finan-*  
21   *cial independence; and*

22   *“(B) to live in the community through a*  
23   *new financing strategy for community living as-*  
24   *sistance services and supports;*

1           “(2) establish an infrastructure that will help  
2 address the Nation’s community living assistance  
3 services and supports needs;

4           “(3) alleviate burdens on family caregivers; and

5           “(4) address institutional bias by providing a fi-  
6 nancing mechanism that supports personal choice and  
7 independence to live in the community.

8 **“SEC. 3202. DEVELOPMENT AND MANAGEMENT OF PRO-**  
9 **GRAM.**

10           *“The Secretary shall develop the CLASS Independence*  
11 *Benefit Plan in an actuarially sound manner and—*

12           “(1) set criteria for participation in the CLASS  
13 Independence Benefit Plan that do not restrict eligi-  
14 bility based on underwriting;

15           “(2) establish criteria for eligibility for benefits;

16           “(3) establish benefit levels;

17           “(4) establish mechanisms for collecting and dis-  
18 tributing payments;

19           “(5) provide mechanisms to assist beneficiaries  
20 in the use of benefits;

21           “(6) promulgate such regulations as are nec-  
22 essary to carry out the CLASS program in accord-  
23 ance with this title; and

24           “(7) take any other action appropriate to de-  
25 velop, manage, and maintain the CLASS Independ-

1        *ence Benefit Plan, including making adjustments to*  
 2        *benefits paid out and premiums collected in order*  
 3        *to—*

4                    *“(A) maintain program solvency; and*

5                    *“(B) ensure the program remains deficit*  
 6        *neutral.*

7        **“SEC. 3203. REPORT.**

8                    *“The Secretary shall submit to the Congress an annual*  
 9        *report on the program under this title.”.*

10        *(b) EFFECTIVE DATE.—Title XXXII of the Public*  
 11        *Health Service Act, as added by subsection (a), shall take*  
 12        *effect on the effective date of a statute establishing a vol-*  
 13        *untary payroll deduction under the Internal Revenue Code*  
 14        *of 1986 to support the program authorized by such title.*

15                    ***Subtitle E—Miscellaneous***

16        **SEC. 2581. STATES FAILING TO ADHERE TO CERTAIN EM-**  
 17                    **PLOYMENT OBLIGATIONS.**

18                    *A State is eligible for Federal funds under the provi-*  
 19        *sions of the Public Health Service Act (42 U.S.C. 201 et*  
 20        *seq.) only if the State—*

21                    *(1) agrees to be subject in its capacity as an em-*  
 22        *ployer to each obligation under division A of this Act*  
 23        *and the amendments made by such division applica-*  
 24        *ble to persons in their capacity as an employer; and*

1           (2) assures that all political subdivisions in the  
2           State will do the same.

3 **SEC. 2582. STUDY, REPORT, AND TERMINATION OF DUPLI-**  
4 **CATIVE GRANT PROGRAMS.**

5           (a) *STUDY.*—The Secretary of Health and Human  
6 Services (in this section referred to as the “Secretary”) shall  
7 conduct a study to determine if any grant program estab-  
8 lished by this division, or any amendment made by this  
9 division, is duplicative of one or more other Federal grant  
10 programs under the authority of the Secretary in existence  
11 as of the date of the enactment of this Act.

12           (b) *REPORT.*—Not later than 1 year after the date of  
13 the enactment of this Act, the Secretary shall submit to Con-  
14 gress and make available to the public a report that con-  
15 tains the results of the study required under subsection (a).

16           (c) *TERMINATION OF DUPLICATIVE GRANT PRO-*  
17 *GRAMS.*—If the Secretary determines under subsection (a)  
18 that any grant program established by this division, or any  
19 amendment made by this division, is duplicative of one or  
20 more other Federal grant programs under the authority of  
21 the Secretary, the Secretary shall, to maximum extent ap-  
22 propriate, terminate such other Federal grant programs not  
23 later than 180 days after the date of the submission of the  
24 report under subsection (b).

1 **SEC. 2583. HEALTH CENTERS UNDER PUBLIC HEALTH SERV-**  
2 **ICE ACT; LIABILITY PROTECTIONS FOR VOL-**  
3 **UNTEER PRACTITIONERS.**

4 (a) *IN GENERAL.*—Section 224 (42 U.S.C. 233) is  
5 amended—

6 (1) *in subsection (g)(1)(A)—*

7 (A) *in the first sentence, by striking “or em-*  
8 *ployee” and inserting “employee, or (subject to*  
9 *subsection (k)(4)) volunteer practitioner”; and*

10 (B) *in the second sentence, by inserting*  
11 *“and subsection (k)(4)” after “subject to para-*  
12 *graph (5)”;* and

13 (2) *in each of subsections (g), (i), (j), (l), and*  
14 *(m), by striking the term “employee, or contractor”*  
15 *each place such term appears and inserting “em-*  
16 *ployee, volunteer practitioner, or contractor”;*

17 (3) *in subsection (g)(1)(H), by striking the term*  
18 *“employee, and contractor” each place such term ap-*  
19 *pears and inserting “employee, volunteer practitioner,*  
20 *and contractor”;*

21 (4) *in subsection (l), by striking the term “em-*  
22 *ployee, or any contractor” and inserting “employee,*  
23 *volunteer practitioner, or contractor”;* and

24 (5) *in subsections (h)(3) and (k), by striking the*  
25 *term “employees, or contractors” each place such term*

1        *appears and inserting “employees, volunteer practi-*  
2        *tioners, or contractors”.*

3        *(b) APPLICABILITY; DEFINITION.—Section 224(k) (42*  
4        *U.S.C. 233(k)) is amended by adding at the end the fol-*  
5        *lowing paragraph:*

6            *“(4)(A) Subsections (g) through (m) apply with respect*  
7        *to volunteer practitioners beginning with the first fiscal*  
8        *year for which an appropriations Act provides that*  
9        *amounts in the fund under paragraph (2) are available*  
10       *with respect to such practitioners.*

11           *“(B) For purposes of subsections (g) through (m), the*  
12       *term ‘volunteer practitioner’ means a practitioner who,*  
13       *with respect to an entity described in subsection (g)(4),*  
14       *meets the following conditions:*

15            *“(i) The practitioner is a licensed physician, a*  
16       *licensed clinical psychologist, or other licensed or cer-*  
17       *tified health care practitioner.*

18            *“(ii) At the request of such entity, the practi-*  
19       *tioner provides services to patients of the entity, at a*  
20       *site at which the entity operates or at a site des-*  
21       *ignated by the entity. The weekly number of hours of*  
22       *services provided to the patients by the practitioner is*  
23       *not a factor with respect to meeting conditions under*  
24       *this subparagraph.*

1           “(iii) The practitioner does not for the provision  
2           of such services receive any compensation from such  
3           patients, from the entity, or from third-party payors  
4           (including reimbursement under any insurance policy  
5           or health plan, or under any Federal or State health  
6           benefits program).”.

7   **SEC. 2584. REPORT TO CONGRESS ON THE CURRENT STATE**  
8                   **OF PARASITIC DISEASES THAT HAVE BEEN**  
9                   **OVERLOOKED AMONG THE POOREST AMERI-**  
10                  **CANS.**

11           *Not later than 12 months after the date of the enact-*  
12           *ment of this Act, the Secretary of Health and Human Serv-*  
13           *ices shall report to Congress on the epidemiology of, impact*  
14           *of, and appropriate funding required to address neglected*  
15           *diseases of poverty, including neglected parasitic diseases*  
16           *identified as Chagas Disease, cysticercosis, toxocariasis, tox-*  
17           *oplasmosis, trichomoniasis, the soil-transmitted helminths,*  
18           *and others. The report should provide the information nec-*  
19           *essary to enhance health policy to accurately evaluate and*  
20           *address the threat of these diseases.*

1 **SEC. 2585. STUDY OF IMPACT OF OPTOMETRISTS ON AC-**  
2 **CESS TO HEALTH CARE AND ON AVAIL-**  
3 **ABILITY OF SUPPORT UNDER FEDERAL**  
4 **HEALTH PROGRAMS FOR OPTOMETRY.**

5 (a) *IN GENERAL.*—*The Secretary of Health and*  
6 *Human Services (in this section referred to as the “Sec-*  
7 *retary”)* shall conduct a study with respect to optometrists  
8 *and optometry to determine—*

9 (1) *whether there is a current and projected role*  
10 *for, and the impact of, optometrists in increasing ac-*  
11 *cess to primary eye and vision care to underserved,*  
12 *rural, and senior populations;*

13 (2) *the role and impact of optometrists in the*  
14 *early diagnosis and treatment of glaucoma, cataract,*  
15 *diabetes, and other conditions;*

16 (3) *whether there is a need for optometrists to be*  
17 *recognized and supported as primary care providers;*

18 (4) *whether there is an existence of, and the ex-*  
19 *tent of, any barriers to recruitment and participation*  
20 *of underrepresented minorities in optometry, includ-*  
21 *ing the potential role played by the lack of eligibility*  
22 *of optometrists, optometry students, and facilities for*  
23 *certain Federal health programs; and*

24 (5) *the scope of Federal support for clinical opto-*  
25 *metric education and options for enhancing that sup-*  
26 *port—*



1           (A) to address barriers to underrepresented  
2           minority recruitment and participation in op-  
3           tometry; and

4           (B) to improve access to primary eye and  
5           vision care, especially in underserved and rural  
6           areas.

7           (b) COMMENT ON MATTERS STUDIED.—In carrying  
8           out the study under subsection (a), the Secretary shall seek  
9           the comments of appropriate public and private entities.

10          (c) REPORT TO CONGRESS.—Not later than 18 months  
11          after the date of the enactment of this Act, the Secretary  
12          shall submit to the Congress a report containing—

13                 (1) the results of the study under subsection (a);

14                 (2) a summary of comments received from public  
15                 and private entities under subsection (b); and

16                 (3) recommendations for such legislation and ad-  
17                 ministrative action as the Secretary determines to be  
18                 appropriate regarding the issues studied under sub-  
19                 section (a).

20   **SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES,**  
21                 **AND SUBTITLES.**

22           **(a) SHORT TITLE.—This Act may be cited as**  
23           **the “America’s Affordable Health Choices Act**  
24           **of 2009”.**

- 1           **(b) TABLE OF DIVISIONS, TITLES, AND SUB-**  
 2 **TITLES.—This Act is divided into divisions, ti-**  
 3 **les, and 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

Subtitle G—Early Investments

**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 carry out health insurance exchange subsidies

Subtitle D—Other revenue provisions

**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 Provision  
Subtitle E—Public Reporting on Health Care-Associated Infections

**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, Waste, and Abuse

**TITLE VII—MEDICAID AND CHIP**

Subtitle A—Medicaid and Health Reform

Subtitle B—Prevention

Subtitle C—Access

Subtitle D—Coverage

Subtitle E—Financing

Subtitle F—Waste, Fraud, and Abuse

Subtitle G—Puerto Rico and the Territories

Subtitle H—Miscellaneous

**TITLE VIII—REVENUE-RELATED PROVISIONS**

**TITLE IX—MISCELLANEOUS PROVISIONS**

**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**

Subtitle A—Drug discount for rural and other hospitals

Subtitle B—School-Based health clinics

Subtitle C—National medical device registry

Subtitle D—Grants for comprehensive programs To provide education to nurses and create a pipeline to nursing

Subtitle E—States failing To adhere to certain employment obligations

1           **DIVISION A—AFFORDABLE**  
2           **HEALTH CARE CHOICES**

3   **SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION;**  
4           **GENERAL DEFINITIONS.**

5           **(a) PURPOSE.—**

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

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

10          **(3) INSURANCE REFORMS.—This divi-**  
11          **sion—**

12               **(A) enacts strong insurance mar-**  
13               **ket reforms;**

14               **(B) creates a new Health Insur-**  
15               **ance Exchange, with a public health**  
16               **insurance option alongside private**  
17               **plans;**

18               **(C) includes sliding scale afford-**  
19               **ability credits; and**

20               **(D) initiates shared responsibility**  
21               **among workers, employers, and the**  
22               **government;**

23           **so that all Americans have coverage of es-**  
24           **sential health benefits.**

1           **(4) HEALTH DELIVERY REFORM.—This**  
 2           **division institutes health delivery system**  
 3           **reforms both to increase quality and to**  
 4           **reduce growth in health spending so that**  
 5           **health care becomes more affordable for**  
 6           **businesses, families, and government.**

7           **(b) TABLE OF CONTENTS OF DIVISION.—The**  
 8           **table 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; parity in mental health and substance abuse disorder benefits.

Sec. 115. Ensuring adequacy of provider networks.

Sec. 116. Ensuring value and lower premiums.

**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 standards.

**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.
- Sec. 137. Application of administrative simplification.

#### 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.
- Sec. 153. Whistleblower protection.
- Sec. 154. Construction regarding collective bargaining.
- Sec. 155. Severability.

#### Subtitle G—Early Investments

- Sec. 161. Ensuring value and lower premiums.
- Sec. 162. Ending health insurance rescission abuse.
- Sec. 163. Administrative simplification.
- Sec. 164. Reinsurance program for retirees.

### 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 Carry Out Health Insurance Exchange Subsidies**

**Sec. 431. Disclosures to carry out health insurance exchange subsidies.**

**Subtitle D—Other Revenue Provisions**

**PART 1—GENERAL PROVISIONS**

**Sec. 441. Surcharge on high income individuals.**

**Sec. 442. Distributions for medicine qualified only if for prescribed drug or insulin.**

**Sec. 443. Delay in application of worldwide allocation of interest.**

**PART 2—PREVENTION OF TAX AVOIDANCE**

**Sec. 451. Limitation on treaty benefits for certain deductible payments.**

**Sec. 452. Codification of economic substance doctrine.**

**Sec. 453. Penalties for underpayments.**

**PART 3—PARITY IN HEALTH BENEFITS**

**Sec. 461. Certain health related benefits applicable to spouses and dependents extended to eligible beneficiaries.**

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

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

5               **(2) BASIC PLAN.—The term “basic**  
6               **plan” has the meaning given such term in**  
7               **section 203(c).**

8               **(3) COMMISSIONER.—The term “Com-**  
9               **missioner” means the Health Choices**  
10              **Commissioner established under section**  
11              **141.**  
12



1           **(4) COST-SHARING.—**The term “cost-  
2           **sharing”** includes deductibles, coinsur-  
3           **ance, copayments, and similar charges**  
4           **but does not include premiums or any**  
5           **network payment differential for covered**  
6           **services or spending for non-covered**  
7           **services.**

8           **(5) DEPENDENT.—**The term “depend-  
9           **ent”** has the meaning given such term by  
10          **the Commissioner and includes a spouse.**

11          **(6) EMPLOYMENT-BASED HEALTH PLAN.—**  
12          **The term “employment-based health**  
13          **plan”—**

14               **(A) means a group health plan (as**  
15               **defined in section 733(a)(1) of the Em-**  
16               **ployee Retirement Income Security**  
17               **Act of 1974); and**

18               **(B) includes such a plan that is**  
19               **the following:**

20                       **(i) FEDERAL, STATE, AND TRIBAL**  
21                       **GOVERNMENTAL PLANS.—**A govern-  
22                       **mental plan (as defined in section**  
23                       **3(32) of the Employee Retirement**  
24                       **Income Security Act of 1974), in-**  
25                       **cluding a health benefits plan of-**

1           **ferred under chapter 89 of title 5,**  
2           **United States Code.**

3           **(ii) CHURCH PLANS.—A church**  
4           **plan (as defined in section 3(33) of**  
5           **the Employee Retirement Income**  
6           **Security Act of 1974).**

7           **(7) ENHANCED PLAN.—The term “en-**  
8           **hanced plan” has the meaning given such**  
9           **term in section 203(c).**

10          **(8) ESSENTIAL BENEFITS PACKAGE.—The**  
11          **term “essential benefits package” is de-**  
12          **fin ed in section 122(a).**

13          **(9) FAMILY.—The term “family” means**  
14          **an individual and includes the individ-**  
15          **ual’s dependents.**

16          **(10) FEDERAL POVERTY LEVEL; FPL.—**  
17          **The terms “Federal poverty level” and**  
18          **“FPL” have the meaning given the term**  
19          **“poverty line” in section 673(2) of the**  
20          **Community Services Block Grant Act (42**  
21          **U.S.C. 9902(2)), including any revision re-**  
22          **quired by such section.**

23          **(11) HEALTH BENEFITS PLAN.—The**  
24          **terms “health benefits plan” means**  
25          **health insurance coverage and an em-**

1        **ployment-based health plan and includes**  
2        **the public health insurance option.**

3            **(12) HEALTH INSURANCE COVERAGE;**  
4        **HEALTH INSURANCE ISSUER.—The terms**  
5        **“health insurance coverage” and “health**  
6        **insurance issuer” have the meanings**  
7        **given such terms in section 2791 of the**  
8        **Public Health Service Act.**

9            **(13) HEALTH INSURANCE EXCHANGE.—**  
10       **The term “Health Insurance Exchange”**  
11       **means the Health Insurance Exchange es-**  
12       **tablished under section 201.**

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

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

22           **(16) PLAN SPONSOR.—The term “plan**  
23       **sponsor” has the meaning given such**  
24       **term in section 3(16)(B) of the Employee**  
25       **Retirement Income Security Act of 1974.**

1           **(17) PLAN YEAR.—The term “plan year”**  
2           **means—**

3                   **(A) with respect to an employ-**  
4                   **ment-based health plan, a plan year**  
5                   **as specified under such plan; or**

6                   **(B) with respect to a health bene-**  
7                   **fits plan other than an employment-**  
8                   **based health plan, a 12-month period**  
9                   **as specified by the Commissioner.**

10           **(18) PREMIUM PLAN; PREMIUM-PLUS**  
11           **PLAN.—The terms “premium plan” and**  
12           **“premium-plus plan” have the meanings**  
13           **given such terms in section 203(c).**

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

18                   **(A) a group health plan (as de-**  
19                   **finied, subject to subsection (d), in**  
20                   **section 733(a)(1) of the Employee Re-**  
21                   **tirement Income Security Act of**  
22                   **1974), the plan sponsor in relation to**  
23                   **such group health plan, except that,**  
24                   **in the case of a plan maintained joint-**  
25                   **ly by 1 or more employers and 1 or**

1 more employee organizations and  
2 with respect to which an employer is  
3 the primary source of financing, such  
4 term means such employer;

5 (B) health insurance coverage,  
6 the health insurance issuer offering  
7 the coverage;

8 (C) the public health insurance  
9 option, the Secretary of Health and  
10 Human Services;

11 (D) a non-Federal governmental  
12 plan (as defined in section 2791(d) of  
13 the Public Health Service Act), the  
14 State or political subdivision of a  
15 State (or agency or instrumentality of  
16 such State or subdivision) which es-  
17 tablishes or maintains such plan; or

18 (E) a Federal governmental plan  
19 (as defined in section 2791(d) of the  
20 Public Health Service Act), the appro-  
21 priate Federal official.

22 (20) **QUALIFIED HEALTH BENEFITS**  
23 **PLAN.**—The term “qualified health bene-  
24 fits plan” means a health benefits plan  
25 that meets the requirements for such a

1       **plan under title I and includes the public**  
2       **health insurance option.**

3           **(21) PUBLIC HEALTH INSURANCE OP-**  
4       **TION.—The term “public health insurance**  
5       **option” means the public health insur-**  
6       **ance option as provided under subtitle B**  
7       **of title II.**

8           **(22) SERVICE AREA; PREMIUM RATING**  
9       **AREA.—The terms “service area” and “pre-**  
10       **mium rating area” mean with respect to**  
11       **health insurance coverage—**

12           **(A) offered other than through**  
13       **the Health Insurance Exchange, such**  
14       **an area as established by the QHBP**  
15       **offering entity of such coverage in ac-**  
16       **cordance with applicable State law;**  
17       **and**

18           **(B) offered through the Health In-**  
19       **surance Exchange, such an area as**  
20       **established by such entity in accord-**  
21       **ance with applicable State law and**  
22       **applicable rules of the Commissioner**  
23       **for Exchange-participating health**  
24       **benefits plans.**

1           **(23) STATE.**—The term “State” means  
2           the 50 States and the District of Colum-  
3           bia.

4           **(24) STATE MEDICAID AGENCY.**—The  
5           term “State Medicaid agency” means,  
6           with respect to a Medicaid plan, the sin-  
7           gle State agency responsible for admin-  
8           istering such plan under title XIX of the  
9           Social Security Act.

10           **(25) Y1, Y2, ETC..**—The terms “Y1” ,  
11           “Y2”, “Y3”, “Y4”, “Y5”, and similar subse-  
12           quently numbered terms, mean 2013 and  
13           subsequent years, respectively.

14           **TITLE I—PROTECTIONS AND**  
15           **STANDARDS FOR QUALIFIED**  
16           **HEALTH BENEFITS PLANS**  
17           **Subtitle A—General Standards**

18           **SEC. 101. REQUIREMENTS REFORMING HEALTH INSUR-**  
19           **ANCE MARKETPLACE.**

20           **(a) PURPOSE.**—The purpose of this title is  
21           to establish standards to ensure that new  
22           health insurance coverage and employment-  
23           based health plans that are offered meet  
24           standards guaranteeing access to affordable

1 coverage, essential benefits, and other con-  
2 sumer protections.

3       **(b) REQUIREMENTS FOR QUALIFIED HEALTH**  
4 **BENEFITS PLANS.—**On or after the first day of  
5 Y1, a health benefits plan shall not be a quali-  
6 fied health benefits plan under this division  
7 unless the plan meets the applicable require-  
8 ments of the following subtitles for the type  
9 of plan and plan year involved:

10           (1) Subtitle B (relating to affordable  
11 coverage).

12           (2) Subtitle C (relating to essential  
13 benefits).

14           (3) Subtitle D (relating to consumer  
15 protection).

16       **(c) TERMINOLOGY.—**In this division:

17           (1) **ENROLLMENT IN EMPLOYMENT-BASED**  
18 **HEALTH PLANS.—**An individual shall be  
19 treated as being “enrolled” in an employ-  
20 ment-based health plan if the individual  
21 is a participant or beneficiary (as such  
22 terms are defined in section 3(7) and 3(8),  
23 respectively, of the Employee Retirement  
24 Income Security Act of 1974) in such  
25 plan.



1           **(2) INDIVIDUAL AND GROUP HEALTH IN-**  
2           **SURANCE COVERAGE.—The terms “indi-**  
3           **vidual health insurance coverage” and**  
4           **“group health insurance coverage” mean**  
5           **health insurance coverage offered in the**  
6           **individual market or large or small group**  
7           **market, respectively, as defined in sec-**  
8           **tion 2791 of the Public Health Service**  
9           **Act.**

10 **SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT**  
11           **COVERAGE.**

12           **(a) GRANDFATHERED HEALTH INSURANCE**  
13           **COVERAGE DEFINED.—Subject to the suc-**  
14           **ceeding provisions of this section, for pur-**  
15           **poses of establishing acceptable coverage**  
16           **under this division, the term “grandfathered**  
17           **health insurance coverage” means individual**  
18           **health insurance coverage that is offered and**  
19           **in force and effect before the first day of Y1**  
20           **if the following conditions are met:**

21           **(1) LIMITATION ON NEW ENROLLMENT.—**

22           **(A) IN GENERAL.—Except as pro-**  
23           **vided in this paragraph, the indi-**  
24           **vidual health insurance issuer offer-**  
25           **ing such coverage does not enroll any**

1 individual in such coverage if the  
2 first effective date of coverage is on  
3 or after the first day of Y1.

4 (B) DEPENDENT COVERAGE PER-  
5 MITTED.—Subparagraph (A) shall not  
6 affect the subsequent enrollment of a  
7 dependent of an individual who is  
8 covered as of such first day.

9 (2) LIMITATION ON CHANGES IN TERMS  
10 OR CONDITIONS.—Subject to paragraph (3)  
11 and except as required by law, the issuer  
12 does not change any of its terms or condi-  
13 tions, including benefits and cost-sharing,  
14 from those in effect as of the day before  
15 the first day of Y1.

16 (3) RESTRICTIONS ON PREMIUM IN-  
17 CREASES.—The issuer cannot vary the per-  
18 centage increase in the premium for a  
19 risk group of enrollees in specific grand-  
20 fathered health insurance coverage with-  
21 out changing the premium for all enroll-  
22 ees in the same risk group at the same  
23 rate, as specified by the Commissioner.

24 (b) GRACE PERIOD FOR CURRENT EMPLOY-  
25 MENT-BASED HEALTH PLANS.—

1           **(1) GRACE PERIOD.—**

2           **(A) IN GENERAL.—**The Commis-  
3           **sioner shall establish a grace period**  
4           **whereby, for plan years beginning**  
5           **after the end of the 5-year period be-**  
6           **ginning with Y1, an employment-**  
7           **based health plan in operation as of**  
8           **the day before the first day of Y1**  
9           **must meet the same requirements as**  
10           **apply to a qualified health benefits**  
11           **plan under section 101, including the**  
12           **essential benefit package require-**  
13           **ment under section 121.**

14           **(B) EXCEPTION FOR LIMITED BENE-**  
15           **FITS PLANS.—**Subparagraph (A) shall  
16           **not apply to an employment-based**  
17           **health plan in which the coverage**  
18           **consists only of one or more of the**  
19           **following:**

20                   **(i) Any coverage described in**  
21                   **section 3001(a)(1)(B)(ii)(IV) of di-**  
22                   **vision B of the American Recov-**  
23                   **ery and Reinvestment Act of 2009**  
24                   **(PL 111-5).**

1           (ii) Excepted benefits (as de-  
2           fined in section 733(c) of the Em-  
3           ployee Retirement Income Secu-  
4           rity Act of 1974), including cov-  
5           erage under a specified disease or  
6           illness policy described in para-  
7           graph (3)(A) of such section.

8           (iii) Such other limited bene-  
9           fits as the Commissioner may  
10          specify.

11          In no case shall an employment-based  
12          health plan in which the coverage  
13          consists only of one or more of the  
14          coverage or benefits described in  
15          clauses (i) through (iii) be treated as  
16          acceptable coverage under this divi-  
17          sion

18          (2) TRANSITIONAL TREATMENT AS AC-  
19          CEPTABLE COVERAGE.—During the grace  
20          period specified in paragraph (1)(A), an  
21          employment-based health plan that is de-  
22          scribed in such paragraph shall be treat-  
23          ed as acceptable coverage under this di-  
24          vision.

1       **(c) LIMITATION ON INDIVIDUAL HEALTH IN-**  
2 **SURANCE COVERAGE.—**

3           **(1) IN GENERAL.—Individual health in-**  
4 **surance coverage that is not grand-**  
5 **fathered health insurance coverage**  
6 **under subsection (a) may only be offered**  
7 **on or after the first day of Y1 as an Ex-**  
8 **change-participating health benefits**  
9 **plan.**

10           **(2) SEPARATE, EXCEPTED COVERAGE PER-**  
11 **MITTED.—Excepted benefits (as defined in**  
12 **section 2791(c) of the Public Health Serv-**  
13 **ice Act) are not included within the defi-**  
14 **inition of health insurance coverage.**  
15 **Nothing in paragraph (1) shall prevent**  
16 **the offering, other than through the**  
17 **Health Insurance Exchange, of excepted**  
18 **benefits so long as it is offered and priced**  
19 **separately from health insurance cov-**  
20 **erage.**

1 **Subtitle B—Standards Guaranteing Access to Affordable Cov-**  
2 **erage**  
3

4 **SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLU-**  
5 **SIONS.**

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

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

18 **The requirements of sections 2711 (other**  
19 **than subsections (c) and (e)) and 2712 (other**  
20 **than paragraphs (3), and (6) of subsection (b)**  
21 **and subsection (e)) of the Public Health Serv-**  
22 **ice Act, relating to guaranteed availability**  
23 **and renewability of health insurance cov-**  
24 **erage, shall apply to individuals and employ-**  
25 **ers in all individual and group health insur-**

1 **ance coverage, whether offered to individuals**  
2 **or employers through the Health Insurance**  
3 **Exchange, through any employment-based**  
4 **health plan, or otherwise, in the same manner**  
5 **as such sections apply to employers and**  
6 **health insurance coverage offered in the**  
7 **small group market, except that such section**  
8 **2712(b)(1) shall apply only if, before non-**  
9 **renewal or discontinuation of coverage, the**  
10 **issuer has provided the enrollee with notice**  
11 **of non-payment of premiums and there is a**  
12 **grace period during which the enrollees has**  
13 **an opportunity to correct such nonpayment.**  
14 **Rescissions of such coverage shall be prohib-**  
15 **ited except in cases of fraud as defined in sec-**  
16 **tions 2712(b)(2) of such Act.**

17 **SEC. 113. INSURANCE RATING RULES.**

18 **(a) IN GENERAL.—The premium rate**  
19 **charged for an insured qualified health bene-**  
20 **fits plan may not vary except as follows:**

21 **(1) LIMITED AGE VARIATION PER-**  
22 **MITTED.—By age (within such age cat-**  
23 **egories as the Commissioner shall speci-**  
24 **fy) so long as the ratio of the highest**

1 such premium to the lowest such pre-  
2 mium does not exceed the ratio of 2 to 1.

3 (2) **BY AREA.**—By premium rating area  
4 (as permitted by State insurance regu-  
5 lators or, in the case of Exchange-partici-  
6 pating health benefits plans, as specified  
7 by the Commissioner in consultation with  
8 such regulators).

9 (3) **BY FAMILY ENROLLMENT.**—By family  
10 enrollment (such as variations within cat-  
11 egories and compositions of families) so  
12 long as the ratio of the premium for fam-  
13 ily enrollment (or enrollments) to the  
14 premium for individual enrollment is uni-  
15 form, as specified under State law and  
16 consistent with rules of the Commis-  
17 sioner.

18 (b) **STUDY AND REPORTS.**—

19 (1) **STUDY.**—The Commissioner, in co-  
20 ordination with the Secretary of Health  
21 and Human Services and the Secretary of  
22 Labor, shall conduct a study of the large  
23 group insured and self-insured employer  
24 health care markets. Such study shall ex-  
25 amine the following:



1           **(A) The types of employers by key**  
2           **characteristics, including size, that**  
3           **purchase insured products versus**  
4           **those that self-insure.**

5           **(B) The similarities and dif-**  
6           **ferences between typical insured and**  
7           **self-insured health plans.**

8           **(C) The financial solvency and**  
9           **capital reserve levels of employers**  
10          **that self-insure by employer size.**

11          **(D) The risk of self-insured em-**  
12          **ployers not being able to pay obliga-**  
13          **tions or otherwise becoming finan-**  
14          **cially insolvent.**

15          **(E) The extent to which rating**  
16          **rules are likely to cause adverse se-**  
17          **lection in the large group market or**  
18          **to encourage small and mid size em-**  
19          **ployers to self-insure**

20          **(2) REPORTS.—Not later than 18**  
21          **months after the date of the enactment of**  
22          **this Act, the Commissioner shall submit**  
23          **to Congress and the applicable agencies a**  
24          **report on the study conducted under**  
25          **paragraph (1). Such report shall include**

1       **any recommendations the Commissioner**  
2       **deems appropriate to ensure that the law**  
3       **does not provide incentives for small and**  
4       **mid-size employers to self-insure or cre-**  
5       **ate adverse selection in the risk pools of**  
6       **large group insurers and self-insured em-**  
7       **ployers. Not later than 18 months after**  
8       **the first day of Y1, the Commissioner**  
9       **shall submit to Congress and the applica-**  
10      **ble agencies an updated report on such**  
11      **study, including updates on such rec-**  
12      **ommendations.**

13      **SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN**  
14                      **MENTAL HEALTH AND SUBSTANCE ABUSE**  
15                      **DISORDER BENEFITS.**

16      **(a) NONDISCRIMINATION IN BENEFITS.—A**  
17      **qualified health benefits plan shall comply**  
18      **with standards established by the Commis-**  
19      **sioner to prohibit discrimination in health**  
20      **benefits or benefit structures for qualifying**  
21      **health benefits plans, building from sections**  
22      **702 of Employee Retirement Income Security**  
23      **Act of 1974, 2702 of the Public Health Service**  
24      **Act, and section 9802 of the Internal Revenue**  
25      **Code of 1986.**

1       **(b) PARITY IN MENTAL HEALTH AND SUB-**  
2 **STANCE ABUSE DISORDER BENEFITS.—To the ex-**  
3 **tent such provisions are not superceded by or**  
4 **inconsistent with subtitle C, the provisions of**  
5 **section 2705 (other than subsections (a)(1),**  
6 **(a)(2), and (c)) of section 2705 of the Public**  
7 **Health Service Act shall apply to a qualified**  
8 **health benefits plan, regardless of whether it**  
9 **is offered in the individual or group market,**  
10 **in the same manner as such provisions apply**  
11 **to health insurance coverage offered in the**  
12 **large group market.**

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

14       **(a) IN GENERAL.—A qualified health bene-**  
15 **fits plan that uses a provider network for**  
16 **items and services shall meet such standards**  
17 **respecting provider networks as the Commis-**  
18 **sioner may establish to assure the adequacy**  
19 **of such networks in ensuring enrollee access**  
20 **to such items and services and transparency**  
21 **in the cost-sharing differentials between in-**  
22 **network coverage and out-of-network cov-**  
23 **erage.**

24       **(b) PROVIDER NETWORK DEFINED.—In this**  
25 **division, the term “provider network” means**

1 the providers with respect to which covered  
2 benefits, treatments, and services are avail-  
3 able under a health benefits plan.

4 SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.

5 (a) IN GENERAL.—A qualified health bene-  
6 fits plan shall meet a medical loss ratio as de-  
7 fined by the Commissioner. For any plan year  
8 in which the qualified health benefits plan  
9 does not meet such medical loss ratio, QHBP  
10 offering entity shall provide in a manner  
11 specified by the Commissioner for rebates to  
12 enrollees of payment sufficient to meet such  
13 loss ratio.

14 (b) BUILDING ON INTERIM RULES.—In imple-  
15 menting subsection (a), the Commissioner  
16 shall build on the definition and methodology  
17 developed by the Secretary of Health and  
18 Human Services under the amendments made  
19 by section 161 for determining how to cal-  
20 culate the medical loss ratio. Such method-  
21 ology shall be set at the highest level medical  
22 loss ratio possible that is designed to ensure  
23 adequate participation by QHBP offering en-  
24 tities, competition in the health insurance  
25 market in and out of the Health Insurance Ex-

1 **change, and value for consumers so that their**  
2 **premiums are used for services.**

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

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

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

13 **(b) CHOICE OF COVERAGE.—**

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

22 **(2) EXCHANGE-PARTICIPATING HEALTH**  
23 **BENEFITS PLANS.—In the case of an Ex-**  
24 **change-participating health benefits**  
25 **plan, such plan is required under section**

1       **203 to provide specified levels of benefits**  
2       **and, in the case of a plan offering a pre-**  
3       **mium-plus level of benefits, provide addi-**  
4       **tional benefits.**

5           **(3) CONTINUATION OF OFFERING OF SEP-**  
6       **ARATE EXCEPTED BENEFITS COVERAGE.—**  
7       **Nothing in this division shall be con-**  
8       **strued as affecting the offering of health**  
9       **benefits in the form of excepted benefits**  
10       **(described in section 102(b)(1)(B)(ii)) if**  
11       **such benefits are offered under a sepa-**  
12       **rate policy, contract, or certificate of in-**  
13       **surance.**

14       **(c) NO RESTRICTIONS ON COVERAGE UNRE-**  
15       **LATED TO CLINICAL APPROPRIATENESS.—A quali-**  
16       **fied health benefits plan may not impose any**  
17       **restriction (other than cost-sharing) unre-**  
18       **lated to clinical appropriateness on the cov-**  
19       **erage of the health care items and services.**

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

21       **(a) IN GENERAL.—In this division, the term**  
22       **“essential benefits package” means health**  
23       **benefits coverage, consistent with standards**  
24       **adopted under section 124 to ensure the pro-**

1 **vision of quality health care and financial se-**  
2 **curity, that—**

3           **(1) provides payment for the items**  
4           **and services described in subsection (b)**  
5           **in accordance with generally accepted**  
6           **standards of medical or other appro-**  
7           **priate clinical or professional practice;**

8           **(2) limits cost-sharing for such cov-**  
9           **ered health care items and services in ac-**  
10          **cordance with such benefit standards,**  
11          **consistent with subsection (c);**

12          **(3) does not impose any annual or**  
13          **lifetime limit on the coverage of covered**  
14          **health care items and services;**

15          **(4) complies with section 115(a) (relat-**  
16          **ing to network adequacy); and**

17          **(5) is equivalent, as certified by Office**  
18          **of the Actuary of the Centers for Medi-**  
19          **care & Medicaid Services, to the average**  
20          **prevailing employer-sponsored coverage.**

21          **(b) MINIMUM SERVICES TO BE COVERED.—**

22          **The items and services described in this sub-**  
23          **section are the following:**

24                 **(1) Hospitalization.**

1           **(2) Outpatient hospital and out-**  
2           **patient clinic services, including emer-**  
3           **gency department services.**

4           **(3) Professional services of physicians**  
5           **and other health professionals.**

6           **(4) Such services, equipment, and**  
7           **supplies incident to the services of a phy-**  
8           **sician's or a health professional's delivery**  
9           **of care in institutional settings, physician**  
10           **offices, patients' homes or place of resi-**  
11           **dence, or other settings, as appropriate.**

12           **(5) Prescription drugs.**

13           **(6) Rehabilitative and habilitative**  
14           **services.**

15           **(7) Mental health and substance use**  
16           **disorder services.**

17           **(8) Preventive services, including**  
18           **those services recommended with a grade**  
19           **of A or B by the Task Force on Clinical**  
20           **Preventive Services and those vaccines**  
21           **recommended for use by the Director of**  
22           **the Centers for Disease Control and Pre-**  
23           **vention.**

24           **(9) Maternity care.**



1           **(10) Well baby and well child care and**  
2           **oral health, vision, and hearing services,**  
3           **equipment, and supplies at least for chil-**  
4           **dren under 21 years of age.**

5           **(c) REQUIREMENTS RELATING TO COST-SHAR-**  
6           **ING AND MINIMUM ACTUARIAL VALUE.—**

7           **(1) NO COST-SHARING FOR PREVENTIVE**  
8           **SERVICES.—There shall be no cost-sharing**  
9           **under the essential benefits package for**  
10          **preventive items and services (as speci-**  
11          **fied under the benefit standards), includ-**  
12          **ing well baby and well child care.**

13          **(2) ANNUAL LIMITATION.—**

14               **(A) ANNUAL LIMITATION.—The cost-**  
15               **sharing incurred under the essential**  
16               **benefits package with respect to an**  
17               **individual (or family) for a year does**  
18               **not exceed the applicable level speci-**  
19               **fied in subparagraph (B).**

20               **(B) APPLICABLE LEVEL.—The appli-**  
21               **cable level specified in this subpara-**  
22               **graph for Y1 is \$5,000 for an indi-**  
23               **vidual and \$10,000 for a family. Such**  
24               **levels shall be increased (rounded to**  
25               **the nearest \$100) for each subsequent**

1 year by the annual percentage in-  
2 crease in the Consumer Price Index  
3 (United States city average) applica-  
4 ble to such year.

5 (C) USE OF COPAYMENTS.—In estab-  
6 lishing cost-sharing levels for basic,  
7 enhanced, and premium plans under  
8 this subsection, the Secretary shall,  
9 to the maximum extent possible, use  
10 only copayments and not coinsur-  
11 ance.

12 (3) MINIMUM ACTUARIAL VALUE.—

13 (A) IN GENERAL.—The cost-sharing  
14 under the essential benefits package  
15 shall be designed to provide a level of  
16 coverage that is designed to provide  
17 benefits that are actuarially equiva-  
18 lent to approximately 70 percent of  
19 the full actuarial value of the benefits  
20 provided under the reference benefits  
21 package described in subparagraph  
22 (B).

23 (B) REFERENCE BENEFITS PACKAGE  
24 DESCRIBED.—The reference benefits  
25 package described in this subpara-

1           **graph is the essential benefits pack-**  
2           **age if there were no cost-sharing im-**  
3           **posed.**

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

5           **(a) ESTABLISHMENT.—**

6           **(1) IN GENERAL.—There is established**  
7           **a private-public advisory committee**  
8           **which shall be a panel of medical and**  
9           **other experts to be known as the Health**  
10           **Benefits Advisory Committee to rec-**  
11           **ommend covered benefits and essential,**  
12           **enhanced, and premium plans.**

13           **(2) CHAIR.—The Surgeon General**  
14           **shall be a member and the chair of the**  
15           **Health Benefits Advisory Committee.**

16           **(3) MEMBERSHIP.—The Health Benefits**  
17           **Advisory Committee shall be composed of**  
18           **the following members, in addition to the**  
19           **Surgeon General:**

20           **(A) 9 members who are not Fed-**  
21           **eral employees or officers and who**  
22           **are appointed by the President.**

23           **(B) 9 members who are not Fed-**  
24           **eral employees or officers and who**  
25           **are appointed by the Comptroller**

1           **General of the United States in a**  
2           **manner similar to the manner in**  
3           **which the Comptroller General ap-**  
4           **points members to the Medicare Pay-**  
5           **ment Advisory Commission under**  
6           **section 1805(c) of the Social Security**  
7           **Act.**

8           **(C) Such even number of mem-**  
9           **bers (not to exceed 8) who are Fed-**  
10          **eral employees and officers, as the**  
11          **President may appoint.**

12          **Such initial appointments shall be made**  
13          **not later than 60 days after the date of**  
14          **the enactment of this Act.**

15          **(4) TERMS.—Each member of the**  
16          **Health Benefits Advisory Committee shall**  
17          **serve a 3-year term on the Committee, ex-**  
18          **cept that the terms of the initial members**  
19          **shall be adjusted in order to provide for**  
20          **a staggered term of appointment for all**  
21          **such members.**

22          **(5) PARTICIPATION.—The membership**  
23          **of the Health Benefits Advisory Com-**  
24          **mittee shall at least reflect providers,**  
25          **consumer representatives, employers,**

1 labor, health insurance issuers, experts  
2 in health care financing and delivery, ex-  
3 perts in racial and ethnic disparities, ex-  
4 perts in care for those with disabilities,  
5 representatives of relevant governmental  
6 agencies. and at least one practicing phy-  
7 sician or other health professional and an  
8 expert on children’s health and shall rep-  
9 resent a balance among various sectors of  
10 the health care system so that no single  
11 sector unduly influences the rec-  
12 ommendations of such Committee.

13 **(b) DUTIES.—**

14 **(1) RECOMMENDATIONS ON BENEFIT**  
15 **STANDARDS.—**The Health Benefits Advi-  
16 sory Committee shall recommend to the  
17 Secretary of Health and Human Services  
18 (in this subtitle referred to as the “Sec-  
19 retary”) benefit standards (as defined in  
20 paragraph (4)), and periodic updates to  
21 such standards. In developing such rec-  
22 ommendations, the Committee shall take  
23 into account innovation in health care  
24 and consider how such standards could  
25 reduce health disparities.

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

6           **(3) PUBLIC INPUT.—**The Health Bene-  
7           **fits Advisory Committee shall allow for**  
8           **public input as a part of developing rec-**  
9           **ommendations under this subsection.**

10           **(4) BENEFIT STANDARDS DEFINED.—**In  
11           **this subtitle, the term “benefit standards”**  
12           **means standards respecting—**

13                   **(A) the essential benefits package**  
14                   **described in section 122, including**  
15                   **categories of covered treatments,**  
16                   **items and services within benefit**  
17                   **classes, and cost-sharing; and**

18                   **(B) the cost-sharing levels for en-**  
19                   **hanced plans and premium plans (as**  
20                   **provided under section 203(c)) con-**  
21                   **sistent with paragraph (5).**

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

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

1           be designed so that such plans have  
2           benefits that are actuarially equiva-  
3           lent to approximately 85 percent of  
4           the actuarial value of the benefits  
5           provided under the reference benefits  
6           package described in section  
7           122(c)(3)(B).

8           **(B) PREMIUM PLAN.**—The level of  
9           cost-sharing for premium plans shall  
10          be designed so that such plans have  
11          benefits that are actuarially equiva-  
12          lent to approximately 95 percent of  
13          the actuarial value of the benefits  
14          provided under the reference benefits  
15          package described in section  
16          122(c)(3)(B).

17          **(c) OPERATIONS.**—

18               **(1) PER DIEM PAY.**—Each member of  
19               the Health Benefits Advisory Committee  
20               shall receive travel expenses, including  
21               per diem in accordance with applicable  
22               provisions under subchapter I of chapter  
23               57 of title 5, United States Code, and shall  
24               otherwise serve without additional pay.

1           **(2) MEMBERS NOT TREATED AS FEDERAL**  
2           **EMPLOYEES.—Members of the Health Ben-**  
3           **efits Advisory Committee shall not be**  
4           **considered employees of the Federal gov-**  
5           **ernment solely by reason of any service**  
6           **on the Committee.**

7           **(3) APPLICATION OF FACA.—The Fed-**  
8           **eral Advisory Committee Act (5 U.S.C.**  
9           **App.), other than section 14, shall apply**  
10          **to the Health Benefits Advisory Com-**  
11          **mittee.**

12          **(d) PUBLICATION.—The Secretary shall pro-**  
13          **vide for publication in the Federal Register**  
14          **and the posting on the Internet website of the**  
15          **Department of Health and Human Services of**  
16          **all recommendations made by the Health Ben-**  
17          **efits Advisory Committee under this section.**

18          **SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDA-**

19    **TIONS; ADOPTION OF BENEFIT STANDARDS.**

20          **(a) PROCESS FOR ADOPTION OF REC-**  
21          **OMMENDATIONS.—**

22                          **(1) REVIEW OF RECOMMENDED STAND-**  
23                          **ARDS.—Not later than 45 days after the**  
24                          **date of receipt of benefit standards rec-**  
25                          **ommended under section 123 (including**



1 such standards as modified under para-  
2 graph (2)(B)), the Secretary shall review  
3 such standards and shall determine  
4 whether to propose adoption of such  
5 standards as a package.

6 (2) DETERMINATION TO ADOPT STAND-  
7 ARDS.—If the Secretary determines—

8 (A) to propose adoption of benefit  
9 standards so recommended as a pack-  
10 age, the Secretary shall, by regulation  
11 under section 553 of title 5, United  
12 States Code, propose adoption such  
13 standards; or

14 (B) not to propose adoption of  
15 such standards as a package, the Sec-  
16 retary shall notify the Health Benefits  
17 Advisory Committee in writing of  
18 such determination and the reasons  
19 for not proposing the adoption of  
20 such recommendation and provide  
21 the Committee with a further oppor-  
22 tunity to modify its previous rec-  
23 ommendations and submit new rec-  
24 ommendations to the Secretary on a  
25 timely basis.

1           **(3) CONTINGENCY.—**If, because of the  
2           **application of paragraph (2)(B), the Sec-**  
3           **retary would otherwise be unable to pro-**  
4           **pose initial adoption of such rec-**  
5           **ommended standards by the deadline**  
6           **specified in subsection (b)(1), the Sec-**  
7           **retary shall, by regulation under section**  
8           **553 of title 5, United States Code, propose**  
9           **adoption of initial benefit standards by**  
10          **such deadline.**

11          **(4) PUBLICATION.—**The Secretary shall  
12          **provide for publication in the Federal**  
13          **Register of all determinations made by**  
14          **the Secretary under this subsection.**

15          **(b) ADOPTION OF STANDARDS.—**

16               **(1) INITIAL STANDARDS.—**Not later than  
17               **18 months after the date of the enactment**  
18               **of this Act, the Secretary shall, through**  
19               **the rulemaking process consistent with**  
20               **subsection (a), adopt an initial set of ben-**  
21               **efit standards.**

22               **(2) PERIODIC UPDATING STANDARDS.—**  
23               **Under subsection (a), the Secretary shall**  
24               **provide for the periodic updating of the**

1 benefit standards previously adopted  
2 under this section.

3 (3) REQUIREMENT.—The Secretary may  
4 not adopt any benefit standards for an es-  
5 sential benefits package or for level of  
6 cost-sharing that are inconsistent with  
7 the requirements for such a package or  
8 level under sections 122 and 123(b)(5).

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

11 SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY  
12 HEALTH INSURERS.

13 The Commissioner shall establish uniform  
14 marketing standards that all insured QHBP  
15 offering entities shall meet.

16 SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS  
17 MECHANISMS.

18 (a) IN GENERAL.—A QHBP offering entity  
19 shall provide for timely grievance and ap-  
20 peals mechanisms that the Commissioner  
21 shall establish.

22 (b) INTERNAL CLAIMS AND APPEALS PROC-  
23 ESS.—Under a qualified health benefits plan  
24 the QHBP offering entity shall provide an in-  
25 ternal claims and appeals process that ini-

1 tially incorporates the claims and appeals  
2 procedures (including urgent claims) set forth  
3 at section 2560.503–1 of title 29, Code of Fed-  
4 eral Regulations, as published on November  
5 21, 2000 (65 Fed. Reg. 70246) and shall update  
6 such process in accordance with any stand-  
7 ards that the Commissioner may establish.

8 (c) **EXTERNAL REVIEW PROCESS.—**

9 (1) **IN GENERAL.—**The Commissioner  
10 shall establish an external review process  
11 (including procedures for expedited re-  
12 views of urgent claims) that provides for  
13 an impartial, independent, and de novo  
14 review of denied claims under this divi-  
15 sion.

16 (2) **REQUIRING FAIR GRIEVANCE AND AP-  
17 PEALS MECHANISMS.—**A determination  
18 made, with respect to a qualified health  
19 benefits plan offered by a QHBP offering  
20 entity, under the external review process  
21 established under this subsection shall be  
22 binding on the plan and the entity.

23 (d) **CONSTRUCTION.—**Nothing in this sec-  
24 tion shall be construed as affecting the avail-  
25 ability of judicial review under State law for

1 **adverse decisions under subsection (b) or (c),**  
2 **subject to section 151.**

3 **SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND**  
4 **PLAN DISCLOSURE.**

5 **(a) ACCURATE AND TIMELY DISCLOSURE.—**

6 **(1) IN GENERAL.—A qualified health**  
7 **benefits plan shall comply with standards**  
8 **established by the Commissioner for the**  
9 **accurate and timely disclosure of plan**  
10 **documents, plan terms and conditions,**  
11 **claims payment policies and practices,**  
12 **periodic financial disclosure, data on en-**  
13 **rollment, data on disenrollment, data on**  
14 **the number of claims denials, data on rat-**  
15 **ing practices, information on cost-sharing**  
16 **and payments with respect to any out-of-**  
17 **network coverage, and other information**  
18 **as determined appropriate by the Com-**  
19 **missioner. The Commissioner shall re-**  
20 **quire that such disclosure be provided in**  
21 **plain language.**

22 **(2) PLAIN LANGUAGE.—In this sub-**  
23 **section, the term “plain language” means**  
24 **language that the intended audience, in-**  
25 **cluding individuals with limited English**

1       **proficiency, can readily understand and**  
2       **use because that language is clean, con-**  
3       **cise, well-organized, and follows other**  
4       **best practices of plain language writing.**

5           **(3) GUIDANCE.—The Commissioner**  
6       **shall develop and issue guidance on best**  
7       **practices of plain language writing.**

8       **(b) CONTRACTING REIMBURSEMENT.—A**  
9       **qualified health benefits plan shall comply**  
10      **with standards established by the Commis-**  
11      **sioner to ensure transparency to each health**  
12      **care provider relating to reimbursement ar-**  
13      **rangements between such plan and such pro-**  
14      **vider.**

15      **(c) ADVANCE NOTICE OF PLAN CHANGES.—A**  
16      **change in a qualified health benefits plan**  
17      **shall not be made without such reasonable**  
18      **and timely advance notice to enrollees of such**  
19      **change.**

20      **SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS**  
21                      **PLANS NOT OFFERED THROUGH THE**  
22                      **HEALTH INSURANCE EXCHANGE.**

23      **The requirements of the previous provi-**  
24      **sions of this subtitle shall apply to qualified**  
25      **health benefits plans that are not being of-**

1 **ferred through the Health Insurance Exchange**  
2 **only to the extent specified by the Commis-**  
3 **sioner.**

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

5 **A QHBP offering entity shall comply with**  
6 **the requirements of section 1857(f) of the So-**  
7 **cial Security Act with respect to a qualified**  
8 **health benefits plan it offers in the same man-**  
9 **ner an Medicare Advantage organization is**  
10 **required to comply with such requirements**  
11 **with respect to a Medicare Advantage plan it**  
12 **offers under part C of Medicare.**

13 **SEC. 136. STANDARDIZED RULES FOR COORDINATION AND**  
14 **SUBROGATION OF BENEFITS.**

15 **The Commissioner shall establish stand-**  
16 **ards for the coordination and subrogation of**  
17 **benefits and reimbursement of payments in**  
18 **cases involving individuals and multiple plan**  
19 **coverage.**

20 **SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICA-**  
21 **TION.**

22 **A QHBP offering entity is required to**  
23 **comply with standards for electronic finan-**  
24 **cial and administrative transactions under**

1 section 1173A of the Social Security Act,  
2 added by section 163(a).

3 **Subtitle E—Governance**

4 SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH  
5 CHOICES COMMISSIONER.

6 (a) IN GENERAL.—There is hereby estab-  
7 lished, as an independent agency in the exec-  
8 utive branch of the Government, a Health  
9 Choices Administration (in this division re-  
10 ferred to as the “Administration”).

11 (b) COMMISSIONER.—

12 (1) IN GENERAL.—The Administration  
13 shall be headed by a Health Choices Com-  
14 missioner (in this division referred to as  
15 the “Commissioner”) who shall be ap-  
16 pointed by the President, by and with the  
17 advice and consent of the Senate.

18 (2) COMPENSATION; ETC.—The provi-  
19 sions of paragraphs (2), (5), and (7) of  
20 subsection (a) (relating to compensation,  
21 terms, general powers, rulemaking, and  
22 delegation) of section 702 of the Social  
23 Security Act (42 U.S.C. 902) shall apply to  
24 the Commissioner and the Administra-  
25 tion in the same manner as such provi-



1        **sions apply to the Commissioner of Social**  
2        **Security and the Social Security Adminis-**  
3        **tration.**

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

5        **(a) DUTIES.—The Commissioner is respon-**  
6        **sible for carrying out the following functions**  
7        **under this division:**

8                **(1) QUALIFIED PLAN STANDARDS.—The**  
9                **establishment of qualified health benefits**  
10              **plan standards under this title, including**  
11              **the enforcement of such standards in co-**  
12              **ordination with State insurance regu-**  
13              **lators and the Secretaries of Labor and**  
14              **the Treasury.**

15              **(2) HEALTH INSURANCE EXCHANGE.—The**  
16              **establishment and operation of a Health**  
17              **Insurance Exchange under subtitle A of**  
18              **title II.**

19              **(3) INDIVIDUAL AFFORDABILITY CRED-**  
20              **ITS.—The administration of individual af-**  
21              **fordability credits under subtitle C of**  
22              **title II, including determination of eligi-**  
23              **bility for such credits.**

1           **(4) ADDITIONAL FUNCTIONS.—Such ad-**  
2           **ditional functions as may be specified in**  
3           **this division.**

4           **(b) PROMOTING ACCOUNTABILITY.—**

5           **(1) IN GENERAL.—The Commissioner**  
6           **shall undertake activities in accordance**  
7           **with this subtitle to promote account-**  
8           **ability of QHBP offering entities in meet-**  
9           **ing Federal health insurance require-**  
10           **ments, regardless of whether such ac-**  
11           **countability is with respect to qualified**  
12           **health benefits plans offered through the**  
13           **Health Insurance Exchange or outside of**  
14           **such Exchange.**

15           **(2) COMPLIANCE EXAMINATION AND AU-**  
16           **DITS.—**

17           **(A) IN GENERAL.—The commis-**  
18           **sioner shall, in coordination with**  
19           **States, conduct audits of qualified**  
20           **health benefits plan compliance with**  
21           **Federal requirements. Such audits**  
22           **may include random compliance au-**  
23           **ditions and targeted audits in response**  
24           **to complaints or other suspected non-**  
25           **compliance.**

1           **(B) RECOUPMENT OF COSTS IN CON-**  
2           **NECTION WITH EXAMINATION AND AU-**  
3           **DITS.—The Commissioner is author-**  
4           **ized to recoup from qualified health**  
5           **benefits plans reimbursement for the**  
6           **costs of such examinations and audit**  
7           **of such QHBP offering entities.**

8           **(c) DATA COLLECTION.—The Commissioner**  
9           **shall collect data for purposes of carrying out**  
10          **the Commissioner’s duties, including for pur-**  
11          **poses of promoting quality and value, pro-**  
12          **tecting consumers, and addressing disparities**  
13          **in health and health care and may share such**  
14          **data with the Secretary of Health and Human**  
15          **Services.**

16          **(d) SANCTIONS AUTHORITY.—**

17                 **(1) IN GENERAL.—In the case that the**  
18                 **Commissioner determines that a QHBP**  
19                 **offering entity violates a requirement of**  
20                 **this title, the Commissioner may, in co-**  
21                 **ordination with State insurance regu-**  
22                 **lators and the Secretary of Labor, pro-**  
23                 **vide, in addition to any other remedies**  
24                 **authorized by law, for any of the rem-**  
25                 **edies described in paragraph (2).**

1           **(2) REMEDIES.—**The remedies de-  
2           scribed in this paragraph, with respect to  
3           a qualified health benefits plan offered  
4           by a QHBP offering entity, are—

5                   **(A) civil money penalties of not**  
6                   **more than the amount that would be**  
7                   **applicable under similar cir-**  
8                   **cumstances for similar violations**  
9                   **under section 1857(g) of the Social Se-**  
10                  **curity Act;**

11                  **(B) suspension of enrollment of**  
12                  **individuals under such plan after the**  
13                  **date the Commissioner notifies the**  
14                  **entity of a determination under para-**  
15                  **graph (1) and until the Commissioner**  
16                  **is satisfied that the basis for such de-**  
17                  **termination has been corrected and is**  
18                  **not likely to recur;**

19                  **(C) in the case of an Exchange-**  
20                  **participating health benefits plan,**  
21                  **suspension of payment to the entity**  
22                  **under the Health Insurance Ex-**  
23                  **change for individuals enrolled in**  
24                  **such plan after the date the Commis-**  
25                  **sioner notifies the entity of a deter-**

1           **mination under paragraph (1) and**  
2           **until the Secretary is satisfied that**  
3           **the basis for such determination has**  
4           **been corrected and is not likely to**  
5           **recur; or**

6           **(D) working with State insurance**  
7           **regulators to terminate plans for re-**  
8           **peated failure by the offering entity**  
9           **to meet the requirements of this title.**

10          **(e) STANDARD DEFINITIONS OF INSURANCE**  
11          **AND MEDICAL TERMS.—The Commissioner shall**  
12          **provide for the development of standards for**  
13          **the definitions of terms used in health insur-**  
14          **ance coverage, including insurance-related**  
15          **terms.**

16          **(f) EFFICIENCY IN ADMINISTRATION.—The**  
17          **Commissioner shall issue regulations for the**  
18          **effective and efficient administration of the**  
19          **Health Insurance Exchange and affordability**  
20          **credits under subtitle C, including, with re-**  
21          **spect to the determination of eligibility for af-**  
22          **fordability credits, the use of personnel who**  
23          **are employed in accordance with the require-**  
24          **ments of title 5, United States Code, to carry**  
25          **out the duties of the Commissioner or, in the**

1 case of sections 208 and 241(b)(2), the use of  
2 State personnel who are employed in accord-  
3 ance with standards prescribed by the Office  
4 of Personnel Management pursuant to section  
5 208 of the Intergovernmental Personnel Act of  
6 1970 (42 U.S.C. 4728).

7 SEC. 143. CONSULTATION AND COORDINATION.

8 (a) CONSULTATION.—In carrying out the  
9 Commissioner’s duties under this division,  
10 the Commissioner, as appropriate, shall con-  
11 sult with at least with the following:

12 (1) The National Association of Insur-  
13 ance Commissioners, State attorneys gen-  
14 eral, and State insurance regulators, in-  
15 cluding concerning the standards for in-  
16 sured qualified health benefits plans  
17 under this title and enforcement of such  
18 standards.

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

1           **(3) Other appropriate Federal agen-**  
2           **cies.**

3           **(4) Indian tribes and tribal organiza-**  
4           **tions.**

5           **(5) The National Association of Insur-**  
6           **ance Commissioners for purposes of**  
7           **using model guidelines established by**  
8           **such association for purposes of subtitles**  
9           **B and D.**

10          **(b) COORDINATION.—**

11           **(1) IN GENERAL.—In carrying out the**  
12           **functions of the Commissioner, including**  
13           **with respect to the enforcement of the**  
14           **provisions of this division, the Commis-**  
15           **sioner shall work in coordination with**  
16           **existing Federal and State entities to the**  
17           **maximum extent feasible consistent with**  
18           **this division and in a manner that pre-**  
19           **vents conflicts of interest in duties and**  
20           **ensures effective enforcement.**

21           **(2) UNIFORM STANDARDS.—The Com-**  
22           **missioner, in coordination with such enti-**  
23           **ties, shall seek to achieve uniform stand-**  
24           **ards that adequately protect consumers**

1       **in a manner that does not unreasonably**  
2       **affect employers and insurers.**

3       **SEC. 144. HEALTH INSURANCE OMBUDSMAN.**

4       **(a) IN GENERAL.—The Commissioner shall**  
5       **appoint within the Health Choices Adminis-**  
6       **tration a Qualified Health Benefits Plan Om-**  
7       **budsman who shall have expertise and experi-**  
8       **ence in the fields of health care and education**  
9       **of (and assistance to) individuals.**

10       **(b) DUTIES.—The Qualified Health Bene-**  
11       **fits Plan Ombudsman shall, in a linguistically**  
12       **appropriate manner—**

13               **(1) receive complaints, grievances,**  
14               **and requests for information submitted**  
15               **by individuals;**

16               **(2) provide assistance with respect to**  
17               **complaints, grievances, and requests re-**  
18               **ferred to in paragraph (1), including—**

19                       **(A) helping individuals determine**  
20                       **the relevant information needed to**  
21                       **seek an appeal of a decision or deter-**  
22                       **mination;**

23                       **(B) assistance to such individuals**  
24                       **with any problems arising from**  
25                       **disenrollment from such a plan;**



1           **(C) assistance to such individuals**  
2           **in choosing a qualified health bene-**  
3           **fits plan in which to enroll; and**

4           **(D) assistance to such individuals**  
5           **in presenting information under sub-**  
6           **title C (relating to affordability cred-**  
7           **its); and**

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

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

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

22           **(a) COVERAGE NOT OFFERED THROUGH EX-**  
23           **CHANGE.—**

24           **(1) IN GENERAL.—In the case of health**  
25           **insurance coverage not offered through**

1       **the Health Insurance Exchange (whether**  
2       **or not offered in connection with an em-**  
3       **ployment-based health plan), and in the**  
4       **case of employment-based health plans,**  
5       **the requirements of this title do not**  
6       **supercede any requirements applicable**  
7       **under titles XXII and XXVII of the Public**  
8       **Health Service Act, parts 6 and 7 of sub-**  
9       **title B of title I of the Employee Retire-**  
10      **ment Income Security Act of 1974, or**  
11      **State law, except insofar as such require-**  
12      **ments prevent the application of a re-**  
13      **quirement of this division, as determined**  
14      **by the Commissioner.**

15           **(2) CONSTRUCTION.—Nothing in para-**  
16      **graph (1) shall be construed as affecting**  
17      **the application of section 514 of the Em-**  
18      **ployee Retirement Income Security Act of**  
19      **1974.**

20      **(b) COVERAGE OFFERED THROUGH EX-**  
21      **CHANGE.—**

22           **(1) IN GENERAL.—In the case of health**  
23      **insurance coverage offered through the**  
24      **Health Insurance Exchange—**

1           **(A) the requirements of this title**  
2           **do not supercede any requirements**  
3           **(including requirements relating to**  
4           **genetic information nondiscrimina-**  
5           **tion and mental health) applicable**  
6           **under title XXVII of the Public Health**  
7           **Service Act or under State law, ex-**  
8           **cept insofar as such requirements**  
9           **prevent the application of a require-**  
10           **ment of this division, as determined**  
11           **by the Commissioner; and**

12           **(B) individual rights and rem-**  
13           **edies under State laws shall apply.**

14           **(2) CONSTRUCTION.—In the case of cov-**  
15           **erage described in paragraph (1), nothing**  
16           **in such paragraph shall be construed as**  
17           **preventing the application of rights and**  
18           **remedies under State laws with respect**  
19           **to any requirement referred to in para-**  
20           **graph (1)(A).**

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

22           **(a) IN GENERAL.—Except as otherwise ex-**  
23           **PLICITLY permitted by this Act and by subse-**  
24           **quent regulations consistent with this Act, all**  
25           **health care and related services (including in-**

1 **urance coverage and public health activities)**  
2 **covered by this Act shall be provided without**  
3 **regard to personal characteristics extraneous**  
4 **to the provision of high quality health care or**  
5 **related services.**

6 **(b) IMPLEMENTATION.—To implement the**  
7 **requirement set forth in subsection (a), the**  
8 **Secretary of Health and Human Services**  
9 **shall, not later than 18 months after the date**  
10 **of the enactment of this Act, promulgate such**  
11 **regulations as are necessary or appropriate to**  
12 **insure that all health care and related serv-**  
13 **ices (including insurance coverage and public**  
14 **health activities) covered by this Act are pro-**  
15 **vided (whether directly or through contrac-**  
16 **tual, licensing, or other arrangements) with-**  
17 **out regard to personal characteristics extra-**  
18 **neous to the provision of high quality health**  
19 **care or related services.**

20 **SEC. 153. WHISTLEBLOWER PROTECTION.**

21 **(a) RETALIATION PROHIBITED.—No em-**  
22 **ployer may discharge any employee or other-**  
23 **wise discriminate against any employee with**  
24 **respect to his compensation, terms, condi-**  
25 **tions, or other privileges of employment be-**

1 **cause the employee (or any person acting pur-**  
2 **suant to a request of the employee)—**

3           **(1) provided, caused to be provided,**  
4           **or is about to provide or cause to be pro-**  
5           **vided to the employer, the Federal Gov-**  
6           **ernment, or the attorney general of a**  
7           **State information relating to any viola-**  
8           **tion of, or any act or omission the em-**  
9           **ployee reasonably believes to be a viola-**  
10          **tion of any provision of this Act or any**  
11          **order, rule, or regulation promulgated**  
12          **under this Act;**

13           **(2) testified or is about to testify in a**  
14          **proceeding concerning such violation;**

15           **(3) assisted or participated or is**  
16          **about to assist or participate in such a**  
17          **proceeding; or**

18           **(4) objected to, or refused to partici-**  
19          **pate in, any activity, policy, practice, or**  
20          **assigned task that the employee (or other**  
21          **such person) reasonably believed to be in**  
22          **violation of any provision of this Act or**  
23          **any order, rule, or regulation promul-**  
24          **gated under this Act.**

1       **(b) ENFORCEMENT ACTION.**—An employee  
2 covered by this section who alleges discrimi-  
3 nation by an employer in violation of sub-  
4 section (a) may bring an action governed by  
5 the rules, procedures, legal burdens of proof,  
6 and remedies set forth in section 40(b) of the  
7 Consumer Product Safety Act (15 U.S.C.  
8 2087(b)).

9       **(c) EMPLOYER DEFINED.**—As used in this  
10 section, the term “employer” means any per-  
11 son (including one or more individuals, part-  
12 nerships, associations, corporations, trusts,  
13 professional membership organization includ-  
14 ing a certification, disciplinary, or other pro-  
15 fessional body, unincorporated organizations,  
16 nongovernmental organizations, or trustees)  
17 engaged in profit or nonprofit business or in-  
18 dustry whose activities are governed by this  
19 Act, and any agent, contractor, subcontractor,  
20 grantee, or consultant of such person.

21       **(d) RULE OF CONSTRUCTION.**—The rule of  
22 construction set forth in section 20109(h) of  
23 title 49, United States Code, shall also apply  
24 to this section.

1 SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BAR-  
2 GAINING.

3 **Nothing in this division shall be con-**  
4 **strued to alter or supercede any statutory or**  
5 **other obligation to engage in collective bar-**  
6 **gaining over the terms and conditions of em-**  
7 **ployment related to health care.**

8 SEC. 155. SEVERABILITY.

9 **If any provision of this Act, or any appli-**  
10 **cation of such provision to any person or cir-**  
11 **cumstance, is held to be unconstitutional, the**  
12 **remainder of the provisions of this Act and**  
13 **the application of the provision to any other**  
14 **person or circumstance shall not be affected.**

## 15 **Subtitle G—Early Investments**

16 SEC. 161. ENSURING VALUE AND LOWER PREMIUMS.

17 **(a) GROUP HEALTH INSURANCE COVERAGE.—**  
18 **Title XXVII of the Public Health Service Act**  
19 **is amended by inserting after section 2713 the**  
20 **following new section:**

21 **“SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.**

22 **“(a) IN GENERAL.—Each health insurance**  
23 **issuer that offers health insurance coverage**  
24 **in the small or large group market shall pro-**  
25 **vide that for any plan year in which the cov-**  
26 **erage has a medical loss ratio below a level**

1 specified by the Secretary, the issuer shall  
2 provide in a manner specified by the Sec-  
3 retary for rebates to enrollees of payment suf-  
4 ficient to meet such loss ratio. Such method-  
5 ology shall be set at the highest level medical  
6 loss ratio possible that is designed to ensure  
7 adequate participation by issuers, competi-  
8 tion in the health insurance market, and  
9 value for consumers so that their premiums  
10 are used for services.

11       “(b) UNIFORM DEFINITIONS.—The Secretary  
12 shall establish a uniform definition of medical  
13 loss ratio and methodology for determining  
14 how to calculate the medical loss ratio. Such  
15 methodology shall be designed to take into ac-  
16 count the special circumstances of smaller  
17 plans, different types of plans, and newer  
18 plans.”.

19       (b) INDIVIDUAL HEALTH INSURANCE COV-  
20 ERAGE.—Such title is further amended by in-  
21 serting after section 2753 the following new  
22 section:

23 “SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

24       “The provisions of section 2714 shall apply  
25 to health insurance coverage offered in the in-



1 **dividual market in the same manner as such**  
2 **provisions apply to health insurance coverage**  
3 **offered in the small or large group market.”.**

4 **(c) IMMEDIATE IMPLEMENTATION.—The**  
5 **amendments made by this section shall apply**  
6 **in the group and individual market for plan**  
7 **years beginning on or after January 1, 2011.**

8 **SEC. 162. ENDING HEALTH INSURANCE RESCISSION ABUSE.**

9 **(a) CLARIFICATION REGARDING APPLICATION**  
10 **OF GUARANTEED RENEWABILITY OF INDIVIDUAL**  
11 **HEALTH INSURANCE COVERAGE.—Section 2742**  
12 **of the Public Health Service Act (42 U.S.C.**  
13 **300gg-42) is amended—**

14 **(1) in its heading, by inserting “AND**  
15 **CONTINUATION IN FORCE, INCLUDING PROHI-**  
16 **BITION OF RESCISSION,” after “GUARANTEED**  
17 **RENEWABILITY”; and**

18 **(2) in subsection (a), by inserting “,**  
19 **including without rescission,” after “con-**  
20 **tinue in force”.**

21 **(b) SECRETARIAL GUIDANCE REGARDING RE-**  
22 **SCISSIONS.—Section 2742 of such Act (42 U.S.C.**  
23 **300gg-42) is amended by adding at the end the**  
24 **following:**

1       “(f) **RESCISSION.—A health insurance**  
2 **issuer may rescind health insurance coverage**  
3 **only upon clear and convincing evidence of**  
4 **fraud described in subsection (b)(2). The Sec-**  
5 **retary, no later than July 1, 2010, shall issue**  
6 **guidance implementing this requirement, in-**  
7 **cluding procedures for independent, external**  
8 **third party review.”.**

9       **(c) OPPORTUNITY FOR INDEPENDENT, EXTER-**  
10 **NAL THIRD PARTY REVIEW IN CERTAIN CASES.—**  
11 **Subpart 1 of part B of title XXVII of such Act**  
12 **(42 U.S.C. 300gg–41 et seq.) is amended by add-**  
13 **ing at the end the following:**

14 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
15 **THIRD PARTY REVIEW IN CASES OF RESCIS-**  
16 **SION.**

17       **“(a) NOTICE AND REVIEW RIGHT.—If a**  
18 **health insurance issuer determines to rescind**  
19 **health insurance coverage for an individual**  
20 **in the individual market, before such rescis-**  
21 **sion may take effect the issuer shall provide**  
22 **the individual with notice of such proposed**  
23 **rescission and an opportunity for a review of**  
24 **such determination by an independent, exter-**

1 **nal third party under procedures specified by**  
2 **the Secretary under section 2742(f).**

3 **“(b) INDEPENDENT DETERMINATION.—If the**  
4 **individual requests such review by an inde-**  
5 **pendent, external third party of a rescission**  
6 **of health insurance coverage, the coverage**  
7 **shall remain in effect until such third party**  
8 **determines that the coverage may be re-**  
9 **scinded under the guidance issued by the Sec-**  
10 **retary under section 2742(f).”.**

11 **(d) EFFECTIVE DATE.—The amendments**  
12 **made by this section shall apply on and after**  
13 **October 1, 2010, with respect to health insur-**  
14 **ance coverage issued before, on, or after such**  
15 **date.**

16 **SEC. 163. ADMINISTRATIVE SIMPLIFICATION.**

17 **(a) STANDARDIZING ELECTRONIC ADMINIS-**  
18 **TRATIVE TRANSACTIONS.—**

19 **(1) IN GENERAL.—Part C of title XI of**  
20 **the Social Security Act (42 U.S.C. 1320d et**  
21 **seq.) is amended by inserting after sec-**  
22 **tion 1173 the following new section:**

1 **“SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE**  
2 **TRANSACTIONS.**

3 **“(a) STANDARDS FOR FINANCIAL AND ADMIN-**  
4 **ISTRATIVE TRANSACTIONS.—**

5 **“(1) IN GENERAL.—The Secretary shall**  
6 **adopt and regularly update standards**  
7 **consistent with the goals described in**  
8 **paragraph (2).**

9 **“(2) GOALS FOR FINANCIAL AND ADMINIS-**  
10 **TRATIVE TRANSACTIONS.—The goals for**  
11 **standards under paragraph (1) are that**  
12 **such standards shall—**

13 **“(A) be unique with no conflicting**  
14 **or redundant standards;**

15 **“(B) be authoritative, permitting**  
16 **no additions or constraints for elec-**  
17 **tronic transactions, including com-**  
18 **panion guides;**

19 **“(C) be comprehensive, efficient**  
20 **and robust, requiring minimal aug-**  
21 **mentation by paper transactions or**  
22 **clarification by further communica-**  
23 **tions;**

24 **“(D) enable the real-time (or near**  
25 **real-time) determination of an indi-**  
26 **vidual’s financial responsibility at the**

1 point of service and, to the extent  
2 possible, prior to service, including  
3 whether the individual is eligible for  
4 a specific service with a specific phy-  
5 sician at a specific facility, which  
6 may include utilization of a machine-  
7 readable health plan beneficiary  
8 identification card;

9 “(E) enable, where feasible, near  
10 real-time adjudication of claims;

11 “(F) provide for timely acknowl-  
12 edgment, response, and status report-  
13 ing applicable to any electronic trans-  
14 action deemed appropriate by the  
15 Secretary;

16 “(G) describe all data elements  
17 (such as reason and remark codes) in  
18 unambiguous terms, not permit op-  
19 tional fields, require that data ele-  
20 ments be either required or condi-  
21 tioned upon set values in other fields,  
22 and prohibit additional conditions;  
23 and

1           **“(H) harmonize all common data**  
2           **elements across administrative and**  
3           **clinical transaction standards.**

4           **“(3) TIME FOR ADOPTION.—Not later**  
5           **than 2 years after the date of implemen-**  
6           **tation of the X12 Version 5010 transaction**  
7           **standards implemented under this part,**  
8           **the Secretary shall adopt standards**  
9           **under this section.**

10           **“(4) REQUIREMENTS FOR SPECIFIC**  
11           **STANDARDS.—The standards under this**  
12           **section shall be developed, adopted, and**  
13           **enforced so as to—**

14                   **“(A) clarify, refine, complete, and**  
15                   **expand, as needed, the standards re-**  
16                   **quired under section 1173;**

17                   **“(B) require paper versions of**  
18                   **standardized transactions to comply**  
19                   **with the same standards as to data**  
20                   **content such that a fully compliant,**  
21                   **equivalent electronic transaction can**  
22                   **be populated from the data from a**  
23                   **paper version;**

24                   **“(C) enable electronic funds**  
25                   **transfers, in order to allow auto-**

1 mated reconciliation with the related  
2 health care payment and remittance  
3 advice;

4 “(D) require timely and trans-  
5 parent claim and denial management  
6 processes, including tracking, adju-  
7 dication, and appeal processing ;

8 “(E) require the use of a standard  
9 electronic transaction with which  
10 health care providers may quickly  
11 and efficiently enroll with a health  
12 plan to conduct the other electronic  
13 transactions provided for in this part;  
14 and

15 “(F) provide for other require-  
16 ments relating to administrative sim-  
17 plification as identified by the Sec-  
18 retary, in consultation with stake-  
19 holders.

20 “(5) BUILDING ON EXISTING STAND-  
21 ARDS.—In developing the standards under  
22 this section, the Secretary shall build  
23 upon existing and planned standards.

24 “(6) IMPLEMENTATION AND ENFORCE-  
25 MENT.—Not later than 6 months after the

1       **date of the enactment of this section, the**  
2       **Secretary shall submit to the appropriate**  
3       **committees of Congress a plan for the im-**  
4       **plementation and enforcement, by not**  
5       **later than 5 years after such date of en-**  
6       **actment, of the standards under this sec-**  
7       **tion. Such plan shall include—**

8               **“(A) a process and timeframe with**  
9               **milestones for developing the com-**  
10              **plete set of standards;**

11              **“(B) an expedited upgrade pro-**  
12              **gram for continually developing and**  
13              **approving additions and modifica-**  
14              **tions to the standards as often as an-**  
15              **nually to improve their quality and**  
16              **extend their functionality to meet**  
17              **evolving requirements in health care;**

18              **“(C) programs to provide incen-**  
19              **tives for, and ease the burden of, im-**  
20              **plementation for certain health care**  
21              **providers, with special consideration**  
22              **given to such providers serving rural**  
23              **or underserved areas and ensure co-**  
24              **ordination with standards, implemen-**  
25              **tation specifications, and certifi-**



1           **cation criteria being adopted under**  
2           **the HITECH Act;**

3           **“(D) programs to provide incen-**  
4           **tives for, and ease the burden of,**  
5           **health care providers who volunteer**  
6           **to participate in the process of set-**  
7           **ting standards for electronic trans-**  
8           **actions;**

9           **“(E) an estimate of total funds**  
10           **needed to ensure timely completion**  
11           **of the implementation plan; and**

12           **“(F) an enforcement process that**  
13           **includes timely investigation of com-**  
14           **plaints, random audits to ensure com-**  
15           **pliance, civil monetary and pro-**  
16           **grammatic penalties for non-compli-**  
17           **ance consistent with existing laws**  
18           **and regulations, and a fair and rea-**  
19           **sonable appeals process building off**  
20           **of enforcement provisions under this**  
21           **part.**

22           **“(b) LIMITATIONS ON USE OF DATA.—Noth-**  
23           **ing in this section shall be construed to per-**  
24           **mit the use of information collected under**

1 **this section in a manner that would adversely**  
2 **affect any individual.**

3 **“(c) PROTECTION OF DATA.—The Secretary**  
4 **shall ensure (through the promulgation of**  
5 **regulations or otherwise) that all data col-**  
6 **lected pursuant to subsection (a) are—**

7 **“(1) used and disclosed in a manner**  
8 **that meets the HIPAA privacy and secu-**  
9 **urity law (as defined in section 3009(a)(2)**  
10 **of the Public Health Service Act), includ-**  
11 **ing any privacy or security standard**  
12 **adopted under section 3004 of such Act;**  
13 **and**

14 **“(2) protected from all inappropriate**  
15 **internal use by any entity that collects,**  
16 **stores, or receives the data, including use**  
17 **of such data in determinations of eligi-**  
18 **bility (or continued eligibility) in health**  
19 **plans, and from other inappropriate uses,**  
20 **as defined by the Secretary.”.**

21 **(2) DEFINITIONS.—Section 1171 of such**  
22 **Act (42 U.S.C. 1320d) is amended—**

23 **(A) in paragraph (7), by striking**  
24 **“with reference to” and all that fol-**  
25 **lows and inserting “with reference to**

1 a transaction or data element of  
2 health information in section 1173  
3 means implementation specifications,  
4 certification criteria, operating rules,  
5 messaging formats, codes, and code  
6 sets adopted or established by the  
7 Secretary for the electronic exchange  
8 and use of information”; and

9 (B) by adding at the end the fol-  
10 lowing new paragraph:

11 “(9) OPERATING RULES.—The term ‘op-  
12 erating rules’ means business rules for  
13 using and processing transactions. Oper-  
14 ating rules should address the following:

15 “(A) Requirements for data con-  
16 tent using available and established  
17 national standards.

18 “(B) Infrastructure requirements  
19 that establish best practices for  
20 streamlining data flow to yield timely  
21 execution of transactions.

22 “(C) Policies defining the trans-  
23 action related rights and responsibil-  
24 ities for entities that are transmitting  
25 or receiving data.”.

1           **(3) CONFORMING AMENDMENT.—Section**  
2           **1179(a) of such Act (42 U.S.C. 1320d–8(a))**  
3           **is amended, in the matter before para-**  
4           **graph (1)—**

5                   **(A) by inserting “on behalf of an**  
6                   **individual” after “1978”;** and

7                   **(B) by inserting “on behalf of an**  
8                   **individual” after “for a financial insti-**  
9                   **tution” and**

10           **(b) STANDARDS FOR CLAIMS ATTACHMENTS**  
11           **AND COORDINATION OF BENEFITS .—**

12                   **(1) STANDARD FOR HEALTH CLAIMS AT-**  
13                   **TACHMENTS.—Not later than 1 year after**  
14                   **the date of the enactment of this Act, the**  
15                   **Secretary of Health and Human Services**  
16                   **shall promulgate a final rule to establish**  
17                   **a standard for health claims attachment**  
18                   **transaction described in section**  
19                   **1173(a)(2)(B) of the Social Security Act**  
20                   **(42 U.S.C. 1320d-2(a)(2)(B)) and coordina-**  
21                   **tion of benefits.**

22                   **(2) REVISION IN PROCESSING PAYMENT**  
23                   **TRANSACTIONS BY FINANCIAL INSTITU-**  
24                   **TIONS.—**

1           **(A) IN GENERAL.—Section 1179 of**  
2           **the Social Security Act (42 U.S.C.**  
3           **1320d–8) is amended, in the matter**  
4           **before paragraph (1)—**

5                   **(i) by striking “or is engaged”**  
6                   **and inserting “and is engaged”;**  
7                   **and**

8                   **(ii) by inserting “(other than**  
9                   **as a business associate for a cov-**  
10                  **ered entity)” after “for a financial**  
11                  **institution”.**

12           **(B) EFFECTIVE DATE.—The amend-**  
13           **ments made by paragraph (1) shall**  
14           **apply to transactions occurring on or**  
15           **after such date (not later than 6**  
16           **months after the date of the enact-**  
17           **ment of this Act) as the Secretary of**  
18           **Health and Human Services shall**  
19           **specify.**

20 **SEC. 164. REINSURANCE PROGRAM FOR RETIREES.**

21           **(a) ESTABLISHMENT.—**

22                   **(1) IN GENERAL.—Not later than 90**  
23                   **days after the date of the enactment of**  
24                   **this Act, the Secretary of Health and**  
25                   **Human Services shall establish a tem-**

1       porary reinsurance program (in this sec-  
2       tion referred to as the “reinsurance pro-  
3       gram”) to provide reimbursement to as-  
4       sist participating employment-based  
5       plans with the cost of providing health  
6       benefits to retirees and to eligible  
7       spouses, surviving spouses and depend-  
8       ents of such retirees.

9               (2) **DEFINITIONS.**—For purposes of this  
10       section:

11               (A) The term “eligible employ-  
12               ment-based plan” means a group  
13               health benefits plan that—

14                       (i) is maintained by one or  
15                       more employers, former employ-  
16                       ers or employee associations, or a  
17                       voluntary employees’ beneficiary  
18                       association, or a committee or  
19                       board of individuals appointed to  
20                       administer such plan, and

21                       (ii) provides health benefits to  
22                       retirees.

23               (B) The term “health benefits”  
24               means medical, surgical, hospital,  
25               prescription drug, and such other

1           **benefits as shall be determined by the**  
2           **Secretary, whether self-funded or de-**  
3           **livered through the purchase of in-**  
4           **surance or otherwise.**

5           **(C) The term “participating em-**  
6           **ployment-based plan” means an eligi-**  
7           **ble employment-based plan that is**  
8           **participating in the reinsurance pro-**  
9           **gram.**

10           **(D) The term “retiree” means,**  
11           **with respect to a participating em-**  
12           **ployment-benefit plan, an individual**  
13           **who—**

14                   **(i) is 55 years of age or older;**

15                   **(ii) is not eligible for coverage**  
16                   **under title XVIII of the Social Se-**  
17                   **curity Act; and**

18                   **(iii) is not an active employee**  
19                   **of an employer maintaining the**  
20                   **plan or of any employer that**  
21                   **makes or has made substantial**  
22                   **contributions to fund such plan.**

23           **(E) The term “Secretary” means**  
24           **Secretary of Health and Human Serv-**  
25           **ices.**

1       **(b) PARTICIPATION.—**To be eligible to par-  
2       **ticipate in the reinsurance program, an eligi-**  
3       **ble employment-based plan shall submit to**  
4       **the Secretary an application for participation**  
5       **in the program, at such time, in such manner,**  
6       **and containing such information as the Sec-**  
7       **retary shall require.**

8       **(c) PAYMENT.—**

9               **(1) SUBMISSION OF CLAIMS.—**

10                   **(A) IN GENERAL.—**Under the rein-  
11                   **surance program, a participating em-**  
12                   **ployment-based plan shall submit**  
13                   **claims for reimbursement to the Sec-**  
14                   **retary which shall contain docu-**  
15                   **mentation of the actual costs of the**  
16                   **items and services for which each**  
17                   **claim is being submitted.**

18                   **(B) BASIS FOR CLAIMS.—**Each claim  
19                   **submitted under subparagraph (A)**  
20                   **shall be based on the actual amount**  
21                   **expended by the participating em-**  
22                   **ployment-based plan involved within**  
23                   **the plan year for the appropriate em-**  
24                   **ployment based health benefits pro-**  
25                   **vided to a retiree or to the spouse,**



1           **surviving spouse, or dependent of a**  
2           **retiree. In determining the amount of**  
3           **any claim for purposes of this sub-**  
4           **section, the participating employ-**  
5           **ment-based plan shall take into ac-**  
6           **count any negotiated price conces-**  
7           **sions (such as discounts, direct or in-**  
8           **direct subsidies, rebates, and direct**  
9           **or indirect remunerations) obtained**  
10          **by such plan with respect to such**  
11          **health benefits. For purposes of cal-**  
12          **culating the amount of any claim, the**  
13          **costs paid by the retiree or by the**  
14          **spouse, surviving spouse, or depend-**  
15          **ent of the retiree in the form of**  
16          **deductibles, co-payments, and co-in-**  
17          **surance shall be included along with**  
18          **the amounts paid by the participating**  
19          **employment-based plan.**

20           **(2) PROGRAM PAYMENTS AND LIMIT.—If**  
21          **the Secretary determines that a partici-**  
22          **pating employment-based plan has sub-**  
23          **mitted a valid claim under paragraph (1),**  
24          **the Secretary shall reimburse such plan**  
25          **for 80 percent of that portion of the costs**

1       **attributable to such claim that exceeds**  
2       **\$15,000, but is less than \$90,000. Such**  
3       **amounts shall be adjusted each year**  
4       **based on the percentage increase in the**  
5       **medical care component of the Consumer**  
6       **Price Index (rounded to the nearest mul-**  
7       **tiiple of \$1,000) for the year involved.**

8               **(3) USE OF PAYMENTS.—Amounts paid**  
9       **to a participating employment-based plan**  
10       **under this subsection shall be used to**  
11       **lower the costs borne directly by the par-**  
12       **ticipants and beneficiaries for health**  
13       **benefits provided under such plan in the**  
14       **form of premiums, co-payments,**  
15       **deductibles, co-insurance, or other out-of-**  
16       **pocket costs. Such payments shall not be**  
17       **used to reduce the costs of an employer**  
18       **maintaining the participating employ-**  
19       **ment-based plan. The Secretary shall de-**  
20       **velop a mechanism to monitor the appro-**  
21       **priate use of such payments by such**  
22       **plans.**

23               **(4) APPEALS AND PROGRAM PROTEC-**  
24       **TIONS.—The Secretary shall establish—**

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

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

9           (5) AUDITS.—The Secretary shall con-  
10 duct annual audits of claims data sub-  
11 mitted by participating employment-  
12 based plans under this section to ensure  
13 that they are in compliance with the re-  
14 quirements of this section.

15           (d) RETIREE RESERVE TRUST FUND.—

16           (1) ESTABLISHMENT.—

17           (A) IN GENERAL.—There is estab-  
18 lished in the Treasury of the United  
19 States a trust fund to be known as  
20 the “Retiree Reserve Trust Fund” (re-  
21 ferred to in this section as the “Trust  
22 Fund”), that shall consist of such  
23 amounts as may be appropriated or  
24 credited to the Trust Fund as pro-  
25 vided for in this subsection to enable

1           **the Secretary to carry out the rein-**  
2           **surance program. Such amounts shall**  
3           **remain available until expended.**

4           **(B) FUNDING.—There are hereby**  
5           **appropriated to the Trust Fund, out**  
6           **of any moneys in the Treasury not**  
7           **otherwise appropriated, an amount**  
8           **requested by the Secretary as nec-**  
9           **essary to carry out this section, ex-**  
10          **cept that the total of all such**  
11          **amounts requested shall not exceed**  
12          **\$10,000,000,000.**

13          **(C) APPROPRIATIONS FROM THE**  
14          **TRUST FUND.—**

15               **(i) IN GENERAL.—Amounts in**  
16               **the Trust Fund are appropriated**  
17               **to provide funding to carry out**  
18               **the reinsurance program and**  
19               **shall be used to carry out such**  
20               **program.**

21               **(ii) BUDGETARY IMPLICATIONS.—**  
22               **Amounts appropriated under**  
23               **clause (i), and outlays flowing**  
24               **from such appropriations, shall**  
25               **not be taken into account for pur-**

1           **poses of any budget enforcement**  
2           **procedures including allocations**  
3           **under section 302(a) and (b) of**  
4           **the Balanced Budget and Emer-**  
5           **gency Deficit Control Act and**  
6           **budget resolutions for fiscal years**  
7           **during which appropriations are**  
8           **made from the Trust Fund.**

9           **(iii) LIMITATION TO AVAILABLE**  
10          **FUNDS.—The Secretary has the au-**  
11          **thority to stop taking applica-**  
12          **tions for participation in the pro-**  
13          **gram or take such other steps in**  
14          **reducing expenditures under the**  
15          **reinsurance program in order to**  
16          **ensure that expenditures under**  
17          **the reinsurance program do not**  
18          **exceed the funds available under**  
19          **this subsection.**

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**  
9 **within the Health Choices Administration and**  
10 **under the direction of the Commissioner a**  
11 **Health Insurance Exchange in order to facili-**  
12 **tate access of individuals and employers,**  
13 **through a transparent process, to a variety of**  
14 **choices of affordable, quality health insur-**  
15 **ance coverage, including a public health in-**  
16 **surance option.**

17 **(b) OUTLINE OF DUTIES OF COMMISSIONER.—**  
18 **In accordance with this subtitle and in co-**  
19 **ordination with appropriate Federal and**  
20 **State officials as provided under section**  
21 **143(b), the Commissioner shall—**

22 **(1) under section 204 establish stand-**  
23 **ards for, accept bids from, and negotiate**  
24 **and enter into contracts with, QHBP of-**  
25 **fering entities for the offering of health**

1       **benefits plans through the Health Insur-**  
2       **ance Exchange, with different levels of**  
3       **benefits required under section 203, and**  
4       **including with respect to oversight and**  
5       **enforcement;**

6           **(2) under section 205 facilitate out-**  
7       **reach and enrollment in such plans of Ex-**  
8       **change-eligible individuals and employ-**  
9       **ers described in section 202; and**

10           **(3) conduct such activities related to**  
11       **the Health Insurance Exchange as re-**  
12       **quired, including establishment of a risk**  
13       **pooling mechanism under section 206 and**  
14       **consumer protections under subtitle D of**  
15       **title I.**

16       **(c) EXCHANGE-PARTICIPATING HEALTH BENE-**  
17       **FITS PLAN DEFINED.—In this division, the term**  
18       **“Exchange-participating health benefits plan”**  
19       **means a qualified health benefits plan that is**  
20       **offered through the Health Insurance Ex-**  
21       **change.**

22       **SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOY-**  
23           **ERS.**

24           **(a) ACCESS TO COVERAGE.—In accordance**  
25       **with this section, all individuals are eligible**

1 to obtain coverage through enrollment in an  
2 Exchange-participating health benefits plan  
3 offered through the Health Insurance Ex-  
4 change unless such individuals are enrolled  
5 in another qualified health benefits plan or  
6 other acceptable coverage.

7 (b) DEFINITIONS.—In this division:

8 (1) EXCHANGE-ELIGIBLE INDIVIDUAL.—

9 The term “Exchange-eligible individual”  
10 means an individual who is eligible  
11 under this section to be enrolled through  
12 the Health Insurance Exchange in an Ex-  
13 change-participating health benefits plan  
14 and, with respect to family coverage, in-  
15 cludes dependents of such individual.

16 (2) EXCHANGE-ELIGIBLE EMPLOYER.—

17 The term “Exchange-eligible employer”  
18 means an employer that is eligible under  
19 this section to enroll through the Health  
20 Insurance Exchange employees of the em-  
21 ployer (and their dependents) in Ex-  
22 change-eligible health benefits plans.

23 (3) EMPLOYMENT-RELATED DEFINI-

24 TIONS.—The terms “employer”, “em-  
25 ployee”, “full-time employee”, and “part-



1       **time employee” have the meanings given**  
2       **such terms by the Commissioner for pur-**  
3       **poses of this division.**

4       **(c) TRANSITION.—Individuals and employ-**  
5       **ers shall only be eligible to enroll or partici-**  
6       **pate in the Health Insurance Exchange in ac-**  
7       **cordance with the following transition sched-**  
8       **ule:**

9               **(1) FIRST YEAR.—In Y1 (as defined in**  
10       **section 100(c))—**

11                       **(A) individuals described in sub-**  
12                       **section (d)(1), including individuals**  
13                       **described in paragraphs (3) and (4) of**  
14                       **subsection (d); and**

15                       **(B) smallest employers described**  
16                       **in subsection (e)(1).**

17               **(2) SECOND YEAR.—In Y2—**

18                       **(A) individuals and employers de-**  
19                       **scribed in paragraph (1); and**

20                       **(B) smaller employers described**  
21                       **in subsection (e)(2).**

22               **(3) THIRD AND SUBSEQUENT YEARS.—In**  
23       **Y3 and subsequent years—**

24                       **(A) individuals and employers de-**  
25                       **scribed in paragraph (2); and**

1           **(B) larger employers as permitted**  
2           **by the Commissioner under sub-**  
3           **section (e)(3).**

4           **(d) INDIVIDUALS.—**

5           **(1) INDIVIDUAL DESCRIBED.—Subject to**  
6           **the succeeding provisions of this sub-**  
7           **section, an individual described in this**  
8           **paragraph is an individual who—**

9                   **(A) is not enrolled in coverage de-**  
10                   **scribed in subparagraphs (C) through**  
11                   **(F) of paragraph (2); and**

12                   **(B) is not enrolled in coverage as**  
13                   **a full-time employee (or as a depend-**  
14                   **ent of such an employee) under a**  
15                   **group health plan if the coverage and**  
16                   **an employer contribution under the**  
17                   **plan meet the requirements of section**  
18                   **312.**

19           **For purposes of subparagraph (B), in the**  
20           **case of an individual who is self-em-**  
21           **ployed, who has at least 1 employee, and**  
22           **who meets the requirements of section**  
23           **312, such individual shall be deemed a**  
24           **full-time employee described in such sub-**  
25           **paragraph.**

1           **(2) ACCEPTABLE COVERAGE.—**For pur-  
2           poses of this division, the term “accept-  
3           able coverage” means any of the fol-  
4           lowing:

5                   **(A) QUALIFIED HEALTH BENEFITS**  
6                   **PLAN COVERAGE.—**Coverage under a  
7                   qualified health benefits plan.

8                   **(B) GRANDFATHERED HEALTH INSUR-**  
9                   **ANCE COVERAGE; COVERAGE UNDER CUR-**  
10                   **RENT GROUP HEALTH PLAN.—**Coverage  
11                   under a grandfathered health insur-  
12                   ance coverage (as defined in sub-  
13                   section (a) of section 102) or under a  
14                   current group health plan (described  
15                   in subsection (b) of such section).

16                   **(C) MEDICARE.—**Coverage under  
17                   part A of title XVIII of the Social Se-  
18                   curity Act.

19                   **(D) MEDICAID.—**Coverage for med-  
20                   ical assistance under title XIX of the  
21                   Social Security Act, excluding such  
22                   coverage that is only available be-  
23                   cause of the application of subsection  
24                   (u), (z), or (aa) of section 1902 of such  
25                   Act

1           **(E) MEMBERS OF THE ARMED**  
2           **FORCES AND DEPENDENTS (INCLUDING**  
3           **TRICARE).—Coverage under chapter 55**  
4           **of title 10, United States Code, includ-**  
5           **ing similar coverage furnished under**  
6           **section 1781 of title 38 of such Code.**

7           **(F) VA.—Coverage under the vet-**  
8           **eran’s health care program under**  
9           **chapter 17 of title 38, United States**  
10           **Code, but only if the coverage for the**  
11           **individual involved is determined by**  
12           **the Commissioner in coordination**  
13           **with the Secretary of Treasury to be**  
14           **not less than a level specified by the**  
15           **Commissioner and Secretary of Vet-**  
16           **eran’s Affairs, in coordination with**  
17           **the Secretary of Treasury, based on**  
18           **the individual’s priority for services**  
19           **as provided under section 1705(a) of**  
20           **such title.**

21           **(G) OTHER COVERAGE.—Such other**  
22           **health benefits coverage, such as a**  
23           **State health benefits risk pool, as the**  
24           **Commissioner, in coordination with**

1           the Secretary of the Treasury, recog-  
2           nizes for purposes of this paragraph.  
3       **The Commissioner shall make determina-**  
4       **tions under this paragraph in coordina-**  
5       **tion with the Secretary of the Treasury.**

6           **(3) TREATMENT OF CERTAIN NON-TRADI-**  
7       **TIONAL MEDICAID ELIGIBLE INDIVIDUALS.—**  
8       **An individual who is a non-traditional**  
9       **Medicaid eligible individual (as defined**  
10      **in section 205(e)(4)(C)) in a State may be**  
11      **an Exchange-eligible individual if the in-**  
12      **dividual was enrolled in a qualified**  
13      **health benefits plan, grandfathered**  
14      **health insurance coverage, or current**  
15      **group health plan during the 6 months**  
16      **before the individual became a non-tradi-**  
17      **tional Medicaid eligible individual. Dur-**  
18      **ing the period in which such an indi-**  
19      **vidual has chosen to enroll in an Ex-**  
20      **change-participating health benefits**  
21      **plan, the individual is not also eligible**  
22      **for medical assistance under Medicaid.**

23           **(4) CONTINUING ELIGIBILITY PER-**  
24      **MITTED.—**

1           **(A) IN GENERAL.—**Except as pro-  
2           vided in subparagraph (B), once an  
3           individual qualifies as an Exchange-  
4           eligible individual under this sub-  
5           section (including as an employee or  
6           dependent of an employee of an Ex-  
7           change-eligible employer) and enrolls  
8           under an Exchange-participating  
9           health benefits plan through the  
10          Health Insurance Exchange, the indi-  
11          vidual shall continue to be treated as  
12          an Exchange-eligible individual until  
13          the individual is no longer enrolled  
14          with an Exchange-participating  
15          health benefits plan.

16           **(B) EXCEPTIONS.—**

17           **(i) IN GENERAL.—**Subpara-  
18           graph (A) shall not apply to an in-  
19           dividual once the individual be-  
20           comes eligible for coverage—

21                   **(I) under part A of the**  
22                   **Medicare program;**

23                   **(II) under the Medicaid**  
24                   **program as a Medicaid eligi-**  
25                   **ble individual, except as per-**

1           mitted under paragraph (3) or  
2           clause (ii); or

3                   (III) in such other cir-  
4                   cumstances as the Commis-  
5                   sioner may provide.

6           (ii) **TRANSITION PERIOD.**—In the  
7           case described in clause (i)(II),  
8           the Commissioner shall permit  
9           the individual to continue treat-  
10          ment under subparagraph (A)  
11          until such limited time as the  
12          Commissioner determines it is ad-  
13          ministratively feasible, consistent  
14          with minimizing disruption in the  
15          individual’s access to health care.

16       (e) **EMPLOYERS.**—

17           (1) **SMALLEST EMPLOYER.**—Subject to  
18           paragraph (4), smallest employers de-  
19           scribed in this paragraph are employers  
20           with 10 or fewer employees.

21           (2) **SMALLER EMPLOYERS.**—Subject to  
22           paragraph (4), smaller employers de-  
23           scribed in this paragraph are employers  
24           that are not smallest employers described

1 in paragraph (1) and have 20 or fewer  
2 employees.

3 (3) LARGER EMPLOYERS.—

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

9 (B) PHASE-IN.—In applying sub-  
10 paragraph (A), the Commissioner may  
11 phase-in the application of such sub-  
12 paragraph based on the number of  
13 full-time employees of an employer  
14 and such other considerations as the  
15 Commissioner deems appropriate.

16 (4) CONTINUING ELIGIBILITY.—Once an  
17 employer is permitted to be an Exchange-  
18 eligible employer under this subsection  
19 and enrolls employees through the  
20 Health Insurance Exchange, the em-  
21 ployer shall continue to be treated as an  
22 Exchange-eligible employer for each sub-  
23 sequent plan year regardless of the num-  
24 ber of employees involved unless and  
25 until the employer meets the requirement



1 of section 311(a) through paragraph (1) of  
2 such section by offering a group health  
3 plan and not through offering an Ex-  
4 change-participating health benefits  
5 plan.

6 (5) EMPLOYER PARTICIPATION AND CON-  
7 TRIBUTIONS.—

8 (A) SATISFACTION OF EMPLOYER RE-  
9 SPONSIBILITY.—For any year in which  
10 an employer is an Exchange-eligible  
11 employer, such employer may meet  
12 the requirements of section 312 with  
13 respect to employees of such em-  
14 ployer by offering such employees the  
15 option of enrolling with Exchange-  
16 participating health benefits plans  
17 through the Health Insurance Ex-  
18 change consistent with the provisions  
19 of subtitle B of title III.

20 (B) EMPLOYEE CHOICE.—Any em-  
21 ployee offered Exchange-partici-  
22 pating health benefits plans by the  
23 employer of such employee under  
24 subparagraph (A) may choose cov-  
25 erage under any such plan. That

1           **choice includes, with respect to fam-**  
2           **ily coverage, coverage of the depend-**  
3           **ents of such employee.**

4           **(6) AFFILIATED GROUPS.—Any employer**  
5           **which is part of a group of employers**  
6           **who are treated as a single employer**  
7           **under subsection (b), (c), (m), or (o) of**  
8           **section 414 of the Internal Revenue Code**  
9           **of 1986 shall be treated, for purposes of**  
10          **this subtitle, as a single employer.**

11          **(7) OTHER COUNTING RULES.—The Com-**  
12          **missioner shall establish rules relating to**  
13          **how employees are counted for purposes**  
14          **of carrying out this subsection.**

15          **(f) SPECIAL SITUATION AUTHORITY.—The**  
16          **Commissioner shall have the authority to es-**  
17          **tablish such rules as may be necessary to deal**  
18          **with special situations with regard to unin-**  
19          **sured individuals and employers partici-**  
20          **pating as Exchange-eligible individuals and**  
21          **employers, such as transition periods for indi-**  
22          **viduals and employers who gain, or lose, Ex-**  
23          **change-eligible participation status, and to es-**  
24          **tablish grace periods for premium payment.**

1       **(g) SURVEYS OF INDIVIDUALS AND EMPLOY-**  
2 **ERS.—The Commissioner shall provide for**  
3 **periodic surveys of Exchange-eligible individ-**  
4 **uals and employers concerning satisfaction of**  
5 **such individuals and employers with the**  
6 **Health Insurance Exchange and Exchange-**  
7 **participating health benefits plans.**

8       **(h) EXCHANGE ACCESS STUDY.—**

9           **(1) IN GENERAL.—The Commissioner**  
10 **shall conduct a study of access to the**  
11 **Health Insurance Exchange for individ-**  
12 **uals and for employers, including individ-**  
13 **uals and employers who are not eligible**  
14 **and enrolled in Exchange-participating**  
15 **health benefits plans. The goal of the**  
16 **study is to determine if there are signifi-**  
17 **cant groups and types of individuals and**  
18 **employers who are not Exchange eligible**  
19 **individuals or employers, but who would**  
20 **have improved benefits and affordability**  
21 **if made eligible for coverage in the Ex-**  
22 **change.**

23           **(2) ITEMS INCLUDED IN STUDY.—Such**  
24 **study also shall examine—**

1           **(A) the terms, conditions, and af-**  
2           **fordability of group health coverage**  
3           **offered by employers and QHBP of-**  
4           **fering entities outside of the Ex-**  
5           **change compared to Exchange-par-**  
6           **ticipating health benefits plans; and**

7           **(B) the affordability-test standard**  
8           **for access of certain employed indi-**  
9           **viduals to coverage in the Health In-**  
10           **surance Exchange.**

11           **(3) REPORT.—Not later than January 1**  
12           **of Y3, in Y6, and thereafter, the Commis-**  
13           **sioner shall submit to Congress on the**  
14           **study conducted under this subsection**  
15           **and shall include in such report rec-**  
16           **ommendations regarding changes in**  
17           **standards for Exchange eligibility for in-**  
18           **dividuals and employers.**

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

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

1           **(b) LIMITATION ON HEALTH BENEFITS PLANS**  
2 **OFFERED BY OFFERING ENTITIES.—The Commis-**  
3 **sioner may not enter into a contract with a**  
4 **QHBP offering entity under section 204(c) for**  
5 **the offering of an Exchange-participating**  
6 **health benefits plan in a service area unless**  
7 **the following requirements are met:**

8           **(1) REQUIRED OFFERING OF BASIC**  
9 **PLAN.—The entity offers only one basic**  
10 **plan for such service area.**

11           **(2) OPTIONAL OFFERING OF ENHANCED**  
12 **PLAN.—If and only if the entity offers a**  
13 **basic plan for such service area, the enti-**  
14 **ty may offer one enhanced plan for such**  
15 **area.**

16           **(3) OPTIONAL OFFERING OF PREMIUM**  
17 **PLAN.—If and only if the entity offers an**  
18 **enhanced plan for such service area, the**  
19 **entity may offer one premium plan for**  
20 **such area.**

21           **(4) OPTIONAL OFFERING OF PREMIUM-**  
22 **PLUS PLANS.—If and only if the entity of-**  
23 **fers a premium plan for such service**  
24 **area, the entity may offer one or more**  
25 **premium-plus plans for such area.**

1 **All such plans may be offered under a single**  
2 **contract with the Commissioner.**

3 **(c) SPECIFICATION OF BENEFIT LEVELS FOR**  
4 **PLANS.—**

5 **(1) IN GENERAL.—The Commissioner**  
6 **shall establish the following standards**  
7 **consistent with this subsection and title**  
8 **I:**

9 **(A) BASIC, ENHANCED, AND PREMIUM**  
10 **PLANS.—Standards for 3 levels of Ex-**  
11 **change-participating health benefits**  
12 **plans: basic, enhanced, and premium**  
13 **(in this division referred to as a**  
14 **“basic plan”, “enhanced plan”, and**  
15 **“premium plan”, respectively).**

16 **(B) PREMIUM-PLUS PLAN BENE-**  
17 **FITS.—Standards for additional bene-**  
18 **fits that may be offered, consistent**  
19 **with this subsection and subtitle C of**  
20 **title I, under a premium plan (such a**  
21 **plan with additional benefits referred**  
22 **to in this division as a “premium-plus**  
23 **plan”).**

24 **(2) BASIC PLAN.—**

1           **(A) IN GENERAL.—A basic plan**  
2           **shall offer the essential benefits pack-**  
3           **age required under title I for a quali-**  
4           **fied health benefits plan.**

5           **(B) TIERED COST-SHARING FOR AF-**  
6           **FORDABLE CREDIT ELIGIBLE INDIVID-**  
7           **UALS.—In the case of an affordable**  
8           **credit eligible individual (as defined**  
9           **in section 242(a)(1)) enrolled in an Ex-**  
10          **change-participating health benefits**  
11          **plan, the benefits under a basic plan**  
12          **are modified to provide for the re-**  
13          **duced cost-sharing for the income**  
14          **tier applicable to the individual**  
15          **under section 244(c).**

16          **(3) ENHANCED PLAN.—An enhanced**  
17          **plan shall offer, in addition to the level of**  
18          **benefits under the basic plan, a lower**  
19          **level of cost-sharing as provided under**  
20          **title I consistent with section 123(b)(5)(A).**

21          **(4) PREMIUM PLAN.—A premium plan**  
22          **shall offer, in addition to the level of ben-**  
23          **efits under the basic plan, a lower level**  
24          **of cost-sharing as provided under title I**  
25          **consistent with section 123(b)(5)(B).**

1           **(5) PREMIUM-PLUS PLAN.—A premium-**  
2           **plus plan is a premium plan that also**  
3           **provides additional benefits, such as**  
4           **adult oral health and vision care, ap-**  
5           **proved by the Commissioner. The portion**  
6           **of the premium that is attributable to**  
7           **such additional benefits shall be sepa-**  
8           **rately specified.**

9           **(6) RANGE OF PERMISSIBLE VARIATION IN**  
10          **COST-SHARING.—The Commissioner shall**  
11          **establish a permissible range of variation**  
12          **of cost-sharing for each basic, enhanced,**  
13          **and premium plan, except with respect to**  
14          **any benefit for which there is no cost-**  
15          **sharing permitted under the essential**  
16          **benefits package. Such variation shall**  
17          **permit a variation of not more than plus**  
18          **(or minus) 10 percent in cost-sharing**  
19          **with respect to each benefit category**  
20          **specified under section 122.**

21          **(d) TREATMENT OF STATE BENEFIT MAN-**  
22          **DATES.—Insofar as a State requires a health**  
23          **insurance issuer offering health insurance**  
24          **coverage to include benefits beyond the es-**  
25          **sential benefits package, such requirement**



1 shall continue to apply to an Exchange-par-  
2 ticipating health benefits plan, if the State  
3 has entered into an arrangement satisfactory  
4 to the Commissioner to reimburse the Com-  
5 missioner for the amount of any net increase  
6 in affordability premium credits under sub-  
7 title C as a result of an increase in premium  
8 in basic plans as a result of application of  
9 such requirement.

10 SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-  
11 PARTICIPATING HEALTH BENEFITS PLANS.

12 (a) CONTRACTING DUTIES.—In carrying out  
13 section 201(b)(1) and consistent with this sub-  
14 title:

15 (1) OFFERING ENTITY AND PLAN STAND-  
16 ARDS.—The Commissioner shall—

17 (A) establish standards necessary  
18 to implement the requirements of this  
19 title and title I for—

20 (i) QHBP offering entities for  
21 the offering of an Exchange-par-  
22 ticipating health benefits plan;  
23 and

24 (ii) for Exchange-partici-  
25 pating health benefits plans; and

1           **(B) certify QHBP offering entities**  
2           **and qualified health benefits plans as**  
3           **meeting such standards and require-**  
4           **ments of this title and title I for pur-**  
5           **poses of this subtitle.**

6           **(2) SOLICITING AND NEGOTIATING BIDS;**  
7           **CONTRACTS.—The Commissioner shall—**

8           **(A) solicit bids from QHBP offer-**  
9           **ing entities for the offering of Ex-**  
10           **change-participating health benefits**  
11           **plans;**

12           **(B) based upon a review of such**  
13           **bids, negotiate with such entities for**  
14           **the offering of such plans; and**

15           **(C) enter into contracts with such**  
16           **entities for the offering of such plans**  
17           **through the Health Insurance Ex-**  
18           **change under terms (consistent with**  
19           **this title) negotiated between the**  
20           **Commissioner and such entities.**

21           **(3) FAR NOT APPLICABLE.—The provi-**  
22           **sions of the Federal Acquisition Regula-**  
23           **tion shall not apply to contracts between**  
24           **the Commissioner and QHBP offering en-**  
25           **tities for the offering of Exchange-partici-**

1        **pating health benefits plans under this**  
2        **title.**

3        **(b) STANDARDS FOR QHBP OFFERING ENTI-**  
4        **TIES TO OFFER EXCHANGE-PARTICIPATING**  
5        **HEALTH BENEFITS PLANS.—The standards es-**  
6        **tablished under subsection (a)(1)(A) shall re-**  
7        **quire that, in order for a QHBP offering entity**  
8        **to offer an Exchange-participating health**  
9        **benefits plan, the entity must meet the fol-**  
10       **lowing requirements:**

11            **(1) LICENSED.—The entity shall be li-**  
12            **censed to offer health insurance coverage**  
13            **under State law for each State in which**  
14            **it is offering such coverage.**

15            **(2) DATA REPORTING.—The entity shall**  
16            **provide for the reporting of such infor-**  
17            **mation as the Commissioner may specify,**  
18            **including information necessary to ad-**  
19            **minister the risk pooling mechanism de-**  
20            **scribed in section 206(b) and information**  
21            **to address disparities in health and**  
22            **health care.**

23            **(3) IMPLEMENTING AFFORDABILITY CRED-**  
24            **ITS.—The entity shall provide for imple-**  
25            **mentation of the affordability credits pro-**

1 vided for enrollees under subtitle C, in-  
2 cluding the reduction in cost-sharing  
3 under section 244(c).

4 (4) **ENROLLMENT.**—The entity shall ac-  
5 cept all enrollments under this subtitle,  
6 subject to such exceptions (such as ca-  
7 pacity limitations) in accordance with  
8 the requirements under title I for a quali-  
9 fied health benefits plan. The entity shall  
10 notify the Commissioner if the entity  
11 projects or anticipates reaching such a  
12 capacity limitation that would result in a  
13 limitation in enrollment.

14 (5) **RISK POOLING PARTICIPATION.**—The  
15 entity shall participate in such risk pool-  
16 ing mechanism as the Commissioner es-  
17 tablishes under section 206(b).

18 (6) **ESSENTIAL COMMUNITY PROVIDERS.**—  
19 With respect to the basic plan offered by  
20 the entity, the entity shall contract for  
21 outpatient services with covered entities  
22 (as defined in section 340B(a)(4) of the  
23 Public Health Service Act, as in effect as  
24 of July 1, 2009). The Commissioner shall  
25 specify the extent to which and manner

1 in which the previous sentence shall  
2 apply in the case of a basic plan with re-  
3 spect to which the Commissioner deter-  
4 mines provides substantially all benefits  
5 through a health maintenance organiza-  
6 tion, as defined in section 2791(b)(3) of  
7 the Public Health Service Act.

8 (7) CULTURALLY AND LINGUISTICALLY  
9 APPROPRIATE SERVICES AND COMMUNICA-  
10 TIONS.—The entity shall provide for cul-  
11 turally and linguistically appropriate  
12 communication and health services.

13 (8) ADDITIONAL REQUIREMENTS.—The  
14 entity shall comply with other applicable  
15 requirements of this title, as specified by  
16 the Commissioner, which shall include  
17 standards regarding billing and collec-  
18 tion practices for premiums and related  
19 grace periods and which may include  
20 standards to ensure that the entity does  
21 not use coercive practices to force pro-  
22 viders not to contract with other entities  
23 offering coverage through the Health In-  
24 surance Exchange.

25 (c) CONTRACTS.—

1           **(1) BID APPLICATION.—To be eligible to**  
2 **enter into a contract under this section, a**  
3 **QHBP offering entity shall submit to the**  
4 **Commissioner a bid at such time, in such**  
5 **manner, and containing such information**  
6 **as the Commissioner may require.**

7           **(2) TERM.—Each contract with a**  
8 **QHBP offering entity under this section**  
9 **shall be for a term of not less than one**  
10 **year, but may be made automatically re-**  
11 **newable from term to term in the ab-**  
12 **sence of notice of termination by either**  
13 **party.**

14           **(3) ENFORCEMENT OF NETWORK ADE-**  
15 **QUACY.—In the case of a health benefits**  
16 **plan of a QHBP offering entity that uses**  
17 **a provider network, the contract under**  
18 **this section with the entity shall provide**  
19 **that if—**

20                   **(A) the Commissioner determines**  
21 **that such provider network does not**  
22 **meet such standards as the Commis-**  
23 **sioner shall establish under section**  
24 **115; and**

1           **(B) an individual enrolled in such**  
2           **plan receives an item or service from**  
3           **a provider that is not within such**  
4           **network;**

5           **then any cost-sharing for such item or**  
6           **service shall be equal to the amount of**  
7           **such cost-sharing that would be imposed**  
8           **if such item or service was furnished by**  
9           **a provider within such network.**

10           **(4) OVERSIGHT AND ENFORCEMENT RE-**  
11           **SPONSIBILITIES.—The Commissioner shall**  
12           **establish processes, in coordination with**  
13           **State insurance regulators, to oversee,**  
14           **monitor, and enforce applicable require-**  
15           **ments of this title with respect to QHBP**  
16           **offering entities offering Exchange-par-**  
17           **ticipating health benefits plans and such**  
18           **plans, including the marketing of such**  
19           **plans. Such processes shall include the**  
20           **following:**

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

1           **viduals and employers may file com-**  
2           **plaints concerning violations of such**  
3           **standards.**

4           **(B) ENFORCEMENT.—In carrying**  
5           **out authorities under this division re-**  
6           **lating to the Health Insurance Ex-**  
7           **change, the Commissioner may im-**  
8           **pose one or more of the intermediate**  
9           **sanctions described in section 142(c).**

10           **(C) TERMINATION.—**

11           **(i) IN GENERAL.—The Commis-**  
12           **sioner may terminate a contract**  
13           **with a QHBP offering entity**  
14           **under this section for the offering**  
15           **of an Exchange-participating**  
16           **health benefits plan if such entity**  
17           **fails to comply with the applica-**  
18           **ble requirements of this title. Any**  
19           **determination by the Commis-**  
20           **sioner to terminate a contract**  
21           **shall be made in accordance with**  
22           **formal investigation and compli-**  
23           **ance procedures established by**  
24           **the Commissioner under which—**



1           **(I) the Commissioner pro-**  
2           **vides the entity with the rea-**  
3           **sonable opportunity to de-**  
4           **velop and implement a correc-**  
5           **tive action plan to correct the**  
6           **deficiencies that were the**  
7           **basis of the Commissioner’s**  
8           **determination; and**

9           **(II) the Commissioner pro-**  
10          **vides the entity with reason-**  
11          **able notice and opportunity**  
12          **for hearing (including the**  
13          **right to appeal an initial deci-**  
14          **sion) before terminating the**  
15          **contract.**

16          **(ii) EXCEPTION FOR IMMINENT**  
17          **AND SERIOUS RISK TO HEALTH.—**  
18          **Clause (i) shall not apply if the**  
19          **Commissioner determines that a**  
20          **delay in termination, resulting**  
21          **from compliance with the proce-**  
22          **dures specified in such clause**  
23          **prior to termination, would pose**  
24          **an imminent and serious risk to**  
25          **the health of individuals enrolled**

1           under the qualified health bene-  
2           fits plan of the QHBP offering en-  
3           tity.

4           **(D) CONSTRUCTION.**—Nothing in  
5           this subsection shall be construed as  
6           preventing the application of other  
7           sanctions under subtitle E of title I  
8           with respect to an entity for a viola-  
9           tion of such a requirement.

10 **SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-EL-**  
11           **IGIBLE INDIVIDUALS AND EMPLOYERS IN EX-**  
12           **CHANGE-PARTICIPATING HEALTH BENEFITS**  
13           **PLAN.**

14           **(a) IN GENERAL.**—

15           **(1) OUTREACH.**—The Commissioner  
16           shall conduct outreach activities con-  
17           sistent with subsection (c), including  
18           through use of appropriate entities as de-  
19           scribed in paragraph (4) of such sub-  
20           section, to inform and educate individ-  
21           uals and employers about the Health In-  
22           surance Exchange and Exchange-partici-  
23           pating health benefits plan options. Such  
24           outreach shall include outreach specific  
25           to vulnerable populations, such as chil-

1        **dren, individuals with disabilities, indi-**  
2        **viduals with mental illness, and individ-**  
3        **uals with other cognitive impairments.**

4            **(2) ELIGIBILITY.—The Commissioner**  
5        **shall make timely determinations of**  
6        **whether individuals and employers are**  
7        **Exchange-eligible individuals and em-**  
8        **ployers (as defined in section 202).**

9            **(3) ENROLLMENT.—The Commissioner**  
10       **shall establish and carry out an enroll-**  
11       **ment process for Exchange-eligible indi-**  
12       **viduals and employers, including at com-**  
13       **munity locations, in accordance with sub-**  
14       **section (b).**

15        **(b) ENROLLMENT PROCESS.—**

16            **(1) IN GENERAL.—The Commissioner**  
17       **shall establish a process consistent with**  
18       **this title for enrollments in Exchange-**  
19       **participating health benefits plans. Such**  
20       **process shall provide for enrollment**  
21       **through means such as the mail, by tele-**  
22       **phone, electronically, and in person.**

23            **(2) ENROLLMENT PERIODS.—**

24            **(A) OPEN ENROLLMENT PERIOD.—**

25        **The Commissioner shall establish an**

1           **annual open enrollment period dur-**  
2           **ing which an Exchange-eligible indi-**  
3           **vidual or employer may elect to en-**  
4           **roll in an Exchange-participating**  
5           **health benefits plan for the following**  
6           **plan year and an enrollment period**  
7           **for affordability credits under sub-**  
8           **title C. Such periods shall be during**  
9           **September through November of each**  
10          **year, or such other time that would**  
11          **maximize timeliness of income**  
12          **verification for purposes of such sub-**  
13          **title. The open enrollment period**  
14          **shall not be less than 30 days.**

15           **(B) SPECIAL ENROLLMENT.—The**  
16          **Commissioner shall also provide for**  
17          **special enrollment periods to take**  
18          **into account special circumstances of**  
19          **individuals and employers, such as an**  
20          **individual who—**

21                   **(i) loses acceptable coverage;**

22                   **(ii) experiences a change in**  
23                   **marital or other dependent sta-**  
24                   **tus;**

1           (iii) moves outside the service  
2           area of the Exchange-partici-  
3           pating health benefits plan in  
4           which the individual is enrolled;  
5           or

6           (iv) experiences a significant  
7           change in income.

8           (C) ENROLLMENT INFORMATION.—

9           The Commissioner shall provide for  
10          the broad dissemination of informa-  
11          tion to prospective enrollees on the  
12          enrollment process, including before  
13          each open enrollment period. In car-  
14          rying out the previous sentence, the  
15          Commissioner may work with other  
16          appropriate entities to facilitate such  
17          provision of information.

18          (3) AUTOMATIC ENROLLMENT FOR NON-  
19          MEDICAID ELIGIBLE INDIVIDUALS.—

20          (A) IN GENERAL.—The Commis-  
21          sioner shall provide for a process  
22          under which individuals who are Ex-  
23          change-eligible individuals described  
24          in subparagraph (B) are automati-  
25          cally enrolled under an appropriate

1           **Exchange-participating health bene-**  
2           **fits plan. Such process may involve a**  
3           **random assignment or some other**  
4           **form of assignment that takes into ac-**  
5           **count the health care providers used**  
6           **by the individual involved or such**  
7           **other relevant factors as the Commis-**  
8           **sioner may specify.**

9           **(B) SUBSIDIZED INDIVIDUALS DE-**  
10          **SCRIBED.—An individual described in**  
11          **this subparagraph is an Exchange-eli-**  
12          **gible individual who is either of the**  
13          **following:**

14               **(i) AFFORDABILITY CREDIT ELI-**  
15               **GIBLE INDIVIDUALS.—The indi-**  
16               **vidual—**

17                       **(I) has applied for, and**  
18                       **been determined eligible for,**  
19                       **affordability credits under**  
20                       **subtitle C;**

21                       **(II) has not opted out from**  
22                       **receiving such affordability**  
23                       **credit; and**

24                       **(III) does not otherwise**  
25                       **enroll in another Exchange-**

1           **participating health benefits**  
2           **plan.**

3           **(ii) INDIVIDUALS ENROLLED IN A**  
4           **TERMINATED PLAN.—The individual**  
5           **is enrolled in an Exchange-par-**  
6           **ticipating health benefits plan**  
7           **that is terminated (during or at**  
8           **the end of a plan year) and who**  
9           **does not otherwise enroll in an-**  
10           **other       Exchange-participating**  
11           **health benefits plan.**

12           **(4) DIRECT PAYMENT OF PREMIUMS TO**  
13           **PLANS.—Under the enrollment process, in-**  
14           **dividuals enrolled in an Exchange-par-**  
15           **ticipating health benefits plan shall pay**  
16           **such plans directly, and not through the**  
17           **Commissioner or the Health Insurance**  
18           **Exchange.**

19           **(c) COVERAGE INFORMATION AND ASSIST-**  
20           **ANCE.—**

21           **(1) COVERAGE INFORMATION.—The**  
22           **Commissioner shall provide for the broad**  
23           **dissemination of information on Ex-**  
24           **change-participating health benefits**  
25           **plans offered under this title. Such infor-**

1        **mation shall be provided in a compara-**  
2        **tive manner, and shall include informa-**  
3        **tion on benefits, premiums, cost-sharing,**  
4        **quality, provider networks, and con-**  
5        **sumer satisfaction.**

6            **(2) CONSUMER ASSISTANCE WITH**  
7        **CHOICE.—To provide assistance to Ex-**  
8        **change-eligible individuals and employ-**  
9        **ers, the Commissioner shall—**

10            **(A) provide for the operation of a**  
11            **toll-free telephone hotline to respond**  
12            **to requests for assistance and main-**  
13            **tain an Internet website through**  
14            **which individuals may obtain infor-**  
15            **mation on coverage under Exchange-**  
16            **participating health benefits plans**  
17            **and file complaints;**

18            **(B) develop and disseminate in-**  
19            **formation to Exchange-eligible enroll-**  
20            **ees on their rights and responsibil-**  
21            **ities;**

22            **(C) assist Exchange-eligible indi-**  
23            **viduals in selecting Exchange-partici-**  
24            **pating health benefits plans and ob-**



1           **taining benefits through such plans;**  
2           **and**

3           **(D) ensure that the Internet**  
4           **website described in subparagraph**  
5           **(A) and the information described in**  
6           **subparagraph (B) is developed using**  
7           **plain language (as defined in section**  
8           **133(a)(2)).**

9           **(3) USE OF OTHER ENTITIES.—In car-**  
10          **rying out this subsection, the Commis-**  
11          **sioner may work with other appropriate**  
12          **entities to facilitate the dissemination of**  
13          **information under this subsection and to**  
14          **provide assistance as described in para-**  
15          **graph (2).**

16          **(d) SPECIAL DUTIES RELATED TO MEDICAID**  
17          **AND CHIP.—**

18                 **(1) COVERAGE FOR CERTAIN**  
19                 **NEWBORNS.—**

20                         **(A) IN GENERAL.—In the case of a**  
21                         **child born in the United States who**  
22                         **at the time of birth is not otherwise**  
23                         **covered under acceptable coverage,**  
24                         **for the period of time beginning on**  
25                         **the date of birth and ending on the**

1           **date the child otherwise is covered**  
2           **under acceptable coverage (or, if ear-**  
3           **lier, the end of the month in which**  
4           **the 60-day period, beginning on the**  
5           **date of birth, ends), the child shall be**  
6           **deemed—**

7                   **(i) to be a non-traditional**  
8                   **Medicaid eligible individual (as**  
9                   **defined in subsection (e)(5)) for**  
10                   **purposes of this division and**  
11                   **Medicaid; and**

12                   **(ii) to have elected to enroll in**  
13                   **Medicaid through the application**  
14                   **of paragraph (3).**

15           **(B) EXTENDED TREATMENT AS TRADI-**  
16           **TIONAL MEDICAID ELIGIBLE INDI-**  
17           **VIDUAL.—In the case of a child de-**  
18           **scribed in subparagraph (A) who at**  
19           **the end of the period referred to in**  
20           **such subparagraph is not otherwise**  
21           **covered under acceptable coverage,**  
22           **the child shall be deemed (until such**  
23           **time as the child obtains such cov-**  
24           **erage or the State otherwise makes a**  
25           **determination of the child’s eligibility**

1           **for medical assistance under its Med-**  
2           **icaid plan pursuant to section**  
3           **1943(c)(1) of the Social Security Act)**  
4           **to be a traditional Medicaid eligible**  
5           **individual described in section**  
6           **1902(l)(1)(B) of such Act.**

7           **(2) CHIP TRANSITION.—A child who, as**  
8           **of the day before the first day of Y1, is el-**  
9           **igible for child health assistance under**  
10          **title XXI of the Social Security Act (in-**  
11          **cluding a child receiving coverage under**  
12          **an arrangement described in section**  
13          **2101(a)(2) of such Act) is deemed as of**  
14          **such first day to be an Exchange-eligible**  
15          **individual unless the individual is a tra-**  
16          **ditional Medicaid eligible individual as of**  
17          **such day.**

18          **(3) AUTOMATIC ENROLLMENT OF MED-**  
19          **ICAID ELIGIBLE INDIVIDUALS INTO MED-**  
20          **ICAID.—The Commissioner shall provide**  
21          **for a process under which an individual**  
22          **who is described in section 202(d)(3) and**  
23          **has not elected to enroll in an Exchange-**  
24          **participating health benefits plan is auto-**  
25          **matically enrolled under Medicaid.**

1           **(4) NOTIFICATIONS.—The Commis-**  
2           **sioner shall notify each State in Y1 and**  
3           **for purposes of section 1902(gg)(1) of the**  
4           **Social Security Act (as added by section**  
5           **1703(a)) whether the Health Insurance**  
6           **Exchange can support enrollment of chil-**  
7           **dren described in paragraph (2) in such**  
8           **State in such year.**

9           **(e) MEDICAID COVERAGE FOR MEDICAID ELI-**  
10          **GIBLE INDIVIDUALS.—**

11           **(1) IN GENERAL.—**

12           **(A) CHOICE FOR LIMITED EXCHANGE-**  
13           **ELIGIBLE INDIVIDUALS.—As part of the**  
14           **enrollment process under subsection**  
15           **(b), the Commissioner shall provide**  
16           **the option, in the case of an Ex-**  
17           **change-eligible individual described**  
18           **in section 202(d)(3), for the individual**  
19           **to elect to enroll under Medicaid in-**  
20           **stead of under an Exchange-partici-**  
21           **pating health benefits plan. Such an**  
22           **individual may change such election**  
23           **during an enrollment period under**  
24           **subsection (b)(2).**

1           **(B) MEDICAID ENROLLMENT OBLIGA-**  
2           **TION.—An Exchange eligible indi-**  
3           **vidual may apply, in the manner de-**  
4           **scribed in section 241(b)(1), for a de-**  
5           **termination of whether the individual**  
6           **is a Medicaid-eligible individual. If**  
7           **the individual is determined to be so**  
8           **eligible, the Commissioner, through**  
9           **the Medicaid memorandum of under-**  
10          **standing, shall provide for the enroll-**  
11          **ment of the individual under the**  
12          **State Medicaid plan in accordance**  
13          **with the Medicaid memorandum of**  
14          **understanding under paragraph (4).**  
15          **In the case of such an enrollment, the**  
16          **State shall provide for the same peri-**  
17          **odic redetermination of eligibility**  
18          **under Medicaid as would otherwise**  
19          **apply if the individual had directly**  
20          **applied for medical assistance to the**  
21          **State Medicaid agency.**

22          **(2) NON-TRADITIONAL MEDICAID ELIGI-**  
23          **BLE INDIVIDUALS.—In the case of a non-tra-**  
24          **ditional Medicaid eligible individual de-**  
25          **scribed in section 202(d)(3) who elects to**

1 enroll under Medicaid under paragraph  
2 (1)(A), the Commissioner shall provide for  
3 the enrollment of the individual under  
4 the State Medicaid plan in accordance  
5 with the Medicaid memorandum of un-  
6 derstanding under paragraph (4).

7 (3) COORDINATED ENROLLMENT WITH  
8 STATE THROUGH MEMORANDUM OF UNDER-  
9 STANDING.—The Commissioner, in con-  
10 sultation with the Secretary of Health  
11 and Human Services, shall enter into a  
12 memorandum of understanding with  
13 each State (each in this division referred  
14 to as a “Medicaid memorandum of under-  
15 standing”) with respect to coordinating  
16 enrollment of individuals in Exchange-  
17 participating health benefits plans and  
18 under the State’s Medicaid program con-  
19 sistent with this section and to otherwise  
20 coordinate the implementation of the  
21 provisions of this division with respect to  
22 the Medicaid program. Such memo-  
23 randum shall permit the exchange of in-  
24 formation consistent with the limitations  
25 described in section 1902(a)(7) of the So-

1        **cial Security Act. Nothing in this section**  
2        **shall be construed as permitting such**  
3        **memorandum to modify or vitiate any re-**  
4        **quirement of a State Medicaid plan.**

5            **(4) MEDICAID ELIGIBLE INDIVIDUALS.—**

6        **For purposes of this division:**

7            **(A) MEDICAID ELIGIBLE INDI-**  
8            **VIDUAL.—The term “Medicaid eligible**  
9            **individual” means an individual who**  
10          **is eligible for medical assistance**  
11          **under Medicaid.**

12          **(B) TRADITIONAL MEDICAID ELIGI-**  
13          **BLE INDIVIDUAL.—The term “tradi-**  
14          **tional Medicaid eligible individual”**  
15          **means a Medicaid eligible individual**  
16          **other than an individual who is—**

17                  **(i) a Medicaid eligible indi-**  
18                  **vidual by reason of the applica-**  
19                  **tion of subclause (VIII) of section**  
20                  **1902(a)(10)(A)(i) of the Social Se-**  
21                  **curity Act; or**

22                  **(ii) a childless adult not de-**  
23                  **scribed in section 1902(a)(10)(A)**  
24                  **or (C) of such Act (as in effect as**

1           of the day before the date of the  
2           enactment of this Act).

3           **(C) NON-TRADITIONAL MEDICAID ELI-**  
4           **GIBLE INDIVIDUAL.—**The term “non-tra-  
5           ditional Medicaid eligible individual”  
6           means a Medicaid eligible individual  
7           who is not a traditional Medicaid eli-  
8           gible individual.

9           **(f) EFFECTIVE CULTURALLY AND LINGUIS-**  
10          **TICALLY APPROPRIATE COMMUNICATION.—**In  
11          carrying out this section, the Commissioner  
12          shall establish effective methods for commu-  
13          nicating in plain language and a culturally  
14          and linguistically appropriate manner.

15        SEC. 206. OTHER FUNCTIONS.

16          **(a) COORDINATION OF AFFORDABILITY CRED-**  
17          **ITS.—**The Commissioner shall coordinate the  
18          distribution of affordability premium and  
19          cost-sharing credits under subtitle C to QHBP  
20          offering entities offering Exchange-partici-  
21          pating health benefits plans.

22          **(b) COORDINATION OF RISK POOLING.—**The  
23          Commissioner shall establish a mechanism  
24          whereby there is an adjustment made of the  
25          premium amounts payable among QHBP of-



1 **fering entities offering Exchange-partici-**  
2 **pating health benefits plans of premiums col-**  
3 **lected for such plans that takes into account**  
4 **(in a manner specified by the Commissioner)**  
5 **the differences in the risk characteristics of**  
6 **individuals and employers enrolled under the**  
7 **different Exchange-participating health bene-**  
8 **fits plans offered by such entities so as to min-**  
9 **imize the impact of adverse selection of en-**  
10 **rollees among the plans offered by such enti-**  
11 **ties.**

12 **(c) SPECIAL INSPECTOR GENERAL FOR THE**  
13 **HEALTH INSURANCE EXCHANGE.—**

14 **(1) ESTABLISHMENT; APPOINTMENT.—**

15 **There is hereby established the Office of**  
16 **the Special Inspector General for the**  
17 **Health Insurance Exchange, to be headed**  
18 **by a Special Inspector General for the**  
19 **Health Insurance Exchange (in this sub-**  
20 **section referred to as the “Special Inspec-**  
21 **tor General”) to be appointed by the**  
22 **President, by and with the advice and**  
23 **consent of the Senate. The nomination of**  
24 **an individual as Special Inspector Gen-**  
25 **eral shall be made as soon as practicable**

1       **after the establishment of the program**  
2       **under this subtitle.**

3           **(2) DUTIES.—The Special Inspector**  
4       **General shall—**

5           **(A) conduct, supervise, and co-**  
6       **ordinate audits, evaluations and in-**  
7       **vestigations of the Health Insurance**  
8       **Exchange to protect the integrity of**  
9       **the Health Insurance Exchange, as**  
10      **well as the health and welfare of par-**  
11      **ticipants in the Exchange;**

12          **(B) report both to the Commis-**  
13      **sioner and to the Congress regarding**  
14      **program and management problems**  
15      **and recommendations to correct**  
16      **them;**

17          **(C) have other duties (described**  
18      **in paragraphs (2) and (3) of section**  
19      **121 of division A of Public Law 110-**  
20      **343) in relation to the duties de-**  
21      **scribed in the previous subpara-**  
22      **graphs; and**

23          **(D) have the authorities provided**  
24      **in section 6 of the Inspector General**

1           **Act of 1978 in carrying out duties**  
2           **under this paragraph.**

3           **(3) APPLICATION OF OTHER SPECIAL IN-**  
4           **SPECTOR GENERAL PROVISIONS.—The provi-**  
5           **sions of subsections (b) (other than para-**  
6           **graphs (1) and (3)), (d) (other than para-**  
7           **graph (1)), and (e) of section 121 of divi-**  
8           **sion A of the Emergency Economic Sta-**  
9           **bilization Act of 2009 (Public Law 110-**  
10           **343) shall apply to the Special Inspector**  
11           **General under this subsection in the**  
12           **same manner as such provisions apply to**  
13           **the Special Inspector General under such**  
14           **section.**

15           **(4) REPORTS.—Not later than one year**  
16           **after the confirmation of the Special In-**  
17           **spector General, and annually thereafter,**  
18           **the Special Inspector General shall sub-**  
19           **mit to the appropriate committees of**  
20           **Congress a report summarizing the ac-**  
21           **tivities of the Special Inspector General**  
22           **during the one year period ending on the**  
23           **date such report is submitted.**

24           **(5) TERMINATION.—The Office of the**  
25           **Special Inspector General shall terminate**

1       **five years after the date of the enactment**  
2       **of this Act.**

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

4       **(a) ESTABLISHMENT OF HEALTH INSURANCE**  
5       **EXCHANGE TRUST FUND.—There is created**  
6       **within the Treasury of the United States a**  
7       **trust fund to be known as the “Health Insur-**  
8       **ance Exchange Trust Fund” (in this section**  
9       **referred to as the “Trust Fund”), consisting of**  
10       **such amounts as may be appropriated or**  
11       **credited to the Trust Fund under this section**  
12       **or any other provision of law.**

13       **(b) PAYMENTS FROM TRUST FUND.—The**  
14       **Commissioner shall pay from time to time**  
15       **from the Trust Fund such amounts as the**  
16       **Commissioner determines are necessary to**  
17       **make payments to operate the Health Insur-**  
18       **ance Exchange, including payments under**  
19       **subtitle C (relating to affordability credits).**

20       **(c) TRANSFERS TO TRUST FUND.—**

21               **(1) DEDICATED PAYMENTS.—There is**  
22       **hereby appropriated to the Trust Fund**  
23       **amounts equivalent to the following:**

24                       **(A) TAXES ON INDIVIDUALS NOT OB-**  
25       **TAINING ACCEPTABLE COVERAGE.—The**

1           **amounts received in the Treasury**  
2           **under section 59B of the Internal**  
3           **Revenue Code of 1986 (relating to re-**  
4           **quirement of health insurance cov-**  
5           **erage for individuals).**

6           **(B) EMPLOYMENT TAXES ON EMPLOY-**  
7           **ERS NOT PROVIDING ACCEPTABLE COV-**  
8           **ERAGE.—The amounts received in the**  
9           **Treasury under section 3111(c) of the**  
10          **Internal Revenue Code of 1986 (relat-**  
11          **ing to employers electing to not pro-**  
12          **vide health benefits).**

13          **(C) EXCISE TAX ON FAILURES TO**  
14          **MEET CERTAIN HEALTH COVERAGE RE-**  
15          **QUIREMENTS.—The amounts received**  
16          **in the Treasury under section**  
17          **4980H(b) (relating to excise tax with**  
18          **respect to failure to meet health cov-**  
19          **erage participation requirements).**

20          **(2) APPROPRIATIONS TO COVER GOVERN-**  
21          **MENT CONTRIBUTIONS.—There are hereby**  
22          **appropriated, out of any moneys in the**  
23          **Treasury not otherwise appropriated, to**  
24          **the Trust Fund, an amount equivalent to**  
25          **the amount of payments made from the**

1       **Trust Fund under subsection (b) plus**  
2       **such amounts as are necessary reduced**  
3       **by the amounts deposited under para-**  
4       **graph (1).**

5       **(d) APPLICATION OF CERTAIN RULES.—Rules**  
6       **similar to the rules of subchapter B of chapter**  
7       **98 of the Internal Revenue Code of 1986 shall**  
8       **apply with respect to the Trust Fund.**

9       **SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH**  
10               **INSURANCE EXCHANGES.**

11       **(a) IN GENERAL.—If—**

12               **(1) a State (or group of States, subject**  
13               **to the approval of the Commissioner) ap-**  
14               **plies to the Commissioner for approval of**  
15               **a State-based Health Insurance Exchange**  
16               **to operate in the State (or group of**  
17               **States); and**

18               **(2) the Commissioner approves such**  
19               **State-based Health Insurance Exchange,**  
20       **then, subject to subsections (c) and (d), the**  
21       **State-based Health Insurance Exchange shall**  
22       **operate, instead of the Health Insurance Ex-**  
23       **change, with respect to such State (or group**  
24       **of States). The Commissioner shall approve a**  
25       **State-based Health Insurance Exchange if it**

1 meets the requirements for approval under  
2 subsection (b).

3 **(b) REQUIREMENTS FOR APPROVAL.—The**  
4 **Commissioner may not approve a State-based**  
5 **Health Insurance Exchange under this sec-**  
6 **tion unless the following requirements are**  
7 **met:**

8 **(1) The State-based Health Insurance**  
9 **Exchange must demonstrate the capacity**  
10 **to and provide assurances satisfactory to**  
11 **the Commissioner that the State-based**  
12 **Health Insurance Exchange will carry**  
13 **out the functions specified for the Health**  
14 **Insurance Exchange in the State (or**  
15 **States) involved, including—**

16 **(A) negotiating and contracting**  
17 **with QHBP offering entities for the**  
18 **offering of Exchange-participating**  
19 **health benefits plan, which satisfy**  
20 **the standards and requirements of**  
21 **this title and title I;**

22 **(B) enrolling Exchange-eligible in-**  
23 **dividuals and employers in such State**  
24 **in such plans;**

1           **(C) the establishment of sufficient**  
2           **local offices to meet the needs of Ex-**  
3           **change-eligible individuals and em-**  
4           **ployers;**

5           **(D) administering affordability**  
6           **credits under subtitle B using the**  
7           **same methodologies (and at least the**  
8           **same income verification methods) as**  
9           **would otherwise apply under such**  
10          **subtitle and at a cost to the Federal**  
11          **Government which does exceed the**  
12          **cost to the Federal Government if**  
13          **this section did not apply; and**

14          **(E) enforcement activities con-**  
15          **sistent with federal requirements.**

16          **(2) There is no more than one Health**  
17          **Insurance Exchange operating with re-**  
18          **spect to any one State.**

19          **(3) The State provides assurances sat-**  
20          **isfactory to the Commissioner that ap-**  
21          **proval of such an Exchange will not re-**  
22          **sult in any net increase in expenditures**  
23          **to the Federal Government.**

24          **(4) The State provides for reporting**  
25          **of such information as the Commissioner**



1 **determines and assurances satisfactory**  
2 **to the Commissioner that it will vigor-**  
3 **ously enforce violations of applicable re-**  
4 **quirements.**

5 **(5) Such other requirements as the**  
6 **Commissioner may specify.**

7 **(c) CEASING OPERATION.—**

8 **(1) IN GENERAL.—A State-based Health**  
9 **Insurance Exchange may, at the option of**  
10 **each State involved, and only after pro-**  
11 **viding timely and reasonable notice to**  
12 **the Commissioner, cease operation as**  
13 **such an Exchange, in which case the**  
14 **Health Insurance Exchange shall operate,**  
15 **instead of such State-based Health Insur-**  
16 **ance Exchange, with respect to such**  
17 **State (or States).**

18 **(2) TERMINATION; HEALTH INSURANCE**  
19 **EXCHANGE RESUMPTION OF FUNCTIONS.—The**  
20 **Commissioner may terminate the ap-**  
21 **proval (for some or all functions) of a**  
22 **State-based Health Insurance Exchange**  
23 **under this section if the Commissioner**  
24 **determines that such Exchange no longer**  
25 **meets the requirements of subsection (b)**

1 or is no longer capable of carrying out  
2 such functions in accordance with the re-  
3 quirements of this subtitle. In lieu of ter-  
4 minating such approval, the Commis-  
5 sioner may temporarily assume some or  
6 all functions of the State-based Health In-  
7 surance Exchange until such time as the  
8 Commissioner determines the State-  
9 based Health Insurance Exchange meets  
10 such requirements of subsection (b) and  
11 is capable of carrying out such functions  
12 in accordance with the requirements of  
13 this subtitle.

14 (3) **EFFECTIVENESS.**—The ceasing or  
15 termination of a State-based Health In-  
16 surance Exchange under this subsection  
17 shall be effective in such time and man-  
18 ner as the Commissioner shall specify.

19 (d) **RETENTION OF AUTHORITY.**—

20 (1) **AUTHORITY RETAINED.**—Enforce-  
21 ment authorities of the Commissioner  
22 shall be retained by the Commissioner.

23 (2) **DISCRETION TO RETAIN ADDITIONAL**  
24 **AUTHORITY.**—The Commissioner may

1       **specify functions of the Health Insurance**  
2       **Exchange that—**

3               **(A) may not be performed by a**  
4               **State-based Health Insurance Ex-**  
5               **change under this section; or**

6               **(B) may be performed by the**  
7               **Commissioner and by such a State-**  
8               **based Health Insurance Exchange.**

9       **(e) REFERENCES.—In the case of a State-**  
10       **based Health Insurance Exchange, except as**  
11       **the Commissioner may otherwise specify**  
12       **under subsection (d), any references in this**  
13       **subtitle to the Health Insurance Exchange or**  
14       **to the Commissioner in the area in which the**  
15       **State-based Health Insurance Exchange oper-**  
16       **ates shall be deemed a reference to the State-**  
17       **based Health Insurance Exchange and the**  
18       **head of such Exchange, respectively.**

19       **(f) FUNDING.—In the case of a State-based**  
20       **Health Insurance Exchange, there shall be as-**  
21       **sistance provided for the operation of such**  
22       **Exchange in the form of a matching grant**  
23       **with a State share of expenditures required.**

1                   **Subtitle B—Public Health**  
2                   **Insurance Option**

3   **SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A**  
4                   **PUBLIC HEALTH INSURANCE OPTION AS AN**  
5                   **EXCHANGE-QUALIFIED HEALTH BENEFITS**  
6                   **PLAN.**

7           **(a) ESTABLISHMENT.—For years beginning**  
8   **with Y1, the Secretary of Health and Human**  
9   **Services (in this subtitle referred to as the**  
10 **“Secretary”) shall provide for the offering of**  
11 **an Exchange-participating health benefits**  
12 **plan (in this division referred to as the “pub-**  
13 **lic health insurance option”) that ensures**  
14 **choice, competition, and stability of afford-**  
15 **able, high quality coverage throughout the**  
16 **United States in accordance with this sub-**  
17 **title. In designing the option, the Secretary’s**  
18 **primary responsibility is to create a low-cost**  
19 **plan without compromising quality or access**  
20 **to care.**

21           **(b) OFFERING AS AN EXCHANGE-PARTICI-**  
22 **PATING HEALTH BENEFITS PLAN.—**

23                   **(1) EXCLUSIVE TO THE EXCHANGE.—The**  
24           **public health insurance option shall only**

1       **be made available through the Health In-**  
2       **surance Exchange.**

3           **(2) ENSURING A LEVEL PLAYING FIELD.—**  
4       **Consistent with this subtitle, the public**  
5       **health insurance option shall comply**  
6       **with requirements that are applicable**  
7       **under this title to an Exchange-partici-**  
8       **pating health benefits plan, including re-**  
9       **quirements related to benefits, benefit**  
10       **levels, provider networks, notices, con-**  
11       **sumer protections, and cost sharing.**

12           **(3) PROVISION OF BENEFIT LEVELS.—The**  
13       **public health insurance option—**

14           **(A) shall offer basic, enhanced,**  
15           **and premium plans; and**

16           **(B) may offer premium-plus plans.**

17       **(c) ADMINISTRATIVE CONTRACTING.—The**  
18       **Secretary may enter into contracts for the**  
19       **purpose of performing administrative func-**  
20       **tions (including functions described in sub-**  
21       **section (a)(4) of section 1874A of the Social Se-**  
22       **curity Act) with respect to the public health**  
23       **insurance option in the same manner as the**  
24       **Secretary may enter into contracts under sub-**  
25       **section (a)(1) of such section. The Secretary**

1 has the same authority with respect to the  
2 public health insurance option as the Sec-  
3 retary has under subsections (a)(1) and (b) of  
4 section 1874A of the Social Security Act with  
5 respect to title XVIII of such Act. Contracts  
6 under this subsection shall not involve the  
7 transfer of insurance risk to such entity.

8 (d) OMBUDSMAN.—The Secretary shall es-  
9 tablish an office of the ombudsman for the  
10 public health insurance option which shall  
11 have duties with respect to the public health  
12 insurance option similar to the duties of the  
13 Medicare Beneficiary Ombudsman under sec-  
14 tion 1808(c)(2) of the Social Security Act.

15 (e) DATA COLLECTION.—The Secretary shall  
16 collect such data as may be required to estab-  
17 lish premiums and payment rates for the pub-  
18 lic health insurance option and for other pur-  
19 poses under this subtitle, including to im-  
20 prove quality and to reduce racial, ethnic,  
21 and other disparities in health and health  
22 care.

23 (f) TREATMENT OF PUBLIC HEALTH INSUR-  
24 ANCE OPTION.—With respect to the public  
25 health insurance option, the Secretary shall

1 be treated as a QHBP offering entity offering  
2 an Exchange-participating health benefits  
3 plan.

4 (g) ACCESS TO FEDERAL COURTS.—The pro-  
5 visions of Medicare (and related provisions of  
6 title II of the Social Security Act) relating to  
7 access of Medicare beneficiaries to Federal  
8 courts for the enforcement of rights under  
9 Medicare, including with respect to amounts  
10 in controversy, shall apply to the public  
11 health insurance option and individuals en-  
12 rolled under such option under this title in  
13 the same manner as such provisions apply to  
14 Medicare and Medicare beneficiaries.

15 SEC. 222. PREMIUMS AND FINANCING.

16 (a) ESTABLISHMENT OF PREMIUMS.—

17 (1) IN GENERAL.—The Secretary shall  
18 establish geographically-adjusted pre-  
19 mium rates for the public health insur-  
20 ance option in a manner—

21 (A) that complies with the pre-  
22 mium rules established by the Com-  
23 missioner under section 113 for Ex-  
24 change-participating health benefit  
25 plans; and

1           **(B) at a level sufficient to fully fi-**  
2           **nance the costs of—**

3                   **(i) health benefits provided by**  
4                   **the public health insurance op-**  
5                   **tion; and**

6                   **(ii) administrative costs re-**  
7                   **lated to operating the public**  
8                   **health insurance option.**

9           **(2) CONTINGENCY MARGIN.—In estab-**  
10           **lishing premium rates under paragraph**  
11           **(1), the Secretary shall include an appro-**  
12           **priate amount for a contingency margin.**

13           **(b) ACCOUNT.—**

14                   **(1) ESTABLISHMENT.—There is estab-**  
15                   **lished in the Treasury of the United**  
16                   **States an Account for the receipts and**  
17                   **disbursements attributable to the oper-**  
18                   **ation of the public health insurance op-**  
19                   **tion, including the start-up funding**  
20                   **under paragraph (2). Section 1854(g) of**  
21                   **the Social Security Act shall apply to re-**  
22                   **ceipts described in the previous sentence**  
23                   **in the same manner as such section ap-**  
24                   **plies to payments or premiums described**  
25                   **in such section.**



1           **(2) START-UP FUNDING.—**

2           **(A) IN GENERAL.—**In order to pro-  
3           **vide for the establishment of the pub-**  
4           **lic health insurance option there is**  
5           **hereby appropriated to the Secretary,**  
6           **out of any funds in the Treasury not**  
7           **otherwise                           appropriated,**  
8           **\$2,000,000,000. In order to provide for**  
9           **initial claims reserves before the col-**  
10           **lection of premiums, there is hereby**  
11           **appropriated to the Secretary, out of**  
12           **any funds in the Treasury not other-**  
13           **wise appropriated, such sums as nec-**  
14           **essary to cover 90 days worth of**  
15           **claims reserves based on projected**  
16           **enrollment.**

17           **(B) AMORTIZATION OF START-UP**  
18           **FUNDING.—**The Secretary shall pro-  
19           **vide for the repayment of the startup**  
20           **funding provided under subpara-**  
21           **graph (A) to the Treasury in an amor-**  
22           **tized manner over the 10-year period**  
23           **beginning with Y1.**

24           **(C) LIMITATION ON FUNDING.—**Noth-  
25           **ing in this section shall be construed**

1           **as authorizing any additional appro-**  
2           **priations to the Account, other than**  
3           **such amounts as are otherwise pro-**  
4           **vided with respect to other Exchange-**  
5           **participating health benefits plans.**

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

7           **(a) RATES ESTABLISHED BY SECRETARY.—**

8                 **(1) IN GENERAL.—The Secretary shall**  
9                 **establish payment rates for the public**  
10                **health insurance option for services and**  
11                **health care providers consistent with this**  
12                **section and may change such payment**  
13                **rates in accordance with section 224.**

14                **(2) INITIAL PAYMENT RULES.—**

15                    **(A) IN GENERAL.—Except as pro-**  
16                    **vided in subparagraph (B) and sub-**  
17                    **section (b)(1), during Y1, Y2, and Y3,**  
18                    **the Secretary shall base the payment**  
19                    **rates under this section for services**  
20                    **and providers described in paragraph**  
21                    **(1) on the payment rates for similar**  
22                    **services and providers under parts A**  
23                    **and B of Medicare.**

24                    **(B) EXCEPTIONS.—**

1           **(i) PRACTITIONERS' SERVICES.—**  
2           **Payment rates for practitioners'**  
3           **services otherwise established**  
4           **under the fee schedule under sec-**  
5           **tion 1848 of the Social Security**  
6           **Act shall be applied without re-**  
7           **gard to the provisions under sub-**  
8           **section (f) of such section and the**  
9           **update under subsection (d)(4)**  
10           **under such section for a year as**  
11           **applied under this paragraph**  
12           **shall be not less than 1 percent.**

13           **(ii) ADJUSTMENTS.—The Sec-**  
14           **retary may determine the extent**  
15           **to which Medicare adjustments**  
16           **applicable to base payment rates**  
17           **under parts A and B of Medicare**  
18           **shall apply under this subtitle.**

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

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

6           **(b) INCENTIVES FOR PARTICIPATING PRO-**  
7 **VIDERS.—**

8           **(1) INITIAL INCENTIVE PERIOD.—**

9           **(A) IN GENERAL.—**The Secretary  
10 shall provide, in the case of services  
11 described in subparagraph (B) fur-  
12 nished during Y1, Y2, and Y3, for pay-  
13 ment rates that are 5 percent greater  
14 than the rates established under sub-  
15 section (a).

16           **(B) SERVICES DESCRIBED.—**The  
17 services described in this subpara-  
18 graph are items and professional  
19 services, under the public health in-  
20 surance option by a physician or  
21 other health care practitioner who  
22 participates in both Medicare and the  
23 public health insurance option.

24           **(C) SPECIAL RULES.—**A pediatri-  
25 cian and any other health care practi-

1           **tioner who is a type of practitioner**  
2           **that does not typically participate in**  
3           **Medicare (as determined by the Sec-**  
4           **retary) shall also be eligible for the**  
5           **increased payment rates under sub-**  
6           **paragraph (A).**

7           **(2) SUBSEQUENT PERIODS.—Beginning**  
8           **with Y4 and for subsequent years, the**  
9           **Secretary shall continue to use an admin-**  
10          **istrative process to set such rates in**  
11          **order to promote payment accuracy, to**  
12          **ensure adequate beneficiary access to**  
13          **providers, and to promote affordability**  
14          **and the efficient delivery of medical care**  
15          **consistent with section 221(a). Such rates**  
16          **shall not be set at levels expected to in-**  
17          **crease overall medical costs under the**  
18          **option beyond what would be expected if**  
19          **the process under subsection (a)(2) and**  
20          **paragraph (1) of this subsection were**  
21          **continued.**

22          **(3) ESTABLISHMENT OF A PROVIDER NET-**  
23          **WORK.—Health care providers partici-**  
24          **pating under Medicare are participating**  
25          **providers in the public health insurance**

1 option unless they opt out in a process  
2 established by the Secretary.

3 (c) ADMINISTRATIVE PROCESS FOR SETTING  
4 RATES.—Chapter 5 of title 5, United States  
5 Code shall apply to the process for the initial  
6 establishment of payment rates under this  
7 section but not to the specific methodology  
8 for establishing such rates or the calculation  
9 of such rates.

10 (d) CONSTRUCTION.—Nothing in this sub-  
11 title shall be construed as limiting the Sec-  
12 retary’s authority to correct for payments  
13 that are excessive or deficient, taking into ac-  
14 count the provisions of section 221(a) and the  
15 amounts paid for similar health care pro-  
16 viders and services under other Exchange-  
17 participating health benefits plans.

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

24 (f) LIMITATIONS ON REVIEW.—There shall be  
25 no administrative or judicial review of a pay-

1 **ment rate or methodology established under**  
2 **this section or under section 224.**

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

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

18 **(b) REQUIREMENTS FOR INNOVATIVE PAY-**  
19 **MENTS.—The Secretary shall design and imple-**  
20 **ment the payment mechanisms and policies**  
21 **under this section in a manner that—**

22 **(1) seeks to—**

23 **(A) improve health outcomes;**

1           **(B) reduce health disparities (in-**  
2           **cluding racial, ethnic, and other dis-**  
3           **parities);**

4           **(C) provide efficient and afford-**  
5           **able care;**

6           **(D) address geographic variation**  
7           **in the provision of health services; or**

8           **(E) prevent or manage chronic ill-**  
9           **ness; and**

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

12          **(c) ENCOURAGING THE USE OF HIGH VALUE**  
13          **SERVICES.—To the extent allowed by the ben-**  
14          **efit standards applied to all Exchange-partici-**  
15          **pating health benefits plans, the public health**  
16          **insurance option may modify cost sharing**  
17          **and payment rates to encourage the use of**  
18          **services that promote health and value.**

19          **(d) NON-UNIFORMITY PERMITTED.—Nothing**  
20          **in this subtitle shall prevent the Secretary**  
21          **from varying payments based on different**  
22          **payment structure models (such as account-**  
23          **able care organizations and medical homes)**  
24          **under the public health insurance option for**  
25          **different geographic areas.**



1 **SEC. 225. PROVIDER PARTICIPATION.**

2       **(a) IN GENERAL.—The Secretary shall es-**  
3 **tablish conditions of participation for health**  
4 **care providers under the public health insur-**  
5 **ance option.**

6       **(b) LICENSURE OR CERTIFICATION.—The**  
7 **Secretary shall not allow a health care pro-**  
8 **vider to participate in the public health insur-**  
9 **ance option unless such provider is appro-**  
10 **priately licensed or certified under State law.**

11       **(c) PAYMENT TERMS FOR PROVIDERS.—**

12           **(1) PHYSICIANS.—The Secretary shall**  
13 **provide for the annual participation of**  
14 **physicians under the public health insur-**  
15 **ance option, for which payment may be**  
16 **made for services furnished during the**  
17 **year, in one of 2 classes:**

18                   **(A) PREFERRED PHYSICIANS.—Those**  
19 **physicians who agree to accept the**  
20 **payment rate established under sec-**  
21 **tion 223 (without regard to cost-shar-**  
22 **ing) as the payment in full.**

23                   **(B) PARTICIPATING, NON-PREFERRED**  
24 **PHYSICIANS.—Those physicians who**  
25 **agree not to impose charges (in rela-**  
26 **tion to the payment rate described in**

1           **section 223 for such physicians) that**  
2           **exceed the ratio permitted under sec-**  
3           **tion 1848(g)(2)(C) of the Social Secu-**  
4           **rity Act.**

5           **(2) OTHER PROVIDERS.—The Secretary**  
6           **shall provide for the participation (on an**  
7           **annual or other basis specified by the**  
8           **Secretary) of health care providers (other**  
9           **than physicians) under the public health**  
10          **insurance option under which payment**  
11          **shall only be available if the provider**  
12          **agrees to accept the payment rate estab-**  
13          **lished under section 223 (without regard**  
14          **to cost-sharing) as the payment in full.**

15          **(d) EXCLUSION OF CERTAIN PROVIDERS.—**  
16          **The Secretary shall exclude from participa-**  
17          **tion under the public health insurance option**  
18          **a health care provider that is excluded from**  
19          **participation in a Federal health care pro-**  
20          **gram (as defined in section 1128B(f) of the So-**  
21          **cial Security Act).**

22          **SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVI-**  
23          **SIONS.**

24          **Provisions of law (other than criminal law**  
25          **provisions) identified by the Secretary by reg-**

1 **ulation, in consultation with the Inspector**  
2 **General of the Department of Health and**  
3 **Human Services, that impose sanctions with**  
4 **respect to waste, fraud, and abuse under**  
5 **Medicare, such as the False Claims Act (31**  
6 **U.S.C. 3729 et seq.), shall also apply to the**  
7 **public health insurance option.**

## 8 **Subtitle C—Individual** 9 **Affordability Credits**

10 **SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EX-**  
11 **CHANGE.**

12 **(a) IN GENERAL.—Subject to the suc-**  
13 **ceeding provisions of this subtitle, in the case**  
14 **of an affordable credit eligible individual en-**  
15 **rolled in an Exchange-participating health**  
16 **benefits plan—**

17 **(1) the individual shall be eligible for,**  
18 **in accordance with this subtitle, afford-**  
19 **ability credits consisting of—**

20 **(A) an affordability premium**  
21 **credit under section 243 to be applied**  
22 **against the premium for the Ex-**  
23 **change-participating health benefits**  
24 **plan in which the individual is en-**  
25 **rolled; and**

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

5           **(2) the Commissioner shall pay the**  
6           **QHBP offering entity that offers such**  
7           **plan from the Health Insurance Exchange**  
8           **Trust Fund the aggregate amount of af-**  
9           **fordability credits for all affordable cred-**  
10          **it eligible individuals enrolled in such**  
11          **plan.**

12          **(b) APPLICATION.—**

13           **(1) IN GENERAL.—An Exchange eligible**  
14          **individual may apply to the Commis-**  
15          **sioner through the Health Insurance Ex-**  
16          **change or through another entity under**  
17          **an arrangement made with the Commis-**  
18          **sioner, in a form and manner specified by**  
19          **the Commissioner. The Commissioner**  
20          **through the Health Insurance Exchange**  
21          **or through another public entity under**  
22          **an arrangement made with the Commis-**  
23          **sioner shall make a determination as to**  
24          **eligibility of an individual for afford-**  
25          **ability credits under this subtitle. The**

1       **Commissioner shall establish a process**  
2       **whereby, on the basis of information oth-**  
3       **erwise available, individuals may be**  
4       **deemed to be affordable credit eligible in-**  
5       **dividuals. In carrying this subtitle, the**  
6       **Commissioner shall establish effective**  
7       **methods that ensure that individuals**  
8       **with limited English proficiency are able**  
9       **to apply for affordability credits.**

10           **(2) USE OF STATE MEDICAID AGENCIES.—**

11       **If the Commissioner determines that a**  
12       **State Medicaid agency has the capacity**  
13       **to make a determination of eligibility for**  
14       **affordability credits under this subtitle**  
15       **and under the same standards as used by**  
16       **the Commissioner, under the Medicaid**  
17       **memorandum of understanding (as de-**  
18       **finied in section 205(c)(4))—**

19           **(A) the State Medicaid agency is**  
20           **authorized to conduct such deter-**  
21           **minations for any Exchange-eligible**  
22           **individual who requests such a deter-**  
23           **mination; and**

24           **(B) the Commissioner shall reim-**  
25           **burse the State Medicaid agency for**

1           **the costs of conducting such deter-**  
2           **minations.**

3           **(3) MEDICAID SCREEN AND ENROLL OBLI-**  
4           **GATION.—In the case of an application**  
5           **made under paragraph (1), there shall be**  
6           **a determination of whether the indi-**  
7           **vidual is a Medicaid-eligible individual. If**  
8           **the individual is determined to be so eli-**  
9           **gible, the Commissioner, through the**  
10           **Medicaid memorandum of understanding,**  
11           **shall provide for the enrollment of the in-**  
12           **dividual under the State Medicaid plan in**  
13           **accordance with the Medicaid memo-**  
14           **randum of understanding. In the case of**  
15           **such an enrollment, the State shall pro-**  
16           **vide for the same periodic redetermina-**  
17           **tion of eligibility under Medicaid as**  
18           **would otherwise apply if the individual**  
19           **had directly applied for medical assist-**  
20           **ance to the State Medicaid agency.**

21           **(c) USE OF AFFORDABILITY CREDITS.—**

22           **(1) IN GENERAL.—In Y1 and Y2 an af-**  
23           **fordable credit eligible individual may**  
24           **use an affordability credit only with re-**  
25           **spect to a basic plan.**

1           **(2) FLEXIBILITY IN PLAN ENROLLMENT**  
2           **AUTHORIZED.—Beginning with Y3, the**  
3           **Commissioner shall establish a process to**  
4           **allow an affordability credit to be used**  
5           **for enrollees in enhanced or premium**  
6           **plans. In the case of an affordable credit**  
7           **eligible individual who enrolls in an en-**  
8           **hanced or premium plan, the individual**  
9           **shall be responsible for any difference be-**  
10          **tween the premium for such plan and the**  
11          **affordability credit amount otherwise ap-**  
12          **plicable if the individual had enrolled in**  
13          **a basic plan.**

14          **(d) ACCESS TO DATA.—In carrying out this**  
15          **subtitle, the Commissioner shall request from**  
16          **the Secretary of the Treasury consistent with**  
17          **section 6103 of the Internal Revenue Code of**  
18          **1986 such information as may be required to**  
19          **carry out this subtitle.**

20          **(e) NO CASH REBATES.—In no case shall an**  
21          **affordable credit eligible individual receive**  
22          **any cash payment as a result of the applica-**  
23          **tion of this subtitle.**

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

25          **(a) DEFINITION.—**

1           **(1) IN GENERAL.—For purposes of this**  
2           **division, the term “affordable credit eligi-**  
3           **ble individual” means, subject to sub-**  
4           **section (b), an individual who is lawfully**  
5           **present in a State in the United States**  
6           **(other than as a nonimmigrant described**  
7           **in a subparagraph (excluding subpara-**  
8           **graphs (K), (T), (U), and (V)) of section**  
9           **101(a)(15) of the Immigration and Nation-**  
10          **ality Act)—**

11                 **(A) who is enrolled under an Ex-**  
12                 **change-participating health benefits**  
13                 **plan and is not enrolled under such**  
14                 **plan as an employee (or dependent of**  
15                 **an employee) through an employer**  
16                 **qualified health benefits plan that**  
17                 **meets the requirements of section**  
18                 **312;**

19                 **(B) with family income below 400**  
20                 **percent of the Federal poverty level**  
21                 **for a family of the size involved; and**

22                 **(C) who is not a Medicaid eligible**  
23                 **individual, other than an individual**  
24                 **described in section 202(d)(3) or an**



1 individual during a transition period  
2 under section 202(d)(4)(B)(ii).

3 (2) TREATMENT OF FAMILY.—Except as  
4 the Commissioner may otherwise pro-  
5 vide, members of the same family who  
6 are affordable credit eligible individuals  
7 shall be treated as a single affordable  
8 credit individual eligible for the applica-  
9 ble credit for such a family under this  
10 subtitle.

11 (b) LIMITATIONS ON EMPLOYEE AND DEPEND-  
12 ENT DISQUALIFICATION.—

13 (1) IN GENERAL.—Subject to paragraph  
14 (2), the term “affordable credit eligible in-  
15 dividual” does not include a full-time em-  
16 ployee of an employer if the employer of-  
17 fers the employee coverage (for the em-  
18 ployee and dependents) as a full-time em-  
19 ployee under a group health plan if the  
20 coverage and employer contribution  
21 under the plan meet the requirements of  
22 section 312.

23 (2) EXCEPTIONS.—

24 (A) FOR CERTAIN FAMILY CIR-  
25 CUMSTANCES.—The Commissioner

1 shall establish such exceptions and  
2 special rules in the case described in  
3 paragraph (1) as may be appropriate  
4 in the case of a divorced or separated  
5 individual or such a dependent of an  
6 employee who would otherwise be an  
7 affordable credit eligible individual.

8 (B) FOR UNAFFORDABLE EMPLOYER  
9 COVERAGE.—Beginning in Y2, in the  
10 case of full-time employees for which  
11 the cost of the employee premium for  
12 coverage under a group health plan  
13 would exceed 11 percent of current  
14 family income (determined by the  
15 Commissioner on the basis of  
16 verifiable documentation and without  
17 regard to section 245), paragraph (1)  
18 shall not apply.

19 (c) INCOME DEFINED.—

20 (1) IN GENERAL.—In this title, the term  
21 “income” means modified adjusted gross  
22 income (as defined in section 59B of the  
23 Internal Revenue Code of 1986).

24 (2) STUDY OF INCOME DISREGARDS.—The  
25 Commissioner shall conduct a study that

1 examines the application of income dis-  
2 regards for purposes of this subtitle. Not  
3 later than the first day of Y2, the Com-  
4 missioner shall submit to Congress a re-  
5 port on such study and shall include such  
6 recommendations as the Commissioner  
7 determines appropriate.

8 (d) CLARIFICATION OF TREATMENT OF AF-  
9 FORDABILITY CREDITS.—Affordability credits  
10 under this subtitle shall not be treated, for  
11 purposes of title IV of the Personal Responsi-  
12 bility and Work Opportunity Reconciliation  
13 Act of 1996, to be a benefit provided under  
14 section 403 of such title.

15 SEC. 243. AFFORDABILITY PREMIUM CREDIT.

16 (a) IN GENERAL.—The affordability pre-  
17 mium credit under this section for an afford-  
18 able credit eligible individual enrolled in an  
19 Exchange-participating health benefits plan  
20 is in an amount equal to the amount (if any)  
21 by which the premium for the plan (or, if less,  
22 the reference premium amount specified in  
23 subsection (c)), exceeds the affordable pre-  
24 mium amount specified in subsection (b) for  
25 the individual.

1       **(b) AFFORDABLE PREMIUM AMOUNT.—**

2           **(1) IN GENERAL.—**The affordable pre-  
3       **mium amount specified in this subsection**  
4       **for an individual for monthly premium in**  
5       **a plan year shall be equal to  $\frac{1}{12}$  of the**  
6       **product of—**

7           **(A) the premium percentage limit**  
8       **specified in paragraph (2) for the in-**  
9       **dividual based upon the individual's**  
10      **family income for the plan year; and**

11          **(B) the individual's family income**  
12      **for such plan year.**

13          **(2) PREMIUM PERCENTAGE LIMITS BASED**  
14      **ON TABLE.—**The Commissioner shall estab-  
15      **lish premium percentage limits so that**  
16      **for individuals whose family income is**  
17      **within an income tier specified in the**  
18      **table in subsection (d) such percentage**  
19      **limits shall increase, on a sliding scale in**  
20      **a linear manner, from the initial pre-**  
21      **mium percentage to the final premium**  
22      **percentage specified in such table for**  
23      **such income tier.**

24          **(c) REFERENCE PREMIUM AMOUNT.—**The ref-  
25      **erence premium amount specified in this sub-**

1 section for a plan year for an individual in a  
 2 premium rating area is equal to the average  
 3 premium for the 3 basic plans in the area for  
 4 the plan year with the lowest premium levels.  
 5 In computing such amount the Commissioner  
 6 may exclude plans with extremely limited en-  
 7 rollments.

8 (d) TABLE OF PREMIUM PERCENTAGE LIMITS  
 9 AND ACTUARIAL VALUE PERCENTAGES BASED ON  
 10 INCOME TIER.—

11 (1) IN GENERAL.—For purposes of this  
 12 subtitle, the table specified in this sub-  
 13 section is as follows:

In the case of fam- ily income (ex- pressed as a per- cent of FPL) within the following in- come tier:	The initial premium percentage is—	The final premium percentage is—	The actu- arial value percentage is—
133% through 150%	1.5%	3%	97%
150% through 200%	3%	5%	93%
200% through 250%	5%	7%	85%
250% through 300%	7%	9%	78%
300% through 350%	9%	10%	72%
350% through 400%	10%	11%	70%

14 (2) SPECIAL RULES.—For purposes of  
 15 applying the table under paragraph (1)—

16 (A) FOR LOWEST LEVEL OF IN-  
 17 COME.—In the case of an individual  
 18 with income that does not exceed 133  
 19 percent of FPL, the individual shall

1           **be considered to have income that is**  
2           **133% of FPL.**

3           **(B) APPLICATION OF HIGHER ACTU-**  
4           **ARIAL VALUE PERCENTAGE AT TIER TRAN-**  
5           **SITION POINTS.—If two actuarial value**  
6           **percentages may be determined with**  
7           **respect to an individual, the actuarial**  
8           **value percentage shall be the higher**  
9           **of such percentages.**

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

11           **(a) IN GENERAL.—The affordability cost-**  
12           **sharing credit under this section for an af-**  
13           **fordable credit eligible individual enrolled in**  
14           **an Exchange-participating health benefits**  
15           **plan is in the form of the cost-sharing reduc-**  
16           **tion described in subsection (b) provided**  
17           **under this section for the income tier in**  
18           **which the individual is classified based on the**  
19           **individual's family income.**

20           **(b) COST-SHARING REDUCTIONS.—The Com-**  
21           **missioner shall specify a reduction in cost-**  
22           **sharing amounts and the annual limitation on**  
23           **cost-sharing specified in section 122(c)(2)(B)**  
24           **under a basic plan for each income tier speci-**  
25           **fied in the table under section 243(d), with re-**

1 spect to a year, in a manner so that, as esti-  
2 mated by the Commissioner, the actuarial  
3 value of the coverage with such reduced cost-  
4 sharing amounts (and the reduced annual  
5 cost-sharing limit) is equal to the actuarial  
6 value percentage (specified in the table under  
7 section 243(d) for the income tier involved) of  
8 the full actuarial value if there were no cost-  
9 sharing imposed under the plan.

10 (c) **DETERMINATION AND PAYMENT OF COST-**  
11 **SHARING AFFORDABILITY CREDIT.**—In the case  
12 of an affordable credit eligible individual in  
13 a tier enrolled in an Exchange-participating  
14 health benefits plan offered by a QHBP offer-  
15 ing entity, the Commissioner shall provide for  
16 payment to the offering entity of an amount  
17 equivalent to the increased actuarial value of  
18 the benefits under the plan provided under  
19 section 203(c)(2)(B) resulting from the reduc-  
20 tion in cost-sharing described in subsection  
21 (b).

22 **SEC. 245. INCOME DETERMINATIONS.**

23 (a) **IN GENERAL.**—In applying this subtitle  
24 for an affordability credit for an individual  
25 for a plan year, the individual's income shall

1 be the income (as defined in section 242(c))  
2 for the individual for the most recent taxable  
3 year (as determined in accordance with rules  
4 of the Commissioner). The Federal poverty  
5 level applied shall be such level in effect as  
6 of the date of the application.

7 (b) PROGRAM INTEGRITY; INCOME  
8 VERIFICATION PROCEDURES.—

9 (1) PROGRAM INTEGRITY.—The Commis-  
10 sioner shall take such steps as may be ap-  
11 propriate to ensure the accuracy of deter-  
12 minations and redeterminations under  
13 this subtitle.

14 (2) INCOME VERIFICATION.—

15 (A) IN GENERAL.—Upon an initial  
16 application of an individual for an af-  
17 fordability credit under this subtitle  
18 (or in applying section 242(b)) or  
19 upon an application for a change in  
20 the affordability credit based upon a  
21 significant change in family income  
22 described in subparagraph (A)—

23 (i) the Commissioner shall re-  
24 quest from the Secretary of the  
25 Treasury the disclosure to the



1           **Commissioner of such informa-**  
2           **tion as may be permitted to verify**  
3           **the information contained in such**  
4           **application; and**

5           **(ii) the Commissioner shall**  
6           **use the information so disclosed**  
7           **to verify such information.**

8           **(B) ALTERNATIVE PROCEDURES.—**  
9           **The Commissioner shall establish**  
10          **procedures for the verification of in-**  
11          **come for purposes of this subtitle if**  
12          **no income tax return is available for**  
13          **the most recent completed tax year.**

14          **(c) SPECIAL RULES.—**

15           **(1) CHANGES IN INCOME AS A PERCENT**  
16           **OF FPL.—In the case that an individual's**  
17           **income (expressed as a percentage of the**  
18           **Federal poverty level for a family of the**  
19           **size involved) for a plan year is expected**  
20           **(in a manner specified by the Commis-**  
21           **sioner) to be significantly different from**  
22           **the income (as so expressed) used under**  
23           **subsection (a), the Commissioner shall es-**  
24           **tablish rules requiring an individual to**  
25           **report, consistent with the mechanism es-**

1 **tablished under paragraph (2), significant**  
2 **changes in such income (including a sig-**  
3 **nificant change in family composition) to**  
4 **the Commissioner and requiring the sub-**  
5 **stitution of such income for the income**  
6 **otherwise applicable.**

7 **(2) REPORTING OF SIGNIFICANT CHANGES**  
8 **IN INCOME.—The Commissioner shall es-**  
9 **tablish rules under which an individual**  
10 **determined to be an affordable credit eli-**  
11 **gible individual would be required to in-**  
12 **form the Commissioner when there is a**  
13 **significant change in the family income**  
14 **of the individual (expressed as a percent-**  
15 **age of the FPL for a family of the size in-**  
16 **volved) and of the information regarding**  
17 **such change. Such mechanism shall pro-**  
18 **vide for guidelines that specify the cir-**  
19 **cumstances that qualify as a significant**  
20 **change, the verifiable information re-**  
21 **quired to document such a change, and**  
22 **the process for submission of such infor-**  
23 **mation. If the Commissioner receives new**  
24 **information from an individual regarding**  
25 **the family income of the individual, the**

1       **Commissioner shall provide for a redeter-**  
2       **mination of the individual’s eligibility to**  
3       **be an affordable credit eligible indi-**  
4       **vidual.**

5           **(3) TRANSITION FOR CHIP.—In the case**  
6       **of a child described in section 202(d)(2),**  
7       **the Commissioner shall establish rules**  
8       **under which the family income of the**  
9       **child is deemed to be no greater than the**  
10       **family income of the child as most re-**  
11       **cently determined before Y1 by the State**  
12       **under title XXI of the Social Security Act.**

13           **(4) STUDY OF GEOGRAPHIC VARIATION IN**  
14       **APPLICATION OF FPL.—The Commissioner**  
15       **shall examine the feasibility and implica-**  
16       **tion of adjusting the application of the**  
17       **Federal poverty level under this subtitle**  
18       **for different geographic areas so as to re-**  
19       **fect the variations in cost-of-living**  
20       **among different areas within the United**  
21       **States. If the Commissioner determines**  
22       **that an adjustment is feasible, the study**  
23       **should include a methodology to make**  
24       **such an adjustment. Not later than the**  
25       **first day of Y2, the Commissioner shall**

1       submit to Congress a report on such  
2       study and shall include such rec-  
3       ommendations as the Commissioner de-  
4       termines appropriate.

5       **(d) PENALTIES FOR MISREPRESENTATION.—**

6       **In the case of an individual intentionally mis-**  
7       **represents family income or the individual**  
8       **fails (without regard to intent) to disclose to**  
9       **the Commissioner a significant change in**  
10      **family income under subsection (c) in a man-**  
11      **ner that results in the individual becoming an**  
12      **affordable credit eligible individual when the**  
13      **individual is not or in the amount of the af-**  
14      **fordability credit exceeding the correct**  
15      **amount—**

16            (1) the individual is liable for repay-  
17            ment of the amount of the improper af-  
18            fordability credit; ;and

19            (2) in the case of such an intentional  
20            misrepresentation or other egregious cir-  
21            cumstances specified by the Commis-  
22            sioner, the Commissioner may impose an  
23            additional penalty.

1 SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED  
2 ALIENS.

3 Nothing in this subtitle shall allow Fed-  
4 eral payments for affordability credits on be-  
5 half of individuals who are not lawfully  
6 present in the United States.

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

11 SEC. 301. INDIVIDUAL RESPONSIBILITY.

12 For an individual's responsibility to ob-  
13 tain acceptable coverage, see section 59B of  
14 the Internal Revenue Code of 1986 (as added  
15 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  
23 this section if such employer does all of the  
24 following:

25 (1) **OFFER OF COVERAGE.**—The em-  
26 ployer offers each employee individual

1       **and family coverage under a qualified**  
2       **health benefits plan (or under a current**  
3       **employment-based health plan (within**  
4       **the meaning of section 102(b))) in accord-**  
5       **ance with section 312.**

6           **(2) CONTRIBUTION TOWARDS COV-**  
7       **ERAGE.—If an employee accepts such offer**  
8       **of coverage, the employer makes timely**  
9       **contributions towards such coverage in**  
10       **accordance with section 312.**

11           **(3) CONTRIBUTION IN LIEU OF COV-**  
12       **ERAGE.—Beginning with Y2, if an em-**  
13       **ployee declines such offer but otherwise**  
14       **obtains coverage in an Exchange-partici-**  
15       **pating health benefits plan (other than**  
16       **by reason of being covered by family cov-**  
17       **erage as a spouse or dependent of the**  
18       **primary insured), the employer shall**  
19       **make a timely contribution to the Health**  
20       **Insurance Exchange with respect to each**  
21       **such employee in accordance with sec-**  
22       **tion 313.**

1 **SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TO-**  
2 **WARDS EMPLOYEE AND DEPENDENT COV-**  
3 **ERAGE.**

4 **(a) IN GENERAL.—An employer meets the**  
5 **requirements of this section with respect to**  
6 **an employee if the following requirements are**  
7 **met:**

8 **(1) OFFERING OF COVERAGE.—The em-**  
9 **ployer offers the coverage described in**  
10 **section 311(1) either through an Ex-**  
11 **change-participating health benefits plan**  
12 **or other than through such a plan.**

13 **(2) EMPLOYER REQUIRED CONTRIBU-**  
14 **TION.—The employer timely pays to the**  
15 **issuer of such coverage an amount not**  
16 **less than the employer required contribu-**  
17 **tion specified in subsection (b) for such**  
18 **coverage.**

19 **(3) PROVISION OF INFORMATION.—The**  
20 **employer provides the Health Choices**  
21 **Commissioner, the Secretary of Labor,**  
22 **the Secretary of Health and Human Serv-**  
23 **ices, and the Secretary of the Treasury,**  
24 **as applicable, with such information as**  
25 **the Commissioner may require to ascer-**

1       **tain compliance with the requirements of**  
2       **this section.**

3               **(4) AUTOENROLLMENT OF EMPLOYEES.—**

4       **The employer provides for**  
5       **autoenrollment of the employee in ac-**  
6       **cordance with subsection (c).**

7               **(b) REDUCTION OF EMPLOYEE PREMIUMS**  
8       **THROUGH MINIMUM EMPLOYER CONTRIBUTION.—**

9               **(1) FULL-TIME EMPLOYEES.—The min-**  
10       **imum employer contribution described in**  
11       **this subsection for coverage of a full-time**  
12       **employee (and, if any, the employee’s**  
13       **spouse and qualifying children (as de-**  
14       **fin ed in section 152(c) of the Internal**  
15       **Revenue Code of 1986) under a qualified**  
16       **health benefits plan (or current employ-**  
17       **ment-based health plan) is equal to—**

18                       **(A) in case of individual coverage,**  
19                       **not less than 72.5 percent of the ap-**  
20                       **plicable premium (as defined in sec-**  
21                       **tion 4980B(f)(4) of such Code, subject**  
22                       **to paragraph (2)) of the lowest cost**  
23                       **plan offered by the employer that is a**  
24                       **qualified health benefits plan (or is**



1           such     current     employment-based  
2           health plan); and

3           **(B) in the case of family coverage**  
4           **which includes coverage of such**  
5           **spouse and children, not less 65 per-**  
6           **cent of such applicable premium of**  
7           **such lowest cost plan.**

8           **(2) APPLICABLE PREMIUM FOR EX-**  
9           **CHANGE COVERAGE.—In this subtitle, the**  
10          **amount of the applicable premium of the**  
11          **lowest cost plan with respect to coverage**  
12          **of an employee under an Exchange-par-**  
13          **ticipating health benefits plan is the ref-**  
14          **erence premium amount under section**  
15          **243(c) for individual coverage (or, if elect-**  
16          **ed, family coverage) for the premium rat-**  
17          **ing area in which the individual or fam-**  
18          **ily resides.**

19          **(3) MINIMUM EMPLOYER CONTRIBUTION**  
20          **FOR EMPLOYEES OTHER THAN FULL-TIME EM-**  
21          **PLOYEES.—In the case of coverage for an**  
22          **employee who is not a full-time employee,**  
23          **the amount of the minimum employer**  
24          **contribution under this subsection shall**  
25          **be a proportion (as determined in accord-**

1       **ance with rules of the Health Choices**  
2       **Commissioner, the Secretary of Labor,**  
3       **the Secretary of Health and Human Serv-**  
4       **ices, and the Secretary of the Treasury,**  
5       **as applicable) of the minimum employer**  
6       **contribution under this subsection with**  
7       **respect to a full-time employee that re-**  
8       **flects the proportion of—**

9               **(A) the average weekly hours of**  
10              **employment of the employee by the**  
11              **employer, to**

12              **(B) the minimum weekly hours**  
13              **specified by the Commissioner for an**  
14              **employee to be a full-time employee.**

15       **(4) SALARY REDUCTIONS NOT TREATED**  
16       **AS EMPLOYER CONTRIBUTIONS.—For pur-**  
17       **poses of this section, any contribution on**  
18       **behalf of an employee with respect to**  
19       **which there is a corresponding reduction**  
20       **in the compensation of the employee**  
21       **shall not be treated as an amount paid by**  
22       **the employer.**

23       **(c) AUTOMATIC ENROLLMENT FOR EMPLOYER**  
24       **SPONSORED HEALTH BENEFITS.—**

1           **(1) IN GENERAL.—**The requirement of  
2           **this subsection with respect to an em-**  
3           **ployer and an employee is that the em-**  
4           **ployer automatically enroll such em-**  
5           **ployee into the employment-based health**  
6           **benefits plan for individual coverage**  
7           **under the plan option with the lowest ap-**  
8           **plicable employee premium.**

9           **(2) OPT-OUT.—**In no case may an em-  
10          **ployer automatically enroll an employee**  
11          **in a plan under paragraph (1) if such em-**  
12          **ployee makes an affirmative election to**  
13          **opt out of such plan or to elect coverage**  
14          **under an employment-based health bene-**  
15          **fits plan offered by such employer. An**  
16          **employer shall provide an employee with**  
17          **a 30-day period to make such an affirma-**  
18          **tive election before the employer may**  
19          **automatically enroll the employee in**  
20          **such a plan.**

21          **(3) NOTICE REQUIREMENTS.—**

22                 **(A) IN GENERAL.—**Each employer  
23                 **described in paragraph (1) who auto-**  
24                 **matically enrolls an employee into a**  
25                 **plan as described in such paragraph**

1 shall provide the employees, within a  
2 reasonable period before the begin-  
3 ning of each plan year (or, in the case  
4 of new employees, within a reason-  
5 able period before the end of the en-  
6 rollment period for such a new em-  
7 ployee), written notice of the employ-  
8 ees' rights and obligations relating to  
9 the automatic enrollment require-  
10 ment under such paragraph. Such no-  
11 tice must be comprehensive and un-  
12 derstood by the average employee to  
13 whom the automatic enrollment re-  
14 quirement applies.

15 (B) INCLUSION OF SPECIFIC INFOR-  
16 MATION.—The written notice under  
17 subparagraph (A) must explain an  
18 employee's right to opt out of being  
19 automatically enrolled in a plan and  
20 in the case that more than one level  
21 of benefits or employee premium  
22 level is offered by the employer in-  
23 volved, the notice must explain which  
24 level of benefits and employee pre-  
25 mium level the employee will be auto-

1           **matically enrolled in the absence of**  
2           **an affirmative election by the em-**  
3           **ployee.**

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

6           **(a) IN GENERAL.—A contribution is made**  
7 **in accordance with this section with respect**  
8 **to an employee if such contribution is equal**  
9 **to an amount equal to 8 percent of the aver-**  
10 **age wages paid by the employer during the**  
11 **period of enrollment (determined by taking**  
12 **into account all employees of the employer**  
13 **and in such manner as the Commissioner pro-**  
14 **vides, including rules providing for the appro-**  
15 **priate aggregation of related employers). Any**  
16 **such contribution—**

17           **(1) shall be paid to the Health**  
18 **Choices Commissioner for deposit into**  
19 **the Health Insurance Exchange Trust**  
20 **Fund, and**

21           **(2) shall not be applied against the**  
22 **premium of the employee under the Ex-**  
23 **change-participating health benefits plan**  
24 **in which the employee is enrolled.**

1       **(b) SPECIAL RULES FOR SMALL EMPLOY-**  
 2 **ERS.—**

3           **(1) IN GENERAL.—**In the case of any  
 4 employer who is a small employer for any  
 5 calendar year, subsection (a) shall be ap-  
 6 plied by substituting the applicable per-  
 7 centage determined in accordance with  
 8 the following table for “8 percent”:

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed \$250,000 .....	0 percent
Exceeds \$250,000, but does not exceed \$300,000.	2 percent
Exceeds \$300,000, but does not exceed \$350,000.	4 percent
Exceeds \$350,000, but does not exceed \$400,000.	6 percent

9           **(2) SMALL EMPLOYER.—**For purposes of  
 10 this subsection, the term “small em-  
 11 ployer” means any employer for any cal-  
 12 endar year if the annual payroll of such  
 13 employer for the preceding calendar year  
 14 does not exceed \$400,000.

15           **(3) ANNUAL PAYROLL.—**For purposes of  
 16 this paragraph, the term “annual payroll”  
 17 means, with respect to any employer for  
 18 any calendar year, the aggregate wages  
 19 paid by the employer during such cal-  
 20 endar year.

1           **(4) AGGREGATION RULES.—Related em-**  
2           **ployers and predecessors shall be treated**  
3           **as a single employer for purposes of this**  
4           **subsection.**

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

6           **The Health Choices Commissioner (in co-**  
7           **ordination with the Secretary of Labor, the**  
8           **Secretary of Health and Human Services, and**  
9           **the Secretary of the Treasury) shall have au-**  
10          **thority to set standards for determining**  
11          **whether employers or insurers are under-**  
12          **taking any actions to affect the risk pool with-**  
13          **in the Health Insurance Exchange by induc-**  
14          **ing individuals to decline coverage under a**  
15          **qualified health benefits plan (or current em-**  
16          **ployment-based health plan (within the mean-**  
17          **ing of section 102(b)) offered by the employer**  
18          **and instead to enroll in an Exchange-partici-**  
19          **pating health benefits plan. An employer vio-**  
20          **lating such standards shall be treated as not**  
21          **meeting the requirements of this section.**

1 **PART 2—SATISFACTION OF HEALTH COVERAGE**  
2 **PARTICIPATION REQUIREMENTS**

3 **SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICI-**  
4 **PATION REQUIREMENTS UNDER THE EM-**  
5 **PLOYEE RETIREMENT INCOME SECURITY**  
6 **ACT OF 1974.**

7 **(a) IN GENERAL.—**Subtitle B of title I of the  
8 **Employee Retirement Income Security Act of**  
9 **1974 is amended by adding at the end the fol-**  
10 **lowing new part:**

11 **“PART 8—NATIONAL HEALTH COVERAGE**  
12 **PARTICIPATION REQUIREMENTS**  
13 **“SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NA-**  
14 **TIONAL HEALTH COVERAGE PARTICIPATION**  
15 **REQUIREMENTS.**

16 **“(a) IN GENERAL.—**An employer may make  
17 **an election with the Secretary to be subject**  
18 **to the health coverage participation require-**  
19 **ments.**

20 **“(b) TIME AND MANNER.—**An election under  
21 **subsection (a) may be made at such time and**  
22 **in such form and manner as the Secretary**  
23 **may prescribe.**



1 **“SEC. 802. TREATMENT OF COVERAGE RESULTING FROM**  
2 **ELECTION.**

3 **“(a) IN GENERAL.—If an employer makes**  
4 **an election to the Secretary under section**  
5 **801—**

6 **“(1) such election shall be treated as**  
7 **the establishment and maintenance of a**  
8 **group health plan (as defined in section**  
9 **733(a)) for purposes of this title, subject**  
10 **to section 151 of the America’s Affordable**  
11 **Health Choices Act of 2009, and**

12 **“(2) the health coverage participation**  
13 **requirements shall be deemed to be in-**  
14 **cluded as terms and conditions of such**  
15 **plan.**

16 **“(b) PERIODIC INVESTIGATIONS TO DISCOVER**  
17 **NONCOMPLIANCE.—The Secretary shall regu-**  
18 **larly audit a representative sampling of em-**  
19 **ployers and group health plans and conduct**  
20 **investigations and other activities under sec-**  
21 **tion 504 with respect to such sampling of**  
22 **plans so as to discover noncompliance with**  
23 **the health coverage participation require-**  
24 **ments in connection with such plans. The Sec-**  
25 **retary shall communicate findings of non-**  
26 **compliance made by the Secretary under this**

1 subsection to the Secretary of the Treasury  
2 and the Health Choices Commissioner. The  
3 Secretary shall take such timely enforcement  
4 action as appropriate to achieve compliance.

5 “SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIRE-  
6 MENTS.

7 “For purposes of this part, the term  
8 ‘health coverage participation requirements’  
9 means the requirements of part 1 of subtitle  
10 B of title III of division A of America’s Afford-  
11 able Health Choices Act of 2009 (as in effect  
12 on the date of the enactment of such Act).

13 “SEC. 804. RULES FOR APPLYING REQUIREMENTS.

14 “(a) **AFFILIATED GROUPS.**—In the case of  
15 any employer which is part of a group of em-  
16 ployers who are treated as a single employer  
17 under subsection (b), (c), (m), or (o) of section  
18 414 of the Internal Revenue Code of 1986, the  
19 election under section 801 shall be made by  
20 such employer as the Secretary may provide.  
21 Any such election, once made, shall apply to  
22 all members of such group.

23 “(b) **SEPARATE ELECTIONS.**—Under regula-  
24 tions prescribed by the Secretary, separate

1 elections may be made under section 801 with  
2 respect to—

3 “(1) separate lines of business, and

4 “(2) full-time employees and employ-  
5 ees who are not full-time employees.

6 “SEC. 805. TERMINATION OF ELECTION IN CASES OF SUB-  
7 STANTIAL NONCOMPLIANCE.

8 “The Secretary may terminate the elec-  
9 tion of any employer under section 801 if the  
10 Secretary (in coordination with the Health  
11 Choices Commissioner) determines that such  
12 employer is in substantial noncompliance  
13 with the health coverage participation re-  
14 quirements and shall refer any such deter-  
15 mination to the Secretary of the Treasury as  
16 appropriate.

17 “SEC. 806. REGULATIONS.

18 “The Secretary may promulgate such reg-  
19 ulations as may be necessary or appropriate  
20 to carry out the provisions of this part, in ac-  
21 cordance with section 324(a) of the America’s  
22 Affordable Health Choices Act of 2009. The  
23 Secretary may promulgate any interim final  
24 rules as the Secretary determines are appro-  
25 priate to carry out this part.”.

1       **(b) ENFORCEMENT OF HEALTH COVERAGE**  
2 **PARTICIPATION REQUIREMENTS.—Section 502 of**  
3 **such Act (29 U.S.C. 1132) is amended—**

4           **(1) in subsection (a)(6), by striking**  
5 **“paragraph” and all that follows through**  
6 **“subsection (c)” and inserting “paragraph**  
7 **(2), (4), (5), (6), (7), (8), (9), (10), or (11) of**  
8 **subsection (c)”;** and

9           **(2) in subsection (c), by redesignating**  
10 **the second paragraph (10) as paragraph**  
11 **(12) and by inserting after the first para-**  
12 **graph (10) the following new paragraph:**

13           **“(11) HEALTH COVERAGE PARTICIPATION**  
14 **REQUIREMENTS.—**

15           **“(A) CIVIL PENALTIES.—In the case**  
16 **of any employer who fails (during any**  
17 **period with respect to which an elec-**  
18 **tion under section 801(a) is in effect)**  
19 **to satisfy the health coverage partici-**  
20 **pation requirements with respect to**  
21 **any employee, the Secretary may as-**  
22 **sess a civil penalty against the em-**  
23 **ployer of \$100 for each day in the pe-**  
24 **riod beginning on the date such fail-**

1           **ure first occurs and ending on the**  
2           **date such failure is corrected.**

3           **“(B) HEALTH COVERAGE PARTICIPA-**  
4           **TION REQUIREMENTS.—For purposes of**  
5           **this paragraph, the term ‘health cov-**  
6           **erage participation requirements’ has**  
7           **the meaning provided in section 803.**

8           **“(C) LIMITATIONS ON AMOUNT OF**  
9           **PENALTY.—**

10           **“(i) PENALTY NOT TO APPLY**  
11           **WHERE FAILURE NOT DISCOVERED**  
12           **EXERCISING REASONABLE DILI-**  
13           **GENCE.—No penalty shall be as-**  
14           **sessed under subparagraph (A)**  
15           **with respect to any failure during**  
16           **any period for which it is estab-**  
17           **lished to the satisfaction of the**  
18           **Secretary that the employer did**  
19           **not know, or exercising reason-**  
20           **able diligence would not have**  
21           **known, that such failure existed.**

22           **“(ii) PENALTY NOT TO APPLY TO**  
23           **FAILURES CORRECTED WITHIN 30**  
24           **DAYS.—No penalty shall be as-**

1           **essed under subparagraph (A)**  
2           **with respect to any failure if—**

3                   **“(I) such failure was due**  
4                   **to reasonable cause and not**  
5                   **to willful neglect, and**

6                   **“(II) such failure is cor-**  
7                   **rected during the 30-day pe-**  
8                   **riod beginning on the 1st date**  
9                   **that the employer knew, or**  
10                  **exercising reasonable dili-**  
11                  **gence would have known, that**  
12                  **such failure existed.**

13                  **“(iii) OVERALL LIMITATION FOR**  
14                  **UNINTENTIONAL FAILURES.—In the**  
15                  **case of failures which are due to**  
16                  **reasonable cause and not to will-**  
17                  **ful neglect, the penalty assessed**  
18                  **under subparagraph (A) for fail-**  
19                  **ures during any 1-year period**  
20                  **shall not exceed the amount equal**  
21                  **to the lesser of—**

22                   **“(I) 10 percent of the ag-**  
23                   **gregate amount paid or in-**  
24                   **curred by the employer (or**  
25                   **predecessor employer) during**

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

3           “(II) \$500,000.

4           “(D) ADVANCE NOTIFICATION OF  
5 FAILURE PRIOR TO ASSESSMENT.—Before  
6 a reasonable time prior to the assess-  
7 ment of any penalty under this para-  
8 graph with respect to any failure by  
9 an employer, the Secretary shall in-  
10 form the employer in writing of such  
11 failure and shall provide the em-  
12 ployer information regarding efforts  
13 and procedures which may be under-  
14 taken by the employer to correct such  
15 failure.

16           “(E) COORDINATION WITH EXCISE  
17 TAX.—Under regulations prescribed in  
18 accordance with section 324 of the  
19 America’s Affordable Health Choices  
20 Act of 2009, the Secretary and the  
21 Secretary of the Treasury shall co-  
22 ordinate the assessment of penalties  
23 under this section in connection with  
24 failures to satisfy health coverage  
25 participation requirements with the

1           **imposition of excise taxes on such**  
2           **failures under section 4980H(b) of the**  
3           **Internal Revenue Code of 1986 so as**  
4           **to avoid duplication of penalties with**  
5           **respect to such failures.**

6           **“(F) DEPOSIT OF PENALTY COL-**  
7           **LECTED.—Any amount of penalty col-**  
8           **lected under this paragraph shall be**  
9           **deposited as miscellaneous receipts**  
10          **in the Treasury of the United States.”.**

11          **(c) CLERICAL AMENDMENTS.—The table of**  
12          **contents in section 1 of such Act is amended**  
13          **by inserting after the item relating to section**  
14          **734 the following new items:**

“PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION  
REQUIREMENTS

“Sec. 801. Election of employer to be subject to national health  
coverage participation requirements.

“Sec. 802. Treatment of coverage resulting from election.

“Sec. 803. Health coverage participation requirements.

“Sec. 804. Rules for applying requirements.

“Sec. 805. Termination of election in cases of substantial non-  
compliance.

“Sec. 806. Regulations.”.

15          **(d) EFFECTIVE DATE.—The amendments**  
16          **made by this section shall apply to periods be-**  
17          **ginning after December 31, 2012.**



1 SEC. 322. SATISFACTION OF HEALTH COVERAGE PARTICI-  
2 PATION REQUIREMENTS UNDER THE INTER-  
3 NAL REVENUE CODE OF 1986.

4 (a) FAILURE TO ELECT, OR SUBSTANTIALLY  
5 COMPLY WITH, HEALTH COVERAGE PARTICIPA-  
6 TION REQUIREMENTS.—For employment tax on  
7 employers who fail to elect, or substantially  
8 comply with, the health coverage participa-  
9 tion requirements described in part 1, see sec-  
10 tion 3111(c) of the Internal Revenue Code of  
11 1986 (as added by section 412 of this Act).

12 (b) OTHER FAILURES.—For excise tax on  
13 other failures of electing employers to comply  
14 with such requirements, see section 4980H of  
15 the Internal Revenue Code of 1986 (as added  
16 by section 411 of this Act).

17 SEC. 323. SATISFACTION OF HEALTH COVERAGE PARTICI-  
18 PATION REQUIREMENTS UNDER THE PUBLIC  
19 HEALTH SERVICE ACT.

20 (a) IN GENERAL.—Part C of title XXVII of  
21 the Public Health Service Act is amended by  
22 adding at the end the following new section:

1 **“SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION**  
2 **REQUIREMENTS.**

3 **“(a) ELECTION OF EMPLOYER TO BE SUBJECT**  
4 **TO NATIONAL HEALTH COVERAGE PARTICIPATION**  
5 **REQUIREMENTS.—**

6 **“(1) IN GENERAL.—An employer may**  
7 **make an election with the Secretary to be**  
8 **subject to the health coverage participa-**  
9 **tion requirements.**

10 **“(2) TIME AND MANNER.—An election**  
11 **under paragraph (1) may be made at such**  
12 **time and in such form and manner as the**  
13 **Secretary may prescribe.**

14 **“(b) TREATMENT OF COVERAGE RESULTING**  
15 **FROM ELECTION.—**

16 **“(1) IN GENERAL.—If an employer**  
17 **makes an election to the Secretary under**  
18 **subsection (a)—**

19 **“(A) such election shall be treated**  
20 **as the establishment and mainte-**  
21 **nance of a group health plan for pur-**  
22 **poses of this title, subject to section**  
23 **151 of the America’s Affordable**  
24 **Health Choices Act of 2009, and**

25 **“(B) the health coverage partici-**  
26 **pation requirements shall be deemed**

1           to be included as terms and condi-  
2           tions of such plan.

3           “(2) PERIODIC INVESTIGATIONS TO DE-  
4           TERMINE COMPLIANCE WITH HEALTH COV-  
5           ERAGE PARTICIPATION REQUIREMENTS.—The  
6           Secretary shall regularly audit a rep-  
7           resentative sampling of employers and  
8           conduct investigations and other activi-  
9           ties with respect to such sampling of em-  
10          ployers so as to discover noncompliance  
11          with the health coverage participation  
12          requirements in connection with such  
13          employers (during any period with re-  
14          spect to which an election under sub-  
15          section (a) is in effect). The Secretary  
16          shall communicate findings of noncompli-  
17          ance made by the Secretary under this  
18          subsection to the Secretary of the Treas-  
19          ury and the Health Choices Commis-  
20          sioner. The Secretary shall take such  
21          timely enforcement action as appropriate  
22          to achieve compliance.

23          “(c) HEALTH COVERAGE PARTICIPATION RE-  
24          QUIREMENTS.—For purposes of this section,  
25          the term ‘health coverage participation re-

1 requirements' means the requirements of part 1  
2 of subtitle B of title III of division A of the  
3 America's Affordable Health Choices Act of  
4 2009 (as in effect on the date of the enactment  
5 of this section).

6       “(d) SEPARATE ELECTIONS.—Under regula-  
7 tions prescribed by the Secretary, separate  
8 elections may be made under subsection (a)  
9 with respect to full-time employees and em-  
10 ployees who are not full-time employees.

11       “(e) TERMINATION OF ELECTION IN CASES OF  
12 SUBSTANTIAL NONCOMPLIANCE.—The Secretary  
13 may terminate the election of any employer  
14 under subsection (a) if the Secretary (in co-  
15 ordination with the Health Choices Commis-  
16 sioner) determines that such employer is in  
17 substantial noncompliance with the health  
18 coverage participation requirements and  
19 shall refer any such determination to the Sec-  
20 retary of the Treasury as appropriate.

21       “(f) ENFORCEMENT OF HEALTH COVERAGE  
22 PARTICIPATION REQUIREMENTS.—

23               “(1) CIVIL PENALTIES.—In the case of  
24 any employer who fails (during any pe-  
25 riod with respect to which the election

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

9 “(2) LIMITATIONS ON AMOUNT OF PEN-  
10 ALTY.—

11 “(A) PENALTY NOT TO APPLY WHERE  
12 FAILURE NOT DISCOVERED EXERCISING  
13 REASONABLE DILIGENCE.—No penalty  
14 shall be assessed under paragraph (1)  
15 with respect to any failure during  
16 any period for which it is established  
17 to the satisfaction of the Secretary  
18 that the employer did not know, or  
19 exercising reasonable diligence  
20 would not have known, that such fail-  
21 ure existed.

22 “(B) PENALTY NOT TO APPLY TO  
23 FAILURES CORRECTED WITHIN 30 DAYS.—  
24 No penalty shall be assessed under

1 paragraph (1) with respect to any  
2 failure if—

3 “(i) such failure was due to  
4 reasonable cause and not to will-  
5 ful neglect, and

6 “(ii) such failure is corrected  
7 during the 30-day period begin-  
8 ning on the 1st date that the em-  
9 ployer knew, or exercising rea-  
10 sonable diligence would have  
11 known, that such failure existed.

12 “(C) OVERALL LIMITATION FOR UNIN-  
13 TENTIONAL FAILURES.—In the case of  
14 failures which are due to reasonable  
15 cause and not to willful neglect, the  
16 penalty assessed under paragraph (1)  
17 for failures during any 1-year period  
18 shall not exceed the amount equal to  
19 the lesser of—

20 “(i) 10 percent of the aggre-  
21 gate amount paid or incurred by  
22 the employer (or predecessor em-  
23 ployer) during the preceding tax-  
24 able year for group health plans,  
25 or

1                   **“(ii) \$500,000.**

2                   **“(3) ADVANCE NOTIFICATION OF FAILURE**  
3                   **PRIOR TO ASSESSMENT.—Before a reason-**  
4                   **able time prior to the assessment of any**  
5                   **penalty under paragraph (1) with respect**  
6                   **to any failure by an employer, the Sec-**  
7                   **retary shall inform the employer in writ-**  
8                   **ing of such failure and shall provide the**  
9                   **employer information regarding efforts**  
10                   **and procedures which may be under-**  
11                   **taken by the employer to correct such**  
12                   **failure.**

13                   **“(4) ACTIONS TO ENFORCE ASSESS-**  
14                   **MENTS.—The Secretary may bring a civil**  
15                   **action in any District Court of the United**  
16                   **States to collect any civil penalty under**  
17                   **this subsection.**

18                   **“(5) COORDINATION WITH EXCISE TAX.—**  
19                   **Under regulations prescribed in accord-**  
20                   **ance with section 324 of the America’s Af-**  
21                   **ordable Health Choices Act of 2009, the**  
22                   **Secretary and the Secretary of the Treas-**  
23                   **ury shall coordinate the assessment of**  
24                   **penalties under paragraph (1) in connec-**  
25                   **tion with failures to satisfy health cov-**

1        **erage participation requirements with**  
2        **the imposition of excise taxes on such**  
3        **failures under section 4980H(b) of the In-**  
4        **ternal Revenue Code of 1986 so as to**  
5        **avoid duplication of penalties with re-**  
6        **spect to such failures.**

7            **“(6) DEPOSIT OF PENALTY COLLECTED.—**  
8        **Any amount of penalty collected under**  
9        **this subsection shall be deposited as mis-**  
10       **cellaneous receipts in the Treasury of the**  
11       **United States.**

12          **“(g) REGULATIONS.—The Secretary may**  
13       **promulgate such regulations as may be nec-**  
14       **essary or appropriate to carry out the provi-**  
15       **sions of this section, in accordance with sec-**  
16       **tion 324(a) of the America’s Affordable Health**  
17       **Choices Act of 2009. The Secretary may pro-**  
18       **mulgate any interim final rules as the Sec-**  
19       **retary determines are appropriate to carry**  
20       **out this section.”.**

21          **(b) EFFECTIVE DATE.—The amendments**  
22       **made by subsection (a) shall apply to periods**  
23       **beginning after December 31, 2012.**



1 SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COV-  
2 ERAGE PARTICIPATION REQUIREMENTS.

3 (a) ASSURING COORDINATION.—The officers  
4 consisting of the Secretary of Labor, the Sec-  
5 retary of the Treasury, the Secretary of  
6 Health and Human Services, and the Health  
7 Choices Commissioner shall ensure, through  
8 the execution of an interagency memorandum  
9 of understanding among such officers, that—

10 (1) regulations, rulings, and interpre-  
11 tations issued by such officers relating to  
12 the same matter over which two or more  
13 of such officers have responsibility under  
14 subpart B of part 6 of subtitle B of title I  
15 of the Employee Retirement Income Se-  
16 curity Act of 1974, section 4980H of the  
17 Internal Revenue Code of 1986, and sec-  
18 tion 2793 of the Public Health Service Act  
19 are administered so as to have the same  
20 effect at all times; and

21 (2) coordination of policies relating to  
22 enforcing the same requirements through  
23 such officers in order to have a coordi-  
24 nated enforcement strategy that avoids  
25 duplication of enforcement efforts and  
26 assigns priorities in enforcement.

1       **(b) MULTIEmployer PLANS.—**In the case of  
2 a group health plan that is a multiemployer  
3 plan (as defined in section 3(37) of the Em-  
4 ployee Retirement Income Security Act of  
5 1974), the regulations prescribed in accord-  
6 ance with subsection (a) by the officers re-  
7 ferred to in subsection (a) shall provide for  
8 the application of the health coverage partici-  
9 pation requirements to the plan sponsor and  
10 contributing sponsors of such plan.

11 **TITLE IV—AMENDMENTS TO IN-**  
12 **TERNAL REVENUE CODE OF**  
13 **1986**

14 **Subtitle A—Shared Responsibility**

15 **PART 1—INDIVIDUAL RESPONSIBILITY**

16 **SEC. 401. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE**  
17 **HEALTH CARE COVERAGE.**

18       **(a) IN GENERAL.—**Subchapter A of chapter  
19 1 of the Internal Revenue Code of 1986 is  
20 amended by adding at the end the following  
21 new part:

22 **“PART VIII—HEALTH CARE RELATED TAXES**

**“SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH**  
**CARE COVERAGE.**

1 **“Subpart A—Tax on Individuals Without Acceptable**  
2 **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 indi-**  
6 **vidual who does not meet the requirements of**  
7 **subsection (d) at any time during the taxable**  
8 **year, there is hereby imposed a tax equal to**  
9 **2.5 percent of the excess of—**

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

12 **“(2) the amount of gross income speci-**  
13 **fied in section 6012(a)(1) with respect to**  
14 **the taxpayer.**

15 **“(b) LIMITATIONS.—**

16 **“(1) TAX LIMITED TO AVERAGE PRE-**  
17 **MIUM.—**

18 **“(A) IN GENERAL.—The tax im-**  
19 **posed under subsection (a) with re-**  
20 **spect to any taxpayer for any taxable**  
21 **year shall not exceed the applicable**  
22 **national average premium for such**  
23 **taxable year.**

1           **“(B) APPLICABLE NATIONAL AVER-**  
2           **AGE PREMIUM.—**

3           **“(i) IN GENERAL.—For purposes**  
4           **of subparagraph (A), the ‘applica-**  
5           **ble national average premium’**  
6           **means, with respect to any tax-**  
7           **able year, the average premium**  
8           **(as determined by the Secretary,**  
9           **in coordination with the Health**  
10           **Choices Commissioner) for self-**  
11           **only coverage under a basic plan**  
12           **which is offered in a Health In-**  
13           **surance Exchange for the cal-**  
14           **endar year in which such taxable**  
15           **year begins.**

16           **“(ii) FAILURE TO PROVIDE COV-**  
17           **ERAGE FOR MORE THAN ONE INDI-**  
18           **VIDUAL.—In the case of any tax-**  
19           **payer who fails to meet the re-**  
20           **quirements of subsection (e) with**  
21           **respect to more than one indi-**  
22           **vidual during the taxable year,**  
23           **clause (i) shall be applied by sub-**  
24           **stituting ‘family coverage’ for**  
25           **‘self-only coverage’.**

1           **“(2) PRORATION FOR PART YEAR FAIL-**  
2           **URES.—The tax imposed under subsection**  
3           **(a) with respect to any taxpayer for any**  
4           **taxable year shall not exceed the amount**  
5           **which bears the same ratio to the amount**  
6           **of tax so imposed (determined without**  
7           **regard to this paragraph and after appli-**  
8           **cation of paragraph (1)) as—**

9                   **“(A) the aggregate periods during**  
10                   **such taxable year for which such in-**  
11                   **dividual failed to meet the require-**  
12                   **ments of subsection (d), bears to**

13                   **“(B) the entire taxable year.**

14           **“(c) EXCEPTIONS.—**

15                   **“(1) DEPENDENTS.—Subsection (a)**  
16                   **shall not apply to any individual for any**  
17                   **taxable year if a deduction is allowable**  
18                   **under section 151 with respect to such in-**  
19                   **dividual to another taxpayer for any tax-**  
20                   **able year beginning in the same calendar**  
21                   **year as such taxable year.**

22                   **“(2) NONRESIDENT ALIENS.—Subsection**  
23                   **(a) shall not apply to any individual who**  
24                   **is a nonresident alien.**

1           **“(3) INDIVIDUALS RESIDING OUTSIDE**  
2           **UNITED STATES.—Any qualified individual**  
3           **(as defined in section 911(d)) (and any**  
4           **qualifying child residing with such indi-**  
5           **vidual) shall be treated for purposes of**  
6           **this section as covered by acceptable cov-**  
7           **erage during the period described in sub-**  
8           **paragraph (A) or (B) of section 911(d)(1),**  
9           **whichever is applicable.**

10           **“(4) INDIVIDUALS RESIDING IN POSSES-**  
11           **SIONS OF THE UNITED STATES.—Any indi-**  
12           **vidual who is a bona fide resident of any**  
13           **possession of the United States (as deter-**  
14           **mined under section 937(a)) for any tax-**  
15           **able year (and any qualifying child resid-**  
16           **ing with such individual) shall be treated**  
17           **for purposes of this section as covered by**  
18           **acceptable coverage during such taxable**  
19           **year.**

20           **“(5) RELIGIOUS CONSCIENCE EXEMP-**  
21           **TION.—**

22           **“(A) IN GENERAL.—Subsection (a)**  
23           **shall not apply to any individual (and**  
24           **any qualifying child residing with**  
25           **such individual) for any period if**

1       such individual has in effect an ex-  
2       emption which certifies that such in-  
3       dividual is a member of a recognized  
4       religious sect or division thereof de-  
5       scribed in section 1402(g)(1) and an  
6       adherent of established tenets or  
7       teachings of such sect or division as  
8       described in such section.

9               “(B) EXEMPTION.—An application  
10       for the exemption described in sub-  
11       paragraph (A) shall be filed with the  
12       Secretary at such time and in such  
13       form and manner as the Secretary  
14       may prescribe. Any such exemption  
15       granted by the Secretary shall be ef-  
16       fective for such period as the Sec-  
17       retary determines appropriate.

18       “(d) ACCEPTABLE COVERAGE REQUIRE-  
19       MENT.—

20               “(1) IN GENERAL.—The requirements of  
21       this subsection are met with respect to  
22       any individual for any period if such in-  
23       dividual (and each qualifying child of  
24       such individual) is covered by acceptable  
25       coverage at all times during such period.

1           **“(2) ACCEPTABLE COVERAGE.—For pur-**  
2           **poses of this section, the term ‘acceptable**  
3           **coverage’ means any of the following:**

4           **“(A) QUALIFIED HEALTH BENEFITS**  
5           **PLAN COVERAGE.—Coverage under a**  
6           **qualified health benefits plan (as de-**  
7           **defined in section 100(c) of the Amer-**  
8           **ica’s Affordable Health Choices Act of**  
9           **2009).**

10           **“(B) GRANDFATHERED HEALTH IN-**  
11           **SURANCE COVERAGE; COVERAGE UNDER**  
12           **GRANDFATHERED EMPLOYMENT-BASED**  
13           **HEALTH PLAN.—Coverage under a**  
14           **grandfathered health insurance cov-**  
15           **erage (as defined in subsection (a) of**  
16           **section 102 of the America’s Afford-**  
17           **able Health Choices Act of 2009) or**  
18           **under a current employment-based**  
19           **health plan (within the meaning of**  
20           **subsection (b) of such section).**

21           **“(C) MEDICARE.—Coverage under**  
22           **part A of title XVIII of the Social Se-**  
23           **curity Act.**



1           **“(D) MEDICAID.—Coverage for**  
2 **medical assistance under title XIX of**  
3 **the Social Security Act.**

4           **“(E) MEMBERS OF THE ARMED**  
5 **FORCES AND DEPENDENTS (INCLUDING**  
6 **TRICARE).—Coverage under chapter 55**  
7 **of title 10, United States Code, includ-**  
8 **ing similar coverage furnished under**  
9 **section 1781 of title 38 of such Code.**

10          **“(F) VA.—Coverage under the vet-**  
11 **eran’s health care program under**  
12 **chapter 17 of title 38, United States**  
13 **Code, but only if the coverage for the**  
14 **individual involved is determined by**  
15 **the Secretary in coordination with**  
16 **the Health Choices Commissioner to**  
17 **be not less than the level specified by**  
18 **the Secretary of the Treasury, in co-**  
19 **ordination with the Secretary of Vet-**  
20 **eran’s Affairs and the Health Choices**  
21 **Commissioner, based on the individ-**  
22 **ual’s priority for services as provided**  
23 **under section 1705(a) of such title.**

24          **“(G) OTHER COVERAGE.—Such**  
25 **other health benefits coverage as the**

1           **Secretary, in coordination with the**  
2           **Health Choices Commissioner, recog-**  
3           **nizes for purposes of this subsection.**

4           **“(e) OTHER DEFINITIONS AND SPECIAL**  
5 **RULES.—**

6           **“(1) QUALIFYING CHILD.—For purposes**  
7           **of this section, the term ‘qualifying child’**  
8           **has the meaning given such term by sec-**  
9           **tion 152(c). With respect to any period**  
10          **during which health coverage for a child**  
11          **must be provided by an individual pursu-**  
12          **ant to a child support order, such child**  
13          **shall be treated as a qualifying child of**  
14          **such individual (and not as a qualifying**  
15          **child of any other individual).**

16          **“(2) BASIC PLAN.—For purposes of this**  
17          **section, the term ‘basic plan’ has the**  
18          **meaning given such term under section**  
19          **100(c) of the America’s Affordable Health**  
20          **Choices Act of 2009.**

21          **“(3) HEALTH INSURANCE EXCHANGE.—**  
22          **For purposes of this section, the term**  
23          **‘Health Insurance Exchange’ has the**  
24          **meaning given such term under section**  
25          **100(c) of the America’s Affordable Health**

1       **Choices Act of 2009, including any State-**  
2       **based health insurance exchange ap-**  
3       **proved for operation under section 208 of**  
4       **such Act.**

5               **“(4) FAMILY COVERAGE.—For purposes**  
6       **of this section, the term ‘family coverage’**  
7       **means any coverage other than self-only**  
8       **coverage.**

9               **“(5) MODIFIED ADJUSTED GROSS IN-**  
10       **COME.—For purposes of this section, the**  
11       **term ‘modified adjusted gross income’**  
12       **means adjusted gross income—**

13               **“(A) determined without regard to**  
14               **section 911, and**

15               **“(B) increased by the amount of**  
16       **interest received or accrued by the**  
17       **taxpayer during the taxable year**  
18       **which is exempt from tax.**

19               **“(6) NOT TREATED AS TAX IMPOSED BY**  
20       **THIS CHAPTER FOR CERTAIN PURPOSES.—The**  
21       **tax imposed under this section shall not**  
22       **be treated as tax imposed by this chapter**  
23       **for purposes of determining the amount**  
24       **of any credit under this chapter or for**  
25       **purposes of section 55.**

1       **“(f) REGULATIONS.—The Secretary shall**  
2 **prescribe such regulations or other guidance**  
3 **as may be necessary or appropriate to carry**  
4 **out the purposes of this section, including**  
5 **regulations or other guidance (developed in**  
6 **coordination with the Health Choices Com-**  
7 **missioner) which provide—**

8           **“(1) exemption from the tax imposed**  
9 **under subsection (a) in cases of de mini-**  
10 **mis lapses of acceptable coverage, and**

11           **“(2) a process for applying for a waiv-**  
12 **er of the application of subsection (a) in**  
13 **cases of hardship.”.**

14       **(b) INFORMATION REPORTING.—**

15           **(1) IN GENERAL.—Subpart B of part III**  
16 **of subchapter A of chapter 61 of such**  
17 **Code is amended by inserting after sec-**  
18 **tion 6050W the following new section:**

19 **“SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE**  
20 **COVERAGE.**

21           **“(a) REQUIREMENT OF REPORTING.—Every**  
22 **person who provides acceptable coverage (as**  
23 **defined in section 59B(d)) to any individual**  
24 **during any calendar year shall, at such time**  
25 **as the Secretary may prescribe, make the re-**

1 turn described in subsection (b) with respect  
2 to such individual.

3 **“(b) FORM AND MANNER OF RETURNS.—A re-**  
4 **turn is described in this subsection if such re-**  
5 **turn—**

6 **“(1) is in such form as the Secretary**  
7 **may prescribe, and**

8 **“(2) contains—**

9 **“(A) the name, address, and TIN**  
10 **of the primary insured and the name**  
11 **of each other individual obtaining**  
12 **coverage under the policy,**

13 **“(B) the period for which each**  
14 **such individual was provided with**  
15 **the coverage referred to in subsection**  
16 **(a), and**

17 **“(C) such other information as the**  
18 **Secretary may require.**

19 **“(c) STATEMENTS TO BE FURNISHED TO INDI-**  
20 **VIDUALS WITH RESPECT TO WHOM INFORMATION**  
21 **IS REQUIRED.—Every person required to make**  
22 **a return under subsection (a) shall furnish to**  
23 **each primary insured whose name is required**  
24 **to be set forth in such return a written state-**  
25 **ment showing—**

1           “(1) the name and address of the per-  
2           son required to make such return and the  
3           phone number of the information contact  
4           for such person, and

5           “(2) the information required to be  
6           shown on the return with respect to such  
7           individual.

8           The written statement required under the  
9           preceding sentence shall be furnished on or  
10          before January 31 of the year following the  
11          calendar year for which the return under sub-  
12          section (a) is required to be made.

13          “(d) COVERAGE PROVIDED BY GOVERN-  
14          MENTAL UNITS.—In the case of coverage pro-  
15          vided by any governmental unit or any agen-  
16          cy or instrumentality thereof, the officer or  
17          employee who enters into the agreement to  
18          provide such coverage (or the person appro-  
19          priately designated for purposes of this sec-  
20          tion) shall make the returns and statements  
21          required by this section.”.

22                   (2) PENALTY FOR FAILURE TO FILE.—

23                           (A) RETURN.—Subparagraph (B) of  
24                           section 6724(d)(1) of such Code is  
25                           amended by striking “or” at the end

1 of clause (xxii), by striking “and” at  
2 the end of clause (xxiii) and inserting  
3 “or”, and by adding at the end the fol-  
4 lowing new clause:

5 “(xxiv) section 6050X (relating  
6 to returns relating to health in-  
7 surance coverage), and”.

8 (B) STATEMENT.—Paragraph (2) of  
9 section 6724(d) of such Code is  
10 amended by striking “or” at the end  
11 of subparagraph (EE), by striking the  
12 period at the end of subparagraph  
13 (FF) and inserting “, or”, and by in-  
14 serting after subparagraph (FF) the  
15 following new subparagraph:

16 “(GG) section 6050X (relating to  
17 returns relating to health insurance  
18 coverage).”.

19 (c) RETURN REQUIREMENT.—Subsection (a)  
20 of section 6012 of such Code is amended by in-  
21 serting after paragraph (9) the following new  
22 paragraph:

23 “(10) Every individual to whom sec-  
24 tion 59B(a) applies and who fails to meet  
25 the requirements of section 59B(d) with

1       **respect to such individual or any quali-**  
2       **ifying child (as defined in section 152(c))**  
3       **of such individual.”.**

4       **(d) CLERICAL AMENDMENTS.—**

5           **(1) The table of parts for subchapter**  
6       **A of chapter 1 of the Internal Revenue**  
7       **Code of 1986 is amended by adding at the**  
8       **end the following new item:**

**“PART VIII. HEALTH CARE RELATED TAXES.”.**

9           **(2) The table of sections for subpart B**  
10       **of part III of subchapter A of chapter 61**  
11       **is amended by adding at the end the fol-**  
12       **lowing new item:**

**“Sec. 6050X. Returns relating to health insurance coverage.”.**

13       **(e) SECTION 15 NOT TO APPLY.—The amend-**  
14       **ment made by subsection (a) shall not be**  
15       **treated as a change in a rate of tax for pur-**  
16       **poses of section 15 of the Internal Revenue**  
17       **Code of 1986.**

18       **(f) EFFECTIVE DATE.—**

19           **(1) IN GENERAL.—The amendments**  
20       **made by this section shall apply to tax-**  
21       **able years beginning after December 31,**  
22       **2012.**



1           **(2) RETURNS.—**The amendments made  
2           **by subsection (b) shall apply to calendar**  
3           **years beginning after December 31, 2012.**

4           **PART 2—EMPLOYER RESPONSIBILITY**

5           **SEC. 411. ELECTION TO SATISFY HEALTH COVERAGE PAR-**  
6           **TICIPATION REQUIREMENTS.**

7           **(a) IN GENERAL.—**Chapter 43 of the Inter-  
8           **nal Revenue Code of 1986 is amended by add-**  
9           **ing at the end the following new section:**

10          **“SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COV-**  
11          **ERAGE PARTICIPATION REQUIREMENTS.**

12          **“(a) ELECTION OF EMPLOYER RESPONSI-**  
13          **BILITY TO PROVIDE HEALTH COVERAGE.—**

14               **“(1) IN GENERAL.—**Subsection (b) shall  
15               **apply to any employer with respect to**  
16               **whom an election under paragraph (2) is**  
17               **in effect.**

18               **“(2) TIME AND MANNER.—**An employer  
19               **may make an election under this para-**  
20               **graph at such time and in such form and**  
21               **manner as the Secretary may prescribe.**

22               **“(3) AFFILIATED GROUPS.—**In the case  
23               **of any employer which is part of a group**  
24               **of employers who are treated as a single**  
25               **employer under subsection (b), (c), (m), or**

1 (o) of section 414, the election under  
2 paragraph (2) shall be made by such per-  
3 son as the Secretary may provide. Any  
4 such election, once made, shall apply to  
5 all members of such group.

6 “(4) SEPARATE ELECTIONS.—Under reg-  
7 ulations prescribed by the Secretary, sep-  
8 arate elections may be made under para-  
9 graph (2) with respect to—

10 “(A) separate lines of business,

11 and

12 “(B) full-time employees and em-  
13 ployees who are not full-time employ-  
14 ees.

15 “(5) TERMINATION OF ELECTION IN CASES  
16 OF SUBSTANTIAL NONCOMPLIANCE.—The  
17 Secretary may terminate the election of  
18 any employer under paragraph (2) if the  
19 Secretary (in coordination with the  
20 Health Choices Commissioner) deter-  
21 mines that such employer is in substan-  
22 tial noncompliance with the health cov-  
23 erage participation requirements.

1       **“(b) EXCISE TAX WITH RESPECT TO FAILURE**  
2 **TO MEET HEALTH COVERAGE PARTICIPATION RE-**  
3 **QUIREMENTS.—**

4           **“(1) IN GENERAL.—In the case of any**  
5 **employer who fails (during any period**  
6 **with respect to which the election under**  
7 **subsection (a) is in effect) to satisfy the**  
8 **health coverage participation require-**  
9 **ments with respect to any employee to**  
10 **whom such election applies, there is**  
11 **hereby imposed on each such failure with**  
12 **respect to each such employee a tax of**  
13 **\$100 for each day in the period beginning**  
14 **on the date such failure first occurs and**  
15 **ending on the date such failure is cor-**  
16 **rected.**

17           **“(2) LIMITATIONS ON AMOUNT OF TAX.—**

18           **“(A) TAX NOT TO APPLY WHERE FAIL-**  
19 **URE NOT DISCOVERED EXERCISING REA-**  
20 **SONABLE DILIGENCE.—No tax shall be**  
21 **imposed by paragraph (1) on any fail-**  
22 **ure during any period for which it is**  
23 **established to the satisfaction of the**  
24 **Secretary that the employer neither**  
25 **knew, nor exercising reasonable dili-**

1           **gence would have known, that such**  
2           **failure existed.**

3           **“(B) TAX NOT TO APPLY TO FAILURES**  
4           **CORRECTED WITHIN 30 DAYS.—No tax**  
5           **shall be imposed by paragraph (1) on**  
6           **any failure if—**

7                   **“(i) such failure was due to**  
8                   **reasonable cause and not to will-**  
9                   **ful neglect, and**

10                   **“(ii) such failure is corrected**  
11                   **during the 30-day period begin-**  
12                   **ning on the 1st date that the em-**  
13                   **ployer knew, or exercising rea-**  
14                   **sonable diligence would have**  
15                   **known, that such failure existed.**

16           **“(C) OVERALL LIMITATION FOR UNIN-**  
17           **TENTIONAL FAILURES.—In the case of**  
18           **failures which are due to reasonable**  
19           **cause and not to willful neglect, the**  
20           **tax imposed by subsection (a) for fail-**  
21           **ures during the taxable year of the**  
22           **employer shall not exceed the amount**  
23           **equal to the lesser of—**

24                   **“(i) 10 percent of the aggre-**  
25                   **gate amount paid or incurred by**

1           **the employer (or predecessor em-**  
2           **ployer) during the preceding tax-**  
3           **able year for employment-based**  
4           **health plans, or**  
5           **“(ii) \$500,000.**

6           **“(D) COORDINATION WITH OTHER EN-**  
7           **FORCEMENT PROVISIONS.—The tax im-**  
8           **posed under paragraph (1) with re-**  
9           **spect to any failure shall be reduced**  
10          **(but not below zero) by the amount of**  
11          **any civil penalty collected under sec-**  
12          **tion 502(c)(11) of the Employee Re-**  
13          **tirement Income Security Act of 1974**  
14          **or section 2793(g) of the Public**  
15          **Health Service Act with respect to**  
16          **such failure.**

17          **“(c) HEALTH COVERAGE PARTICIPATION RE-**  
18          **QUIREMENTS.—For purposes of this section,**  
19          **the term ‘health coverage participation re-**  
20          **quirements’ means the requirements of part I**  
21          **of subtitle B of title III of the America’s Af-**  
22          **fordable Health Choices Act of 2009 (as in ef-**  
23          **fect on the date of the enactment of this sec-**  
24          **tion).”.**

1 (b) **CLERICAL AMENDMENT.**—The table of  
2 sections for chapter 43 of such Code is amend-  
3 ed by adding at the end the following new  
4 item:

“Sec. 4980H. Election with respect to health coverage partici-  
pation requirements.”.

5 (c) **EFFECTIVE DATE.**—The amendments  
6 made by this section shall apply to periods be-  
7 ginning after December 31, 2012.

8 **SEC. 412. RESPONSIBILITIES OF NONELECTING EMPLOY-**  
9 **ERS.**

10 (a) **IN GENERAL.**—Section 3111 of the Inter-  
11 nal Revenue Code of 1986 is amended by re-  
12 designating subsection (c) as subsection (d)  
13 and by inserting after subsection (b) the fol-  
14 lowing new subsection:

15 “(c) **EMPLOYERS ELECTING TO NOT PROVIDE**  
16 **HEALTH BENEFITS.**—

17 “(1) **IN GENERAL.**—In addition to other  
18 taxes, there is hereby imposed on every  
19 nonelecting employer an excise tax, with  
20 respect to having individuals in his em-  
21 ploy, equal to 8 percent of the wages (as  
22 defined in section 3121(a)) paid by him  
23 with respect to employment (as defined  
24 in section 3121(b)).

1           **“(2) SPECIAL RULES FOR SMALL EMPLOY-**  
 2           **ERS.—**

3           **“(A) IN GENERAL.—In the case of**  
 4           **any employer who is small employer**  
 5           **for any calendar year, paragraph (1)**  
 6           **shall be applied by substituting the**  
 7           **applicable percentage determined in**  
 8           **accordance with the following table**  
 9           **for ‘8 percent’:**

<b>“If the annual payroll of such employer for the preceding calendar year:</b>	<b>The applicable percentage is:</b>
<b>Does not exceed \$250,000 .....</b>	<b>0 percent</b>
<b>Exceeds \$250,000, but does not exceed \$300,000.</b>	<b>2 percent</b>
<b>Exceeds \$300,000, but does not exceed \$350,000.</b>	<b>4 percent</b>
<b>Exceeds \$350,000, but does not exceed \$400,000.</b>	<b>6 percent</b>

10           **“(B) SMALL EMPLOYER.—For pur-**  
 11           **poses of this paragraph, the term**  
 12           **‘small employer’ means any employer**  
 13           **for any calendar year if the annual**  
 14           **payroll of such employer for the pre-**  
 15           **ceding calendar year does not exceed**  
 16           **\$400,000.**

17           **“(C) ANNUAL PAYROLL.—For pur-**  
 18           **poses of this paragraph, the term ‘an-**  
 19           **annual payroll’ means, with respect to**  
 20           **any employer for any calendar year,**  
 21           **the aggregate wages (as defined in**

1           **section 3121(a)) paid by him with re-**  
2           **spect to employment (as defined in**  
3           **section 3121(b)) during such calendar**  
4           **year.**

5           **“(3) NONELECTING EMPLOYER.—For**  
6           **purposes of paragraph (1), the term ‘non-**  
7           **electing employer’ means any employer**  
8           **for any period with respect to which such**  
9           **employer does not have an election under**  
10          **section 4980H(a) in effect.**

11          **“(4) SPECIAL RULE FOR SEPARATE ELEC-**  
12          **TIONS.—In the case of an employer who**  
13          **makes a separate election described in**  
14          **section 4980H(a)(4) for any period, para-**  
15          **graph (1) shall be applied for such period**  
16          **by taking into account only the wages**  
17          **paid to employees who are not subject to**  
18          **such election.**

19          **“(5) AGGREGATION; PREDECESSORS.—**  
20          **For purposes of this subsection—**

21                 **“(A) all persons treated as a single**  
22                 **employer under subsection (b), (c),**  
23                 **(m), or (o) of section 414 shall be**  
24                 **treated as 1 employer, and**



1           **“(B) any reference to any person**  
2           **shall be treated as including a ref-**  
3           **erence to any predecessor of such**  
4           **person.”.**

5           **(b) DEFINITIONS.—Section 3121 of such**  
6           **Code is amended by adding at the end the fol-**  
7           **lowing new subsection:**

8           **“(aa) SPECIAL RULES FOR TAX ON EMPLOY-**  
9           **ERS ELECTING NOT TO PROVIDE HEALTH BENE-**  
10          **FITS.—For purposes of section 3111(c)—**

11           **“(1) Paragraphs (1), (5), and (19) of**  
12          **subsection (b) shall not apply.**

13           **“(2) Paragraph (7) of subsection (b)**  
14          **shall apply by treating all services as not**  
15          **covered by the retirement systems re-**  
16          **ferred to in subparagraphs (C) and (F)**  
17          **thereof.**

18           **“(3) Subsection (e) shall not apply and**  
19          **the term ‘State’ shall include the District**  
20          **of Columbia.”.**

21          **(c) CONFORMING AMENDMENT.—Subsection**  
22          **(d) of section 3111 of such Code, as redesign-**  
23          **ated by this section, is amended by striking**  
24          **“this section” and inserting “subsections (a)**  
25          **and (b)”.**

1       **(d) APPLICATION TO RAILROADS.—**

2           **(1) IN GENERAL.—Section 3221 of such**  
3       **Code is amended by redesignating sub-**  
4       **section (c) as subsection (d) and by in-**  
5       **serting after subsection (b) the following**  
6       **new subsection:**

7       **“(c) EMPLOYERS ELECTING TO NOT PROVIDE**  
8       **HEALTH BENEFITS.—**

9           **“(1) IN GENERAL.—In addition to other**  
10       **taxes, there is hereby imposed on every**  
11       **nonelecting employer an excise tax, with**  
12       **respect to having individuals in his em-**  
13       **ploy, equal to 8 percent of the compensa-**  
14       **tion paid during any calendar year by**  
15       **such employer for services rendered to**  
16       **such employer.**

17           **“(2) EXCEPTION FOR SMALL EMPLOY-**  
18       **ERS.—Rules similar to the rules of section**  
19       **3111(c)(2) shall apply for purposes of this**  
20       **subsection.**

21           **“(3) NONELECTING EMPLOYER.—For**  
22       **purposes of paragraph (1), the term ‘non-**  
23       **electing employer’ means any employer**  
24       **for any period with respect to which such**

1       **employer does not have an election under**  
2       **section 4980H(a) in effect.**

3           **“(4) SPECIAL RULE FOR SEPARATE ELEC-**  
4       **TIONS.—In the case of an employer who**  
5       **makes a separate election described in**  
6       **section 4980H(a)(4) for any period, sub-**  
7       **section (a) shall be applied for such pe-**  
8       **riod by taking into account only the**  
9       **wages paid to employees who are not**  
10       **subject to such election.”.**

11           **(2) DEFINITIONS.—Subsection (e) of**  
12       **section 3231 of such Code is amended by**  
13       **adding at the end the following new**  
14       **paragraph:**

15           **“(13) SPECIAL RULES FOR TAX ON EM-**  
16       **PLOYERS ELECTING NOT TO PROVIDE HEALTH**  
17       **BENEFITS.—For purposes of section**  
18       **3221(c)—**

19           **“(A) Paragraph (1) shall be ap-**  
20       **plied without regard to the third sen-**  
21       **tence thereof.**

22           **“(B) Paragraph (2) shall not**  
23       **apply.”.**

24           **(3) CONFORMING AMENDMENT.—Sub-**  
25       **section (d) of section 3221 of such Code,**

1 as redesignated by this section, is amend-  
2 ed by striking “subsections (a) and (b),  
3 see section 3231(e)(2)” and inserting “this  
4 section, see paragraphs (2) and (13)(B) of  
5 section 3231(e)”.

6 (e) **EFFECTIVE DATE.**—The amendments  
7 made by this section shall apply to periods be-  
8 ginning after December 31, 2012.

9 **Subtitle B—Credit for Small Busi-  
10 ness Employee Health Coverage  
11 Expenses**

12 **SEC. 421. CREDIT FOR SMALL BUSINESS EMPLOYEE  
13 HEALTH COVERAGE EXPENSES.**

14 (a) **IN GENERAL.**—Subpart D of part IV of  
15 subchapter A of chapter 1 of the Internal Rev-  
16 enue Code of 1986 (relating to business-re-  
17 lated credits) is amended by adding at the end  
18 the following new section:

19 **“SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COV-  
20 ERAGE CREDIT.**

21 **“(a) IN GENERAL.**—For purposes of section  
22 38, in the case of a qualified small employer,  
23 the small business employee health coverage  
24 credit determined under this section for the  
25 taxable year is an amount equal to the appli-

1 cable percentage of the qualified employee  
2 health coverage expenses of such employer  
3 for such taxable year.

4 “(b) APPLICABLE PERCENTAGE.—

5 “(1) IN GENERAL.—For purposes of this  
6 section, the applicable percentage is 50  
7 percent.

8 “(2) PHASEOUT BASED ON AVERAGE COM-  
9 PENSATION OF EMPLOYEES.—In the case of  
10 an employer whose average annual em-  
11 ployee compensation for the taxable year  
12 exceeds \$20,000, the percentage specified  
13 in paragraph (1) shall be reduced by a  
14 number of percentage points which bears  
15 the same ratio to 50 as such excess bears  
16 to \$20,000.

17 “(c) LIMITATIONS.—

18 “(1) PHASEOUT BASED ON EMPLOYER  
19 SIZE.—In the case of an employer who em-  
20 ploys more than 10 qualified employees  
21 during the taxable year, the credit deter-  
22 mined under subsection (a) shall be re-  
23 duced by an amount which bears the  
24 same ratio to the amount of such credit  
25 (determined without regard to this para-

1 **graph and after the application of the**  
2 **other provisions of this section) as—**

3 **“(A) the excess of—**

4 **“(i) the number of qualified**  
5 **employees employed by the em-**  
6 **ployer during the taxable year,**  
7 **over**

8 **“(ii) 10, bears to**

9 **“(B) 15.**

10 **“(2) CREDIT NOT ALLOWED WITH RE-**  
11 **SPECT TO CERTAIN HIGHLY COMPENSATED**  
12 **EMPLOYEES.—No credit shall be allowed**  
13 **under subsection (a) with respect to**  
14 **qualified employee health coverage ex-**  
15 **penses paid or incurred with respect to**  
16 **any employee for any taxable year if the**  
17 **aggregate compensation paid by the em-**  
18 **ployer to such employee during such tax-**  
19 **able year exceeds \$80,000.**

20 **“(d) QUALIFIED EMPLOYEE HEALTH COV-**  
21 **ERAGE EXPENSES.—For purposes of this sec-**  
22 **tion—**

23 **“(1) IN GENERAL.—The term ‘qualified**  
24 **employee health coverage expenses’**  
25 **means, with respect to any employer for**

1 any taxable year, the aggregate amount  
2 paid or incurred by such employer dur-  
3 ing such taxable year for coverage of any  
4 qualified employee of the employer (in-  
5 cluding any family coverage which covers  
6 such employee) under qualified health  
7 coverage.

8 “(2) QUALIFIED HEALTH COVERAGE.—  
9 The term ‘qualified health coverage’  
10 means acceptable coverage (as defined in  
11 section 59B(d)) which—

12 “(A) is provided pursuant to an  
13 election under section 4980H(a), and

14 “(B) satisfies the requirements re-  
15 ferred to in section 4980H(c).

16 “(e) OTHER DEFINITIONS.—For purposes of  
17 this section—

18 “(1) QUALIFIED SMALL EMPLOYER.—For  
19 purposes of this section, the term ‘quali-  
20 fied small employer’ means any employer  
21 for any taxable year if—

22 “(A) the number of qualified em-  
23 ployees employed by such employer  
24 during the taxable year does not ex-  
25 ceed 25, and

1           **“(B) the average annual employee**  
2           **compensation of such employer for**  
3           **such taxable year does not exceed the**  
4           **sum of the dollar amounts in effect**  
5           **under subsection (b)(2).**

6           **“(2) QUALIFIED EMPLOYEE.—The term**  
7           **‘qualified employee’ means any employee**  
8           **of an employer for any taxable year of**  
9           **the employer if such employee received**  
10          **at least \$5,000 of compensation from such**  
11          **employer for services performed in the**  
12          **trade or business of such employer dur-**  
13          **ing such taxable year.**

14          **“(3) AVERAGE ANNUAL EMPLOYEE COM-**  
15          **PENSATION.—The term ‘average annual**  
16          **employee compensation’ means, with re-**  
17          **spect to any employer for any taxable**  
18          **year, the average amount of compensa-**  
19          **tion paid by such employer to qualified**  
20          **employees of such employer during such**  
21          **taxable year.**

22          **“(4) COMPENSATION.—The term ‘com-**  
23          **ensation’ has the meaning given such**  
24          **term in section 408(p)(6)(A).**



1           **“(5) FAMILY COVERAGE.—The term**  
2           **‘family coverage’ means any coverage**  
3           **other than self-only coverage.**

4           **“(f) SPECIAL RULES.—For purposes of this**  
5           **section—**

6           **“(1) SPECIAL RULE FOR PARTNERSHIPS**  
7           **AND SELF-EMPLOYED.—In the case of a**  
8           **partnership (or a trade or business car-**  
9           **ried on by an individual) which has one**  
10           **or more qualified employees (determined**  
11           **without regard to this paragraph) with**  
12           **respect to whom the election under**  
13           **4980H(a) applies, each partner (or, in the**  
14           **case of a trade or business carried on by**  
15           **an individual, such individual) shall be**  
16           **treated as an employee.**

17           **“(2) AGGREGATION RULE.—All persons**  
18           **treated as a single employer under sub-**  
19           **section (b), (c), (m), or (o) of section 414**  
20           **shall be treated as 1 employer.**

21           **“(3) DENIAL OF DOUBLE BENEFIT.—Any**  
22           **deduction otherwise allowable with re-**  
23           **spect to amounts paid or incurred for**  
24           **health insurance coverage to which sub-**  
25           **section (a) applies shall be reduced by**

1       **the amount of the credit determined**  
2       **under this section.**

3           **“(4) INFLATION ADJUSTMENT.—In the**  
4       **case of any taxable year beginning after**  
5       **2013, each of the dollar amounts in sub-**  
6       **sections (b)(2), (c)(2), and (e)(2) shall be**  
7       **increased by an amount equal to—**

8           **“(A) such dollar amount, multi-**  
9       **plied by**

10          **“(B) the cost of living adjustment**  
11       **determined under section 1(f)(3) for**  
12       **the calendar year in which the tax-**  
13       **able year begins determined by sub-**  
14       **stituting ‘calendar year 2012’ for ‘cal-**  
15       **endar year 1992’ in subparagraph (B)**  
16       **thereof.**

17       **If any increase determined under this**  
18       **paragraph is not a multiple of \$50, such**  
19       **increase shall be rounded to the next**  
20       **lowest multiple of \$50.”.**

21       **(b) CREDIT TO BE PART OF GENERAL BUSI-**  
22       **NESS CREDIT.—Subsection (b) of section 38 of**  
23       **such Code (relating to general business cred-**  
24       **it) is amended by striking “plus” at the end of**  
25       **paragraph (34), by striking the period at the**

1 end of paragraph (35) and inserting “, plus” ,  
2 and by adding at the end the following new  
3 paragraph:

4 “(36) in the case of a qualified small  
5 employer (as defined in section 45R(e)),  
6 the small business employee health cov-  
7 erage credit determined under section  
8 45R(a).”.

9 (c) CLERICAL AMENDMENT.—The table of  
10 sections for subpart D of part IV of sub-  
11 chapter A of chapter 1 of such Code is amend-  
12 ed by inserting after the item relating to sec-  
13 tion 45Q the following new item:

“Sec. 45R. Small business employee health coverage credit.”.

14 (d) EFFECTIVE DATE.—The amendments  
15 made by this section shall apply to taxable  
16 years beginning after December 31, 2012.

17 **Subtitle C—Disclosures to Carry**  
18 **Out Health Insurance Exchange**  
19 **Subsidies**

20 SEC. 431. DISCLOSURES TO CARRY OUT HEALTH INSUR-  
21 ANCE EXCHANGE SUBSIDIES.

22 (a) IN GENERAL.—Subsection (l) of section  
23 6103 of the Internal Revenue Code of 1986 is  
24 amended by adding at the end the following  
25 new paragraph:

1           **“(21) DISCLOSURE OF RETURN INFORMA-**  
2           **TION TO CARRY OUT HEALTH INSURANCE EX-**  
3           **CHANGE SUBSIDIES.—**

4           **“(A) IN GENERAL.—The Secretary,**  
5           **upon written request from the Health**  
6           **Choices Commissioner or the head of**  
7           **a State-based health insurance ex-**  
8           **change approved for operation under**  
9           **section 208 of the America’s Afford-**  
10          **able Health Choices Act of 2009, shall**  
11          **disclose to officers and employees of**  
12          **the Health Choices Administration or**  
13          **such State-based health insurance ex-**  
14          **change, as the case may be, return in-**  
15          **formation of any taxpayer whose in-**  
16          **come is relevant in determining any**  
17          **affordability credit described in sub-**  
18          **title C of title II of the America’s Af-**  
19          **fordable Health Choices Act of 2009.**  
20          **Such return information shall be lim-**  
21          **ited to—**

22                   **“(i) taxpayer identity informa-**  
23                   **tion with respect to such tax-**  
24                   **payer,**

1           “(ii) the filing status of such  
2 taxpayer,

3           “(iii) the modified adjusted  
4 gross income of such taxpayer (as  
5 defined in section 59B(e)(5)),

6           “(iv) the number of depend-  
7 ents of the taxpayer,

8           “(v) such other information as  
9 is prescribed by the Secretary by  
10 regulation as might indicate  
11 whether the taxpayer is eligible  
12 for such affordability credits (and  
13 the amount thereof), and

14           “(vi) the taxable year with re-  
15 spect to which the preceding in-  
16 formation relates or, if applicable,  
17 the fact that such information is  
18 not available.

19           “(B) RESTRICTION ON USE OF DIS-  
20 CLOSED INFORMATION.—Return infor-  
21 mation disclosed under subparagraph  
22 (A) may be used by officers and em-  
23 ployees of the Health Choices Admin-  
24 istration or such State-based health  
25 insurance exchange, as the case may

1           be, only for the purposes of, and to  
2           the extent necessary in, establishing  
3           and verifying the appropriate amount  
4           of any affordability credit described  
5           in subtitle C of title II of the Amer-  
6           ica’s Affordable Health Choices Act of  
7           2009 and providing for the repayment  
8           of any such credit which was in ex-  
9           cess of such appropriate amount.”.

10           **(b) PROCEDURES AND RECORDKEEPING RE-**  
11 **LATED TO DISCLOSURES.—**Paragraph (4) of sec-  
12 **tion 6103(p) of such Code is amended—**

13           (1) by inserting “, or any entity de-  
14           scribed in subsection (l)(21),” after “or  
15           (20)” in the matter preceding subpara-  
16           graph (A),

17           (2) by inserting “or any entity de-  
18           scribed in subsection (l)(21),” after “or  
19           (o)(1)(A),” in subparagraph (F)(ii), and

20           (3) by inserting “or any entity de-  
21           scribed in subsection (l)(21),” after “or  
22           (20),” both places it appears in the matter  
23           after subparagraph (F).

24           **(c) UNAUTHORIZED DISCLOSURE OR INSPEC-**  
25 **TION.—**Paragraph (2) of section 7213(a) of such

1 **Code is amended by striking “or (20)” and in-**  
2 **serting “(20), or (21)”.**

3 **Subtitle D—Other Revenue**  
4 **Provisions**

5 **PART 1—GENERAL PROVISIONS**

6 **SEC. 441. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

7 **(a) IN GENERAL.—Part VIII of subchapter**  
8 **A of chapter 1 of the Internal Revenue Code**  
9 **of 1986, as added by this title, is amended by**  
10 **adding at the end the following new subpart:**

11 **“Subpart B—Surcharge on High Income Individuals**

**“Sec. 59C. Surcharge on high income individuals.**

12 **“SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

13 **“(a) GENERAL RULE.—In the case of a tax-**  
14 **payer other than a corporation, there is here-**  
15 **by imposed (in addition to any other tax im-**  
16 **posed by this subtitle) a tax equal to—**

17 **“(1) 1 percent of so much of the modi-**  
18 **fied adjusted gross income of the tax-**  
19 **payer as exceeds \$350,000 but does not**  
20 **exceed \$500,000,**

21 **“(2) 1.5 percent of so much of the**  
22 **modified adjusted gross income of the**  
23 **taxpayer as exceeds \$500,000 but does not**  
24 **exceed \$1,000,000, and**

1           **“(3) 5.4 percent of so much of the**  
2           **modified adjusted gross income of the**  
3           **taxpayer as exceeds \$1,000,000.**

4           **“(b) TAXPAYERS NOT MAKING A JOINT RE-**  
5           **TURN.—In the case of any taxpayer other than**  
6           **a taxpayer making a joint return under sec-**  
7           **tion 6013 or a surviving spouse (as defined in**  
8           **section 2(a)), subsection (a) shall be applied**  
9           **by substituting for each of the dollar amounts**  
10           **therein (after any increase determined under**  
11           **subsection (e)) a dollar amount equal to—**

12                   **“(1) 50 percent of the dollar amount**  
13                   **so in effect in the case of a married indi-**  
14                   **vidual filing a separate return, and**

15                   **“(2) 80 percent of the dollar amount**  
16                   **so in effect in any other case.**

17           **“(c) ADJUSTMENTS BASED ON FEDERAL**  
18           **HEALTH REFORM SAVINGS.—**

19                   **“(1) IN GENERAL.—Except as provided**  
20                   **in paragraph (2), in the case of any tax-**  
21                   **able year beginning after December 31,**  
22                   **2012, subsection (a) shall be applied—**

23                           **“(A) by substituting ‘2 percent’ for**  
24                           **‘1 percent’, and**



1           **“(B) by substituting ‘3 percent’ for**  
2           **‘1.5 percent’.**

3           **“(2) ADJUSTMENTS BASED ON EXCESS**  
4           **FEDERAL HEALTH REFORM SAVINGS.—**

5           **“(A) EXCEPTION IF FEDERAL HEALTH**  
6           **REFORM SAVINGS SIGNIFICANTLY EX-**  
7           **CEEDS BASE AMOUNT.—If the excess**  
8           **Federal health reform savings is more**  
9           **than \$150,000,000,000 but not more**  
10          **than \$175,000,000,000, paragraph (1)**  
11          **shall not apply.**

12          **“(B) FURTHER ADJUSTMENT FOR AD-**  
13          **DITIONAL FEDERAL HEALTH REFORM SAV-**  
14          **INGS.—If the excess Federal health re-**  
15          **form savings is more than**  
16          **\$175,000,000,000, paragraphs (1) and**  
17          **(2) of subsection (a) (and paragraph**  
18          **(1) of this subsection) shall not apply**  
19          **to any taxable year beginning after**  
20          **December 31, 2012.**

21          **“(C) EXCESS FEDERAL HEALTH RE-**  
22          **FORM SAVINGS.—For purposes of this**  
23          **subsection, the term ‘excess Federal**  
24          **health reform savings’ means the ex-**  
25          **cess of—**

1           “(i) the Federal health reform  
2           savings, over

3           “(ii) \$525,000,000,000.

4           “(D) FEDERAL HEALTH REFORM SAV-  
5           INGS.—The term ‘Federal health re-  
6           form savings’ means the sum of the  
7           amounts described in subparagraphs  
8           (A) and (B) of paragraph (3).

9           “(3) DETERMINATION OF FEDERAL  
10          HEALTH REFORM SAVINGS.—Not later than  
11          December 1, 2012, the Director of the Of-  
12          fice of Management and Budget shall—

13               “(A) determine, on the basis of the  
14               study conducted under paragraph (4),  
15               the aggregate reductions in Federal  
16               expenditures which have been  
17               achieved as a result of the provisions  
18               of, and amendments made by, divi-  
19               sion B of the America’s Affordable  
20               Health Choices Act of 2009 during the  
21               period beginning on October 1, 2009,  
22               and ending with the latest date with  
23               respect to which the Director has suf-  
24               ficient data to make such determina-  
25               tion, and

1           **“(B) estimate, on the basis of such**  
2           **study and the determination under**  
3           **subparagraph (A), the aggregate re-**  
4           **ductions in Federal expenditures**  
5           **which will be achieved as a result of**  
6           **such provisions and amendments**  
7           **during so much of the period begin-**  
8           **ning with fiscal year 2010 and ending**  
9           **with fiscal year 2019 as is not taken**  
10          **into account under subparagraph (A).**

11          **“(4) STUDY OF FEDERAL HEALTH REFORM**  
12          **SAVINGS.—The Director of the Office of**  
13          **Management and Budget shall conduct a**  
14          **study of the reductions in Federal ex-**  
15          **penditures during fiscal years 2010**  
16          **through 2019 which are attributable to**  
17          **the provisions of, and amendments made**  
18          **by, division B of the America’s Affordable**  
19          **Health Choices Act of 2009. The Director**  
20          **shall complete such study not later than**  
21          **December 1, 2012.**

22          **“(5) REDUCTIONS IN FEDERAL EXPENDI-**  
23          **TURES DETERMINED WITHOUT REGARD TO**  
24          **PROGRAM INVESTMENTS.—For purposes of**  
25          **paragraphs (3) and (4), reductions in Fed-**

1       eral expenditures shall be determined  
2       without regard to section 1121 of the  
3       America’s Affordable Health Choices Act  
4       of 2009 and other program investments  
5       under division B thereof.

6       “(d) MODIFIED ADJUSTED GROSS INCOME.—  
7       For purposes of this section, the term ‘modi-  
8       fied adjusted gross income’ means adjusted  
9       gross income reduced by any deduction (not  
10      taken into account in determining adjusted  
11      gross income) allowed for investment interest  
12      (as defined in section 163(d)). In the case of  
13      an estate or trust, adjusted gross income shall  
14      be determined as provided in section 67(e).

15      “(e) INFLATION ADJUSTMENTS.—

16              “(1) IN GENERAL.—In the case of tax-  
17      able years beginning after 2011, the dol-  
18      lar amounts in subsection (a) shall be in-  
19      creased by an amount equal to—

20                      “(A) such dollar amount, multi-  
21                      plied by

22                      “(B) the cost-of-living adjustment  
23                      determined under section 1(f)(3) for  
24                      the calendar year in which the tax-  
25                      able year begins, by substituting ‘cal-

1           **endar year 2010’ for ‘calendar year**  
2           **1992’ in subparagraph (B) thereof.**

3           **“(2) ROUNDING.—If any amount as ad-**  
4           **justed under paragraph (1) is not a mul-**  
5           **tiiple of \$5,000, such amount shall be**  
6           **rounded to the next lowest multiple of**  
7           **\$5,000.**

8           **“(f) SPECIAL RULES.—**

9           **“(1) NONRESIDENT ALIEN.—In the case**  
10          **of a nonresident alien individual, only**  
11          **amounts taken into account in connec-**  
12          **tion with the tax imposed under section**  
13          **871(b) shall be taken into account under**  
14          **this section.**

15          **“(2) CITIZENS AND RESIDENTS LIVING**  
16          **ABROAD.—The dollar amounts in effect**  
17          **under subsection (a) (after the applica-**  
18          **tion of subsections (b) and (e)) shall be**  
19          **decreased by the excess of—**

20                 **“(A) the amounts excluded from**  
21                 **the taxpayer’s gross income under**  
22                 **section 911, over**

23                 **“(B) the amounts of any deduc-**  
24                 **tions or exclusions disallowed under**  
25                 **section 911(d)(6) with respect to the**

1           **amounts described in subparagraph**  
2           **(A).**

3           **“(3) CHARITABLE TRUSTS.—Subsection**  
4           **(a) shall not apply to a trust all the unex-**  
5           **pired interests in which are devoted to**  
6           **one or more of the purposes described in**  
7           **section 170(c)(2)(B).**

8           **“(4) NOT TREATED AS TAX IMPOSED BY**  
9           **THIS CHAPTER FOR CERTAIN PURPOSES.—The**  
10          **tax imposed under this section shall not**  
11          **be treated as tax imposed by this chapter**  
12          **for purposes of determining the amount**  
13          **of any credit under this chapter or for**  
14          **purposes of section 55.”.**

15          **(b) CLERICAL AMENDMENT.—The table of**  
16          **subparts for part VIII of subchapter A of**  
17          **chapter 1 of such Code, as added by this title,**  
18          **is amended by inserting after the item relat-**  
19          **ing to subpart A the following new item:**

**“SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.”.**

20          **(c) SECTION 15 NOT TO APPLY.—The amend-**  
21          **ment made by subsection (a) shall not be**  
22          **treated as a change in a rate of tax for pur-**  
23          **poses of section 15 of the Internal Revenue**  
24          **Code of 1986.**

1       **(d) EFFECTIVE DATE.**—The amendments  
2 made by this section shall apply to taxable  
3 years beginning after December 31, 2010.

4       **SEC. 442. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY**  
5                                   **IF FOR PRESCRIBED DRUG OR INSULIN.**

6       **(a) HSAs.**—Subparagraph (A) of section  
7 223(d)(2) of the Internal Revenue Code of 1986  
8 is amended by adding at the end the fol-  
9 lowing: “Such term shall include an amount  
10 paid for medicine or a drug only if such medi-  
11 cine or drug is a prescribed drug or is insu-  
12 lin.”.

13       **(b) ARCHER MSAs.**—Subparagraph (A) of  
14 section 220(d)(2) of such Code is amended by  
15 adding at the end the following: “Such term  
16 shall include an amount paid for medicine or  
17 a drug only if such medicine or drug is a pre-  
18 scribed drug or is insulin.”.

19       **(c) HEALTH FLEXIBLE SPENDING ARRANGE-**  
20 **MENTS AND HEALTH REIMBURSEMENT ARRANGE-**  
21 **MENTS.**—Section 106 of such Code is amended  
22 by adding at the end the following new sub-  
23 section:

24       **“(f) REIMBURSEMENTS FOR MEDICINE RE-**  
25 **STRICTED TO PRESCRIBED DRUGS AND INSULIN.**—

1 **For purposes of this section and section 105,**  
2 **reimbursement for expenses incurred for a**  
3 **medicine or a drug shall be treated as a reim-**  
4 **bursement for medical expenses only if such**  
5 **medicine or drug is a prescribed drug or is in-**  
6 **sulin.”.**

7 **(d) EFFECTIVE DATES.—The amendment**  
8 **made by this section shall apply to expenses**  
9 **incurred after December 31, 2009.**

10 **SEC. 443. DELAY IN APPLICATION OF WORLDWIDE ALLOCA-**  
11 **TION OF INTEREST.**

12 **(a) IN GENERAL.—Paragraphs (5)(D) and**  
13 **(6) of section 864(f) of the Internal Revenue**  
14 **Code of 1986 are each amended by striking**  
15 **“December 31, 2010” and inserting “December**  
16 **31, 2019”.**

17 **(b) TRANSITION.—Subsection (f) of section**  
18 **864 of such Code is amended by striking para-**  
19 **graph (7).**

20 **PART 2—PREVENTION OF TAX AVOIDANCE**

21 **SEC. 451. LIMITATION ON TREATY BENEFITS FOR CERTAIN**  
22 **DEDUCTIBLE PAYMENTS.**

23 **(a) IN GENERAL.—Section 894 of the Inter-**  
24 **nal Revenue Code of 1986 (relating to income**



1 affected by treaty) is amended by adding at  
2 the end the following new subsection:

3 **“(d) LIMITATION ON TREATY BENEFITS FOR**  
4 **CERTAIN DEDUCTIBLE PAYMENTS.—**

5 **“(1) IN GENERAL.—**In the case of any  
6 **deductible related-party payment, any**  
7 **withholding tax imposed under chapter 3**  
8 **(and any tax imposed under subpart A or**  
9 **B of this part) with respect to such pay-**  
10 **ment may not be reduced under any trea-**  
11 **ty of the United States unless any such**  
12 **withholding tax would be reduced under**  
13 **a treaty of the United States if such pay-**  
14 **ment were made directly to the foreign**  
15 **parent corporation.**

16 **“(2) DEDUCTIBLE RELATED-PARTY PAY-**  
17 **MENT.—**For purposes of this subsection,  
18 **the term ‘deductible related-party pay-**  
19 **ment’ means any payment made, directly**  
20 **or indirectly, by any person to any other**  
21 **person if the payment is allowable as a**  
22 **deduction under this chapter and both**  
23 **persons are members of the same foreign**  
24 **controlled group of entities.**

1           **“(3) FOREIGN CONTROLLED GROUP OF**  
2           **ENTITIES.—For purposes of this sub-**  
3           **section—**

4           **“(A) IN GENERAL.—The term ‘for-**  
5           **ign controlled group of entities’**  
6           **means a controlled group of entities**  
7           **the common parent of which is a for-**  
8           **ign corporation.**

9           **“(B) CONTROLLED GROUP OF ENTI-**  
10           **TIES.—The term ‘controlled group of**  
11           **entities’ means a controlled group of**  
12           **corporations as defined in section**  
13           **1563(a)(1), except that—**

14           **“(i) ‘more than 50 percent’**  
15           **shall be substituted for ‘at least**  
16           **80 percent’ each place it appears**  
17           **therein, and**

18           **“(ii) the determination shall**  
19           **be made without regard to sub-**  
20           **sections (a)(4) and (b)(2) of sec-**  
21           **tion 1563.**

22           **A partnership or any other entity**  
23           **(other than a corporation) shall be**  
24           **treated as a member of a controlled**  
25           **group of entities if such entity is con-**

1           **trolled (within the meaning of section**  
2           **954(d)(3)) by members of such group**  
3           **(including any entity treated as a**  
4           **member of such group by reason of**  
5           **this sentence).**

6           **“(4) FOREIGN PARENT CORPORATION.—**  
7           **For purposes of this subsection, the term**  
8           **‘foreign parent corporation’ means, with**  
9           **respect to any deductible related-party**  
10          **payment, the common parent of the for-**  
11          **foreign controlled group of entities referred**  
12          **to in paragraph (3)(A).**

13          **“(5) REGULATIONS.—The Secretary**  
14          **may prescribe such regulations or other**  
15          **guidance as are necessary or appropriate**  
16          **to carry out the purposes of this sub-**  
17          **section, including regulations or other**  
18          **guidance which provide for—**

19                  **“(A) the treatment of two or more**  
20                  **persons as members of a foreign con-**  
21                  **trolled group of entities if such per-**  
22                  **sons would be the common parent of**  
23                  **such group if treated as one corpora-**  
24                  **tion, and**

1           **“(B) the treatment of any member**  
2           **of a foreign controlled group of enti-**  
3           **ties as the common parent of such**  
4           **group if such treatment is appro-**  
5           **priate taking into account the eco-**  
6           **nomical relationships among such enti-**  
7           **ties.”.**

8           **(b) EFFECTIVE DATE.—The amendment**  
9           **made by this section shall apply to payments**  
10           **made after the date of the enactment of this**  
11           **Act.**

12           **SEC. 452. CODIFICATION OF ECONOMIC SUBSTANCE DOC-**  
13           **TRINE.**

14           **(a) IN GENERAL.—Section 7701 of the Inter-**  
15           **nal Revenue Code of 1986 is amended by re-**  
16           **designating subsection (o) as subsection (p)**  
17           **and by inserting after subsection (n) the fol-**  
18           **lowing new subsection:**

19           **“(o) CLARIFICATION OF ECONOMIC SUB-**  
20           **STANCE DOCTRINE.—**

21           **“(1) APPLICATION OF DOCTRINE.—In the**  
22           **case of any transaction to which the eco-**  
23           **nomical substance doctrine is relevant,**  
24           **such transaction shall be treated as hav-**  
25           **ing economic substance only if—**

1           “(A) the transaction changes in a  
2 meaningful way (apart from Federal  
3 income tax effects) the taxpayer’s eco-  
4 nomic position, and

5           “(B) the taxpayer has a substan-  
6 tial purpose (apart from Federal in-  
7 come tax effects) for entering into  
8 such transaction.

9           “(2) SPECIAL RULE WHERE TAXPAYER RE-  
10 LIES ON PROFIT POTENTIAL.—

11           “(A) IN GENERAL.—The potential  
12 for profit of a transaction shall be  
13 taken into account in determining  
14 whether the requirements of subpara-  
15 graphs (A) and (B) of paragraph (1)  
16 are met with respect to the trans-  
17 action only if the present value of the  
18 reasonably expected pre-tax profit  
19 from the transaction is substantial in  
20 relation to the present value of the  
21 expected net tax benefits that would  
22 be allowed if the transaction were re-  
23 spected.

24           “(B) TREATMENT OF FEES AND FOR-  
25 EIGN TAXES.—Fees and other trans-

1           **action expenses and foreign taxes**  
2           **shall be taken into account as ex-**  
3           **penditures in determining pre-tax profit**  
4           **under subparagraph (A).**

5           **“(3) STATE AND LOCAL TAX BENEFITS.—**  
6           **For purposes of paragraph (1), any State**  
7           **or local income tax effect which is re-**  
8           **lated to a Federal income tax effect shall**  
9           **be treated in the same manner as a Fed-**  
10          **eral income tax effect.**

11          **“(4) FINANCIAL ACCOUNTING BENEFITS.—**  
12          **For purposes of paragraph (1)(B), achiev-**  
13          **ing a financial accounting benefit shall**  
14          **not be taken into account as a purpose**  
15          **for entering into a transaction if the ori-**  
16          **gin of such financial accounting benefit**  
17          **is a reduction of Federal income tax.**

18          **“(5) DEFINITIONS AND SPECIAL RULES.—**  
19          **For purposes of this subsection—**

20                 **“(A) ECONOMIC SUBSTANCE DOC-**  
21                 **TRINE.—The term ‘economic substance**  
22                 **doctrine’ means the common law doc-**  
23                 **trine under which tax benefits under**  
24                 **subtitle A with respect to a trans-**  
25                 **action are not allowable if the trans-**

1           **action does not have economic sub-**  
2           **stance or lacks a business purpose.**

3           **“(B) EXCEPTION FOR PERSONAL**  
4           **TRANSACTIONS OF INDIVIDUALS.—In the**  
5           **case of an individual, paragraph (1)**  
6           **shall apply only to transactions en-**  
7           **tered into in connection with a trade**  
8           **or business or an activity engaged in**  
9           **for the production of income.**

10           **“(C) OTHER COMMON LAW DOC-**  
11           **TRINES NOT AFFECTED.—Except as spe-**  
12           **cifically provided in this subsection,**  
13           **the provisions of this subsection shall**  
14           **not be construed as altering or sup-**  
15           **planting any other rule of law, and**  
16           **the requirements of this subsection**  
17           **shall be construed as being in addi-**  
18           **tion to any such other rule of law.**

19           **“(D) DETERMINATION OF APPLICA-**  
20           **TION OF DOCTRINE NOT AFFECTED.—The**  
21           **determination of whether the eco-**  
22           **nomical substance doctrine is relevant**  
23           **to a transaction (or series of trans-**  
24           **actions) shall be made in the same**

1 manner as if this subsection had  
2 never been enacted.

3 **“(6) REGULATIONS.—The Secretary**  
4 **shall prescribe such regulations as may**  
5 **be necessary or appropriate to carry out**  
6 **the purposes of this subsection.”.**

7 **(b) EFFECTIVE DATE.—The amendments**  
8 **made by this section shall apply to trans-**  
9 **actions entered into after the date of the en-**  
10 **actment of this Act.**

11 **SEC. 453. PENALTIES FOR UNDERPAYMENTS.**

12 **(a) PENALTY FOR UNDERPAYMENTS ATTRIB-**  
13 **UTABLE TO TRANSACTIONS LACKING ECONOMIC**  
14 **SUBSTANCE.—**

15 **(1) IN GENERAL.—Subsection (b) of sec-**  
16 **tion 6662 of the Internal Revenue Code of**  
17 **1986 is amended by inserting after para-**  
18 **graph (5) the following new paragraph:**

19 **“(6) Any disallowance of claimed tax**  
20 **benefits by reason of a transaction lack-**  
21 **ing economic substance (within the**  
22 **meaning of section 7701(o)) or failing to**  
23 **meet the requirements of any similar rule**  
24 **of law.”.**



1           **(2) INCREASED PENALTY FOR NONDIS-**  
2           **CLOSED TRANSACTIONS.—Section 6662 of**  
3           **such Code is amended by adding at the**  
4           **end the following new subsection:**

5           **“(i) INCREASE IN PENALTY IN CASE OF NON-**  
6           **DISCLOSED NONECONOMIC SUBSTANCE TRANS-**  
7           **ACTIONS.—**

8           **“(1) IN GENERAL.—In the case of any**  
9           **portion of an underpayment which is at-**  
10          **tributable to one or more nondisclosed**  
11          **noneconomic substance transactions,**  
12          **subsection (a) shall be applied with re-**  
13          **spect to such portion by substituting ‘40**  
14          **percent’ for ‘20 percent’.**

15          **“(2) NONDISCLOSED NONECONOMIC SUB-**  
16          **STANCE TRANSACTIONS.—For purposes of**  
17          **this subsection, the term ‘nondisclosed**  
18          **noneconomic substance transaction’**  
19          **means any portion of a transaction de-**  
20          **scribed in subsection (b)(6) with respect**  
21          **to which the relevant facts affecting the**  
22          **tax treatment are not adequately dis-**  
23          **closed in the return nor in a statement**  
24          **attached to the return.**

1           **“(3) SPECIAL RULE FOR AMENDED RE-**  
2           **TURNS.—Except as provided in regula-**  
3           **tions, in no event shall any amendment**  
4           **or supplement to a return of tax be taken**  
5           **into account for purposes of this sub-**  
6           **section if the amendment or supplement**  
7           **is filed after the earlier of the date the**  
8           **taxpayer is first contacted by the Sec-**  
9           **retary regarding the examination of the**  
10          **return or such other date as is specified**  
11          **by the Secretary.”.**

12           **(3) CONFORMING AMENDMENT.—Sub-**  
13          **paragraph (B) of section 6662A(e)(2) of**  
14          **such Code is amended—**

15                   **(A) by striking “section 6662(h)”**  
16                   **and inserting “subsections (h) or (i) of**  
17                   **section 6662”, and**

18                   **(B) by striking “GROSS VALUATION**  
19                   **MISSTATEMENT PENALTY” in the head-**  
20                   **ing and inserting “CERTAIN INCREASED**  
21                   **UNDERPAYMENT PENALTIES”.**

22           **(b) REASONABLE CAUSE EXCEPTION NOT AP-**  
23          **PLICABLE TO NONECONOMIC SUBSTANCE TRANS-**  
24          **ACTIONS, TAX SHELTERS, AND CERTAIN LARGE OR**

1 **PUBLICLY TRADED PERSONS.—**Subsection (c) of  
2 **section 6664** of such Code is amended—

3 (1) by redesignating paragraphs (2)  
4 and (3) as paragraphs (3) and (4), respec-  
5 tively,

6 (2) by striking “paragraph (2)” in  
7 paragraph (4)(A), as so redesignated, and  
8 inserting “paragraph (3)”, and

9 (3) by inserting after paragraph (1)  
10 the following new paragraph:

11 “(2) **EXCEPTION.—**Paragraph (1) shall  
12 not apply to—

13 “(A) to any portion of an under-  
14 payment which is attributable to one  
15 or more tax shelters (as defined in  
16 section 6662(d)(2)(C)) or transactions  
17 described in section 6662(b)(6), and

18 “(B) to any taxpayer if such tax-  
19 payer is a specified person (as de-  
20 fined in section 6662(d)(2)(D)(ii)).”.

21 (c) **APPLICATION OF PENALTY FOR ERRO-**  
22 **NEOUS CLAIM FOR REFUND OR CREDIT TO NON-**  
23 **ECONOMIC SUBSTANCE TRANSACTIONS.—**Section  
24 **6676** of such Code is amended by redesignig-  
25 **nating subsection (c) as subsection (d) and in-**

1 **serting after subsection (b) the following new**  
2 **subsection:**

3 **“(c) NONECONOMIC SUBSTANCE TRANS-**  
4 **ACTIONS TREATED AS LACKING REASONABLE**  
5 **BASIS.—For purposes of this section, any ex-**  
6 **cessive amount which is attributable to any**  
7 **transaction described in section 6662(b)(6)**  
8 **shall not be treated as having a reasonable**  
9 **basis.”.**

10 **(d) SPECIAL UNDERSTATEMENT REDUCTION**  
11 **RULE FOR CERTAIN LARGE OR PUBLICLY TRADED**  
12 **PERSONS.—**

13 **(1) IN GENERAL.—Paragraph (2) of sec-**  
14 **tion 6662(d) of such Code is amended by**  
15 **adding at the end the following new sub-**  
16 **paragraph:**

17 **“(D) SPECIAL REDUCTION RULE FOR**  
18 **CERTAIN LARGE OR PUBLICLY TRADED**  
19 **PERSONS.—**

20 **“(i) IN GENERAL.—In the case**  
21 **of any specified person—**

22 **“(I) subparagraph (B)**  
23 **shall not apply, and**

24 **“(II) the amount of the un-**  
25 **derstatement under subpara-**

1 graph (A) shall be reduced by  
2 that portion of the under-  
3 statement which is attrib-  
4 utable to any item with re-  
5 spect to which the taxpayer  
6 has a reasonable belief that  
7 the tax treatment of such item  
8 by the taxpayer is more likely  
9 than not the proper tax treat-  
10 ment of such item.

11 “(ii) SPECIFIED PERSON.—For  
12 purposes of this subparagraph,  
13 the term ‘specified person’  
14 means—

15 “(I) any person required  
16 to file periodic or other re-  
17 ports under section 13 of the  
18 Securities Exchange Act of  
19 1934, and

20 “(II) any corporation with  
21 gross receipts in excess of  
22 \$100,000,000 for the taxable  
23 year involved.

24 All persons treated as a single em-  
25 ployer under section 52(a) shall

1           **be treated as one person for pur-**  
2           **poses of subclause (II).”.**

3           **(2) CONFORMING AMENDMENT.—Sub-**  
4           **paragraph (C) of section 6662(d)(2) of**  
5           **such Code is amended by striking “Sub-**  
6           **paragraph (B)” and inserting “Subpara-**  
7           **graphs (B) and (D)(i)(II)”.**

8           **(e) EFFECTIVE DATE.—The amendments**  
9           **made by this section shall apply to trans-**  
10          **actions entered into after the date of the en-**  
11          **actment of this Act.**

12           **PART 3—PARITY IN HEALTH BENEFITS**

13          **SEC. 461. CERTAIN HEALTH RELATED BENEFITS APPLICA-**  
14                   **BLE TO SPOUSES AND DEPENDENTS EX-**  
15                   **TENDED TO ELIGIBLE BENEFICIARIES.**

16          **(a) APPLICATION OF ACCIDENT AND HEALTH**  
17          **PLANS TO ELIGIBLE BENEFICIARIES.—**

18               **(1) EXCLUSION OF CONTRIBUTIONS.—**  
19               **Section 106 of the Internal Revenue Code**  
20               **of 1986, as amended by section 442, (relat-**  
21               **ing to contributions by employer to acci-**  
22               **dent and health plans) is amended by**  
23               **adding at the end the following new sub-**  
24               **section:**

1       **“(g) COVERAGE PROVIDED FOR ELIGIBLE**  
2 **BENEFICIARIES OF EMPLOYEES.—**

3               **“(1) IN GENERAL.—Subsection (a) shall**  
4 **apply with respect to any eligible bene-**  
5 **ficiary of the employee.**

6               **“(2) ELIGIBLE BENEFICIARY.—For pur-**  
7 **poses of this subsection, the term ‘eligible**  
8 **beneficiary’ means any individual who is**  
9 **eligible to receive benefits or coverage**  
10 **under an accident or health plan.”.**

11               **(2) EXCLUSION OF AMOUNTS EXPENDED**  
12 **FOR MEDICAL CARE.—The first sentence of**  
13 **section 105(b) of such Code (relating to**  
14 **amounts expended for medical care) is**  
15 **amended—**

16                       **(A) by striking “and his depend-**  
17 **ents” and inserting “his dependents”,**  
18 **and**

19                       **(B) by inserting before the period**  
20 **the following: “and any eligible bene-**  
21 **ficiary (within the meaning of section**  
22 **106(f)) with respect to the taxpayer”.**

23               **(3) PAYROLL TAXES.—**

24                       **(A) Section 3121(a)(2) of such**  
25 **Code is amended—**

1           **(i) by striking “or any of his**  
2           **dependents” in the matter pre-**  
3           **ceding subparagraph (A) and in-**  
4           **serting “, any of his dependents,**  
5           **or any eligible beneficiary (within**  
6           **the meaning of section 106(g))**  
7           **with respect to the employee”,**

8           **(ii) by striking “or any of his**  
9           **dependents,” in subparagraph (A)**  
10          **and inserting “, any of his de-**  
11          **pendents, or any eligible bene-**  
12          **ficiary (within the meaning of**  
13          **section 106(g)) with respect to the**  
14          **employee,” and**

15          **(iii) by striking “and their de-**  
16          **pendents” both places it appears**  
17          **and inserting “and such employ-**  
18          **ees’ dependents and eligible bene-**  
19          **ficiaries (within the meaning of**  
20          **section 106(g))”.**

21          **(B) Section 3231(e)(1) of such**  
22          **Code is amended—**

23                **(i) by striking “or any of his**  
24                **dependents” and inserting “, any**  
25                **of his dependents, or any eligible**



1 beneficiary (within the meaning  
2 of section 106(g)) with respect to  
3 the employee,” and

4 (ii) by striking “and their de-  
5 pendants” both places it appears  
6 and inserting “and such employ-  
7 ees’ dependents and eligible bene-  
8 ficiaries (within the meaning of  
9 section 106(g))”.

10 (C) Section 3306(b)(2) of such  
11 Code is amended—

12 (i) by striking “or any of his  
13 dependents” in the matter pre-  
14 ceding subparagraph (A) and in-  
15 serting “, any of his dependents,  
16 or any eligible beneficiary (within  
17 the meaning of section 106(g))  
18 with respect to the employee,”

19 (ii) by striking “or any of his  
20 dependents” in subparagraph (A)  
21 and inserting “, any of his de-  
22 pendants, or any eligible bene-  
23 ficiary (within the meaning of  
24 section 106(g)) with respect to the  
25 employee”, and

1           (iii) by striking “and their de-  
2           pendents” both places it appears  
3           and inserting “and such employ-  
4           ees’ dependents and eligible bene-  
5           ficiaries (within the meaning of  
6           section 106(g))”.

7           (D) Section 3401(a) of such Code  
8           is amended by striking “or” at the  
9           end of paragraph (22), by striking the  
10          period at the end of paragraph (23)  
11          and inserting “; or”, and by inserting  
12          after paragraph (23) the following  
13          new paragraph:

14          “(24) for any payment made to or for  
15          the benefit of an employee or any eligible  
16          beneficiary (within the meaning of sec-  
17          tion 106(g)) if at the time of such pay-  
18          ment it is reasonable to believe that the  
19          employee will be able to exclude such  
20          payment from income under section 106  
21          or under section 105 by reference in sec-  
22          tion 105(b) to section 106(g).”.

23          (b) EXPANSION OF DEPENDENCY FOR PUR-  
24          POSES OF DEDUCTION FOR HEALTH INSURANCE  
25          COSTS OF SELF-EMPLOYED INDIVIDUALS.—

1           **(1) IN GENERAL.—**Paragraph (1) of sec-  
2           **tion 162(l) of the Internal Revenue Code**  
3           **of 1986 (relating to special rules for**  
4           **health insurance costs of self-employed**  
5           **individuals) is amended to read as fol-**  
6           **lows:**

7           **“(1) ALLOWANCE OF DEDUCTION.—**In the  
8           **case of a taxpayer who is an employee**  
9           **within the meaning of section 401(c)(1),**  
10           **there shall be allowed as a deduction**  
11           **under this section an amount equal to**  
12           **the amount paid during the taxable year**  
13           **for insurance which constitutes medical**  
14           **care for—**

15                   **“(A) the taxpayer,**

16                   **“(B) the taxpayer’s spouse,**

17                   **“(C) the taxpayer’s dependents,**

18           **and**

19                   **“(D) any individual who—**

20                           **“(i) satisfies the age require-**  
21                           **ments of section 152(c)(3)(A),**

22                           **“(ii) bears a relationship to**  
23                           **the taxpayer described in section**  
24                           **152(d)(2)(H), and**

1           “(iii) meets the requirements  
2           of section 152(d)(1)(C), and

3           “(E) one individual who—

4           “(i) does not satisfy the age re-  
5           quirements of section 152(c)(3)(A),

6           “(ii) bears a relationship to  
7           the taxpayer described in section  
8           152(d)(2)(H),

9           “(iii) meets the requirements  
10          of section 152(d)(1)(D), and

11          “(iv) is not the spouse of the  
12          taxpayer and does not bear any  
13          relationship to the taxpayer de-  
14          scribed in subparagraphs (A)  
15          through (G) of section 152(d)(2).”.

16          (2) CONFORMING AMENDMENT.—Sub-  
17          paragraph (B) of section 162(l)(2) of such  
18          Code is amended by inserting “, any de-  
19          pendent, or individual described in sub-  
20          paragraph (D) or (E) of paragraph (1)  
21          with respect to” after “spouse”.

22          (c) EXTENSION TO ELIGIBLE BENEFICIARIES  
23          OF SICK AND ACCIDENT BENEFITS PROVIDED TO  
24          MEMBERS OF A VOLUNTARY EMPLOYEES’ BENE-  
25          FICIARY ASSOCIATION AND THEIR DEPENDENTS.—

1 **Section 501(c)(9) of the Internal Revenue**  
2 **Code of 1986 (relating to list of exempt organi-**  
3 **zations) is amended by adding at the end the**  
4 **following new sentence: “For purposes of pro-**  
5 **viding for the payment of sick and accident**  
6 **benefits to members of such an association**  
7 **and their dependents, the term ‘dependents’**  
8 **shall include any individual who is an eligible**  
9 **beneficiary (within the meaning of section**  
10 **106(f)), as determined under the terms of a**  
11 **medical benefit, health insurance, or other**  
12 **program under which members and their de-**  
13 **pendents are entitled to sick and accident**  
14 **benefits.”.**

15 **(d) FLEXIBLE SPENDING ARRANGEMENTS AND**  
16 **HEALTH REIMBURSEMENT ARRANGEMENTS.—The**  
17 **Secretary of Treasury shall issue guidance of**  
18 **general applicability providing that medical**  
19 **expenses that otherwise qualify—**

20 **(1) for reimbursement from a flexible**  
21 **spending arrangement under regulations**  
22 **in effect on the date of the enactment of**  
23 **this Act may be reimbursed from an em-**  
24 **ployee’s flexible spending arrangement,**  
25 **notwithstanding the fact that such ex-**

1       penses are attributable to any individual  
2       who is not the employee's spouse or de-  
3       pendent (within the meaning of section  
4       105(b) of the Internal Revenue Code of  
5       1986) but is an eligible beneficiary (with-  
6       in the meaning of section 106(f) of such  
7       Code) under the flexible spending ar-  
8       rangement with respect to the employee,  
9       and

10               (2) for reimbursement from a health  
11       reimbursement arrangement under regu-  
12       lations in effect on the date of the enact-  
13       ment of this Act may be reimbursed from  
14       an employee's health reimbursement ar-  
15       rangement, notwithstanding the fact that  
16       such expenses are attributable to an indi-  
17       vidual who is not a spouse or dependent  
18       (within the meaning of section 105(b) of  
19       such Code) but is an eligible beneficiary  
20       (within the meaning of section 106(f) of  
21       such Code) under the health reimburse-  
22       ment arrangement with respect to the  
23       employee.

1       **(e) EFFECTIVE DATE.—**The amendments  
 2 made by this section shall apply to taxable  
 3 years beginning after December 31, 2009.

4       **DIVISION B—MEDICARE AND**  
 5       **MEDICAID IMPROVEMENTS**

6       **SEC. 1001. TABLE OF CONTENTS OF DIVISION.**

7       **The table of contents for this division is**  
 8 **as follows:**

**DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS**

**Sec. 1001. Table of contents of division.**

**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 and payment adjustments in response to coverage expansion.**

**Sec. 1113. Extension of hospice regulation moratorium.**

**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 improvements into market basket updates that do not already incorporate such improvements.**

**PART 3—OTHER PROVISIONS**

- Sec. 1141. Rental and purchase of power-driven wheelchairs.
- Sec. 1142. Extension of payment rule for brachytherapy.
- 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.
- Sec. 1148. Durable medical equipment program improvements.
- Sec. 1149. MedPAC study and report on bone mass measurement.

#### 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 and bundling pilot program.
- Sec. 1153. Home health payment update for 2010.
- Sec. 1154. Payment adjustments for home health care.
- Sec. 1155. Incorporating productivity improvements into market basket update for home health services.
- Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.
- Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.
- Sec. 1158. Revision of medicare payment systems to address geographic inequities.
- Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care.

#### 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. Simplification of annual beneficiary election periods.
- Sec. 1165. Extension of reasonable cost contracts.
- Sec. 1166. Limitation of waiver authority for employer group plans.
- Sec. 1167. Improving risk adjustment for payments.
- Sec. 1168. Elimination of MA Regional Plan Stabilization Fund.

##### PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

- Sec. 1171. Limitation on cost-sharing 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 PLANS**

**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.**

#### **Subtitle E—Improvements to Medicare Part D**

**Sec. 1181. Elimination of coverage gap.**

**Sec. 1182. Discounts for certain part D drugs in original 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 that 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. Special enrollment period and 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. Advance care planning consultation.
- Sec. 1234. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.
- Sec. 1235. Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related premium.
- Sec. 1236. Demonstration program on use of patient decisions aids.

### 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. Payment incentive 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. Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers.

### 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 for quality improvement.**
- Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement.**
- Sec. 1443. Multi-stakeholder pre-rulemaking input into selection of quality measures.**
- Sec. 1444. Application of quality measures.**
- Sec. 1445. Consensus-based entity funding.**

**Subtitle D—Physician Payments Sunshine Provision**

- 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.**

**Subtitle E—Public Reporting on Health Care-Associated Infections**

- Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on health care-associated infections.**

**TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION**

- Sec. 1501. Distribution of unused residency positions.**
- Sec. 1502. Increasing training in nonprovider 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 and flexibility to fight fraud and abuse.

##### 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 statements material to a false claim.
- Sec. 1613. Enhanced penalties for delaying inspections.
- 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.
- Sec. 1619. Exclusion of certain individuals and entities from participation in Medicare and State health care programs.

##### 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 enrolled physicians or eligible professionals.
- 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 or durable medical equipment 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. Access to certain information on renal dialysis facilities.
- Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.
- Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.

**Subtitle D—Access to Information Needed to Prevent Fraud,  
Waste, and Abuse**

- Sec. 1651. Access to Information Necessary to Identify Fraud, 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.

[FOR ITEMS RELATING TO TITLE VII OF DIVISION B, SEE  
COPY OF BILL AS INTRODUCED ON JULY 14, 2009]

**TITLE VIII—REVENUE-RELATED PROVISIONS**

- Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration's outreach to eligible individuals.
- Sec. 1802. Comparative Effectiveness Research Trust Fund; financing for Trust Fund.

**TITLE IX—MISCELLANEOUS PROVISIONS**

- Sec. 1901. Repeal of trigger provision.
- Sec. 1902. Repeal of comparative cost adjustment (CCA) program.
- Sec. 1903. Extension of gainsharing demonstration.
- Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.
- Sec. 1905. Improved coordination and protection for dual eligibles.
- Sec. 1906. Assessment of Medicare cost-intensive diseases and conditions.

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)**  
8 **of the Social Security Act (42 U.S.C.**  
9 **1395yy(e)(4)(E)(ii)) is amended—**

10 **(1) in subclause (III), by striking**  
11 **“and” at the end;**

12 **(2) by redesignating subclause (IV) as**  
13 **subclause (VI); and**

14 **(3) by inserting after subclause (III)**  
15 **the following new subclauses:**

16 **“(IV) for each of fiscal**  
17 **years 2004 through 2009, the**  
18 **rate computed for the pre-**  
19 **vious fiscal year increased by**  
20 **the skilled nursing facility**  
21 **market basket percentage**  
22 **change for the fiscal year in-**  
23 **volved;**

1                   **“(V) for fiscal year 2010,**  
2                   **the rate computed for the pre-**  
3                   **vious fiscal year; and”.**

4           **(b) DELAYED EFFECTIVE DATE.—Section**  
5           **1888(e)(4)(E)(ii)(V) of the Social Security Act,**  
6           **as inserted by subsection (a)(3), shall not**  
7           **apply to payment for days before January 1,**  
8           **2010.**

9           **SEC. 1102. INPATIENT REHABILITATION FACILITY PAY-**  
10           **MENT UPDATE.**

11           **(a) IN GENERAL.—Section 1886(j)(3)(C) of**  
12           **the Social Security Act (42 U.S.C.**  
13           **1395ww(j)(3)(C)) is amended by striking “and**  
14           **2009” and inserting “through 2010”.**

15           **(b) DELAYED EFFECTIVE DATE.—The**  
16           **amendment made by subsection (a) shall not**  
17           **apply to payment units occurring before Jan-**  
18           **uary 1, 2010.**

19           **SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVE-**  
20           **MENTS INTO MARKET BASKET UPDATES**  
21           **THAT DO NOT ALREADY INCORPORATE SUCH**  
22           **IMPROVEMENTS.**

23           **(a) INPATIENT ACUTE HOSPITALS.—Section**  
24           **1886(b)(3)(B) of the Social Security Act (42**  
25           **U.S.C. 1395ww(b)(3)(B)) is amended—**

1           **(1) in clause (iii)—**

2                   **(A) by striking “(iii) For purposes**  
3                   **of this subparagraph,” and inserting**  
4                   **“(iii)(I) For purposes of this subpara-**  
5                   **graph, subject to the productivity ad-**  
6                   **justment described in subclause (II),”;**  
7                   **and**

8                   **(B) by adding at the end the fol-**  
9                   **lowing new subclause:**

10           **“(II) The productivity adjustment de-**  
11           **scribed in this subclause, with respect to an**  
12           **increase or change for a fiscal year or year or**  
13           **cost reporting period, or other annual period,**  
14           **is a productivity offset equal to the percent-**  
15           **age change in the 10-year moving average of**  
16           **annual economy-wide private nonfarm busi-**  
17           **ness multi-factor productivity (as recently**  
18           **published before the promulgation of such in-**  
19           **crease for the year or period involved). Ex-**  
20           **cept as otherwise provided, any reference to**  
21           **the increase described in this clause shall be**  
22           **a reference to the percentage increase de-**  
23           **scribed in subclause (I) minus the percentage**  
24           **change under this subclause.”;**



1           **(2) in the first sentence of clause**  
2           **(viii)(I), by inserting “(but not below**  
3           **zero)” after “shall be reduced”; and**

4           **(3) in the first sentence of clause**  
5           **(ix)(I)—**

6                   **(A) by inserting “(determined**  
7                   **without regard to clause (iii)(II)”**  
8                   **after “clause (i)” the second time it**  
9                   **appears; and**

10                   **(B) by inserting “(but not below**  
11                   **zero)” after “reduced”.**

12           **(b) SKILLED NURSING FACILITIES.—Section**  
13           **1888(e)(5)(B) of such Act (42 U.S.C.**  
14           **1395yy(e)(5))(B) is amended by inserting “sub-**  
15           **ject to the productivity adjustment described**  
16           **in section 1886(b)(3)(B)(iii)(II)” after “as cal-**  
17           **culated by the Secretary”.**

18           **(c) LONG TERM CARE HOSPITALS.—Section**  
19           **1886(m) of the Social Security Act (42 U.S.C.**  
20           **1395ww(m)) is amended by adding at the end**  
21           **the following new paragraph:**

22                   **“(3) PRODUCTIVITY ADJUSTMENT.—In**  
23                   **implementing the system described in**  
24                   **paragraph (1) for discharges occurring**  
25                   **during the rate year ending in 2010 or**

1       any subsequent rate year for a hospital,  
2       to the extent that an annual percentage  
3       increase factor applies to a base rate for  
4       such discharges for the hospital, such  
5       factor shall be subject to the productivity  
6       adjustment described in subsection  
7       (b)(3)(B)(iii)(II).”.

8       (d) INPATIENT REHABILITATION FACILI-  
9 TIES.—The second sentence of section  
10 1886(j)(3)(C) of the Social Security Act (42  
11 U.S.C. 1395ww(j)(3)(C)) is amended by insert-  
12 ing “(subject to the productivity adjustment  
13 described in subsection (b)(3)(B)(iii)(II))”  
14 after “appropriate percentage increase”.

15       (e) PSYCHIATRIC HOSPITALS.—Section 1886  
16 of the Social Security Act (42 U.S.C. 1395ww)  
17 is amended by adding at the end the following  
18 new subsection:

19       “(o) PROSPECTIVE PAYMENT FOR PSY-  
20 CHIATRIC HOSPITALS.—

21               “(1) REFERENCE TO ESTABLISHMENT AND  
22       IMPLEMENTATION OF SYSTEM.—For provi-  
23       sions related to the establishment and  
24       implementation of a prospective payment  
25       system for payments under this title for

1       inpatient hospital services furnished by  
2       psychiatric hospitals (as described in  
3       clause (i) of subsection (d)(1)(B) and psy-  
4       chiatric units (as described in the matter  
5       following clause (v) of such subsection),  
6       see section 124 of the Medicare, Medicaid,  
7       and SCHIP Balanced Budget Refinement  
8       Act of 1999.

9               “(2) PRODUCTIVITY ADJUSTMENT.—In  
10       implementing the system described in  
11       paragraph (1) for discharges occurring  
12       during the rate year ending in 2011 or  
13       any subsequent rate year for a psy-  
14       chiatric hospital or unit described in  
15       such paragraph, to the extent that an an-  
16       nual percentage increase factor applies  
17       to a base rate for such discharges for the  
18       hospital or unit, respectively, such factor  
19       shall be subject to the productivity ad-  
20       justment described in subsection  
21       (b)(3)(B)(iii)(II).”.

22       (f) HOSPICE CARE.—Subclause (VII) of sec-  
23       tion 1814(i)(1)(C)(ii) of the Social Security Act  
24       (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended by in-  
25       serting after “the market basket percentage

1 **increase” the following: “(which is subject to**  
2 **the productivity adjustment described in sec-**  
3 **tion 1886(b)(3)(B)(iii)(II))”.**

4 **(g) EFFECTIVE DATE.—The amendments**  
5 **made by subsections (a), (b), (d), and (f) shall**  
6 **apply to annual increases effected for fiscal**  
7 **years beginning with fiscal year 2010.**

8 **PART 2—OTHER MEDICARE PART A PROVISIONS**

9 **SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.**

10 **(a) CHANGE IN RECALIBRATION FACTOR.—**

11 **(1) ANALYSIS.—The Secretary of**  
12 **Health and Human Services shall con-**  
13 **duct, using calendar year 2006 claims**  
14 **data, an initial analysis comparing total**  
15 **payments under title XVIII of the Social**  
16 **Security Act for skilled nursing facility**  
17 **services under the RUG–53 and under the**  
18 **RUG–44 classification systems.**

19 **(2) ADJUSTMENT IN RECALIBRATION FAC-**  
20 **TOR.—Based on the initial analysis under**  
21 **paragraph (1), the Secretary shall adjust**  
22 **the case mix indexes under section**  
23 **1888(e)(4)(G)(i) of the Social Security Act**  
24 **(42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal**  
25 **year 2010 by the appropriate recalibra-**

1        **tion factor as proposed in the proposed**  
2        **rule for Medicare skilled nursing facili-**  
3        **ties issued by such Secretary on May 12,**  
4        **2009 (74 Federal Register 22214 et seq.).**

5        **(b) CHANGE IN PAYMENT FOR NONTHERAPY**  
6        **ANCILLARY (NTA) SERVICES AND THERAPY SERV-**  
7        **ICES.—**

8                **(1) CHANGES UNDER CURRENT SNF CLAS-**  
9                **SIFICATION SYSTEM.—**

10                    **(A) IN GENERAL.—Subject to sub-**  
11                    **paragraph (B), the Secretary of**  
12                    **Health and Human Services shall,**  
13                    **under the system for payment of**  
14                    **skilled nursing facility services under**  
15                    **section 1888(e) of the Social Security**  
16                    **Act (42 U.S.C. 1395yy(e)), increase**  
17                    **payment by 10 percent for non-ther-**  
18                    **apy ancillary services (as specified by**  
19                    **the Secretary in the notice issued on**  
20                    **November 27, 1998 (63 Federal Reg-**  
21                    **ister 65561 et seq.)) and shall de-**  
22                    **crease payment for the therapy case**  
23                    **mix component of such rates by 5.5**  
24                    **percent.**

1           **(B) EFFECTIVE DATE.**—The changes  
2 in payment described in subpara-  
3 graph (A) shall apply for days on or  
4 after January 1, 2010, and until the  
5 Secretary implements an alternative  
6 case mix classification system for  
7 payment of skilled nursing facility  
8 services under section 1888(e) of the  
9 Social Security Act (42 U.S.C.  
10 1395yy(e)).

11           **(C) IMPLEMENTATION.**—Notwith-  
12 standing any other provision of law,  
13 the Secretary may implement by pro-  
14 gram instruction or otherwise the  
15 provisions of this paragraph.

16           **(2) CHANGES UNDER A FUTURE SNF CASE**  
17 **MIX CLASSIFICATION SYSTEM.**—

18           **(A) ANALYSIS.**—

19           **(i) IN GENERAL.**—The Secretary  
20 of Health and Human Services  
21 shall analyze payments for non-  
22 therapy ancillary services under  
23 a future skilled nursing facility  
24 classification system to ensure  
25 the accuracy of payment for non-

1           therapy ancillary services. Such  
2           analysis shall consider use of ap-  
3           propriate predictors which may  
4           include age, physical and mental  
5           status, ability to perform activi-  
6           ties of daily living, prior nursing  
7           home stay, diagnoses, broad RUG  
8           category, and a proxy for length  
9           of stay.

10           (ii) APPLICATION.—Such anal-  
11           ysis shall be conducted in a man-  
12           ner such that the future skilled  
13           nursing facility classification sys-  
14           tem is implemented to apply to  
15           services furnished during a fiscal  
16           year beginning with fiscal year  
17           2011.

18           (B) CONSULTATION.—In conducting  
19           the analysis under subparagraph (A),  
20           the Secretary shall consult with inter-  
21           ested parties, including the Medicare  
22           Payment Advisory Commission and  
23           other interested stakeholders, to  
24           identify appropriate predictors of  
25           nontherapy ancillary costs.

1           **(C) RULEMAKING.—**The Secretary  
2 shall include the result of the anal-  
3 ysis under subparagraph (A) in the  
4 fiscal year 2011 rulemaking cycle for  
5 purposes of implementation begin-  
6 ning for such fiscal year.

7           **(D) IMPLEMENTATION.—**Subject to  
8 subparagraph (E) and consistent with  
9 subparagraph (A)(ii), the Secretary  
10 shall implement changes to payments  
11 for non-therapy ancillary services  
12 (which shall include a separate rate  
13 component for non-therapy ancillary  
14 services and may include use of a  
15 model that predicts payment amounts  
16 applicable for non-therapy ancillary  
17 services) under such future skilled  
18 nursing facility services classification  
19 system as the Secretary determines  
20 appropriate based on the analysis  
21 conducted pursuant to subparagraph  
22 (A).

23           **(E) BUDGET NEUTRALITY.—**The Sec-  
24 retary shall implement changes de-  
25 scribed in subparagraph (D) in a



1 manner such that the estimated ex-  
2 penditures under such future skilled  
3 nursing facility services classification  
4 system for a fiscal year beginning  
5 with fiscal year 2011 with such  
6 changes would be equal to the esti-  
7 mated expenditures that would other-  
8 wise occur under title XVIII of the So-  
9 cial Security Act under such future  
10 skilled nursing facility services classi-  
11 fication system for such year without  
12 such changes.

13 (c) **OUTLIER POLICY FOR NTA AND THER-**  
14 **APY.—**Section 1888(e) of the Social Security  
15 Act (42 U.S.C. 1395yy(e)) is amended by add-  
16 ing at the end the following new paragraph:

17 “(13) **OUTLIERS FOR NTA AND THER-**  
18 **APY.—**

19 “(A) **IN GENERAL.—**With respect to  
20 outliers because of unusual vari-  
21 ations in the type or amount of medi-  
22 cally necessary care, beginning with  
23 October 1, 2010, the Secretary—

24 “(i) shall provide for an addi-  
25 tion or adjustment to the pay-

1           **ment amount otherwise made**  
2           **under this section with respect to**  
3           **non-therapy ancillary services in**  
4           **the case of such outliers; and**

5           **“(ii) may provide for such an**  
6           **addition or adjustment to the**  
7           **payment amount otherwise made**  
8           **under this section with respect to**  
9           **therapy services in the case of**  
10          **such outliers.**

11          **“(B) OUTLIERS BASED ON AGGRE-**  
12          **GATE COSTS.—Outlier adjustments or**  
13          **additional payments described in**  
14          **subparagraph (A) shall be based on**  
15          **aggregate costs during a stay in a**  
16          **skilled nursing facility and not on the**  
17          **number of days in such stay.**

18          **“(C) BUDGET NEUTRALITY.—The**  
19          **Secretary shall reduce estimated pay-**  
20          **ments that would otherwise be made**  
21          **under the prospective payment sys-**  
22          **tem under this subsection with re-**  
23          **spect to a fiscal year by 2 percent.**  
24          **The total amount of the additional**  
25          **payments or payment adjustments for**

1           outliers made under this paragraph  
2           with respect to a fiscal year may not  
3           exceed 2 percent of the total pay-  
4           ments projected or estimated to be  
5           made based on the prospective pay-  
6           ment system under this subsection  
7           for the fiscal year.”.

8           (d) CONFORMING AMENDMENTS.—Section  
9   1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8))  
10 is amended—

11           (1) in subparagraph (A)—

12                   (A) by striking “and” before “ad-  
13                   justments”; and

14                   (B) by inserting “, and adjustment  
15                   under section 1111(b) of the America’s  
16                   Affordable Health Choices Act of  
17                   2009” before the semicolon at the end;

18           (2) in subparagraph (B), by striking  
19           “and”;

20           (3) in subparagraph (C), by striking  
21           the period and inserting “; and”; and

22           (4) by adding at the end the following  
23           new subparagraph:

24                   “(D) the establishment of outliers  
25                   under paragraph (13).”.

1 SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUST-  
2 MENTS IN RESPONSE TO COVERAGE EXPAN-  
3 SION.

4 (a) DSH REPORT.—

5 (1) IN GENERAL.—Not later than Janu-  
6 ary 1, 2016, the Secretary of Health and  
7 Human Services shall submit to Congress  
8 a report on Medicare DSH taking into ac-  
9 count the impact of the health care re-  
10 forms carried out under division A in re-  
11 ducing the number of uninsured individ-  
12 uals. The report shall include rec-  
13 ommendations relating to the following:

14 (A) The appropriate amount, tar-  
15 geting, and distribution of Medicare  
16 DSH to compensate for higher Medi-  
17 care costs associated with serving  
18 low-income beneficiaries (taking into  
19 account variations in the empirical  
20 justification for Medicare DSH attrib-  
21 utable to hospital characteristics, in-  
22 cluding bed size), consistent with the  
23 original intent of Medicare DSH.

24 (B) The appropriate amount, tar-  
25 geting, and distribution of Medicare  
26 DSH to hospitals given their contin-

1           **ued uncompensated care costs, to the**  
2           **extent such costs remain.**

3           **(2) COORDINATION WITH MEDICAID DSH**  
4           **REPORT.—The Secretary shall coordinate**  
5           **the report under this subsection with the**  
6           **report on Medicaid DSH under section**  
7           **1704(a).**

8           **(b) PAYMENT ADJUSTMENTS IN RESPONSE TO**  
9           **COVERAGE EXPANSION.—**

10           **(1) IN GENERAL.—If there is a signifi-**  
11           **cant decrease in the national rate of**  
12           **uninsurance as a result of this Act (as de-**  
13           **termined under paragraph (2)(A)), then**  
14           **the Secretary of Health and Human Serv-**  
15           **ices shall, beginning in fiscal year 2017,**  
16           **implement the following adjustments to**  
17           **Medicare DSH:**

18                   **(A) In lieu of the amount of Medi-**  
19                   **care DSH payment that would other-**  
20                   **wise be made under section**  
21                   **1886(d)(5)(F) of the Social Security**  
22                   **Act, the amount of Medicare DSH**  
23                   **payment shall be an amount based on**  
24                   **the recommendations of the report**  
25                   **under subsection (a)(1)(A) and shall**

1 take into account variations in the  
2 empirical justification for Medicare  
3 DSH attributable to hospital charac-  
4 teristics, including bed size.

5 (B) Subject to paragraph (3),  
6 make an additional payment to a hos-  
7 pital by an amount that is estimated  
8 based on the amount of uncompen-  
9 sated care provided by the hospital  
10 based on criteria for uncompensated  
11 care as determined by the Secretary,  
12 which shall exclude bad debt.

13 (2) SIGNIFICANT DECREASE IN NATIONAL  
14 RATE OF UNINSURANCE AS A RESULT OF THIS  
15 ACT.—For purposes of this subsection—

16 (A) IN GENERAL.—There is a “sig-  
17 nificant decrease in the national rate  
18 of uninsurance as a result of this Act”  
19 if there is a decrease in the national  
20 rate of uninsurance (as defined in  
21 subparagraph (B)) from 2012 to 2014  
22 that exceeds 8 percentage points.

23 (B) NATIONAL RATE OF  
24 UNINSURANCE DEFINED.—The term “na-  
25 tional rate of uninsurance” means, for

1 a year, such rate for the under-65  
2 population for the year as determined  
3 and published by the Bureau of the  
4 Census in its Current Population Sur-  
5 vey in or about September of the suc-  
6 ceeding year.

7 **(3) UNCOMPENSATED CARE INCREASE.—**

8 **(A) COMPUTATION OF DSH SAV-**  
9 **INGS.—**For each fiscal year (beginning  
10 with fiscal year 2017), the Secretary  
11 shall estimate the aggregate reduc-  
12 tion in the amount of Medicare DSH  
13 payment that would be expected to  
14 result from the adjustment under  
15 paragraph (1)(A).

16 **(B) STRUCTURE OF PAYMENT IN-**  
17 **CREASE.—**The Secretary shall compute  
18 the additional payment to a hospital  
19 as described in paragraph (1)(B) for a  
20 fiscal year in accordance with a for-  
21 mula established by the Secretary  
22 that provides that—

23 **(i) the estimated aggregate**  
24 **amount of such increase for the**  
25 **fiscal year does not exceed 50 per-**

1           **cent of the aggregate reduction in**  
2           **Medicare DSH estimated by the**  
3           **Secretary for such fiscal year; and**  
4           **(ii) hospitals with higher lev-**  
5           **els of uncompensated care receive**  
6           **a greater increase.**

7           **(c) MEDICARE DSH.—In this section, the**  
8           **term “Medicare DSH” means adjustments in**  
9           **payments under section 1886(d)(5)(F) of the**  
10           **Social Security Act (42 U.S.C.**  
11           **1395ww(d)(5)(F)) for inpatient hospital serv-**  
12           **ices furnished by disproportionate share hos-**  
13           **pitals.**

14           **SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATO-**  
15           **RIUM.**

16           **Section 4301(a) of division B of the Amer-**  
17           **ican Recovery and Reinvestment Act of 2009**  
18           **(Public Law 111-5) is amended—**

19           **(1) by striking “October 1, 2009” and**  
20           **inserting “October 1, 2010”; and**

21           **(2) by striking “for fiscal year 2009”**  
22           **and inserting “for fiscal years 2009 and**  
23           **2010”.**



1 **Subtitle B—Provisions Related to**  
2 **Part B**

3 **PART 1—PHYSICIANS’ SERVICES**

4 **SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.**

5 **(a) TRANSITIONAL UPDATE FOR 2010.—Sec-**  
6 **tion 1848(d) of the Social Security Act (42**  
7 **U.S.C. 1395w–4(d)) is amended by adding at**  
8 **the end the following new paragraph:**

9 **“(10) UPDATE FOR 2010.—The update to**  
10 **the single conversion factor established**  
11 **in paragraph (1)(C) for 2010 shall be the**  
12 **percentage increase in the MEI (as de-**  
13 **fin ed in section 1842(i)(3)) for that year.”.**

14 **(b) REBASING SGR USING 2009; LIMITATION**  
15 **ON CUMULATIVE ADJUSTMENT PERIOD.—Section**  
16 **1848(d)(4) of such Act (42 U.S.C. 1395w–4(d)(4))**  
17 **is amended—**

18 **(1) in subparagraph (B), by striking**  
19 **“subparagraph (D)” and inserting “sub-**  
20 **paragraphs (D) and (G)”;** and

21 **(2) by adding at the end the following**  
22 **new subparagraph:**

23 **“(G) REBASING USING 2009 FOR FU-**  
24 **TURE UPDATE ADJUSTMENTS.—In deter-**  
25 **mining the update adjustment factor**

1 under subparagraph (B) for 2011 and  
2 subsequent years—

3 “(i) the allowed expenditures  
4 for 2009 shall be equal to the  
5 amount of the actual expendi-  
6 tures for physicians’ services dur-  
7 ing 2009; and

8 “(ii) the reference in subpara-  
9 graph (B)(ii)(I) to ‘April 1, 1996’  
10 shall be treated as a reference to  
11 ‘January 1, 2009 (or, if later, the  
12 first day of the fifth year before  
13 the year involved)’.”

14 (c) LIMITATION ON PHYSICIANS’ SERVICES IN-  
15 CLUDED IN TARGET GROWTH RATE COMPUTATION  
16 TO SERVICES COVERED UNDER PHYSICIAN FEE  
17 SCHEDULE.—Effective for services furnished  
18 on or after January 1, 2009, section  
19 1848(f)(4)(A) of such Act is amended by strik-  
20 ing “(such as clinical” and all that follows  
21 through “in a physician’s office” and inserting  
22 “for which payment under this part is made  
23 under the fee schedule under this section, for  
24 services for practitioners described in section  
25 1842(b)(18)(C) on a basis related to such fee

1 schedule, or for services described in section  
2 1861(p) (other than such services when fur-  
3 nished in the facility of a provider of serv-  
4 ices)”.

5 (d) ESTABLISHMENT OF SEPARATE TARGET  
6 GROWTH RATES FOR CATEGORIES OF SERVICES.—

7 (1) ESTABLISHMENT OF SERVICE CAT-  
8 EGORIES.—Subsection (j) of section 1848 of  
9 the Social Security Act (42 U.S.C. 1395w-  
10 4) is amended by adding at the end the  
11 following new paragraph:

12 “(5) SERVICE CATEGORIES.—For serv-  
13 ices furnished on or after January 1,  
14 2009, each of the following categories of  
15 physicians’ services (as defined in para-  
16 graph (3)) shall be treated as a separate  
17 ‘service category’:

18 “(A) Evaluation and management  
19 services that are procedure codes (for  
20 services covered under this title)  
21 for—

22 “(i) services in the category  
23 designated Evaluation and Man-  
24 agement in the Health Care Com-  
25 mon Procedure Coding System

1 (established by the Secretary  
2 under subsection (c)(5) as of De-  
3 cember 31, 2009, and as subse-  
4 quently modified by the Sec-  
5 retary); and

6 “(ii) preventive services (as  
7 defined in section 1861(iii)) for  
8 which payment is made under  
9 this section.

10 “(B) All other services not de-  
11 scribed in subparagraph (A).

12 Service categories established under this  
13 paragraph shall apply without regard to  
14 the specialty of the physician furnishing  
15 the service.”.

16 (2) ESTABLISHMENT OF SEPARATE CON-  
17 VERSION FACTORS FOR EACH SERVICE CAT-  
18 EGORY.—Subsection (d)(1) of section 1848  
19 of the Social Security Act (42 U.S.C.  
20 1395w-4) is amended—

21 (A) in subparagraph (A)—

22 (i) by designating the sen-  
23 tence beginning “The conversion  
24 factor” as clause (i) with the  
25 heading “APPLICATION OF SINGLE

1           **CONVERSION FACTOR.—” and with**  
2           **appropriate indentation;**

3           **(ii) by striking “The conver-**  
4           **sion factor” and inserting “Sub-**  
5           **ject to clause (ii), the conversion**  
6           **factor”;** and

7           **(iii) by adding at the end the**  
8           **following new clause:**

9           **“(ii) APPLICATION OF MULTIPLE**  
10           **CONVERSION FACTORS BEGINNING**  
11           **WITH 2011.—**

12           **“(I) IN GENERAL.—In apply-**  
13           **ing clause (i) for years begin-**  
14           **ning with 2011, separate con-**  
15           **version factors shall be estab-**  
16           **lished for each service cat-**  
17           **egory of physicians’ services**  
18           **(as defined in subsection**  
19           **(j)(5)) and any reference in**  
20           **this section to a conversion**  
21           **factor for such years shall be**  
22           **deemed to be a reference to**  
23           **the conversion factor for each**  
24           **of such categories.**

1           **“(II) INITIAL CONVERSION**  
2           **FACTORS.—Such factors for**  
3           **2011 shall be based upon the**  
4           **single conversion factor for**  
5           **the previous year multiplied**  
6           **by the update established**  
7           **under paragraph (11) for such**  
8           **category for 2011.**

9           **“(III) UPDATING OF CONVER-**  
10          **SION FACTORS.—Such factor for**  
11          **a service category for a subse-**  
12          **quent year shall be based**  
13          **upon the conversion factor**  
14          **for such category for the pre-**  
15          **vious year and adjusted by**  
16          **the update established for**  
17          **such category under para-**  
18          **graph (11) for the year in-**  
19          **volved.”; and**

20               **(B) in subparagraph (D), by strik-**  
21               **ing “other physicians’ services” and**  
22               **inserting “for physicians’ services de-**  
23               **scribed in the service category de-**  
24               **scribed in subsection (j)(5)(B)”.**

1           **(3) ESTABLISHING UPDATES FOR CONVER-**  
2           **SION FACTORS FOR SERVICE CATEGORIES.—**  
3           **Section 1848(d) of the Social Security Act**  
4           **(42 U.S.C. 1395w-4(d)), as amended by**  
5           **subsection (a), is amended—**

6                   **(A) in paragraph (4)(C)(iii), by**  
7                   **striking “The allowed” and inserting**  
8                   **“Subject to paragraph (11)(B), the al-**  
9                   **lowed”; and**

10                   **(B) by adding at the end the fol-**  
11                   **lowing new paragraph:**

12                   **“(11) UPDATES FOR SERVICE CATEGORIES**  
13                   **BEGINNING WITH 2011.—**

14                           **“(A) IN GENERAL.—In applying**  
15                           **paragraph (4) for a year beginning**  
16                           **with 2011, the following rules apply:**

17                                   **“(i) APPLICATION OF SEPARATE**  
18                                   **UPDATE ADJUSTMENTS FOR EACH**  
19                                   **SERVICE CATEGORY.—Pursuant to**  
20                                   **paragraph (1)(A)(ii)(I), the update**  
21                                   **shall be made to the conversion**  
22                                   **factor for each service category**  
23                                   **(as defined in subsection (j)(5))**  
24                                   **based upon an update adjustment**  
25                                   **factor for the respective category**

1           **and year and the update adjust-**  
2           **ment factor shall be computed,**  
3           **for a year, separately for each**  
4           **service category.**

5           **“(ii) COMPUTATION OF ALLOWED**  
6           **AND ACTUAL EXPENDITURES BASED**  
7           **ON SERVICE CATEGORIES.—In com-**  
8           **puting the prior year adjustment**  
9           **component and the cumulative**  
10           **adjustment component under**  
11           **clauses (i) and (ii) of paragraph**  
12           **(4)(B), the following rules apply:**

13           **“(I) APPLICATION BASED ON**  
14           **SERVICE CATEGORIES.—The al-**  
15           **lowed expenditures and ac-**  
16           **tual expenditures shall be the**  
17           **allowed and actual expendi-**  
18           **tures for the service category,**  
19           **as determined under subpara-**  
20           **graph (B).**

21           **“(II) APPLICATION OF CAT-**  
22           **EGORY SPECIFIC TARGET**  
23           **GROWTH RATE.—The growth**  
24           **rate applied under clause**  
25           **(ii)(II) of such paragraph shall**



1           **be the target growth rate for**  
2           **the service category involved**  
3           **under subsection (f)(5).**

4           **“(B) DETERMINATION OF ALLOWED**  
5           **EXPENDITURES.—In applying para-**  
6           **graph (4) for a year beginning with**  
7           **2010, notwithstanding subparagraph**  
8           **(C)(iii) of such paragraph, the al-**  
9           **lowed expenditures for a service cat-**  
10           **egory for a year is an amount com-**  
11           **puted by the Secretary as follows:**

12           **“(i) FOR 2010.—For 2010:**

13                   **“(I) TOTAL 2009 ACTUAL EX-**  
14                   **PENDITURES FOR ALL SERVICES**  
15                   **INCLUDED IN SGR COMPUTATION**  
16                   **FOR EACH SERVICE CATEGORY.—**  
17                   **Compute total actual expendi-**  
18                   **tures for physicians’ services**  
19                   **(as defined in subsection**  
20                   **(f)(4)(A)) for 2009 for each**  
21                   **service category.**

22                   **“(II) INCREASE BY GROWTH**  
23                   **RATE TO OBTAIN 2010 ALLOWED**  
24                   **EXPENDITURES FOR SERVICE**  
25                   **CATEGORY.—Compute allowed**

1           **expenditures for the service**  
2           **category for 2010 by increas-**  
3           **ing the allowed expenditures**  
4           **for the service category for**  
5           **2009 computed under sub-**  
6           **clause (I) by the target growth**  
7           **rate for such service category**  
8           **under subsection (f) for 2010.**

9           **“(ii) FOR SUBSEQUENT YEARS.—**

10           **For a subsequent year, take the**  
11           **amount of allowed expenditures**  
12           **for such category for the pre-**  
13           **ceding year (under clause (i) or**  
14           **this clause) and increase it by the**  
15           **target growth rate determined**  
16           **under subsection (f) for such cat-**  
17           **egory and year.”.**

18           **(4) APPLICATION OF SEPARATE TARGET**  
19           **GROWTH RATES FOR EACH CATEGORY.—**

20           **(A) IN GENERAL.—Section 1848(f) of**  
21           **the Social Security Act (42 U.S.C.**  
22           **1395w-4(f)) is amended by adding at**  
23           **the end the following new paragraph:**

24           **“(5) APPLICATION OF SEPARATE TARGET**  
25           **GROWTH RATES FOR EACH SERVICE CAT-**

1       EGORY BEGINNING WITH 2010.—The target  
2       growth rate for a year beginning with  
3       2010 shall be computed and applied sepa-  
4       rately under this subsection for each  
5       service category (as defined in subsection  
6       (j)(5)) and shall be computed using the  
7       same method for computing the target  
8       growth rate except that the factor de-  
9       scribed in paragraph (2)(C) for—

10           “(A) the service category de-  
11           scribed in subsection (j)(5)(A) shall be  
12           increased by 0.02; and

13           “(B) the service category de-  
14           scribed in subsection (j)(5)(B) shall be  
15           increased by 0.01.”.

16           (B) USE OF TARGET GROWTH  
17           RATES.—Section 1848 of such Act is  
18           further amended—

19           (i) in subsection (d)—

20                   (I) in paragraph (1)(E)(ii),  
21                   by inserting “or target” after  
22                   “sustainable”; and

23                   (II) in paragraph  
24                   (4)(B)(ii)(II), by inserting “or

1           **target” after “sustainable”;**  
2           **and**

3           **(ii) in the heading of sub-**  
4           **section (f), by inserting “AND TAR-**  
5           **GET GROWTH RATE” after “SUSTAIN-**  
6           **ABLE GROWTH RATE”;**

7           **(iii) in subsection (f)(1)—**

8                   **(I) by striking “and” at the**  
9                   **end of subparagraph (A);**

10                   **(II) in subparagraph (B),**  
11                   **by inserting “before 2010”**  
12                   **after “each succeeding year”**  
13                   **and by striking the period at**  
14                   **the end and inserting “; and”;**  
15                   **and**

16                   **(III) by adding at the end**  
17                   **the following new subpara-**  
18                   **graph:**

19                   **“(C) November 1 of each suc-**  
20                   **ceeding year the target growth rate**  
21                   **for such succeeding year and each of**  
22                   **the 2 preceding years.”; and**

23                   **(iv) in subsection (f)(2), in the**  
24                   **matter before subparagraph (A),**  
25                   **by inserting after “beginning with**

1           **2000” the following: “and ending**  
2           **with 2009”.**

3           **(e) APPLICATION TO ACCOUNTABLE CARE OR-**  
4           **GANIZATION PILOT PROGRAM.—In applying the**  
5           **target growth rate under subsections (d) and**  
6           **(f) of section 1848 of the Social Security Act**  
7           **to services furnished by a practitioner to**  
8           **beneficiaries who are attributable to an ac-**  
9           **countable care organization under the pilot**  
10          **program provided under section 1866D of**  
11          **such Act, the Secretary of Health and Human**  
12          **Services shall develop, not later than January**  
13          **1, 2012, for application beginning with 2012,**  
14          **a method that—**

15               **(1) allows each such organization to**  
16               **have its own expenditure targets and up-**  
17               **dates for such practitioners, with respect**  
18               **to beneficiaries who are attributable to**  
19               **that organization, that are consistent**  
20               **with the methodologies described in such**  
21               **subsection (f); and**

22               **(2) provides that the target growth**  
23               **rate applicable to other physicians shall**  
24               **not apply to such physicians to the extent**  
25               **that the physicians’ services are fur-**

1 nished through the accountable care or-  
2 ganization.

3 In applying paragraph (1), the Secretary of  
4 Health and Human Services may apply the  
5 difference in the update under such para-  
6 graph on a claim-by-claim or lump sum basis  
7 and such a payment shall be taken into ac-  
8 count under the pilot program.

9 SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE  
10 SCHEDULE.

11 (a) IN GENERAL.—Section 1848(c)(2) of the  
12 Social Security Act (42 U.S.C. 1395w-4(c)(2)) is  
13 amended by adding at the end the following  
14 new subparagraphs:

15 (K) POTENTIALLY MISVALUED  
16 CODES.—

17 (i) IN GENERAL.—The Sec-  
18 retary shall—

19 (I) periodically identify  
20 services as being potentially  
21 misvalued using criteria spec-  
22 ified in clause (ii); and

23 (II) review and make ap-  
24 propriate adjustments to the  
25 relative values established

1           under this paragraph for serv-  
2           ices identified as being poten-  
3           tially misvalued under sub-  
4           clause (I).

5           “(ii) IDENTIFICATION OF POTEN-  
6           TIALY MISVALUED CODES.—For  
7           purposes of identifying poten-  
8           tially misvalued services pursu-  
9           ant to clause (i)(I), the Secretary  
10          shall examine (as the Secretary  
11          determines to be appropriate)  
12          codes (and families of codes as ap-  
13          propriate) for which there has  
14          been the fastest growth; codes  
15          (and families of codes as appro-  
16          priate) that have experienced  
17          substantial changes in practice  
18          expenses; codes for new tech-  
19          nologies or services within an ap-  
20          propriate period (such as three  
21          years) after the relative values  
22          are initially established for such  
23          codes; multiple codes that are fre-  
24          quently billed in conjunction with  
25          furnishing a single service; codes

1 with low relative values, particu-  
2 larly those that are often billed  
3 multiple times for a single treat-  
4 ment; codes which have not been  
5 subject to review since the imple-  
6 mentation of the RBRVS (the so-  
7 called ‘Harvard-valued codes’);  
8 and such other codes determined  
9 to be appropriate by the Sec-  
10 retary.

11 “(iii) REVIEW AND ADJUST-  
12 MENTS.—

13 “(I) The Secretary may  
14 use existing processes to re-  
15 ceive recommendations on the  
16 review and appropriate ad-  
17 justment of potentially  
18 misvalued services described  
19 clause (i)(II).

20 “(II) The Secretary may  
21 conduct surveys, other data  
22 collection activities, studies,  
23 or other analyses as the Sec-  
24 retary determines to be ap-  
25 propriate to facilitate the re-



1 view and appropriate adjust-  
2 ment described in clause  
3 (i)(II).

4 “(III) The Secretary may  
5 use analytic contractors to  
6 identify and analyze services  
7 identified under clause (i)(I),  
8 conduct surveys or collect  
9 data, and make recommenda-  
10 tions on the review and ap-  
11 propriate adjustment of serv-  
12 ices described in clause (i)(II).

13 “(IV) The Secretary may  
14 coordinate the review and ap-  
15 propriate adjustment de-  
16 scribed in clause (i)(II) with  
17 the periodic review described  
18 in subparagraph (B).

19 “(V) As part of the review  
20 and adjustment described in  
21 clause (i)(II), including with  
22 respect to codes with low rel-  
23 ative values described in  
24 clause (ii), the Secretary may  
25 make appropriate coding revi-

1           sions (including using exist-  
2           ing processes for consider-  
3           ation of coding changes)  
4           which may include consolida-  
5           tion of individual services  
6           into bundled codes for pay-  
7           ment under the fee schedule  
8           under subsection (b).

9           “(VI) The provisions of  
10          subparagraph (B)(ii)(II) shall  
11          apply to adjustments to rel-  
12          ative value units made pursu-  
13          ant to this subparagraph in  
14          the same manner as such pro-  
15          visions apply to adjustments  
16          under                subparagraph  
17          (B)(ii)(II).

18               “(L) VALIDATING RELATIVE VALUE  
19          UNITS.—

20               “(i) IN GENERAL.—The Sec-  
21          retary shall establish a process to  
22          validate relative value units  
23          under the fee schedule under sub-  
24          section (b).

1           **“(ii) COMPONENTS AND ELE-**  
2           **MENTS OF WORK.—The process de-**  
3           **scribed in clause (i) may include**  
4           **validation of work elements (such**  
5           **as time, mental effort and profes-**  
6           **sional judgment, technical skill**  
7           **and physical effort, and stress**  
8           **due to risk) involved with fur-**  
9           **nishing a service and may include**  
10          **validation of the pre, post, and**  
11          **intra-service components of work.**

12          **“(iii) SCOPE OF CODES.—The**  
13          **validation of work relative value**  
14          **units shall include a sampling of**  
15          **codes for services that is the same**  
16          **as the codes listed under subpara-**  
17          **graph (K)(ii)**

18          **“(iv) METHODS.—The Secretary**  
19          **may conduct the validation under**  
20          **this subparagraph using methods**  
21          **described in subclauses (I)**  
22          **through (V) of subparagraph**  
23          **(K)(iii) as the Secretary deter-**  
24          **mines to be appropriate.**

1           “(v) **ADJUSTMENTS.**—The Sec-  
2           retary shall make appropriate ad-  
3           justments to the work relative  
4           value units under the fee sched-  
5           ule under subsection (b). The pro-  
6           visions of subparagraph (B)(ii)(II)  
7           shall apply to adjustments to rel-  
8           ative value units made pursuant  
9           to this subparagraph in the same  
10          manner as such provisions apply  
11          to adjustments under subpara-  
12          graph (B)(ii)(II).”.

13          **(b) IMPLEMENTATION.**—

14                **(1) FUNDING.**—For purposes of car-  
15                rying out the provisions of subpara-  
16                graphs (K) and (L) of 1848(c)(2) of the So-  
17                cial Security Act, as added by subsection  
18                (a), in addition to funds otherwise avail-  
19                able, out of any funds in the Treasury not  
20                otherwise appropriated, there are appro-  
21                priated to the Secretary of Health and  
22                Human Services for the Center for Medi-  
23                care & Medicaid Services Program Man-  
24                agement Account \$20,000,000 for fiscal  
25                year 2010 and each subsequent fiscal

1       **year. Amounts appropriated under this**  
2       **paragraph for a fiscal year shall be avail-**  
3       **able until expended.**

4               **(2) ADMINISTRATION.—**

5               **(A) Chapter 35 of title 44, United**  
6       **States Code and the provisions of the**  
7       **Federal Advisory Committee Act (5**  
8       **U.S.C. App.) shall not apply to this**  
9       **section or the amendment made by**  
10       **this section.**

11              **(B) Notwithstanding any other**  
12       **provision of law, the Secretary may**  
13       **implement subparagraphs (K) and (L)**  
14       **of 1848(c)(2) of the Social Security**  
15       **Act, as added by subsection (a), by**  
16       **program instruction or otherwise.**

17              **(C) Section 4505(d) of the Bal-**  
18       **anced Budget Act of 1997 is repealed.**

19              **(D) Except for provisions related**  
20       **to confidentiality of information, the**  
21       **provisions of the Federal Acquisition**  
22       **Regulation shall not apply to this sec-**  
23       **tion or the amendment made by this**  
24       **section.**

1           **(3) FOCUSING CMS RESOURCES ON PO-**  
2           **TENTIALLY OVERVALUED CODES.—Section**  
3           **1868(a) of the Social Security Act (42**  
4           **1395ee(a)) is repealed.**

5   **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.**

6           **Section 1833 of the Social Security Act (42**  
7           **U.S.C. 1395l) is amended by adding at the end**  
8           **the following new subsection:**

9           **“(x) INCENTIVE PAYMENTS FOR EFFICIENT**  
10          **AREAS.—**

11           **“(1) IN GENERAL.—In the case of serv-**  
12           **ices furnished under the physician fee**  
13           **schedule under section 1848 on or after**  
14           **January 1, 2011, and before January 1,**  
15           **2013, by a supplier that is paid under**  
16           **such fee schedule in an efficient area (as**  
17           **identified under paragraph (2)), in addi-**  
18           **tion to the amount of payment that would**  
19           **otherwise be made for such services**  
20           **under this part, there also shall be paid**  
21           **(on a monthly or quarterly basis) an**  
22           **amount equal to 5 percent of the payment**  
23           **amount for the services under this part.**

24           **“(2) IDENTIFICATION OF EFFICIENT**  
25          **AREAS.—**

1           **“(A) IN GENERAL.—Based upon**  
2           **available data, the Secretary shall**  
3           **identify those counties or equivalent**  
4           **areas in the United States in the low-**  
5           **est fifth percentile of utilization**  
6           **based on per capita spending under**  
7           **this part and part A for services pro-**  
8           **vided in the most recent year for**  
9           **which data are available as of the**  
10          **date of the enactment of this sub-**  
11          **section, as standardized to eliminate**  
12          **the effect of geographic adjustments**  
13          **in payment rates.**

14          **“(B) IDENTIFICATION OF COUNTIES**  
15          **WHERE SERVICE IS FURNISHED.—For**  
16          **purposes of paying the additional**  
17          **amount specified in paragraph (1), if**  
18          **the Secretary uses the 5-digit postal**  
19          **ZIP Code where the service is fur-**  
20          **nished, the dominant county of the**  
21          **postal ZIP Code (as determined by**  
22          **the United States Postal Service, or**  
23          **otherwise) shall be used to determine**  
24          **whether the postal ZIP Code is in a**

1 county described in subparagraph  
2 (A).

3 “(C) LIMITATION ON REVIEW.—There  
4 shall be no administrative or judicial  
5 review under section 1869, 1878, or  
6 otherwise, respecting—

7 “(i) the identification of a  
8 county or other area under sub-  
9 paragraph (A); or

10 “(ii) the assignment of a post-  
11 al ZIP Code to a county or other  
12 area under subparagraph (B).

13 “(D) PUBLICATION OF LIST OF COUN-  
14 TIES; POSTING ON WEBSITE.—With re-  
15 spect to a year for which a county or  
16 area is identified under this para-  
17 graph, the Secretary shall identify  
18 such counties or areas as part of the  
19 proposed and final rule to implement  
20 the physician fee schedule under sec-  
21 tion 1848 for the applicable year. The  
22 Secretary shall post the list of coun-  
23 ties identified under this paragraph  
24 on the Internet website of the Cen-



1           **ters for Medicare & Medicaid Serv-**  
2           **ices.”.**

3   **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY**  
4           **REPORTING INITIATIVE (PQRI).**

5           **(a) FEEDBACK.—Section 1848(m)(5) of the**  
6   **Social Security Act (42 U.S.C. 1395w–4(m)(5))**  
7   **is amended by adding at the end the following**  
8   **new subparagraph:**

9                   **“(H) FEEDBACK.—The Secretary**  
10                   **shall provide timely feedback to eligi-**  
11                   **ble professionals on the performance**  
12                   **of the eligible professional with re-**  
13                   **spect to satisfactorily submitting data**  
14                   **on quality measures under this sub-**  
15                   **section.”.**

16           **(b) APPEALS.—Such section is further**  
17   **amended—**

18                   **(1) in subparagraph (E), by striking**  
19                   **“There shall be” and inserting “Subject to**  
20                   **subparagraph (I), there shall be”; and**

21                   **(2) by adding at the end the following**  
22   **new subparagraph:**

23                   **“(I) INFORMAL APPEALS PROCESS.—**  
24                   **Notwithstanding subparagraph (E),**  
25                   **by not later than January 1, 2011, the**

1           **Secretary shall establish and have in**  
2           **place an informal process for eligible**  
3           **professionals to appeal the deter-**  
4           **mination that an eligible professional**  
5           **did not satisfactorily submit data on**  
6           **quality measures under this sub-**  
7           **section.”.**

8           **(c) INTEGRATION OF PHYSICIAN QUALITY RE-**  
9           **PORTING AND EHR REPORTING.—Section**  
10          **1848(m) of such Act is amended by adding at**  
11          **the end the following new paragraph:**

12                   **“(7) INTEGRATION OF PHYSICIAN QUALITY**  
13                   **REPORTING AND EHR REPORTING.—Not later**  
14                   **than January 1, 2012, the Secretary shall**  
15                   **develop a plan to integrate clinical re-**  
16                   **porting on quality measures under this**  
17                   **subsection with reporting requirements**  
18                   **under subsection (o) relating to the**  
19                   **meaningful use of electronic health**  
20                   **records. Such integration shall consist of**  
21                   **the following:**

22                           **“(A) The development of meas-**  
23                           **ures, the reporting of which would**  
24                           **both demonstrate—**

1           “(i) meaningful use of an elec-  
2           tronic health record for purposes  
3           of subsection (o); and

4           “(ii) clinical quality of care  
5           furnished to an individual.

6           “(B) The collection of health data  
7           to identify deficiencies in the quality  
8           and coordination of care for individ-  
9           uals eligible for benefits under this  
10          part.

11          “(C) Such other activities as spec-  
12          ified by the Secretary.”.

13          (d) EXTENSION OF INCENTIVE PAYMENTS.—  
14          Section 1848(m)(1) of such Act (42 U.S.C.  
15          1395w-4(m)(1)) is amended—

16                  (1) in subparagraph (A), by striking  
17                  “2010” and inserting “2012”; and

18                  (2) in subparagraph (B)(ii), by strik-  
19                  ing “2009 and 2010” and inserting “for  
20                  each of the years 2009 through 2012”.

21          SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-  
22    ITIES.

23          (a) IN GENERAL.—Section 1848(e) of the So-  
24          cial Security Act (42 U.S.C.1395w-4(e)) is

1 amended by adding at the end the following  
2 new paragraph:

3           **“(6) TRANSITION TO USE OF MSAS AS FEE**  
4           **SCHEDULE AREAS IN CALIFORNIA.—**

5                   **“(A) IN GENERAL.—**

6                           **“(i) REVISION.—Subject to**  
7                           **clause (ii) and notwithstanding**  
8                           **the previous provisions of this**  
9                           **subsection, for services furnished**  
10                           **on or after January 1, 2011, the**  
11                           **Secretary shall revise the fee**  
12                           **schedule areas used for payment**  
13                           **under this section applicable to**  
14                           **the State of California using the**  
15                           **Metropolitan Statistical Area**  
16                           **(MSA) iterative Geographic Ad-**  
17                           **justment Factor methodology as**  
18                           **follows:**

19                                   **“(I) The Secretary shall**  
20                                   **configure the physician fee**  
21                                   **schedule areas using the**  
22                                   **Core-Based Statistical Areas-**  
23                                   **Metropolitan Statistical Areas**  
24                                   **(each in this paragraph re-**  
25                                   **ferred to as an ‘MSA’), as de-**

1           **fin**ed by the Director of the  
2           **Office of Management and**  
3           **Budget, as the basis for the**  
4           **fee schedule areas. The Sec-**  
5           **retary shall employ an**  
6           **iterative process to transition**  
7           **fee schedule areas. First, the**  
8           **Secretary shall list all MSAs**  
9           **within the State by Geo-**  
10          **graphic Adjustment Factor**  
11          **described in paragraph (2) (in**  
12          **this paragraph referred to as**  
13          **a ‘GAF’) in descending order.**  
14          **In the first iteration, the Sec-**  
15          **retary shall compare the GAF**  
16          **of the highest cost MSA in the**  
17          **State to the weighted-average**  
18          **GAF of the group of remain-**  
19          **ing MSAs in the State. If the**  
20          **ratio of the GAF of the high-**  
21          **est cost MSA to the weighted-**  
22          **average GAF of the rest of**  
23          **State is 1.05 or greater then**  
24          **the highest cost MSA becomes**  
25          **a separate fee schedule area.**

1           **“(II) In the next iteration,**  
2           **the Secretary shall compare**  
3           **the MSA of the second-highest**  
4           **GAF to the weighted-average**  
5           **GAF of the group of remain-**  
6           **ing MSAs. If the ratio of the**  
7           **second-highest MSA’s GAF to**  
8           **the weighted-average of the**  
9           **remaining lower cost MSAs is**  
10          **1.05 or greater, the second-**  
11          **highest MSA becomes a sepa-**  
12          **rate fee schedule area. The**  
13          **iterative process continues**  
14          **until the ratio of the GAF of**  
15          **the highest-cost remaining**  
16          **MSA to the weighted-average**  
17          **of the remaining lower-cost**  
18          **MSAs is less than 1.05, and**  
19          **the remaining group of lower**  
20          **cost MSAs form a single fee**  
21          **schedule area, If two MSAs**  
22          **have identical GAFs, they**  
23          **shall be combined in the**  
24          **iterative comparison.**

1           “(ii) **TRANSITION.**—For services  
2           furnished on or after January 1,  
3           2011, and before January 1, 2016,  
4           in the State of California, after  
5           calculating the work, practice ex-  
6           pense, and malpractice geo-  
7           graphic indices described in  
8           clauses (i), (ii), and (iii) of para-  
9           graph (1)(A) that would otherwise  
10          apply through application of this  
11          paragraph, the Secretary shall in-  
12          crease any such index to the  
13          county-based fee schedule area  
14          value on December 31, 2009, if  
15          such index would otherwise be  
16          less than the value on January 1,  
17          2010.

18          “(B) **SUBSEQUENT REVISIONS.**—

19                 “(i) **PERIODIC REVIEW AND AD-**  
20                 **JUSTMENTS IN FEE SCHEDULE**  
21                 **AREAS.**—Subsequent to the proc-  
22                 ess outlined in paragraph (1)(C),  
23                 not less often than every three  
24                 years, the Secretary shall review  
25                 and update the California Rest-of-

1           **State fee schedule area using**  
2           **MSAs as defined by the Director**  
3           **of the Office of Management and**  
4           **Budget and the iterative method-**  
5           **ology described in subparagraph**  
6           **(A)(i).**

7           **“(ii) LINK WITH GEOGRAPHIC**  
8           **INDEX DATA REVISION.—The revi-**  
9           **sion described in clause (i) shall**  
10          **be made effective concurrently**  
11          **with the application of the peri-**  
12          **odic review of the adjustment fac-**  
13          **tors required under paragraph**  
14          **(1)(C) for California for 2012 and**  
15          **subsequent periods. Upon re-**  
16          **quest, the Secretary shall make**  
17          **available to the public any coun-**  
18          **ty-level or MSA derived data used**  
19          **to calculate the geographic prac-**  
20          **tice cost index.**

21          **“(C) REFERENCES TO FEE SCHEDULE**  
22          **AREAS.—Effective for services fur-**  
23          **nished on or after January 1, 2010,**  
24          **for the State of California, any ref-**  
25          **erence in this section to a fee sched-**



1           ule area shall be deemed a reference  
2           to an MSA in the State.”.

3           **(b) CONFORMING AMENDMENT TO DEFINI-**  
4 **TION OF FEE SCHEDULE AREA.—Section**  
5 **1848(j)(2) of the Social Security Act (42 U.S.C.**  
6 **1395w(j)(2)) is amended by striking “The**  
7 **term” and inserting “Except as provided in**  
8 **subsection (e)(6)(C), the term”.**

9           **PART 2—MARKET BASKET UPDATES**

10 **SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVE-**  
11 **MENTS INTO MARKET BASKET UPDATES**  
12 **THAT DO NOT ALREADY INCORPORATE SUCH**  
13 **IMPROVEMENTS.**

14           **(a) OUTPATIENT HOSPITALS.—**

15           **(1) IN GENERAL.—The first sentence of**  
16 **section 1833(t)(3)(C)(iv) of the Social Se-**  
17 **curity Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is**  
18 **amended—**

19           **(A) by inserting “(which is subject**  
20 **to the productivity adjustment de-**  
21 **scribed in subclause (II) of such sec-**  
22 **tion)” after “1886(b)(3)(B)(iii)”;** and

23           **(B) by inserting “(but not below**  
24 **0)” after “reduced”.**

1           **(2) EFFECTIVE DATE.**—The amendments  
2           made by paragraph (1) shall apply to in-  
3           crease factors for services furnished in  
4           years beginning with 2010.

5           **(b) AMBULANCE SERVICES.**—Section  
6           1834(l)(3)(B) of such Act (42 U.S.C.  
7           1395m(l)(3)(B))) is amended by inserting be-  
8           fore the period at the end the following: “and,  
9           in the case of years beginning with 2010, sub-  
10          ject to the productivity adjustment described  
11          in section 1886(b)(3)(B)(iii)(II)”.

12          **(c) AMBULATORY SURGICAL CENTER SERV-**  
13          **ICES.**—Section 1833(i)(2)(D) of such Act (42  
14          U.S.C. 1395l(i)(2)(D)) is amended—

15                 (1) by redesignating clause (v) as  
16                 clause (vi); and

17                 (2) by inserting after clause (iv) the  
18                 following new clause:

19                 “(v) In implementing the system described  
20                 in clause (i), for services furnished during  
21                 2010 or any subsequent year, to the extent  
22                 that an annual percentage change factor ap-  
23                 plies, such factor shall be subject to the pro-  
24                 ductivity adjustment described in section  
25                 1886(b)(3)(B)(iii)(II).”.

1       **(d) LABORATORY SERVICES.—Section**  
2 **1833(h)(2)(A) of such Act (42 U.S.C.**  
3 **1395l(h)(2)(A) is amended—**

4           **(1) in clause (i), by striking “for each**  
5 **of the years 2009 through 2013” and in-**  
6 **serting “for 2009”; and**

7           **(2) clause (ii)—**

8               **(A) by striking “and” at the end of**  
9 **subclause (III);**

10              **(B) by striking the period at the**  
11 **end of subclause (IV) and inserting “;**  
12 **and”; and**

13              **(C) by adding at the end the fol-**  
14 **lowing new subclause:**

15               **“(V) the annual adjustment in the fee**  
16 **schedules determined under clause (i) for**  
17 **years beginning with 2010 shall be sub-**  
18 **ject to the productivity adjustment de-**  
19 **scribed in section 1886(b)(3)(B)(iii)(II).”.**

20       **(e) CERTAIN DURABLE MEDICAL EQUIP-**  
21 **MENT.—Section 1834(a)(14) of such Act (42**  
22 **U.S.C. 1395m(a)(14)) is amended—**

23           **(1) in subparagraph (K), by inserting**  
24 **before the semicolon at the end the fol-**  
25 **lowing: “, subject to the productivity ad-**

1       **justment described in section**  
2       **1886(b)(3)(B)(iii)(II)”;**

3           **(2) in subparagraph (L)(i), by insert-**  
4       **ing after “June 2013,” the following: “sub-**  
5       **ject to the productivity adjustment de-**  
6       **scribed in section 1886(b)(3)(B)(iii)(II),”;**

7           **(3) in subparagraph (L)(ii), by insert-**  
8       **ing after “June 2013” the following: “,**  
9       **subject to the productivity adjustment**  
10      **described in section 1886(b)(3)(B)(iii)(II)”;**  
11      **and**

12           **(4) in subparagraph (M), by inserting**  
13      **before the period at the end the fol-**  
14      **lowing: “, subject to the productivity ad-**  
15      **justment described in section**  
16      **1886(b)(3)(B)(iii)(II)”.**

17           **PART 3—OTHER PROVISIONS**

18      **SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN**  
19           **WHEELCHAIRS.**

20           **(a) IN GENERAL.—Section 1834(a)(7)(A)(iii)**  
21      **of the Social Security Act (42 U.S.C.**  
22      **1395m(a)(7)(A)(iii)) is amended—**

23           **(1) in the heading, by inserting “CER-**  
24      **TAIN COMPLEX REHABILITATIVE” after “OP-**  
25      **TION FOR”; and**

1           (2) by striking “power-driven wheel-  
2           chair” and inserting “complex rehabilita-  
3           tive power-driven wheelchair recognized  
4           by the Secretary as classified within  
5           group 3 or higher”.

6           (b) **EFFECTIVE DATE.**—The amendments  
7 made by subsection (a) shall take effect on  
8 **January 1, 2011**, and shall apply to power-  
9 driven wheelchairs furnished on or after such  
10 date. Such amendments shall not apply to  
11 contracts entered into under section 1847 of  
12 the Social Security Act (42 U.S.C. 1395w-3)  
13 pursuant to a bid submitted under such sec-  
14 tion before **October 1, 2010**, under subsection  
15 (a)(1)(B)(i)(I) of such section.

16 **SEC. 1142. EXTENSION OF PAYMENT RULE FOR**  
17 **BRACHYTHERAPY.**

18           Section 1833(t)(16)(C) of the Social Secu-  
19 rity Act (42 U.S.C. 1395l(t)(16)(C)), as amended  
20 by section 142 of the Medicare Improvements  
21 for Patients and Providers Act of 2008 (Public  
22 Law 110-275), is amended by striking, the first  
23 place it appears, “January 1, 2010” and insert-  
24 ing “January 1, 2012”.

1 SEC. 1143. HOME INFUSION THERAPY REPORT TO CON-  
2 GRESS.

3 Not later than 12 months after the date of  
4 enactment of this Act, the Medicare Payment  
5 Advisory Commission shall submit to Con-  
6 gress a report on the following:

7 (1) The scope of coverage for home in-  
8 fusion therapy in the fee-for-service  
9 Medicare program under title XVIII of  
10 the Social Security Act, Medicare Advan-  
11 tage under part C of such title, the vet-  
12 eran's health care program under chap-  
13 ter 17 of title 38, United States Code, and  
14 among private payers, including an anal-  
15 ysis of the scope of services provided by  
16 home infusion therapy providers to their  
17 patients in such programs.

18 (2) The benefits and costs of pro-  
19 viding such coverage under the Medicare  
20 program, including a calculation of the  
21 potential savings achieved through avoid-  
22 ed or shortened hospital and nursing  
23 home stays as a result of Medicare cov-  
24 erage of home infusion therapy.

25 (3) An assessment of sources of data  
26 on the costs of home infusion therapy

1       **that might be used to construct payment**  
2       **mechanisms in the Medicare program.**

3           **(4) Recommendations, if any, on the**  
4       **structure of a payment system under the**  
5       **Medicare program for home infusion**  
6       **therapy, including an analysis of the pay-**  
7       **ment methodologies used under Medicare**  
8       **Advantage plans and private health plans**  
9       **for the provision of home infusion ther-**  
10       **apy and their applicability to the Medi-**  
11       **care program.**

12 **SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS**  
13           **(ASCS) TO SUBMIT COST DATA AND OTHER**  
14           **DATA.**

15       **(a) COST REPORTING.—**

16           **(1) IN GENERAL.—Section 1833(i) of the**  
17       **Social Security Act (42 U.S.C. 1395l(i)) is**  
18       **amended by adding at the end the fol-**  
19       **lowing new paragraph:**

20       **“(8) The Secretary shall require, as a con-**  
21       **dition of the agreement described in section**  
22       **1832(a)(2)(F)(i), the submission of such cost**  
23       **report as the Secretary may specify, taking**  
24       **into account the requirements for such re-**

1 ports under section 1815 in the case of a hos-  
2 pital.”.

3 (2) DEVELOPMENT OF COST REPORT.—

4 Not later than 3 years after the date of  
5 the enactment of this Act, the Secretary  
6 of Health and Human Services shall de-  
7 velop a cost report form for use under  
8 section 1833(i)(8) of the Social Security  
9 Act, as added by paragraph (1).

10 (3) AUDIT REQUIREMENT.—The Sec-  
11 retary shall provide for periodic auditing  
12 of cost reports submitted under section  
13 1833(i)(8) of the Social Security Act, as  
14 added by paragraph (1).

15 (4) EFFECTIVE DATE.—The amendment  
16 made by paragraph (1) shall apply to  
17 agreements applicable to cost reporting  
18 periods beginning 18 months after the  
19 date the Secretary develops the cost re-  
20 port form under paragraph (2).

21 (b) ADDITIONAL DATA ON QUALITY.—

22 (1) IN GENERAL.—Section 1833(i)(7) of  
23 such Act (42 U.S.C. 1395l(i)(7)) is amend-  
24 ed—



1           (A) in subparagraph (B), by in-  
2           serting “subject to subparagraph (C),”  
3           after “may otherwise provide,”; and

4           (B) by adding at the end the fol-  
5           lowing new subparagraph:

6           “(C) Under subparagraph (B) the Sec-  
7           retary shall require the reporting of such ad-  
8           ditional data relating to quality of services  
9           furnished in an ambulatory surgical facility,  
10          including data on health care associated in-  
11          fections, as the Secretary may specify.”.

12          (2) EFFECTIVE DATE.—The amendment  
13          made by paragraph (1) shall to reporting  
14          for years beginning with 2012.

15   SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

16          Section 1833(t) of the Social Security Act  
17          (42 U.S.C. 1395l(t)) is amended by adding at  
18          the end the following new paragraph:

19          “(18) AUTHORIZATION OF ADJUSTMENT  
20          FOR CANCER HOSPITALS.—

21                 “(A) STUDY.—The Secretary shall  
22                 conduct a study to determine if,  
23                 under the system under this sub-  
24                 section, costs incurred by hospitals  
25                 described in section 1886(d)(1)(B)(v)

1 with respect to ambulatory payment  
2 classification groups exceed those  
3 costs incurred by other hospitals fur-  
4 nishing services under this sub-  
5 section (as determined appropriate  
6 by the Secretary).

7 “(B) AUTHORIZATION OF ADJUST-  
8 MENT.—Insofar as the Secretary deter-  
9 mines under subparagraph (A) that  
10 costs incurred by hospitals described  
11 in section 1886(d)(1)(B)(v) exceed  
12 those costs incurred by other hos-  
13 pitals furnishing services under this  
14 subsection, the Secretary shall pro-  
15 vide for an appropriate adjustment  
16 under paragraph (2)(E) to reflect  
17 those higher costs effective for serv-  
18 ices furnished on or after January 1,  
19 2011.”.

20 SEC. 1146. MEDICARE IMPROVEMENT FUND.

21 Section 1898(b)(1)(A) of the Social Secu-  
22 rity Act (42 U.S.C. 1395iii(b)(1)(A)) is amended  
23 to read as follows:

1           “(A) the period beginning with fis-  
2           cal year 2011 and ending with fiscal  
3           year 2019, \$8,000,000,000; and”.

4 SEC. 1147. PAYMENT FOR IMAGING SERVICES.

5           (a) ADJUSTMENT IN PRACTICE EXPENSE TO  
6 REFLECT HIGHER PRESUMED UTILIZATION.—Sec-  
7 tion 1848 of the Social Security Act (42 U.S.C.  
8 1395w) is amended—

9           (1) in subsection (b)(4)—

10                   (A) in subparagraph (B), by strik-  
11                   ing “subparagraph (A)” and inserting  
12                   “this paragraph”; and

13                   (B) by adding at the end the fol-  
14                   lowing new subparagraph:

15                           “(C) ADJUSTMENT IN PRACTICE EX-  
16                           PENSE TO REFLECT HIGHER PRESUMED  
17                           UTILIZATION.—In computing the num-  
18                           ber of practice expense relative value  
19                           units under subsection (c)(2)(C)(ii)  
20                           with respect to advanced diagnostic  
21                           imaging services (as defined in sec-  
22                           tion 1834(e)(1)(B)) , the Secretary  
23                           shall adjust such number of units so  
24                           it reflects a 75 percent (rather than

1           **50 percent) presumed rate of utiliza-**  
2           **tion of imaging equipment.”; and**

3           **(2) in subsection (c)(2)(B)(v)(II), by in-**  
4           **serting “AND OTHER PROVISIONS” after**  
5           **“OPD PAYMENT CAP”.**

6           **(b) ADJUSTMENT IN TECHNICAL COMPONENT**  
7           **“DISCOUNT” ON SINGLE-SESSION IMAGING TO**  
8           **CONSECUTIVE BODY PARTS.—Section 1848(b)(4)**  
9           **of such Act is further amended by adding at**  
10          **the end the following new subparagraph:**

11                   **“(D) ADJUSTMENT IN TECHNICAL**  
12                   **COMPONENT DISCOUNT ON SINGLE-SES-**  
13                   **SION IMAGING INVOLVING CONSECUTIVE**  
14                   **BODY PARTS.—The Secretary shall in-**  
15                   **crease the reduction in expenditures**  
16                   **attributable to the multiple proce-**  
17                   **dure payment reduction applicable to**  
18                   **the technical component for imaging**  
19                   **under the final rule published by the**  
20                   **Secretary in the Federal Register on**  
21                   **November 21, 2005 (part 405 of title**  
22                   **42, Code of Federal Regulations) from**  
23                   **25 percent to 50 percent.”.**

24           **(c) EFFECTIVE DATE.—Except as otherwise**  
25          **provided, this section, and the amendments**

1 made by this section, shall apply to services  
2 furnished on or after January 1, 2011.

3 SEC. 1148. DURABLE MEDICAL EQUIPMENT PROGRAM IM-  
4 PROVEMENTS.

5 (a) WAIVER OF SURETY BOND REQUIRE-  
6 MENT.—Section 1834(a)(16) of the Social Secu-  
7 rity Act (42 U.S.C. 1395m(a)(16)) is amended  
8 by adding at the end the following: “The re-  
9 quirement for a surety bond described in sub-  
10 paragraph (B) shall not apply in the case of  
11 a pharmacy (i) that has been enrolled under  
12 section 1866(j) as a supplier of durable med-  
13 ical equipment, prosthetics, orthotics, and  
14 supplies and has been issued (which may in-  
15 clude renewal of) a provider number (as de-  
16 scribed in the first sentence of this para-  
17 graph) for at least 5 years, and (ii) for which  
18 a final adverse action (as defined in section  
19 424.57(a) of title 42, Code of Federal Regula-  
20 tions) has never been imposed.”.

21 (b) ENSURING SUPPLY OF OXYGEN EQUIP-  
22 MENT.—

23 (1) IN GENERAL.—Section 1834(a)(5)(F)  
24 of the Social Security Act (42 U.S.C.  
25 1395m(a)(5)(F)) is amended—

1           (A) in clause (ii), by striking  
2 “After the” and inserting “Except as  
3 provided in clause (iii), after the”;  
4 and

5           (B) by adding at the end the fol-  
6 lowing new clause:

7           “(iii) CONTINUATION OF SUP-  
8 PLY.—In the case of a supplier fur-  
9 nishing such equipment to an in-  
10 dividual under this subsection as  
11 of the 27th month of the 36  
12 months described in clause (i),  
13 the supplier furnishing such  
14 equipment as of such month shall  
15 continue to furnish such equip-  
16 ment to such individual (either  
17 directly or through arrangements  
18 with other suppliers of such  
19 equipment) during any subse-  
20 quent period of medical need for  
21 the remainder of the reasonable  
22 useful lifetime of the equipment,  
23 as determined by the Secretary,  
24 regardless of the location of the  
25 individual, unless another sup-

1           plier has accepted responsibility  
2           for continuing to furnish such  
3           equipment during the remainder  
4           of such period.”.

5           (2) **EFFECTIVE DATE.**—The amendments  
6           made by paragraph (1) shall take effect  
7           as of the date of the enactment of this Act  
8           and shall apply to the furnishing of  
9           equipment to individuals for whom the  
10          27th month of a continuous period of use  
11          of oxygen equipment described in section  
12          1834(a)(5)(F) of the Social Security Act  
13          occurs on or after July 1, 2010.

14          (c) **TREATMENT OF CURRENT ACCREDITATION**  
15 **APPLICATIONS.**—Section 1834(a)(20)(F) of such  
16 **Act (42 U.S.C. 1395m(a)(20)(F)) is amended—**

17           (1) **in clause (i)—**

18           (A) **by striking “clause (ii)” and**  
19           **inserting “clauses (ii) and (iii)”;** and

20           (B) **by striking “and” at the end;**

21           (2) **by striking the period at the end**  
22           **of clause (ii)(II) and by inserting “; and”;**

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

1           “(iii) the requirement for ac-  
2           creditation described in clause (i)  
3           shall not apply for purposes of  
4           supplying diabetic testing sup-  
5           plies, canes, and crutches in the  
6           case of a pharmacy that is en-  
7           rolled under section 1866(j) as a  
8           supplier of durable medical  
9           equipment, prosthetics, orthotics,  
10          and supplies.”; and

11          (4) by adding after and below clause  
12          (iii) the following:

13                 “Any supplier that has submitted an  
14                 application for accreditation before  
15                 August 1, 2009, shall be deemed as  
16                 meeting applicable standards and ac-  
17                 creditation requirement under this  
18                 subparagraph until such time as the  
19                 independent accreditation organiza-  
20                 tion takes action on the supplier’s ap-  
21                 plication.”.

22          (d) **RESTORING 36-MONTH OXYGEN RENTAL**  
23 **PERIOD IN CASE OF SUPPLIER BANKRUPTCY FOR**  
24 **CERTAIN INDIVIDUALS.—Section 1834(a)(5)(F) of**  
25 **such Act (42 U.S.C. 1395m(a)(5)(F)), as amend-**



1 ed by subsection (b), is further amended by  
2 adding at the end the following new clause:

3           “(iv) EXCEPTION FOR BANK-  
4           RUPTCY.—If a supplier who fur-  
5           nishes oxygen and oxygen equip-  
6           ment to an individual is declared  
7           bankrupt and its assets are liq-  
8           uidated and at the time of such  
9           declaration and liquidation more  
10          than 24 months of rental pay-  
11          ments have been made, such indi-  
12          vidual may begin a new 36-month  
13          rental period under this subpara-  
14          graph with another supplier of  
15          oxygen.”.

16 SEC. 1149. MEDPAC STUDY AND REPORT ON BONE MASS  
17 MEASUREMENT.

18       (a) IN GENERAL.—The Medicare Payment  
19 Advisory Commission shall conduct a study  
20 regarding bone mass measurement, including  
21 computed tomography, dual-energy x-ray  
22 absorptriometry, and vertebral fracture as-  
23 sessment. The study shall focus on the fol-  
24 lowing:

1           **(1) An assessment of the adequacy of**  
2 **Medicare payment rates for such serv-**  
3 **ices, taking into account costs of acquir-**  
4 **ing the necessary equipment, profes-**  
5 **sional work time, and practice expense**  
6 **costs.**

7           **(2) The impact of Medicare payment**  
8 **changes since 2006 on beneficiary access**  
9 **to bone mass measurement benefits in**  
10 **general and in rural and minority com-**  
11 **munities specifically.**

12           **(3) A review of the clinically appro-**  
13 **priate and recommended use among**  
14 **Medicare beneficiaries and how usage**  
15 **rates among such beneficiaries compares**  
16 **to such recommendations.**

17           **(4) In conjunction with the findings**  
18 **under (3), recommendations, if necessary,**  
19 **regarding methods for reaching appro-**  
20 **priate use of bone mass measurement**  
21 **studies among Medicare beneficiaries.**

22           **(b) REPORT.—The Commission shall sub-**  
23 **mit a report to the Congress, not later than**  
24 **9 months after the date of the enactment of**  
25 **this Act, containing a description of the re-**

1 **sults of the study conducted under subsection**  
2 **(a) and the conclusions and recommenda-**  
3 **tions, if any, regarding each of the issues de-**  
4 **scribed in paragraphs (1), (2) (3) and (4) of**  
5 **such subsection.**

6 **Subtitle C—Provisions Related to**  
7 **Medicare Parts A and B**

8 **SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOS-**  
9 **PITAL READMISSIONS.**

10 **(a) HOSPITALS.—**

11 **(1) IN GENERAL.—Section 1886 of the**  
12 **Social Security Act (42 U.S.C. 1395ww), as**  
13 **amended by section 1103(a), is amended**  
14 **by adding at the end the following new**  
15 **subsection:**

16 **“(p) ADJUSTMENT TO HOSPITAL PAYMENTS**  
17 **FOR EXCESS READMISSIONS.—**

18 **“(1) IN GENERAL.—With respect to pay-**  
19 **ment for discharges from an applicable**  
20 **hospital (as defined in paragraph (5)(C))**  
21 **occurring during a fiscal year beginning**  
22 **on or after October 1, 2011, in order to ac-**  
23 **count for excess readmissions in the hos-**  
24 **pital, the Secretary shall reduce the pay-**  
25 **ments that would otherwise be made to**

1 such hospital under subsection (d) (or  
2 section 1814(b)(3), as the case may be) for  
3 such a discharge by an amount equal to  
4 the product of—

5 “(A) the base operating DRG pay-  
6 ment amount (as defined in para-  
7 graph (2)) for the discharge; and

8 “(B) the adjustment factor (de-  
9 scribed in paragraph (3)(A)) for the  
10 hospital for the fiscal year.

11 “(2) BASE OPERATING DRG PAYMENT  
12 AMOUNT.—

13 “(A) IN GENERAL.—Except as pro-  
14 vided in subparagraph (B), for pur-  
15 poses of this subsection, the term  
16 ‘base operating DRG payment  
17 amount’ means, with respect to a hos-  
18 pital for a fiscal year, the payment  
19 amount that would otherwise be  
20 made under subsection (d) for a dis-  
21 charge if this subsection did not  
22 apply, reduced by any portion of such  
23 amount that is attributable to pay-  
24 ments under subparagraphs (B) and  
25 (F) of paragraph (5).

1           **“(B) ADJUSTMENTS.—For purposes**  
2           **of subparagraph (A), in the case of a**  
3           **hospital that is paid under section**  
4           **1814(b)(3), the term ‘base operating**  
5           **DRG payment amount’ means the**  
6           **payment amount under such section.**

7           **“(3) ADJUSTMENT FACTOR.—**

8           **“(A) IN GENERAL.—For purposes of**  
9           **paragraph (1), the adjustment factor**  
10           **under this paragraph for an applica-**  
11           **ble hospital for a fiscal year is equal**  
12           **to the greater of—**

13                   **“(i) the ratio described in sub-**  
14                   **paragraph (B) for the hospital for**  
15                   **the applicable period (as defined**  
16                   **in paragraph (5)(D)) for such fis-**  
17                   **cal year; or**

18                   **“(ii) the floor adjustment fac-**  
19                   **tor specified in subparagraph (C).**

20           **“(B) RATIO.—The ratio described**  
21           **in this subparagraph for a hospital**  
22           **for an applicable period is equal to 1**  
23           **minus the ratio of—**

24                   **“(i) the aggregate payments**  
25                   **for excess readmissions (as de-**

1           **fined in paragraph (4)(A)) with re-**  
2           **spect to an applicable hospital for**  
3           **the applicable period; and**

4           **“(ii) the aggregate payments**  
5           **for all discharges (as defined in**  
6           **paragraph (4)(B)) with respect to**  
7           **such applicable hospital for such**  
8           **applicable period.**

9           **“(C) FLOOR ADJUSTMENT FACTOR.—**  
10          **For purposes of subparagraph (A),**  
11          **the floor adjustment factor specified**  
12          **in this subparagraph for—**

13               **“(i) fiscal year 2012 is 0.99;**

14               **“(ii) fiscal year 2013 is 0.98;**

15               **“(iii) fiscal year 2014 is 0.97;**

16               **or**

17               **“(iv) a subsequent fiscal year**  
18               **is 0.95.**

19          **“(4) AGGREGATE PAYMENTS, EXCESS RE-**  
20          **ADMISSION RATIO DEFINED.—For purposes**  
21          **of this subsection:**

22               **“(A) AGGREGATE PAYMENTS FOR EX-**  
23               **CESS READMISSIONS.—The term ‘aggre-**  
24               **gate payments for excess readmis-**  
25               **sions’ means, for a hospital for a fis-**

1 cal year, the sum, for applicable con-  
2 ditions (as defined in paragraph  
3 (5)(A)), of the product, for each appli-  
4 cable condition, of—

5 “(i) the base operating DRG  
6 payment amount for such hos-  
7 pital for such fiscal year for such  
8 condition;

9 “(ii) the number of admissions  
10 for such condition for such hos-  
11 pital for such fiscal year; and

12 “(iii) the excess readmissions  
13 ratio (as defined in subparagraph  
14 (C)) for such hospital for the ap-  
15 plicable period for such fiscal  
16 year minus 1.

17 “(B) AGGREGATE PAYMENTS FOR ALL  
18 DISCHARGES.—The term ‘aggregate  
19 payments for all discharges’ means,  
20 for a hospital for a fiscal year, the  
21 sum of the base operating DRG pay-  
22 ment amounts for all discharges for  
23 all conditions from such hospital for  
24 such fiscal year.

25 “(C) EXCESS READMISSION RATIO.—

1           “(i) IN GENERAL.—Subject to  
2 clauses (ii) and (iii), the term ‘ex-  
3 cess readmissions ratio’ means,  
4 with respect to an applicable con-  
5 dition for a hospital for an appli-  
6 cable period, the ratio (but not  
7 less than 1.0) of—

8                   “(I) the risk adjusted re-  
9 admissions based on actual  
10 readmissions, as determined  
11 consistent with a readmission  
12 measure methodology that  
13 has been endorsed under  
14 paragraph (5)(A)(ii)(I), for an  
15 applicable hospital for such  
16 condition with respect to the  
17 applicable period; to

18                   “(II) the risk adjusted ex-  
19 pected readmissions (as deter-  
20 mined consistent with such a  
21 methodology) for such hos-  
22 pital for such condition with  
23 respect to such applicable pe-  
24 riod.



1           **“(ii) EXCLUSION OF CERTAIN RE-**  
2           **ADMISSIONS.—For purposes of**  
3           **clause (i), with respect to a hos-**  
4           **pital, excess readmissions shall**  
5           **not include readmissions for an**  
6           **applicable condition for which**  
7           **there are fewer than a minimum**  
8           **number (as determined by the**  
9           **Secretary) of discharges for such**  
10           **applicable condition for the appli-**  
11           **cable period and such hospital.**

12           **“(iii) ADJUSTMENT.—In order**  
13           **to promote a reduction over time**  
14           **in the overall rate of readmis-**  
15           **sions for applicable conditions,**  
16           **the Secretary may provide, begin-**  
17           **ning with discharges for fiscal**  
18           **year 2014, for the determination**  
19           **of the excess readmissions ratio**  
20           **under subparagraph (C) to be**  
21           **based on a ranking of hospitals**  
22           **by readmission ratios (from lower**  
23           **to higher readmission ratios) nor-**  
24           **malized to a benchmark that is**  
25           **lower than the 50th percentile.**

1           **“(5) DEFINITIONS.—For purposes of**  
2 **this subsection:**

3           **“(A) APPLICABLE CONDITION.—The**  
4 **term ‘applicable condition’ means,**  
5 **subject to subparagraph (B), a condi-**  
6 **tion or procedure selected by the Sec-**  
7 **retary among conditions and proce-**  
8 **dures for which—**

9           **“(i) readmissions (as defined**  
10 **in subparagraph (E)) that rep-**  
11 **resent conditions or procedures**  
12 **that are high volume or high ex-**  
13 **penditures under this title (or**  
14 **other criteria specified by the**  
15 **Secretary); and**

16           **“(ii) measures of such re-**  
17 **admissions—**

18           **“(I) have been endorsed**  
19 **by the entity with a contract**  
20 **under section 1890(a); and**

21           **“(II) such endorsed meas-**  
22 **ures have appropriate exclu-**  
23 **sions for readmissions that**  
24 **are unrelated to the prior dis-**  
25 **charge (such as a planned re-**

1 admission or transfer to an-  
2 other applicable hospital).

3 “(B) EXPANSION OF APPLICABLE  
4 CONDITIONS.—Beginning with fiscal  
5 year 2013, the Secretary shall expand  
6 the applicable conditions beyond the  
7 3 conditions for which measures have  
8 been endorsed as described in sub-  
9 paragraph (A)(ii)(I) as of the date of  
10 the enactment of this subsection to  
11 the additional 4 conditions that have  
12 been so identified by the Medicare  
13 Payment Advisory Commission in its  
14 report to Congress in June 2007 and  
15 to other conditions and procedures  
16 which may include an all-condition  
17 measure of readmissions, as deter-  
18 mined appropriate by the Secretary.  
19 In expanding such applicable condi-  
20 tions, the Secretary shall seek the en-  
21 dorsement described in subparagraph  
22 (A)(ii)(I) but may apply such meas-  
23 ures without such an endorsement.

24 “(C) APPLICABLE HOSPITAL.—The  
25 term ‘applicable hospital’ means a

1 subsection (d) hospital or a hospital  
2 that is paid under section 1814(b)(3).

3 “(D) APPLICABLE PERIOD.—The  
4 term ‘applicable period’ means, with  
5 respect to a fiscal year, such period  
6 as the Secretary shall specify for pur-  
7 poses of determining excess readmis-  
8 sions.

9 “(E) READMISSION.—The term ‘re-  
10 admission’ means, in the case of an  
11 individual who is discharged from an  
12 applicable hospital, the admission of  
13 the individual to the same or another  
14 applicable hospital within a time pe-  
15 riod specified by the Secretary from  
16 the date of such discharge. Insofar as  
17 the discharge relates to an applicable  
18 condition for which there is an en-  
19 dorsed measure described in subpara-  
20 graph (A)(ii)(I), such time period  
21 (such as 30 days) shall be consistent  
22 with the time period specified for  
23 such measure.

24 “(6) LIMITATIONS ON REVIEW.—There  
25 shall be no administrative or judicial re-

1 view under section 1869, section 1878, or  
2 otherwise of—

3 “(A) the determination of base op-  
4 erating DRG payment amounts;

5 “(B) the methodology for deter-  
6 mining the adjustment factor under  
7 paragraph (3), including excess re-  
8 admissions ratio under paragraph  
9 (4)(C), aggregate payments for excess  
10 readmissions under paragraph (4)(A),  
11 and aggregate payments for all dis-  
12 charges under paragraph (4)(B), and  
13 applicable periods and applicable  
14 conditions under paragraph (5);

15 “(C) the measures of readmissions  
16 as described in paragraph (5)(A)(ii);  
17 and

18 “(D) the determination of a tar-  
19 geted hospital under paragraph  
20 (8)(B)(i), the increase in payment  
21 under paragraph (8)(B)(ii), the aggre-  
22 gate cap under paragraph (8)(C)(i),  
23 the hospital-specific limit under para-  
24 graph (8)(C)(ii), and the form of pay-

1           **ment made by the Secretary under**  
2           **paragraph (8)(D).**

3           **“(7) MONITORING INAPPROPRIATE**  
4           **CHANGES IN ADMISSIONS PRACTICES.—The**  
5           **Secretary shall monitor the activities of**  
6           **applicable hospitals to determine if such**  
7           **hospitals have taken steps to avoid pa-**  
8           **tients at risk in order to reduce the likeli-**  
9           **hood of increasing readmissions for ap-**  
10          **plicable conditions. If the Secretary de-**  
11          **termines that such a hospital has taken**  
12          **such a step, after notice to the hospital**  
13          **and opportunity for the hospital to un-**  
14          **dertake action to alleviate such steps, the**  
15          **Secretary may impose an appropriate**  
16          **sanction.**

17          **“(8) ASSISTANCE TO CERTAIN HOS-**  
18          **PITALS.—**

19                 **“(A) IN GENERAL.—For purposes of**  
20                 **providing funds to applicable hos-**  
21                 **pitals to take steps described in sub-**  
22                 **paragraph (E) to address factors that**  
23                 **may impact readmissions of individ-**  
24                 **uals who are discharged from such a**  
25                 **hospital, for fiscal years beginning on**

1 or after October 1, 2011, the Secretary  
2 shall make a payment adjustment for  
3 a hospital described in subparagraph  
4 (B), with respect to each such fiscal  
5 year, by a percent estimated by the  
6 Secretary to be consistent with sub-  
7 paragraph (C).

8 “(B) TARGETED HOSPITALS.—Sub-  
9 paragraph (A) shall apply to an appli-  
10 cable hospital that—

11 “(i) received (or, in the case of  
12 an 1814(b)(3) hospital, otherwise  
13 would have been eligible to re-  
14 ceive) \$10,000,000 or more in dis-  
15 proportionate share payments  
16 using the latest available data as  
17 estimated by the Secretary; and

18 “(ii) provides assurances satis-  
19 factory to the Secretary that the  
20 increase in payment under this  
21 paragraph shall be used for pur-  
22 poses described in subparagraph  
23 (E).

24 “(C) CAPS.—

1           “(i) **AGGREGATE CAP.**—The ag-  
2           gregate amount of the payment  
3           adjustment under this paragraph  
4           for a fiscal year shall not exceed 5  
5           percent of the estimated dif-  
6           ference in the spending that  
7           would occur for such fiscal year  
8           with and without application of  
9           the adjustment factor described  
10          in paragraph (3) and applied pur-  
11          suant to paragraph (1).

12          “(ii) **HOSPITAL-SPECIFIC LIMIT.**—  
13          The aggregate amount of the pay-  
14          ment adjustment for a hospital  
15          under this paragraph shall not ex-  
16          ceed the estimated difference in  
17          spending that would occur for  
18          such fiscal year for such hospital  
19          with and without application of  
20          the adjustment factor described  
21          in paragraph (3) and applied pur-  
22          suant to paragraph (1).

23          “(D) **FORM OF PAYMENT.**—The Sec-  
24          retary may make the additional pay-  
25          ments under this paragraph on a



1 lump sum basis, a periodic basis, a  
2 claim by claim basis, or otherwise.

3 “(E) USE OF ADDITIONAL PAY-  
4 MENT.—Funding under this paragraph  
5 shall be used by targeted hospitals  
6 for transitional care activities de-  
7 signed to address the patient non-  
8 compliance issues that result in high-  
9 er than normal readmission rates,  
10 such as one or more of the following:

11 “(i) Providing care coordina-  
12 tion services to assist in transi-  
13 tions from the targeted hospital  
14 to other settings.

15 “(ii) Hiring translators and in-  
16 terpreters.

17 “(iii) Increasing services of-  
18 fered by discharge planners.

19 “(iv) Ensuring that individ-  
20 uals receive a summary of care  
21 and medication orders upon dis-  
22 charge.

23 “(v) Developing a quality im-  
24 provement plan to assess and

1           **remedy preventable readmission**  
2           **rates.**

3           **“(vi) Assigning discharged in-**  
4           **dividuals to a medical home.**

5           **“(vii) Doing other activities as**  
6           **determined appropriate by the**  
7           **Secretary.**

8           **“(F) GAO REPORT ON USE OF**  
9           **FUNDS.—Not later than 3 years after**  
10           **the date on which funds are first**  
11           **made available under this paragraph,**  
12           **the Comptroller General of the**  
13           **United States shall submit to Con-**  
14           **gress a report on the use of such**  
15           **funds.**

16           **“(G) DISPROPORTIONATE SHARE**  
17           **HOSPITAL PAYMENT.—In this para-**  
18           **graph, the term ‘disproportionate**  
19           **share hospital payment’ means an ad-**  
20           **ditional payment amount under sub-**  
21           **section (d)(5)(F).”.**

22           **(b) APPLICATION TO CRITICAL ACCESS HOS-**  
23           **PITALS.—Section 1814(l) of the Social Security**  
24           **Act (42 U.S.C. 1395f(l)) is amended—**

25           **(1) in paragraph (5)—**

1           **(A) by striking “and” at the end of**  
2           **subparagraph (C);**

3           **(B) by striking the period at the**  
4           **end of subparagraph (D) and insert-**  
5           **ing “; and”;**

6           **(C) by inserting at the end the fol-**  
7           **lowing new subparagraph:**

8           **“(E) the methodology for determining**  
9           **the adjustment factor under paragraph**  
10          **(5), including the determination of aggre-**  
11          **gate payments for actual and expected**  
12          **readmissions, applicable periods, applica-**  
13          **ble conditions and measures of readmis-**  
14          **sions.”; and**

15          **(D) by redesignating such para-**  
16          **graph as paragraph (6); and**

17          **(2) by inserting after paragraph (4)**  
18          **the following new paragraph:**

19          **“(5) The adjustment factor described in**  
20          **section 1886(p)(3) shall apply to payments**  
21          **with respect to a critical access hospital with**  
22          **respect to a cost reporting period beginning**  
23          **in fiscal year 2012 and each subsequent fiscal**  
24          **year (after application of paragraph (4) of this**  
25          **subsection) in a manner similar to the man-**

1 ner in which such section applies with re-  
2 spect to a fiscal year to an applicable hospital  
3 as described in section 1886(p)(2).”.

4 (c) POST ACUTE CARE PROVIDERS.—

5 (1) INTERIM POLICY.—

6 (A) IN GENERAL.—With respect to a  
7 readmission to an applicable hospital  
8 or a critical access hospital (as de-  
9 scribed in section 1814(l) of the Social  
10 Security Act) from a post acute care  
11 provider (as defined in paragraph (3))  
12 and such a readmission is not gov-  
13 erned by section 412.531 of title 42,  
14 Code of Federal Regulations, if the  
15 claim submitted by such a post-acute  
16 care provider under title XVIII of the  
17 Social Security Act indicates that the  
18 individual was readmitted to a hos-  
19 pital from such a post-acute care pro-  
20 vider or admitted from home and  
21 under the care of a home health agen-  
22 cy within 30 days of an initial dis-  
23 charge from an applicable hospital or  
24 critical access hospital, the payment  
25 under such title on such claim shall

1 be the applicable percent specified in  
2 subparagraph (B) of the payment that  
3 would otherwise be made under the  
4 respective payment system under  
5 such title for such post-acute care  
6 provider if this subsection did not  
7 apply.

8 (B) APPLICABLE PERCENT DE-  
9 FINED.—For purposes of subpara-  
10 graph (A), the applicable percent is—

11 (i) for fiscal or rate year 2012  
12 is 0.996;

13 (ii) for fiscal or rate year 2013  
14 is 0.993; and

15 (iii) for fiscal or rate year  
16 2014 is 0.99.

17 (C) EFFECTIVE DATE.—Subpara-  
18 graph (1) shall apply to discharges or  
19 services furnished (as the case may  
20 be with respect to the applicable post  
21 acute care provider) on or after the  
22 first day of the fiscal year or rate  
23 year, beginning on or after October 1,  
24 2011, with respect to the applicable  
25 post acute care provider.

1           **(2) DEVELOPMENT AND APPLICATION OF**  
2           **PERFORMANCE MEASURES.—**

3           **(A) IN GENERAL.—The Secretary of**  
4           **Health and Human Services shall de-**  
5           **velop appropriate measures of read-**  
6           **mission rates for post acute care pro-**  
7           **viders. The Secretary shall seek en-**  
8           **dorsement of such measures by the**  
9           **entity with a contract under section**  
10          **1890(a) of the Social Security Act but**  
11          **may adopt and apply such measures**  
12          **under this paragraph without such**  
13          **an endorsement. The Secretary shall**  
14          **expand such measures in a manner**  
15          **similar to the manner in which appli-**  
16          **cable conditions are expanded under**  
17          **paragraph (5)(B) of section 1886(p) of**  
18          **the Social Security Act, as added by**  
19          **subsection (a).**

20          **(B) IMPLEMENTATION.—The Sec-**  
21          **retary shall apply, on or after Octo-**  
22          **ber 1, 2014, with respect to post acute**  
23          **care providers, policies similar to the**  
24          **policies applied with respect to appli-**  
25          **cable hospitals and critical access**

1 hospitals under the amendments  
2 made by subsection (a). The provi-  
3 sions of paragraph (1) shall apply  
4 with respect to any period on or after  
5 October 1, 2014, and before such ap-  
6 plication date described in the pre-  
7 vious sentence in the same manner as  
8 such provisions apply with respect to  
9 fiscal or rate year 2014.

10 (C) MONITORING AND PENALTIES.—

11 The provisions of paragraph (7) of  
12 such section 1886(p) shall apply to  
13 providers under this paragraph in  
14 the same manner as they apply to  
15 hospitals under such section.

16 (3) DEFINITIONS.—For purposes of this  
17 subsection:

18 (A) POST ACUTE CARE PROVIDER.—

19 The term “post acute care provider”  
20 means—

21 (i) a skilled nursing facility  
22 (as defined in section 1819(a) of  
23 the Social Security Act);

1           (ii) an inpatient rehabilitation  
2           facility (described in section  
3           1886(h)(1)(A) of such Act);

4           (iii) a home health agency (as  
5           defined in section 1861(o) of such  
6           Act); and

7           (iv) a long term care hospital  
8           (as defined in section 1861(ccc) of  
9           such Act).

10           (B) OTHER TERMS.—The terms  
11           “applicable condition”, “applicable  
12           hospital”, and “readmission” have the  
13           meanings given such terms in section  
14           1886(p)(5) of the Social Security Act,  
15           as added by subsection (a)(1).

16           (d) PHYSICIANS.—

17           (1) STUDY.—The Secretary of Health  
18           and Human Services shall conduct a  
19           study to determine how the readmissions  
20           policy described in the previous sub-  
21           sections could be applied to physicians.

22           (2) CONSIDERATIONS.—In conducting  
23           the study, the Secretary shall consider  
24           approaches such as—



1           **(A) creating a new code (or codes)**  
2           **and payment amount (or amounts)**  
3           **under the fee schedule in section 1848**  
4           **of the Social Security Act (in a budget**  
5           **neutral manner) for services fur-**  
6           **nished by an appropriate physician**  
7           **who sees an individual within the**  
8           **first week after discharge from a hos-**  
9           **pital or critical access hospital;**

10           **(B) developing measures of rates**  
11           **of readmission for individuals treated**  
12           **by physicians;**

13           **(C) applying a payment reduction**  
14           **for physicians who treat the patient**  
15           **during the initial admission that re-**  
16           **sults in a readmission; and**

17           **(D) methods for attributing pay-**  
18           **ments or payment reductions to the**  
19           **appropriate physician or physicians.**

20           **(3) REPORT.—The Secretary shall**  
21           **issue a public report on such study not**  
22           **later than the date that is one year after**  
23           **the date of the enactment of this Act.**

24           **(e) FUNDING.—For purposes of carrying**  
25           **out the provisions of this section, in addition**

1 to funds otherwise available, out of any funds  
2 in the Treasury not otherwise appropriated,  
3 there are appropriated to the Secretary of  
4 Health and Human Services for the Center for  
5 Medicare & Medicaid Services Program Man-  
6 agement Account \$25,000,000 for each fiscal  
7 year beginning with 2010. Amounts appro-  
8 priated under this subsection for a fiscal year  
9 shall be available until expended.

10 SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM

11 PLAN AND BUNDLING PILOT PROGRAM.

12 (a) PLAN.—

13 (1) IN GENERAL.—The Secretary of  
14 Health and Human Services (in this sec-  
15 tion referred to as the “Secretary”) shall  
16 develop a detailed plan to reform pay-  
17 ment for post acute care (PAC) services  
18 under the Medicare program under title  
19 XVIII of the Social Security Act (in this  
20 section referred to as the “Medicare pro-  
21 gram”). The goals of such payment re-  
22 form are to—

23 (A) improve the coordination,  
24 quality, and efficiency of such serv-  
25 ices; and

1           **(B) improve outcomes for individ-**  
2           **uals such as reducing the need for re-**  
3           **admission to hospitals from providers**  
4           **of such services.**

5           **(2) BUNDLING POST ACUTE SERVICES.—**  
6           **The plan described in paragraph (1) shall**  
7           **include detailed specifications for a bun-**  
8           **dled payment for post acute services (in**  
9           **this section referred to as the “post acute**  
10          **care bundle”), and may include other ap-**  
11          **proaches determined appropriate by the**  
12          **Secretary.**

13          **(3) POST ACUTE SERVICES.—For pur-**  
14          **poses of this section, the term “post acute**  
15          **services” means services for which pay-**  
16          **ment may be made under the Medicare**  
17          **program that are furnished by skilled**  
18          **nursing facilities, inpatient rehabilitation**  
19          **facilities, long term care hospitals, hos-**  
20          **pital based outpatient rehabilitation fa-**  
21          **ilities and home health agencies to an**  
22          **individual after discharge of such indi-**  
23          **vidual from a hospital, and such other**  
24          **services determined appropriate by the**  
25          **Secretary.**

1       **(b) DETAILS.—The plan described in sub-**  
2 **section (a)(1) shall include consideration of**  
3 **the following issues:**

4           **(1) The nature of payments under a**  
5 **post acute care bundle, including the**  
6 **type of provider or entity to whom pay-**  
7 **ment should be made, the scope of activi-**  
8 **ties and services included in the bundle,**  
9 **whether payment for physicians' services**  
10 **should be included in the bundle, and the**  
11 **period covered by the bundle.**

12           **(2) Whether the payment should be**  
13 **consolidated with the payment under the**  
14 **inpatient prospective system under sec-**  
15 **tion 1886 of the Social Security Act (in**  
16 **this section referred to as MS-DRGs) or a**  
17 **separate payment should be established**  
18 **for such bundle, and if a separate pay-**  
19 **ment is established, whether it should be**  
20 **made only upon use of post acute care**  
21 **services or for every discharge.**

22           **(3) Whether the bundle should be ap-**  
23 **plied across all categories of providers of**  
24 **inpatient services (including critical ac-**  
25 **cess hospitals) and post acute care serv-**

1 ices or whether it should be limited to  
2 certain categories of providers, services,  
3 or discharges, such as high volume or  
4 high cost MS-DRGs.

5 (4) The extent to which payment rates  
6 could be established to achieve offsets for  
7 efficiencies that could be expected to be  
8 achieved with a bundle payment, wheth-  
9 er such rates should be established on a  
10 national basis or for different geographic  
11 areas, should vary according to dis-  
12 charge, case mix, outliers, and geo-  
13 graphic differences in wages or other ap-  
14 propriate adjustments, and how to up-  
15 date such rates.

16 (5) The nature of protections needed  
17 for individuals under a system of bundled  
18 payments to ensure that individuals re-  
19 ceive quality care, are furnished the level  
20 and amount of services needed as deter-  
21 mined by an appropriate assessment in-  
22 strument, are offered choice of provider,  
23 and the extent to which transitional care  
24 services would improve quality of care

1       **for individuals and the functioning of a**  
2       **bundled post-acute system.**

3           **(6) The nature of relationships that**  
4       **may be required between hospitals and**  
5       **providers of post acute care services to**  
6       **facilitate bundled payments, including**  
7       **the application of gainsharing, anti-refer-**  
8       **ral, anti-kickback, and anti-trust laws.**

9           **(7) Quality measures that would be**  
10       **appropriate for reporting by hospitals**  
11       **and post acute providers (such as meas-**  
12       **ures that assess changes in functional**  
13       **status and quality measures appropriate**  
14       **for each type of post acute services pro-**  
15       **vider including how the reporting of such**  
16       **quality measures could be coordinated**  
17       **with other reporting of such quality**  
18       **measures by such providers otherwise re-**  
19       **quired).**

20           **(8) How cost-sharing for a post acute**  
21       **care bundle should be treated relative to**  
22       **current rules for cost-sharing for inpa-**  
23       **tient hospital, home health, skilled nurs-**  
24       **ing facility, and other services.**

1           **(9) How other programmatic issues**  
2           **should be treated in a post acute care**  
3           **bundle, including rules specific to var-**  
4           **ious types of post-acute providers such as**  
5           **the post-acute transfer policy, three-day**  
6           **hospital stay to qualify for services fur-**  
7           **nished by skilled nursing facilities, and**  
8           **the coordination of payments and care**  
9           **under the Medicare program and the**  
10          **Medicaid program.**

11          **(10) Such other issues as the Sec-**  
12          **retary deems appropriate.**

13          **(c) CONSULTATIONS AND ANALYSIS.—**

14                 **(1) CONSULTATION WITH STAKE-**  
15                 **HOLDERS.—In developing the plan under**  
16                 **subsection (a)(1), the Secretary shall con-**  
17                 **sult with relevant stakeholders and shall**  
18                 **consider experience with such research**  
19                 **studies and demonstrations that the Sec-**  
20                 **retary determines appropriate.**

21                 **(2) ANALYSIS AND DATA COLLECTION.—**  
22                 **In developing such plan, the Secretary**  
23                 **shall—**

24                         **(A) analyze the issues described**  
25                         **in subsection (b) and other issues**

1           **that the Secretary determines appro-**  
2           **priate;**

3           **(B) analyze the impacts (includ-**  
4           **ing geographic impacts) of post acute**  
5           **service reform approaches, including**  
6           **bundling of such services on individ-**  
7           **uals, hospitals, post acute care pro-**  
8           **viders, and physicians;**

9           **(C) use existing data (such as data**  
10           **submitted on claims) and collect such**  
11           **data as the Secretary determines are**  
12           **appropriate to develop such plan re-**  
13           **quired in this section; and**

14           **(D) if patient functional status**  
15           **measures are appropriate for the**  
16           **analysis, to the extent practical, build**  
17           **upon the CARE tool being developed**  
18           **pursuant to section 5008 of the Def-**  
19           **icit Reduction Act of 2005.**

20           **(d) ADMINISTRATION.—**

21           **(1) FUNDING.—For purposes of car-**  
22           **rying out the provisions of this section, in**  
23           **addition to funds otherwise available, out**  
24           **of any funds in the Treasury not other-**  
25           **wise appropriated, there are appro-**



1        **priated to the Secretary for the Center**  
2        **for Medicare & Medicaid Services Pro-**  
3        **gram Management Account \$15,000,000**  
4        **for each of the fiscal years 2010 through**  
5        **2012. Amounts appropriated under this**  
6        **paragraph for a fiscal year shall be avail-**  
7        **able until expended.**

8            **(2) EXPEDITED DATA COLLECTION.—**  
9        **Chapter 35 of title 44, United States Code**  
10       **shall not apply to this section.**

11       **(e) PUBLIC REPORTS.—**

12            **(1) INTERIM REPORTS.—The Secretary**  
13       **shall issue interim public reports on a**  
14       **periodic basis on the plan described in**  
15       **subsection (a)(1), the issues described in**  
16       **subsection (b), and impact analyses as**  
17       **the Secretary determines appropriate.**

18            **(2) FINAL REPORT.—Not later than the**  
19       **date that is 3 years after the date of the**  
20       **enactment of this Act, the Secretary shall**  
21       **issue a final public report on such plan,**  
22       **including analysis of issues described in**  
23       **subsection (b) and impact analyses.**

1       **(f) CONVERSION OF ACUTE CARE EPISODE**  
2 **DEMONSTRATION TO PILOT PROGRAM AND EX-**  
3 **PANSION TO INCLUDE POST ACUTE SERVICES.—**

4           **(1) IN GENERAL.—Part E of title XVIII**  
5 **of the Social Security Act is amended by**  
6 **inserting after section 1866C the fol-**  
7 **lowing new section:**

8 **“CONVERSION OF ACUTE CARE EPISODE DEM-**  
9 **ONSTRATION TO PILOT PROGRAM AND EXPAN-**  
10 **SION TO INCLUDE POST ACUTE SERVICES**

11 **“SEC. 1866D. (a) CONVERSION AND EXPAN-**  
12 **SION.—**

13           **“(1) IN GENERAL.—By not later than**  
14 **January 1, 2011, the Secretary shall, for**  
15 **the purpose of promoting the use of bun-**  
16 **dled payments to promote efficient and**  
17 **high quality delivery of care—**

18           **“(A) convert the acute care epi-**  
19 **sode demonstration program con-**  
20 **ducted under section 1866C to a pilot**  
21 **program; and**

22           **“(B) subject to subsection (c), ex-**  
23 **pand such program as so converted**  
24 **to include post acute services and**  
25 **such other services the Secretary de-**

1           **termines to be appropriate, which**  
2           **may include transitional services.**

3           **“(2) BUNDLED PAYMENT STRUCTURES.—**

4                   **“(A) IN GENERAL.—In carrying out**  
5           **paragraph (1), the Secretary may**  
6           **apply bundled payments with respect**  
7           **to—**

8                           **“(i) hospitals and physicians;**

9                           **“(ii) hospitals and post-acute**  
10           **care providers;**

11                          **“(iii) hospitals, physicians,**  
12           **and post-acute care providers; or**

13                          **“(iv) combinations of post-**  
14           **acute providers.**

15           **“(B) FURTHER APPLICATION.—**

16                          **“(i) IN GENERAL.—In carrying**  
17           **out paragraph (1), the Secretary**  
18           **shall apply bundled payments in**  
19           **a manner so as to include collabo-**  
20           **rative care networks and con-**  
21           **tinuing care hospitals.**

22                          **“(ii) COLLABORATIVE CARE NET-**  
23           **WORK DEFINED.—For purposes of**  
24           **this subparagraph, the term ‘col-**  
25           **laborative care network’ means a**

1 consortium of health care pro-  
2 viders that provides a com-  
3 prehensive range of coordinated  
4 and integrated health care serv-  
5 ices to low-income patient popu-  
6 lations (including the uninsured)  
7 which may include coordinated  
8 and comprehensive care by safety  
9 net providers to reduce any un-  
10 necessary use of items and serv-  
11 ices furnished in emergency de-  
12 partments, manage chronic condi-  
13 tions, improve quality and effi-  
14 ciency of care, increase preven-  
15 tive services, and promote adher-  
16 ence to post-acute and follow-up  
17 care plans.

18 “(iii) CONTINUING CARE HOS-  
19 PITAL DEFINED.—For purposes of  
20 this subparagraph, the term ‘con-  
21 tinuing care hospital’ means an  
22 entity that has demonstrated the  
23 ability to meet patient care and  
24 patient safety standards and that  
25 provides under common manage-

1           **ment the medical and rehabilita-**  
2           **tion services provided in inpa-**  
3           **tient rehabilitation hospitals and**  
4           **units (as defined in section**  
5           **1886(d)(1)(B)(ii)), long-term care**  
6           **hospitals (as defined in section**  
7           **1886(d)(1)(B)(iv)(I)), and skilled**  
8           **nursing facilities (as defined in**  
9           **section 1819(a)) that are located**  
10          **in a hospital described in section**  
11          **1886(d).**

12          **“(b) SCOPE.—The pilot program under sub-**  
13          **section (a) may include additional geographic**  
14          **areas and additional conditions which ac-**  
15          **count for significant program spending, as de-**  
16          **fin ed by the Secretary. Nothing in this sub-**  
17          **section shall be construed as limiting the**  
18          **number of hospital and physician groups or**  
19          **the number of hospital and post-acute pro-**  
20          **vider groups that may participate in the pilot**  
21          **program.**

22          **“(c) LIMITATION.—The Secretary shall only**  
23          **expand the pilot program under subsection**  
24          **(a) if the Secretary finds that—**

1           “(1) the demonstration program  
2 under section 1866C and pilot program  
3 under this section maintain or increase  
4 the quality of care received by individ-  
5 uals enrolled under this title; and

6           “(2) such demonstration program and  
7 pilot program reduce program expendi-  
8 tures and, based on the certification  
9 under subsection (d), that the expansion  
10 of such pilot program would result in es-  
11 timated spending that would be less than  
12 what spending would otherwise be in the  
13 absence of this section.

14           “(d) CERTIFICATION.—For purposes of sub-  
15 section (c), the Chief Actuary of the Centers  
16 for Medicare & Medicaid Services shall certify  
17 whether expansion of the pilot program  
18 under this section would result in estimated  
19 spending that would be less than what spend-  
20 ing would otherwise be in the absence of this  
21 section.

22           “(e) VOLUNTARY PARTICIPATION.—Nothing  
23 in this paragraph shall be construed as re-  
24 quiring the participation of an entity in the  
25 pilot program under this section.

1       “(f) **EVALUATION ON COST AND QUALITY OF**  
2 **CARE.—The Secretary shall conduct an eval-**  
3 **uation of the pilot program under subsection**  
4 **(a) to study the effect of such program on**  
5 **costs and quality of care. The findings of such**  
6 **evaluation shall be included in the final re-**  
7 **port required under section 1152(e)(2) of**  
8 **America’s Affordable Health Choices Act of**  
9 **2009.**

10       “(g) **STUDY OF ADDITIONAL BUNDLING AND**  
11 **EPISODE-BASED PAYMENT FOR PHYSICIANS’ SERV-**  
12 **ICES.—**

13               “(1) **IN GENERAL.—The Secretary shall**  
14 **provide for a study of and development**  
15 **of a plan for testing additional ways to**  
16 **increase bundling of payments for physi-**  
17 **cians in connection with an episode of**  
18 **care, such as in connection with out-**  
19 **patient hospital services or services ren-**  
20 **dered in physicians’ offices, other than**  
21 **those provided under the pilot program.**

22               “(2) **APPLICATION.—The Secretary may**  
23 **implement such a plan through a dem-**  
24 **onstration program.”.**

1           **(2) CONFORMING AMENDMENT.—Section**  
2           **1866C(b) of the Social Security Act (42**  
3           **U.S.C. 1395cc–3(b)) is amended by strik-**  
4           **ing “The Secretary” and inserting “Sub-**  
5           **ject to section 1866D, the Secretary”.**

6 **SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.**

7           **Section 1895(b)(3)(B)(ii) of the Social Se-**  
8           **curity Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is**  
9           **amended—**

10           **(1) in subclause (IV), by striking**  
11           **“and”;**

12           **(2) by redesignating subclause (V) as**  
13           **subclause (VII); and**

14           **(3) by inserting after subclause (IV)**  
15           **the following new subclauses:**

16                           **“(V) 2007, 2008, and 2009,**  
17                           **subject to clause (v), the home**  
18                           **health market basket percent-**  
19                           **age increase;**

20                           **“(VI) 2010, subject to**  
21                           **clause (v), 0 percent; and”.**

22 **SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH**  
23           **CARE.**

24           **(a) ACCELERATION OF ADJUSTMENT FOR**  
25 **CASE MIX CHANGES.—Section 1895(b)(3)(B) of**



1 the Social Security Act (42 U.S.C.  
2 1395fff(b)(3)(B)) is amended—

3 (1) in clause (iv), by striking “Insofar  
4 as” and inserting “Subject to clause (vi),  
5 insofar as”; and

6 (2) by adding at the end the following  
7 new clause:

8 “(vi) SPECIAL RULE FOR CASE  
9 MIX CHANGES FOR 2011.—

10 “(I) IN GENERAL.—With re-  
11 spect to the case mix adjust-  
12 ments established in section  
13 484.220(a) of title 42, Code of  
14 Federal Regulations, the Sec-  
15 retary shall apply, in 2010, the  
16 adjustment established in  
17 paragraph (3) of such section  
18 for 2011, in addition to apply-  
19 ing the adjustment estab-  
20 lished in paragraph (2) for  
21 2010.

22 “(II) CONSTRUCTION.—  
23 Nothing in this clause shall be  
24 construed as limiting the  
25 amount of adjustment for case

1           **mix for 2010 or 2011 if more**  
2           **recent data indicate an appro-**  
3           **priate adjustment that is**  
4           **greater than the amount es-**  
5           **tablished in the section de-**  
6           **scribed in subclause (I).”.**

7           **(b) REBASING HOME HEALTH PROSPECTIVE**  
8           **PAYMENT AMOUNT.—Section 1895(b)(3)(A) of**  
9           **the Social Security Act (42 U.S.C.**  
10          **1395fff(b)(3)(A)) is amended—**

11           **(1) in clause (i)—**

12                   **(A) in subclause (III), by inserting**  
13                   **“and before 2011” after “after the pe-**  
14                   **riod described in subclause (II)”;** and

15                   **(B) by inserting after subclause**  
16                   **(III) the following new subclauses:**

17                           **“(IV) Subject to clause**  
18                           **(iii)(I), for 2011, such amount**  
19                           **(or amounts) shall be adjusted**  
20                           **by a uniform percentage de-**  
21                           **termined to be appropriate by**  
22                           **the Secretary based on anal-**  
23                           **ysis of factors such as changes**  
24                           **in the average number and**  
25                           **types of visits in an episode,**

1           **the change in intensity of vis-**  
2           **its in an episode, growth in**  
3           **cost per episode, and other**  
4           **factors that the Secretary**  
5           **considers to be relevant.**

6           **“(V) Subject to clause**  
7           **(iii)(II), for a year after 2011,**  
8           **such a amount (or amounts)**  
9           **shall be equal to the amount**  
10          **(or amounts) determined**  
11          **under this clause for the pre-**  
12          **vious year, updated under**  
13          **subparagraph (B).”;** and

14           **(2) by adding at the end the following**  
15    **new clause:**

16           **“(iii) SPECIAL RULE IN CASE OF**  
17           **INABILITY TO EFFECT TIMELY RE-**  
18           **BASING.—**

19           **“(I) APPLICATION OF PROXY**  
20           **AMOUNT FOR 2011.—If the Sec-**  
21           **retary is not able to compute**  
22           **the amount (or amounts)**  
23           **under clause (i)(IV) so as to**  
24           **permit, on a timely basis, the**  
25           **application of such clause for**

1           **2011, the Secretary shall sub-**  
2           **stitute for such amount (or**  
3           **amounts) 95 percent of the**  
4           **amount (or amounts) that**  
5           **would otherwise be specified**  
6           **under clause (i)(III) if it ap-**  
7           **plied for 2011.**

8           **“(II) ADJUSTMENT FOR SUB-**  
9           **SEQUENT YEARS BASED ON**  
10          **DATA.—If the Secretary ap-**  
11          **plies subclause (I), the Sec-**  
12          **retary before July 1, 2011,**  
13          **shall compare the amount (or**  
14          **amounts) applied under such**  
15          **subclause with the amount (or**  
16          **amounts) that should have**  
17          **been applied under clause**  
18          **(i)(IV). The Secretary shall de-**  
19          **crease or increase the pro-**  
20          **spective payment amount (or**  
21          **amounts) under clause (i)(V)**  
22          **for 2012 (or, at the Secretary’s**  
23          **discretion, over a period of**  
24          **several years beginning with**  
25          **2012) by the amount (if any)**

1 by which the amount (or  
2 amounts) applied under sub-  
3 clause (I) is greater or less, re-  
4 spectively, than the amount  
5 (or amounts) that should have  
6 been applied under clause  
7 (i)(IV).”.

8 SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVE-  
9 MENTS INTO MARKET BASKET UPDATE FOR  
10 HOME HEALTH SERVICES.

11 (a) IN GENERAL.—Section 1895(b)(3)(B) of  
12 the Social Security Act (42 U.S.C.  
13 1395fff(b)(3)(B)) is amended—

14 (1) in clause (iii), by inserting “(in-  
15 cluding being subject to the productivity  
16 adjustment described in section  
17 1886(b)(3)(B)(iii)(II))” after “in the same  
18 manner”; and

19 (2) in clause (v)(I), by inserting “(but  
20 not below 0)” after “reduced”.

21 (b) EFFECTIVE DATE.—The amendment  
22 made by subsection (a) shall apply to home  
23 health market basket percentage increases  
24 for years beginning with 2010.

1 **SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE**  
2 **PROHIBITION ON CERTAIN PHYSICIAN RE-**  
3 **FERRALS MADE TO HOSPITALS.**

4 **(a) IN GENERAL.—Section 1877 of the So-**  
5 **cial Security Act (42 U.S.C. 1395nn) is amend-**  
6 **ed—**

7 **(1) in subsection (d)(2)—**

8 **(A) in subparagraph (A), by strik-**  
9 **ing “and” at the end;**

10 **(B) in subparagraph (B), by strik-**  
11 **ing the period at the end and insert-**  
12 **ing “; and”; and**

13 **(C) by adding at the end the fol-**  
14 **lowing new subparagraph:**

15 **“(C) in the case where the entity**  
16 **is a hospital, the hospital meets the**  
17 **requirements of paragraph (3)(D).”;**

18 **(2) in subsection (d)(3)—**

19 **(A) in subparagraph (B), by strik-**  
20 **ing “and” at the end;**

21 **(B) in subparagraph (C), by strik-**  
22 **ing the period at the end and insert-**  
23 **ing “; and”; and**

24 **(C) by adding at the end the fol-**  
25 **lowing new subparagraph:**

1           “(D) the hospital meets the re-  
2           quirements described in subsection  
3           (i)(1).”;

4           (3) by amending subsection (f) to read  
5           as follows:

6           “(f) REPORTING AND DISCLOSURE REQUIRE-  
7           MENTS.—

8           “(1) IN GENERAL.—Each entity pro-  
9           viding covered items or services for  
10          which payment may be made under this  
11          title shall provide the Secretary with the  
12          information concerning the entity’s own-  
13          ership, investment, and compensation ar-  
14          rangements, including—

15               “(A) the covered items and serv-  
16               ices provided by the entity, and

17               “(B) the names and unique physi-  
18               cian identification numbers of all  
19               physicians with an ownership or in-  
20               vestment interest (as described in  
21               subsection (a)(2)(A)), or with a com-  
22               pensation arrangement (as described  
23               in subsection (a)(2)(B)), in the entity,  
24               or whose immediate relatives have  
25               such an ownership or investment in-

1           **terest or who have such a compensa-**  
2           **tion relationship with the entity.**

3           **Such information shall be provided in**  
4           **such form, manner, and at such times as**  
5           **the Secretary shall specify. The require-**  
6           **ment of this subsection shall not apply to**  
7           **designated health services provided out-**  
8           **side the United States or to entities**  
9           **which the Secretary determines provide**  
10          **services for which payment may be made**  
11          **under this title very infrequently.**

12           **“(2) REQUIREMENTS FOR HOSPITALS**  
13           **WITH PHYSICIAN OWNERSHIP OR INVEST-**  
14           **MENT.—In the case of a hospital that**  
15           **meets the requirements described in sub-**  
16           **section (i)(1), the hospital shall—**

17                   **“(A) submit to the Secretary an**  
18                   **initial report, and periodic updates at**  
19                   **a frequency determined by the Sec-**  
20                   **retary, containing a detailed descrip-**  
21                   **tion of the identity of each physician**  
22                   **owner and physician investor and**  
23                   **any other owners or investors of the**  
24                   **hospital;**



1           **“(B) require that any referring**  
2           **physician owner or investor discloses**  
3           **to the individual being referred, by a**  
4           **time that permits the individual to**  
5           **make a meaningful decision regard-**  
6           **ing the receipt of services, as deter-**  
7           **mined by the Secretary, the owner-**  
8           **ship or investment interest, as appli-**  
9           **cable, of such referring physician in**  
10          **the hospital; and**

11          **“(C) disclose the fact that the hos-**  
12          **pital is partially or wholly owned by**  
13          **one or more physicians or has one or**  
14          **more physician investors—**

15                 **“(i) on any public website for**  
16                 **the hospital; and**

17                 **“(ii) in any public advertising**  
18                 **for the hospital.**

19          **The information to be reported or dis-**  
20          **closed under this paragraph shall be pro-**  
21          **vided in such form, manner, and at such**  
22          **times as the Secretary shall specify. The**  
23          **requirements of this paragraph shall not**  
24          **apply to designated health services fur-**  
25          **nished outside the United States or to en-**

1        **tities which the Secretary determines**  
2        **provide services for which payment may**  
3        **be made under this title very infre-**  
4        **quently.**

5            **“(3) PUBLICATION OF INFORMATION.—**  
6        **The Secretary shall publish, and periodi-**  
7        **cally update, the information submitted**  
8        **by hospitals under paragraph (2)(A) on**  
9        **the public Internet website of the Centers**  
10       **for Medicare & Medicaid Services.”;**

11           **(4) by amending subsection (g)(5) to**  
12       **read as follows:**

13           **“(5) FAILURE TO REPORT OR DISCLOSE**  
14       **INFORMATION.—**

15           **“(A) REPORTING.—Any person who**  
16       **is required, but fails, to meet a re-**  
17       **porting requirement of paragraphs**  
18       **(1) and (2)(A) of subsection (f) is sub-**  
19       **ject to a civil money penalty of not**  
20       **more than \$10,000 for each day for**  
21       **which reporting is required to have**  
22       **been made.**

23           **“(B) DISCLOSURE.—Any physician**  
24       **who is required, but fails, to meet a**  
25       **disclosure requirement of subsection**

1           **(f)(2)(B) or a hospital that is required,**  
2           **but fails, to meet a disclosure require-**  
3           **ment of subsection (f)(2)(C) is subject**  
4           **to a civil money penalty of not more**  
5           **than \$10,000 for each case in which**  
6           **disclosure is required to have been**  
7           **made.**

8           **“(C) APPLICATION.—The provisions**  
9           **of section 1128A (other than the first**  
10           **sentence of subsection (a) and other**  
11           **than subsection (b)) shall apply to a**  
12           **civil money penalty under subpara-**  
13           **graphs (A) and (B) in the same man-**  
14           **ner as such provisions apply to a pen-**  
15           **alty or proceeding under section**  
16           **1128A(a).”;** and

17           **(5) by adding at the end the following**  
18           **new subsection:**

19           **“(i) REQUIREMENTS TO QUALIFY FOR RURAL**  
20           **PROVIDER AND HOSPITAL OWNERSHIP EXCEP-**  
21           **TIONS TO SELF-REFERRAL PROHIBITION.—**

22           **“(1) REQUIREMENTS DESCRIBED.—For**  
23           **purposes of subsection (d)(3)(D), the re-**  
24           **quirements described in this paragraph**  
25           **are as follows:**

1           **“(A) PROVIDER AGREEMENT.—The**  
2           **hospital had—**

3                   **“(i) physician ownership or**  
4                   **investment on January 1, 2009;**  
5                   **and**

6                   **“(ii) a provider agreement**  
7                   **under section 1866 in effect on**  
8                   **such date.**

9           **“(B) PROHIBITION ON PHYSICIAN**  
10           **OWNERSHIP OR INVESTMENT.—The per-**  
11           **centage of the total value of the own-**  
12           **ership or investment interests held in**  
13           **the hospital, or in an entity whose as-**  
14           **sets include the hospital, by physi-**  
15           **cian owners or investors in the aggre-**  
16           **gate does not exceed such percentage**  
17           **as of the date of enactment of this**  
18           **subsection.**

19           **“(C) PROHIBITION ON EXPANSION OF**  
20           **FACILITY CAPACITY.—Except as pro-**  
21           **vided in paragraph (2), the number of**  
22           **operating rooms, procedure rooms, or**  
23           **beds of the hospital at any time on or**  
24           **after the date of the enactment of this**  
25           **subsection are no greater than the**

1           **number of operating rooms, proce-**  
2           **dure rooms, or beds, respectively, as**  
3           **of such date.**

4           **“(D) ENSURING BONA FIDE OWNER-**  
5           **SHIP AND INVESTMENT.—**

6           **“(i) Any ownership or invest-**  
7           **ment interests that the hospital**  
8           **offers to a physician are not of-**  
9           **fered on more favorable terms**  
10          **than the terms offered to a person**  
11          **who is not in a position to refer**  
12          **patients or otherwise generate**  
13          **business for the hospital.**

14          **“(ii) The hospital (or any in-**  
15          **vestors in the hospital) does not**  
16          **directly or indirectly provide**  
17          **loans or financing for any physi-**  
18          **cian owner or investor in the hos-**  
19          **pital.**

20          **“(iii) The hospital (or any in-**  
21          **vestors in the hospital) does not**  
22          **directly or indirectly guarantee a**  
23          **loan, make a payment toward a**  
24          **loan, or otherwise subsidize a**  
25          **loan, for any physician owner or**

1 investor or group of physician  
2 owners or investors that is re-  
3 lated to acquiring any ownership  
4 or investment interest in the hos-  
5 pital.

6 “(iv) Ownership or investment  
7 returns are distributed to each  
8 owner or investor in the hospital  
9 in an amount that is directly pro-  
10 portional to the ownership or in-  
11 vestment interest of such owner  
12 or investor in the hospital.

13 “(v) The investment interest  
14 of the owner or investor is di-  
15 rectly proportional to the owner’s  
16 or investor’s capital contributions  
17 made at the time the ownership  
18 or investment interest is ob-  
19 tained.

20 “(vi) Physician owners and in-  
21 vestors do not receive, directly or  
22 indirectly, any guaranteed receipt  
23 of or right to purchase other busi-  
24 ness interests related to the hos-  
25 pital, including the purchase or

1           **lease of any property under the**  
2           **control of other owners or inves-**  
3           **tors in the hospital or located**  
4           **near the premises of the hospital.**

5           **“(vii) The hospital does not**  
6           **offer a physician owner or inves-**  
7           **tor the opportunity to purchase**  
8           **or lease any property under the**  
9           **control of the hospital or any**  
10          **other owner or investor in the**  
11          **hospital on more favorable terms**  
12          **than the terms offered to a person**  
13          **that is not a physician owner or**  
14          **investor.**

15          **“(viii) The hospital does not**  
16          **condition any physician owner-**  
17          **ship or investment interests ei-**  
18          **ther directly or indirectly on the**  
19          **physician owner or investor mak-**  
20          **ing or influencing referrals to the**  
21          **hospital or otherwise generating**  
22          **business for the hospital.**

23          **“(E) PATIENT SAFETY.—In the case**  
24          **of a hospital that does not offer emer-**

1           **gency services, the hospital has the**  
2           **capacity to—**

3                   **“(i) provide assessment and**  
4                   **initial treatment for medical**  
5                   **emergencies; and**

6                   **“(ii) if the hospital lacks addi-**  
7                   **tional capabilities required to**  
8                   **treat the emergency involved,**  
9                   **refer and transfer the patient**  
10                  **with the medical emergency to a**  
11                  **hospital with the required capa-**  
12                  **bility.**

13                  **“(F) LIMITATION ON APPLICATION TO**  
14                  **CERTAIN CONVERTED FACILITIES.—The**  
15                  **hospital was not converted from an**  
16                  **ambulatory surgical center to a hos-**  
17                  **pital on or after the date of enact-**  
18                  **ment of this subsection.**

19                  **“(2) EXCEPTION TO PROHIBITION ON EX-**  
20                  **PANSION OF FACILITY CAPACITY.—**

21                   **“(A) PROCESS.—**

22                   **“(i) ESTABLISHMENT.—The Sec-**  
23                   **retary shall establish and imple-**  
24                   **ment a process under which a**  
25                   **hospital may apply for an excep-**



1           **tion from the requirement under**  
2           **paragraph (1)(C).**

3           **“(ii) OPPORTUNITY FOR COMMU-**  
4           **NITY INPUT.—The process under**  
5           **clause (i) shall provide persons**  
6           **and entities in the community in**  
7           **which the hospital applying for**  
8           **an exception is located with the**  
9           **opportunity to provide input with**  
10          **respect to the application.**

11          **“(iii) TIMING FOR IMPLEMENTA-**  
12          **TION.—The Secretary shall imple-**  
13          **ment the process under clause (i)**  
14          **on the date that is one month**  
15          **after the promulgation of regula-**  
16          **tions described in clause (iv).**

17          **“(iv) REGULATIONS.—Not later**  
18          **than the first day of the month**  
19          **beginning 18 months after the**  
20          **date of the enactment of this sub-**  
21          **section, the Secretary shall pro-**  
22          **mulgate regulations to carry out**  
23          **the process under clause (i). The**  
24          **Secretary may issue such regula-**  
25          **tions as interim final regulations.**

1           **“(B) FREQUENCY.—**The process de-  
2           **scribed in subparagraph (A) shall per-**  
3           **mit a hospital to apply for an excep-**  
4           **tion up to once every 2 years.**

5           **“(C) PERMITTED INCREASE.—**

6           **“(i) IN GENERAL.—**Subject to  
7           **clause (ii) and subparagraph (D),**  
8           **a hospital granted an exception**  
9           **under the process described in**  
10          **subparagraph (A) may increase**  
11          **the number of operating rooms,**  
12          **procedure rooms, or beds of the**  
13          **hospital above the baseline num-**  
14          **ber of operating rooms, procedure**  
15          **rooms, or beds, respectively, of**  
16          **the hospital (or, if the hospital**  
17          **has been granted a previous ex-**  
18          **ception under this paragraph,**  
19          **above the number of operating**  
20          **rooms, procedure rooms, or beds,**  
21          **respectively, of the hospital after**  
22          **the application of the most recent**  
23          **increase under such an excep-**  
24          **tion).**

1           **“(ii) 100 PERCENT INCREASE**  
2           **LIMITATION.—The Secretary shall**  
3           **not permit an increase in the**  
4           **number of operating rooms, pro-**  
5           **cedure rooms, or beds of a hos-**  
6           **pital under clause (i) to the extent**  
7           **such increase would result in the**  
8           **number of operating rooms, pro-**  
9           **cedure rooms, or beds of the hos-**  
10           **pital exceeding 200 percent of the**  
11           **baseline number of operating**  
12           **rooms, procedure rooms, or beds**  
13           **of the hospital.**

14           **“(iii) BASELINE NUMBER OF OP-**  
15           **ERATING ROOMS, PROCEDURE**  
16           **ROOMS, OR BEDS.—In this para-**  
17           **graph, the term ‘baseline number**  
18           **of operating rooms, procedure**  
19           **rooms, or beds’ means the number**  
20           **of operating rooms, procedure**  
21           **rooms, or beds of a hospital as of**  
22           **the date of enactment of this sub-**  
23           **section.**

24           **“(D) INCREASE LIMITED TO FACILI-**  
25           **TIES ON THE MAIN CAMPUS OF THE HOS-**

1           **PITAL.—Any increase in the number of**  
2           **operating rooms, procedure rooms, or**  
3           **beds of a hospital pursuant to this**  
4           **paragraph may only occur in facili-**  
5           **ties on the main campus of the hos-**  
6           **pital.**

7           **“(E) CONDITIONS FOR APPROVAL OF**  
8           **AN INCREASE IN FACILITY CAPACITY.—**  
9           **The Secretary may grant an excep-**  
10          **tion under the process described in**  
11          **subparagraph (A) only to a hospital—**

12               **“(i) that is located in a county**  
13               **in which the percentage increase**  
14               **in the population during the most**  
15               **recent 5-year period for which**  
16               **data are available is estimated to**  
17               **be at least 150 percent of the per-**  
18               **centage increase in the popu-**  
19               **lation growth of the State in**  
20               **which the hospital is located dur-**  
21               **ing that period, as estimated by**  
22               **Bureau of the Census and avail-**  
23               **able to the Secretary;**

24               **“(ii) whose annual percent of**  
25               **total inpatient admissions that**

1 represent inpatient admissions  
2 under the program under title  
3 XIX is estimated to be equal to or  
4 greater than the average percent  
5 with respect to such admissions  
6 for all hospitals located in the  
7 county in which the hospital is lo-  
8 cated;

9 “(iii) that does not discrimi-  
10 nate against beneficiaries of Fed-  
11 eral health care programs and  
12 does not permit physicians prac-  
13 ticing at the hospital to discrimi-  
14 nate against such beneficiaries;

15 “(iv) that is located in a State  
16 in which the average bed capacity  
17 in the State is estimated to be less  
18 than the national average bed ca-  
19 pacity;

20 “(v) that has an average bed  
21 occupancy rate that is estimated  
22 to be greater than the average  
23 bed occupancy rate in the State  
24 in which the hospital is located;  
25 and

1           “(vi) that meets other condi-  
2           tions as determined by the Sec-  
3           retary.

4           “(F) PROCEDURE ROOMS.—In this  
5           subsection, the term ‘procedure  
6           rooms’ includes rooms in which cath-  
7           eterizations,                   angiographies,  
8           angiograms, and endoscopies are fur-  
9           nished, but such term shall not in-  
10          clude emergency rooms or depart-  
11          ments (except for rooms in which  
12          catheterizations,           angiographies,  
13          angiograms, and endoscopies are fur-  
14          nished).

15          “(G) PUBLICATION OF FINAL DECI-  
16          SIONS.—Not later than 120 days after  
17          receiving a complete application  
18          under this paragraph, the Secretary  
19          shall publish on the public Internet  
20          website of the Centers for Medicare &  
21          Medicaid Services the final decision  
22          with respect to such application.

23          “(H) LIMITATION ON REVIEW.—  
24          There shall be no administrative or  
25          judicial review under section 1869,

1 section 1878, or otherwise of the ex-  
2 ception process under this para-  
3 graph, including the establishment of  
4 such process, and any determination  
5 made under such process.

6 **“(3) PHYSICIAN OWNER OR INVESTOR DE-  
7 FINED.—For purposes of this subsection  
8 and subsection (f)(2), the term ‘physician  
9 owner or investor’ means a physician (or  
10 an immediate family member of such  
11 physician) with a direct or an indirect  
12 ownership or investment interest in the  
13 hospital.**

14 **“(4) PATIENT SAFETY REQUIREMENT.—In  
15 the case of a hospital to which the re-  
16 quirements of paragraph (1) apply, inso-  
17 far as the hospital admits a patient and  
18 does not have any physician available on  
19 the premises 24 hours per day, 7 days per  
20 week, before admitting the patient—**

21 **“(A) the hospital shall disclose  
22 such fact to the patient; and**

23 **“(B) following such disclosure, the  
24 hospital shall receive from the pa-**

1           **tient a signed acknowledgment that**  
2           **the patient understands such fact.**

3           **“(5) CLARIFICATION.—Nothing in this**  
4           **subsection shall be construed as pre-**  
5           **venting the Secretary from terminating a**  
6           **hospital’s provider agreement if the hos-**  
7           **pital is not in compliance with regula-**  
8           **tions pursuant to section 1866.”.**

9           **(b) VERIFYING COMPLIANCE.—The Sec-**  
10          **retary of Health and Human Services shall es-**  
11          **tablish policies and procedures to verify com-**  
12          **pliance with the requirements described in**  
13          **subsections (i)(1) and (i)(4) of section 1877 of**  
14          **the Social Security Act, as added by sub-**  
15          **section (a)(5). The Secretary may use unan-**  
16          **nounced site reviews of hospitals and audits**  
17          **to verify compliance with such requirements.**

18          **(c) IMPLEMENTATION.—**

19               **(1) FUNDING.—For purposes of car-**  
20               **rying out the amendments made by sub-**  
21               **section (a) and the provisions of sub-**  
22               **section (b), in addition to funds otherwise**  
23               **available, out of any funds in the Treas-**  
24               **ury not otherwise appropriated there are**  
25               **appropriated to the Secretary of Health**



1       **and Human Services for the Centers for**  
2       **Medicare & Medicaid Services Program**  
3       **Management Account \$5,000,000 for each**  
4       **fiscal year beginning with fiscal year**  
5       **2010. Amounts appropriated under this**  
6       **paragraph for a fiscal year shall be avail-**  
7       **able until expended.**

8               **(2) ADMINISTRATION.—Chapter 35 of**  
9       **title 44, United States Code, shall not**  
10       **apply to the amendments made by sub-**  
11       **section (a) and the provisions of sub-**  
12       **section (b).**

13       **SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEO-**  
14               **GRAPHIC ADJUSTMENT FACTORS UNDER**  
15               **MEDICARE.**

16       **(a) IN GENERAL.—The Secretary of Health**  
17       **and Human Services shall enter into a con-**  
18       **tract with the Institute of Medicine of the Na-**  
19       **tional Academy of Science to conduct a com-**  
20       **prehensive empirical study, and provide rec-**  
21       **ommendations as appropriate, on the accu-**  
22       **racy of the geographic adjustment factors es-**  
23       **tablished under sections 1848(e) and**  
24       **1886(d)(3)(E) of the Social Security Act (42**  
25       **U.S.C. 1395w–4(e), 11395ww(d)(3)).**

1       **(b) MATTERS INCLUDED.—Such study shall**  
2 **include an evaluation and assessment of the**  
3 **following with respect to such adjustment fac-**  
4 **tors:**

5           **(1) Empirical validity of the adjust-**  
6 **ment factors.**

7           **(2) Methodology used to determine**  
8 **the adjustment factors.**

9           **(3) Measures used for the adjustment**  
10 **factors, taking into account—**

11               **(A) timeliness of data and fre-**  
12 **quency of revisions to such data;**

13               **(B) sources of data and the degree**  
14 **to which such data are representative**  
15 **of costs; and**

16               **(C) operational costs of providers**  
17 **who participate in Medicare.**

18       **(c) EVALUATION.—Such study shall, within**  
19 **the context of the United States health care**  
20 **marketplace, evaluate and consider the fol-**  
21 **lowing:**

22           **(1) The effect of the adjustment fac-**  
23 **tors on the level and distribution of the**  
24 **health care workforce and resources, in-**  
25 **cluding—**

1           **(A) recruitment and retention**  
2           **that takes into account workforce**  
3           **mobility between urban and rural**  
4           **areas;**

5           **(B) ability of hospitals and other**  
6           **facilities to maintain an adequate and**  
7           **skilled workforce; and**

8           **(C) patient access to providers**  
9           **and needed medical technologies.**

10          **(2) The effect of the adjustment fac-**  
11          **tors on population health and quality of**  
12          **care.**

13          **(3) The effect of the adjustment fac-**  
14          **tors on the ability of providers to furnish**  
15          **efficient, high value care.**

16          **(d) REPORT.—The contract under sub-**  
17          **section (a) shall provide for the Institute of**  
18          **Medicine to submit, not later than one year**  
19          **after the date of the enactment of this Act, to**  
20          **the Secretary and the Congress a report con-**  
21          **taining results and recommendations of the**  
22          **study conducted under this section.**

23          **(e) FUNDING.—There are authorized to be**  
24          **appropriated to carry out this section such**  
25          **sums as may be necessary.**

1 SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO  
2 ADDRESS GEOGRAPHIC INEQUITIES.

3 (a) REVISION OF MEDICARE PAYMENT SYS-  
4 TEMS.—Taking into account the recommenda-  
5 tions described in the report under section  
6 1157, and notwithstanding the geographic ad-  
7 justments that would otherwise apply under  
8 section 1848(e) and section 1886(d)(3)(E) of  
9 the Social Security Act ((42 U.S.C. 1395w-4,  
10 1395ww(d)), the Secretary of Health and  
11 Human Services shall include in proposed  
12 rules applicable to the rulemaking cycle for  
13 payment systems for physicians' services and  
14 inpatient hospital services under sections  
15 1848 and section 1886(d) of such Act, respec-  
16 tively, proposals (as the Secretary determines  
17 to be appropriate) to revise the geographic  
18 adjustment factors used in such systems. Such  
19 proposals' rules shall be contained in the next  
20 rulemaking cycle following the submission to  
21 the Secretary of the report described in sec-  
22 tion 1157.

23 (b) PAYMENT ADJUSTMENTS.—

24 (1) FUNDING FOR IMPROVEMENTS.—The  
25 Secretary shall use funds as provided  
26 under subsection (c) in making changes

1 to the geographic adjustment factors pur-  
2 suant to subsection (a). In making such  
3 changes to such geographic adjustment  
4 factors, the Secretary shall ensure that  
5 the estimated increased expenditures re-  
6 sulting from such changes does not ex-  
7 ceed the amounts provided under sub-  
8 section (c).

9 (2) ENSURING FAIRNESS.—In carrying  
10 out this subsection, the Secretary shall  
11 not reduce the geographic adjustment  
12 below the factor that applied for such  
13 payment system in the payment year be-  
14 fore such changes.

15 (c) FUNDING.—Amounts in the Medicare  
16 Improvement Fund under section 1898, as  
17 amended by section 1146, shall be available to  
18 the Secretary to make changes to the geo-  
19 graphic adjustments factors as described in  
20 subsections (a) and (b) with respect to serv-  
21 ices furnished before January 1, 2014. No  
22 more than one-half of such amounts shall be  
23 available with respect to services furnished in  
24 any one payment year.

1 SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEO-  
2 GRAPHIC VARIATION IN HEALTH CARE  
3 SPENDING AND PROMOTING HIGH-VALUE  
4 HEALTH CARE.

5 (a) IN GENERAL.—The Secretary of Health  
6 and Human Services shall enter into an agree-  
7 ment with the Institutes of Medicine of the  
8 National Academies (referred to in this sec-  
9 tion as the “Institute”) to conduct a study on  
10 geographic variation in per capita health care  
11 spending among both the Medicare and pri-  
12 vately insured populations. Such study shall  
13 include each of the following:

14 (1) An evaluation of the extent and  
15 range of such variation using various  
16 units of geographic measurement.

17 (2) The extent to which geographic  
18 variation can be attributed to differences  
19 in input prices, practice patterns, access  
20 to medical services, supply of medical  
21 services, socio-economic factors, and pro-  
22 vider organizational models.

23 (3) The extent to which variations in  
24 spending are correlated with patient ac-  
25 cess to care, distribution of health care

1       **resources, and consensus-based measures**  
2       **of health care quality.**

3           **(4) The extent to which variation can**  
4       **be attributed to physician and practi-**  
5       **tioner discretion in making treatment de-**  
6       **isions, and the degree to which discre-**  
7       **tionary treatment decisions are made**  
8       **that could be characterized as different**  
9       **from the best available medical evidence.**

10          **(5) An assessment of the degree to**  
11       **which variation cannot be explained by**  
12       **empirical evidence.**

13          **(6) Other factors the Institute deems**  
14       **appropriate.**

15       **(b) RECOMMENDATIONS.—Taking into ac-**  
16       **count the findings under subsection (a), the**  
17       **Institute shall recommend strategies for ad-**  
18       **ressing variation in per capita spending by**  
19       **promoting high-value care (as defined in sub-**  
20       **section (e)). In making such recommenda-**  
21       **tions, the Institute shall consider each of the**  
22       **following:**

23           **(1) Measurement and reporting on**  
24       **quality and population health.**

1           **(2) Reducing fragmented and duplica-**  
2           **tive care.**

3           **(3) Promoting the practice of evi-**  
4           **dence-based medicine.**

5           **(4) Empowering patients to make**  
6           **value-based care decisions.**

7           **(5) Leveraging the use of health infor-**  
8           **mation technology.**

9           **(6) The role of financial and other in-**  
10          **centives.**

11          **(7) Other topics the Institute deems**  
12          **appropriate.**

13          **(c) SPECIFIC CONSIDERATIONS.—In making**  
14          **the recommendations under subsection (b),**  
15          **the Institute shall specifically address wheth-**  
16          **er payment systems under title XVIII of the**  
17          **Social Security Act for physicians and hos-**  
18          **pitals should be further modified to**  
19          **incentivize high-value care. In so doing, the**  
20          **Institute shall consider the adoption of a**  
21          **value index based on a composite of appro-**  
22          **priate measures of quality and cost that**  
23          **would adjust provider payments on a regional**  
24          **or provider-level basis. If the Institute finds**  
25          **that application of such a value index would**



1 significantly incentivize providers to furnish  
2 high-value care, it shall make specific rec-  
3 ommendations on how such an index would  
4 be designed and implemented. In so doing, it  
5 should identify specific measures of quality  
6 and cost appropriate for use in such an index,  
7 and include a thorough analysis (including on  
8 a geographic basis) of how payments and  
9 spending under such title would be affected  
10 by such an index.

11 (d) REPORT.—Not later than three years  
12 after the date of the enactment of this Act, the  
13 Institute shall submit to Congress a report  
14 containing findings and recommendations of  
15 the study conducted under this section.

16 (e) HIGH-VALUE CARE DEFINED.—For pur-  
17 poses of this section, the term “high-value  
18 care” means the efficient delivery of high  
19 quality, evidence-based, patient-centered  
20 care.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—  
22 There is authorized to be appropriated such  
23 sums as are necessary to carry out this sec-  
24 tion. Such sums are authorized to remain  
25 available until expended.

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**  
7       **U.S.C. 1395w-23) is amended—**

8                       **(1) in subsection (j)(1)(A)—**

9                               **(A) by striking “beginning with**  
10                               **2007” and inserting “for 2007, 2008,**  
11                               **2009, and 2010”; and**

12                               **(B) by inserting after “(k)(1)” the**  
13                               **following: “, or, beginning with 2011,**  
14                                **$\frac{1}{12}$  of the blended benchmark amount**  
15                               **determined under subsection (n)(1)”;**  
16                               **and**

17                               **(2) by adding at the end the following**  
18                               **new subsection:**

19                               **“(n) DETERMINATION OF BLENDED BENCH-**  
20       **MARK AMOUNT.—**

21                               **“(1) IN GENERAL.—For purposes of sub-**  
22                               **section (j), subject to paragraphs (3) and**  
23                               **(4), the term ‘blended benchmark amount’**  
24                               **means for an area—**

25                                       **“(A) for 2011 the sum of—**

1           “(i)  $\frac{2}{3}$  of the applicable  
2           amount (as defined in subsection  
3           (k)) for the area and year; and

4           “(ii)  $\frac{1}{3}$  of the amount speci-  
5           fied in paragraph (2) for the area  
6           and year;

7           “(B) for 2012 the sum of—

8           “(i)  $\frac{1}{3}$  of the applicable  
9           amount for the area and year; and

10           “(ii)  $\frac{2}{3}$  of the amount speci-  
11           fied in paragraph (2) for the area  
12           and year; and

13           “(C) for a subsequent year the  
14           amount specified in paragraph (2) for  
15           the area and year.

16           “(2) SPECIFIED AMOUNT.—The amount  
17           specified in this paragraph for an area  
18           and year is the amount specified in sub-  
19           section (c)(1)(D)(i) for the area and year  
20           adjusted (in a manner specified by the  
21           Secretary) to take into account the  
22           phase-out in the indirect costs of medical  
23           education from capitation rates de-  
24           scribed in subsection (k)(4).

1           **“(3) FEE-FOR-SERVICE PAYMENT**  
2           **FLOOR.—In no case shall the blended**  
3           **benchmark amount for an area and year**  
4           **be less than the amount specified in para-**  
5           **graph (2).**

6           **“(4) EXCEPTION FOR PACE PLANS.—This**  
7           **subsection shall not apply to payments to**  
8           **a PACE program under section 1894.”.**

9   **SEC. 1162. QUALITY BONUS PAYMENTS.**

10          **(a) IN GENERAL.—Section 1853 of the So-**  
11          **cial Security Act (42 U.S.C. 1395w-23), as**  
12          **amended by section 1161, is amended—**

13                 **(1) in subsection (j), by inserting “sub-**  
14                 **ject to subsection (o),” after “For pur-**  
15                 **poses of this part,”; and**

16                 **(2) by adding at the end the following**  
17                 **new subsection:**

18                 **“(o) QUALITY BASED PAYMENT ADJUST-**  
19                 **MENT.—**

20                         **“(1) IN GENERAL.—In the case of a**  
21                         **qualifying plan in a qualifying county**  
22                         **with respect to a year beginning with**  
23                         **2011, the blended benchmark amount**  
24                         **under subsection (n)(1) shall be in-**  
25                         **creased—**

1           “(A) for 2011, by 2.6 percent;  
2           “(B) for 2012, by 5.3 percent; and  
3           “(C) for a subsequent year, by 8.0  
4           percent.

5           “(2) QUALIFYING PLAN AND QUALIFYING  
6           COUNTY DEFINED.—For purposes of this  
7           subsection:

8           “(A) QUALIFYING PLAN.—The term  
9           ‘qualifying plan’ means, for a year  
10           and subject to paragraph (4), a plan  
11           that, in a preceding year specified by  
12           the Secretary, had a quality ranking  
13           (based on the quality ranking system  
14           established by the Centers for Medi-  
15           care & Medicaid Services for Medi-  
16           care Advantage plans) of 4 stars or  
17           higher.

18           “(B) QUALIFYING COUNTY.—The  
19           term ‘qualifying county’ means, for a  
20           year, a county—

21           “(i) that ranked within the  
22           lowest quartile of counties in the  
23           amount specified in subsection  
24           (n)(2) for the year specified by the

1           **Secretary under subparagraph**  
2           **(A); and**

3           **“(ii) for which, as of June of**  
4           **such specified year, of the Medi-**  
5           **care Advantage eligible individ-**  
6           **uals residing in the county—**

7           **“(I) at least 50 percent of**  
8           **such individuals were en-**  
9           **rolled in Medicare Advantage**  
10           **plans; and**

11           **“(II) of the residents so en-**  
12           **rolled at least 50 percent of**  
13           **such individuals were en-**  
14           **rolled in such plans with a**  
15           **quality ranking (based on the**  
16           **quality ranking system estab-**  
17           **lished by the Centers for**  
18           **Medicare & Medicaid Services**  
19           **for Medicare Advantage**  
20           **plans) of 4 stars or higher.**

21           **“(3) NOTIFICATION.—The Secretary, in**  
22           **the annual announcement required**  
23           **under subsection (b)(1)(B) in 2010 and**  
24           **each succeeding year, shall notify the**  
25           **Medicare Advantage organization that is**

1 offering a qualifying plan in a qualifying  
2 county of such identification for the year.  
3 The Secretary shall provide for publica-  
4 tion on the website for the Medicare pro-  
5 gram of the information described in the  
6 previous sentence.

7 “(4) **AUTHORITY TO DISQUALIFY DEFICI-**  
8 **CIENT PLANS.—**The Secretary may deter-  
9 mine that a Medicare Advantage plan is  
10 not a qualifying plan if the Secretary has  
11 identified deficiencies in the plan’s com-  
12 pliance with rules for Medicare Advan-  
13 tage plans under this part.”.

14 **SEC. 1163. EXTENSION OF SECRETARIAL CODING INTEN-**  
15 **SITY ADJUSTMENT AUTHORITY.**

16 **Section 1853(a)(1)(C)(ii) of the Social Se-**  
17 **curity Act (42 U.S.C. 1395w-23(a)(1)(C)(ii) is**  
18 **amended—**

19 (1) in the matter before subclause (I),  
20 by striking “through 2010” and inserting  
21 “and each subsequent year”; and

22 (2) in subclause (II)—

23 (A) by inserting “periodically” be-  
24 fore “conduct an analysis”;

1           **(B) by inserting “on a timely**  
2           **basis” after “are incorporated”; and**

3           **(C) by striking “only for 2008,**  
4           **2009, and 2010” and inserting “for**  
5           **2008 and subsequent years”.**

6 **SEC. 1164. SIMPLIFICATION OF ANNUAL BENEFICIARY**  
7           **ELECTION PERIODS.**

8           **(a) 2 WEEK PROCESSING PERIOD FOR AN-**  
9           **NUAL ENROLLMENT PERIOD (AEP).—Paragraph**  
10           **(3)(B) of section 1851(e) of the Social Security**  
11           **Act (42 U.S.C. 1395w–21(e)) is amended—**

12           **(1) by striking “and” at the end of**  
13           **clause (iii);**

14           **(2) in clause (iv)—**

15           **(A) by striking “and succeeding**  
16           **years” and inserting “, 2008, 2009, and**  
17           **2010”; and**

18           **(B) by striking the period at the**  
19           **end and inserting “; and”; and**

20           **(3) by adding at the end the following**  
21           **new clause:**

22           **“(v) with respect to 2011 and**  
23           **succeeding years, the period be-**  
24           **ginning on November 1 and end-**



1           **ing on December 15 of the year**  
2           **before such year.”.**

3           **(b) ELIMINATION OF 3-MONTH ADDITIONAL**  
4 **OPEN ENROLLMENT PERIOD (OEP).—Effective**  
5 **for plan years beginning with 2011, paragraph**  
6 **(2) of such section is amended by striking sub-**  
7 **paragraph (C).**

8 **SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.**

9           **Section 1876(h)(5)(C) of the Social Secu-**  
10 **rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amend-**  
11 **ed—**

12           **(1) in clause (ii), by striking “January**  
13 **1, 2010” and inserting “January 1, 2012”;**  
14 **and**

15           **(2) in clause (iii), by striking “the**  
16 **service area for the year” and inserting**  
17 **“the portion of the plan’s service area for**  
18 **the year that is within the service area of**  
19 **a reasonable cost reimbursement con-**  
20 **tract”.**

21 **SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EM-**  
22 **PLOYER GROUP PLANS.**

23           **(a) IN GENERAL.—The first sentence of**  
24 **paragraph (2) of section 1857(i) of the Social**  
25 **Security Act (42 U.S.C. 1395w-27(i)) is amend-**

1 ed by inserting before the period at the end  
2 the following: “, but only if 90 percent of the  
3 Medicare Advantage eligible individuals en-  
4 rolled under such plan reside in a county in  
5 which the MA organization offers an MA local  
6 plan”.

7 (b) **EFFECTIVE DATE.**—The amendment  
8 made by subsection (a) shall apply for plan  
9 years beginning on or after January 1, 2011,  
10 and shall not apply to plans which were in ef-  
11 fect as of December 31, 2010.

12 **SEC. 1167. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.**

13 (a) **REPORT TO CONGRESS.**—Not later than  
14 1 year after the date of the enactment of this  
15 Act, the Secretary of Health and Human Serv-  
16 ices shall submit to Congress a report that  
17 evaluates the adequacy of the risk adjustment  
18 system under section 1853(a)(1)(C) of the So-  
19 cial Security Act (42 U.S.C. 1395–23(a)(1)(C))  
20 in predicting costs for beneficiaries with  
21 chronic or co-morbid conditions, beneficiaries  
22 dually-eligible for Medicare and Medicaid,  
23 and non-Medicaid eligible low-income bene-  
24 ficiaries; and the need and feasibility of in-

1 **cluding further gradations of diseases or con-**  
2 **ditions and multiple years of beneficiary data.**

3 **(b) IMPROVEMENTS TO RISK ADJUSTMENT.—**  
4 **Not later than January 1, 2012, the Secretary**  
5 **shall implement necessary improvements to**  
6 **the risk adjustment system under section**  
7 **1853(a)(1)(C) of the Social Security Act (42**  
8 **U.S.C. 1395–23(a)(1)(C)), taking into account**  
9 **the evaluation under subsection (a).**

10 **SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STA-**  
11 **BILIZATION FUND.**

12 **(a) IN GENERAL.—Section 1858 of the So-**  
13 **cial Security Act (42 U.S.C. 1395w–27a) is**  
14 **amended by striking subsection (e).**

15 **(b) TRANSITION.—Any amount contained in**  
16 **the MA Regional Plan Stabilization Fund as of**  
17 **the date of the enactment of this Act shall be**  
18 **transferred to the Federal Supplementary**  
19 **Medical Insurance Trust Fund.**

1 **PART 2—BENEFICIARY PROTECTIONS AND ANTI-**  
2 **FRAUD**

3 **SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL**  
4 **HEALTH SERVICES.**

5 **(a) IN GENERAL.—Section 1852(a)(1) of the**  
6 **Social Security Act (42 U.S.C. 1395w–22(a)(1))**  
7 **is amended—**

8 **(1) in subparagraph (A), by inserting**  
9 **before the period at the end the fol-**  
10 **lowing: “with cost-sharing that is no**  
11 **greater (and may be less) than the cost-**  
12 **sharing that would otherwise be imposed**  
13 **under such program option”;**

14 **(2) in subparagraph (B)(i), by striking**  
15 **“or an actuarially equivalent level of**  
16 **cost-sharing as determined in this part”;**  
17 **and**

18 **(3) by amending clause (ii) of sub-**  
19 **paragraph (B) to read as follows:**

20 **“(ii) PERMITTING USE OF FLAT**  
21 **COPAYMENT OR PER DIEM RATE.—**  
22 **Nothing in clause (i) shall be con-**  
23 **strued as prohibiting a Medicare**  
24 **Advantage plan from using a flat**  
25 **copayment or per diem rate, in**  
26 **lieu of the cost-sharing that**

1           **would be imposed under part A or**  
2           **B, so long as the amount of the**  
3           **cost-sharing imposed does not ex-**  
4           **ceed the amount of the cost-shar-**  
5           **ing that would be imposed under**  
6           **the respective part if the indi-**  
7           **vidual were not enrolled in a plan**  
8           **under this part.”.**

9           **(b) LIMITATION FOR DUAL ELIGIBLES AND**  
10          **QUALIFIED MEDICARE BENEFICIARIES.—Section**  
11          **1852(a)(7) of such Act is amended to read as**  
12          **follows:**

13               **“(7) LIMITATION ON COST-SHARING FOR**  
14               **DUAL ELIGIBLES AND QUALIFIED MEDICARE**  
15               **BENEFICIARIES.—In the case of a indi-**  
16               **vidual who is a full-benefit dual eligible**  
17               **individual (as defined in section**  
18               **1935(c)(6)) or a qualified medicare bene-**  
19               **ficiary (as defined in section 1905(p)(1))**  
20               **who is enrolled in a Medicare Advantage**  
21               **plan, the plan may not impose cost-shar-**  
22               **ing that exceeds the amount of cost-shar-**  
23               **ing that would be permitted with respect**  
24               **to the individual under this title and title**

1 **XIX if the individual were not enrolled**  
2 **with such plan.”.**

3 **(c) EFFECTIVE DATES.—**

4 **(1) The amendments made by sub-**  
5 **section (a) shall apply to plan years be-**  
6 **ginning on or after January 1, 2011.**

7 **(2) The amendments made by sub-**  
8 **section (b) shall apply to plan years be-**  
9 **ginning on or after January 1, 2011.**

10 **SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLL-**  
11 **EES IN PLANS WITH ENROLLMENT SUSPEN-**  
12 **SION.**

13 **Section 1851(e)(4) of the Social Security**  
14 **Act (42 U.S.C. 1395w(e)(4)) is amended—**

15 **(1) in subparagraph (C), by striking at**  
16 **the end “or”;**

17 **(2) in subparagraph (D)—**

18 **(A) by inserting “, taking into ac-**  
19 **count the health or well-being of the**  
20 **individual” before the period; and**

21 **(B) by redesignating such sub-**  
22 **paragraph as subparagraph (E); and**

23 **(3) by inserting after subparagraph**  
24 **(C) the following new subparagraph:**

1           **“(D) the individual is enrolled in**  
2           **an MA plan and enrollment in the**  
3           **plan is suspended under paragraph**  
4           **(2)(B) or (3)(C) of section 1857(g) be-**  
5           **cause of a failure of the plan to meet**  
6           **applicable requirements; or”.**

7   **SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN**  
8           **ADMINISTRATIVE COSTS.**

9           **(a) DISCLOSURE OF MEDICAL LOSS RATIOS**  
10   **AND OTHER EXPENSE DATA.—Section 1851 of**  
11   **the Social Security Act (42 U.S.C. 1395w–21),**  
12   **as previously amended by this subtitle, is**  
13   **amended by adding at the end the following**  
14   **new subsection:**

15           **“(p) PUBLICATION OF MEDICAL LOSS RATIOS**  
16   **AND OTHER COST-RELATED INFORMATION.—**

17           **“(1) IN GENERAL.—The Secretary shall**  
18           **publish, not later than November 1 of**  
19           **each year (beginning with 2011), for each**  
20           **MA plan contract, the medical loss ratio**  
21           **of the plan in the previous year.**

22           **“(2) SUBMISSION OF DATA.—**

23           **“(A) IN GENERAL.—Each MA orga-**  
24           **nization shall submit to the Sec-**  
25           **retary, in a form and manner speci-**

1           **fi**ed by the Secretary, data necessary  
2           **for** the Secretary to publish the med-  
3           **ical** loss ratio on a timely basis.

4           **“(B) DATA FOR 2010 AND 2011.—**The  
5           **data** submitted under subparagraph  
6           **(A)** for 2010 and for 2011 shall be con-  
7           **sistent** in content with the data re-  
8           **ported** as part of the MA plan bid in  
9           **June 2009** for 2010.

10           **“(C) USE OF STANDARDIZED ELE-**  
11           **MENTS AND DEFINITIONS.—**The data to  
12           **be** submitted under subparagraph (A)  
13           **relating** to medical loss ratio for a  
14           **year,** beginning with 2012, shall be  
15           **submitted** based on the standardized  
16           **elements** and definitions developed  
17           **under** paragraph (3).

18           **“(3) DEVELOPMENT OF DATA REPORTING**  
19           **STANDARDS.—**

20           **“(A) IN GENERAL.—**The Secretary  
21           **shall** develop and implement stand-  
22           **ardized** data elements and definitions  
23           **for** reporting under this subsection,  
24           **for** contract years beginning with  
25           **2012,** of data necessary for the cal-



1           **culat**ion of the medical loss ratio for  
2           **MA** plans. Not later than December  
3           **31, 2010**, the Secretary shall publish a  
4           **report** describing the elements and  
5           **definitions** so developed.

6           **“(B) CONSULTATION.—**The Sec-  
7           **retary** shall consult with the Health  
8           **Choices Commissioner**, representa-  
9           **tives of MA organizations**, experts on  
10          **health plan accounting systems**, and  
11          **representatives of the National Asso-**  
12          **ciation of Insurance Commissioners**,  
13          **in the development of such data ele-**  
14          **ments and definitions.**

15          **“(4) MEDICAL LOSS RATIO TO BE DE-**  
16          **FINED.—**For purposes of this part, the  
17          **term ‘medical loss ratio’** has the meaning  
18          **given such term by the Secretary**, taking  
19          **into account the meaning given such**  
20          **term by the Health Choices Commis-**  
21          **sioner under section 116 of the America’s**  
22          **Affordable Health Choices Act of 2009.”.**

23          **(b) MINIMUM MEDICAL LOSS RATIO.—**Sec-  
24          **tion 1857(e) of the Social Security Act (42**

1 **U.S.C. 1395w-27(e)) is amended by adding at**  
2 **the end the following new paragraph:**

3 **“(4) REQUIREMENT FOR MINIMUM MED-**  
4 **ICAL LOSS RATIO.—If the Secretary deter-**  
5 **mines for a contract year (beginning with**  
6 **2014) that an MA plan has failed to have**  
7 **a medical loss ratio (as defined in section**  
8 **1851(p)(4)) of at least .85—**

9 **“(A) the Secretary shall require**  
10 **the Medicare Advantage organization**  
11 **offering the plan to give enrollees a**  
12 **rebate (in the second succeeding con-**  
13 **tract year) of premiums under this**  
14 **part (or part B or part D, if applica-**  
15 **ble) by such amount as would provide**  
16 **for a benefits ratio of at least .85;**

17 **“(B) for 3 consecutive contract**  
18 **years, the Secretary shall not permit**  
19 **the enrollment of new enrollees**  
20 **under the plan for coverage during**  
21 **the second succeeding contract year;**  
22 **and**

23 **“(C) the Secretary shall terminate**  
24 **the plan contract if the plan fails to**

1           **have such a medical loss ratio for 5**  
2           **consecutive contract years.”.**

3 **SEC. 1174. STRENGTHENING AUDIT AUTHORITY.**

4           **(a) FOR PART C PAYMENTS RISK ADJUST-**  
5 **MENT.—Section 1857(d)(1) of the Social Secu-**  
6 **urity Act (42 U.S.C. 1395w-27(d)(1)) is amended**  
7 **by inserting after “section 1858(c))” the fol-**  
8 **lowing: “, and data submitted with respect to**  
9 **risk adjustment under section 1853(a)(3)”.**

10          **(b) ENFORCEMENT OF AUDITS AND DEFICI-**  
11 **ENCIES.—**

12           **(1) IN GENERAL.—Section 1857(e) of**  
13 **such Act, as amended by section 1173, is**  
14 **amended by adding at the end the fol-**  
15 **lowing new paragraph:**

16           **“(5) ENFORCEMENT OF AUDITS AND DEFICI-**  
17 **ENCIES.—**

18           **“(A) INFORMATION IN CONTRACT.—**  
19 **The Secretary shall require that each**  
20 **contract with an MA organization**  
21 **under this section shall include terms**  
22 **that inform the organization of the**  
23 **provisions in subsection (d).**

24           **“(B) ENFORCEMENT AUTHORITY.—**  
25 **The Secretary is authorized, in con-**

1            **nection with conducting audits and**  
2            **other activities under subsection (d),**  
3            **to take such actions, including pur-**  
4            **suit of financial recoveries, necessary**  
5            **to address deficiencies identified in**  
6            **such audits or other activities.”.**

7            **(2) APPLICATION UNDER PART D.—For**  
8            **provision applying the amendment made**  
9            **by paragraph (1) to prescription drug**  
10           **plans under part D, see section 1860D-**  
11           **12(b)(3)(D) of the Social Security Act.**

12           **(c) EFFECTIVE DATE.—The amendments**  
13           **made by this section shall take effect on the**  
14           **date of the enactment of this Act and shall**  
15           **apply to audits and activities conducted for**  
16           **contract years beginning on or after January**  
17           **1, 2011.**

18           **SEC. 1175. AUTHORITY TO DENY PLAN BIDS.**

19           **(a) IN GENERAL.—Section 1854(a)(5) of the**  
20           **Social Security Act (42 U.S.C. 1395w-24(a)(5))**  
21           **is amended by adding at the end the following**  
22           **new subparagraph:**

23                    **“(C) REJECTION OF BIDS.—Nothing**  
24                    **in this section shall be construed as**  
25                    **requiring the Secretary to accept any**

1           or every bid by an MA organization  
2           under this subsection.”.

3           **(b) APPLICATION UNDER PART D.—Section**  
4 **1860D-11(d) of such Act (42 U.S.C. 1395w-**  
5 **111(d)) is amended by adding at the end the**  
6 **following new paragraph:**

7           **“(3) REJECTION OF BIDS.—Paragraph**  
8 **(5)(C) of section 1854(a) shall apply with**  
9 **respect to bids under this section in the**  
10 **same manner as it applies to bids by an**  
11 **MA organization under such section.”.**

12           **(c) EFFECTIVE DATE.—The amendments**  
13 **made by this section shall apply to bids for**  
14 **contract years beginning on or after January**  
15 **1, 2011.**

16 **PART 3—TREATMENT OF SPECIAL NEEDS PLANS**  
17 **SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN**  
18 **ENROLLMENT PERIOD OF INDIVIDUALS INTO**  
19 **CHRONIC CARE SPECIALIZED MA PLANS FOR**  
20 **SPECIAL NEEDS INDIVIDUALS.**

21           **Section 1859(f)(4) of the Social Security**  
22 **Act (42 U.S.C. 1395w-28(f)(4)) is amended by**  
23 **adding at the end the following new subpara-**  
24 **graph:**

1           “(C) The plan does not enroll an  
2           individual on or after January 1,  
3           2011, other than during an annual,  
4           coordinated open enrollment period  
5           or when at the time of the diagnosis  
6           of the disease or condition that quali-  
7           fies the individual as an individual  
8           described in subsection (b)(6)(B)(iii).”.

9   SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS  
10                                   PLANS TO RESTRICT ENROLLMENT.

11           (a) IN GENERAL.—Section 1859(f)(1) of the  
12   Social Security Act (42 U.S.C. 1395w-28(f)(1))  
13   is amended by striking “January 1, 2011” and  
14   inserting “January 1, 2013 (or January 1, 2016,  
15   in the case of a plan described in section  
16   1177(b)(1) of the America’s Affordable Health  
17   Choices Act of 2009)”.

18           (b) GRANDFATHERING OF CERTAIN PLANS.—

19           (1) PLANS DESCRIBED.—For purposes of  
20   section 1859(f)(1) of the Social Security  
21   Act (42 U.S.C. 1395w-28(f)(1)), a plan de-  
22   scribed in this paragraph is a plan that  
23   had a contract with a State that had a  
24   State program to operate an integrated  
25   Medicaid-Medicare program that had

1       **been approved by the Centers for Medi-**  
2       **care & Medicaid Services as of January 1,**  
3       **2004.**

4               **(2) ANALYSIS; REPORT.—The Secretary**  
5       **of Health and Human Services shall pro-**  
6       **vide, through a contract with an inde-**  
7       **pendent health services evaluation orga-**  
8       **nization, for an analysis of the plans de-**  
9       **scribed in paragraph (1) with regard to**  
10       **the impact of such plans on cost, quality**  
11       **of care, patient satisfaction, and other**  
12       **subjects as specified by the Secretary.**  
13       **Not later than December 31, 2011, the**  
14       **Secretary shall submit to Congress a re-**  
15       **port on such analysis and shall include in**  
16       **such report such recommendations with**  
17       **regard to the treatment of such plans as**  
18       **the Secretary deems appropriate.**

19               **Subtitle E—Improvements to**  
20               **Medicare Part D**

21       **SEC. 1181. ELIMINATION OF COVERAGE GAP.**

22               **(a) IN GENERAL.—Section 1860D-2(b) of**  
23       **such Act (42 U.S.C. 1395w-102(b)) is amend-**  
24       **ed—**

1           (1) in paragraph (3)(A), by striking  
2           “paragraph (4)” and inserting “para-  
3           graphs (4) and (7)”;

4           (2) in paragraph (4)(B)(i), by inserting  
5           “subject to paragraph (7)” after “purposes  
6           of this part”; and

7           (3) by adding at the end the following  
8           new paragraph:

9           “(7) PHASED-IN ELIMINATION OF COV-  
10          ERAGE GAP.—

11           “(A) IN GENERAL.—For each year  
12           beginning with 2011, the Secretary  
13           shall consistent with this paragraph  
14           progressively increase the initial cov-  
15           erage limit (described in subsection  
16           (b)(3)) and decrease the annual out-  
17           of-pocket threshold from the amounts  
18           otherwise computed until there is a  
19           continuation of coverage from the ini-  
20           tial coverage limit for expenditures  
21           incurred through the total amount of  
22           expenditures at which benefits are  
23           available under paragraph (4).

24           “(B) INCREASE IN INITIAL COVERAGE  
25          LIMIT.—For a year beginning with



1           **2011, the initial coverage limit other-**  
2           **wise computed without regard to this**  
3           **paragraph shall be increased by 1/2 of**  
4           **the cumulative phase-in percentage**  
5           **(as defined in subparagraph (D)(ii)**  
6           **for the year) times the out-of-pocket**  
7           **gap amount (as defined in subpara-**  
8           **graph (E)) for the year.**

9           **“(C) DECREASE IN ANNUAL OUT-OF-**  
10          **POCKET THRESHOLD.—For a year begin-**  
11          **ning with 2011, the annual out-of-**  
12          **pocket threshold otherwise computed**  
13          **without regard to this paragraph**  
14          **shall be decreased by 1/2 of the cumu-**  
15          **lative phase-in percentage of the out-**  
16          **of-pocket gap amount for the year**  
17          **multiplied by 1.75.**

18          **“(D) PHASE-IN.—For purposes of**  
19          **this paragraph:**

20                  **“(i) ANNUAL PHASE-IN PERCENT-**  
21                  **AGE.—The term ‘annual phase-in**  
22                  **percentage’ means—**

23                          **“(I) for 2011, 13 percent;**

24                          **“(II) for 2012, 2013, 2014,**  
25                          **and 2015, 5 percent;**

1                   **“(III) for 2016 through**  
2                   **2018, 7.5 percent; and**

3                   **“(IV) for 2019 and each**  
4                   **subsequent year, 10 percent.**

5                   **“(ii) CUMULATIVE PHASE-IN PER-**  
6                   **CENTAGE.—The term ‘cumulative**  
7                   **phase-in percentage’ means for a**  
8                   **year the sum of the annual phase-**  
9                   **in percentage for the year and the**  
10                   **annual phase-in percentages for**  
11                   **each previous year beginning**  
12                   **with 2011, but in no case more**  
13                   **than 100 percent.**

14                   **“(E) OUT-OF-POCKET GAP AMOUNT.—**  
15                   **For purposes of this paragraph, the**  
16                   **term ‘out-of-pocket gap amount’**  
17                   **means for a year the amount by**  
18                   **which—**

19                   **“(i) the annual out-of-pocket**  
20                   **threshold specified in paragraph**  
21                   **(4)(B) for the year (as determined**  
22                   **as if this paragraph did not**  
23                   **apply), exceeds**

24                   **“(ii) the sum of—**

1           **“(I) the annual deductible**  
2           **under paragraph (1) for the**  
3           **year; and**

4           **“(II) ¼ of the amount by**  
5           **which the initial coverage**  
6           **limit under paragraph (3) for**  
7           **the year (as determined as if**  
8           **this paragraph did not apply)**  
9           **exceeds such annual deduct-**  
10          **ible.”.**

11          **(b) REQUIRING DRUG MANUFACTURERS TO**  
12          **PROVIDE DRUG REBATES FOR FULL-BENEFIT**  
13          **DUAL ELIGIBLES.—**

14                 **(1) IN GENERAL.—Section 1860D-2 of**  
15                 **the Social Security Act (42 U.S.C. 1396r-8)**  
16                 **is amended—**

17                         **(A) in subsection (e)(1), in the**  
18                         **matter before subparagraph (A), by**  
19                         **inserting “and subsection (f)” after**  
20                         **“this subsection”; and**

21                         **(B) by adding at the end the fol-**  
22                         **lowing new subsection:**

23                 **“(f) PRESCRIPTION DRUG REBATE AGREE-**  
24                 **MENT FOR FULL-BENEFIT DUAL ELIGIBLE INDI-**  
25                 **VIDUALS.—**

1           **“(1) IN GENERAL.—In this part, the**  
2           **term ‘covered part D drug’ does not in-**  
3           **clude any drug or biologic that is manu-**  
4           **factured by a manufacturer that has not**  
5           **entered into and have in effect a rebate**  
6           **agreement described in paragraph (2).**

7           **“(2) REBATE AGREEMENT.—A rebate**  
8           **agreement under this subsection shall re-**  
9           **quire the manufacturer to provide to the**  
10          **Secretary a rebate for each rebate period**  
11          **(as defined in paragraph (6)(B)) ending**  
12          **after December 31, 2010, in the amount**  
13          **specified in paragraph (3) for any cov-**  
14          **ered part D drug of the manufacturer dis-**  
15          **persed after December 31, 2010, to any**  
16          **full-benefit dual eligible individual (as**  
17          **defined in paragraph (6)(A)) for which**  
18          **payment was made by a PDP sponsor**  
19          **under part D or a MA organization under**  
20          **part C for such period. Such rebate shall**  
21          **be paid by the manufacturer to the Sec-**  
22          **retary not later than 30 days after the**  
23          **date of receipt of the information de-**  
24          **scribed in section 1860D–12(b)(7), includ-**

1       **ing as such section is applied under sec-**  
2       **tion 1857(f)(3).**

3               **“(3) REBATE FOR FULL-BENEFIT DUAL EL-**  
4       **IGIBLE MEDICARE DRUG PLAN ENROLLEES.—**

5               **“(A) IN GENERAL.—The amount of**  
6       **the rebate specified under this para-**  
7       **graph for a manufacturer for a rebate**  
8       **period, with respect to each dosage**  
9       **form and strength of any covered**  
10       **part D drug provided by such manu-**  
11       **facturer and dispensed to a full-ben-**  
12       **efit dual eligible individual, shall be**  
13       **equal to the product of—**

14               **“(i) the total number of units**  
15       **of such dosage form and strength**  
16       **of the drug so provided and dis-**  
17       **persed for which payment was**  
18       **made by a PDP sponsor under**  
19       **part D or a MA organization**  
20       **under part C for the rebate pe-**  
21       **riod (as reported under section**  
22       **1860D-12(b)(7), including as such**  
23       **section is applied under section**  
24       **1857(f)(3)); and**

1           “(ii) the amount (if any) by  
2           which—

3                   “(I) the Medicaid rebate  
4                   amount (as defined in sub-  
5                   paragraph (B)) for such form,  
6                   strength, and period, exceeds

7                   “(II) the average Medicare  
8                   drug program full-benefit  
9                   dual eligible rebate amount  
10                  (as defined in subparagraph  
11                  (C)) for such form, strength,  
12                  and period.

13           “(B) MEDICAID REBATE AMOUNT.—  
14           For purposes of this paragraph, the  
15           term ‘Medicaid rebate amount’  
16           means, with respect to each dosage  
17           form and strength of a covered part D  
18           drug provided by the manufacturer  
19           for a rebate period—

20                   “(i) in the case of a single  
21                   source drug or an innovator mul-  
22                   tiple source drug, the amount  
23                   specified in paragraph (1)(A)(ii) of  
24                   section 1927(b) plus the amount, if  
25                   any, specified in paragraph

1           **(2)(A)(ii) of such section, for such**  
2           **form, strength, and period; or**

3           **“(ii) in the case of any other**  
4           **covered outpatient drug, the**  
5           **amount specified in paragraph**  
6           **(3)(A)(i) of such section for such**  
7           **form, strength, and period.**

8           **“(C) AVERAGE MEDICARE DRUG PRO-**  
9           **GRAM FULL-BENEFIT DUAL ELIGIBLE RE-**  
10           **BATE AMOUNT.—For purposes of this**  
11           **subsection, the term ‘average Medi-**  
12           **care drug program full-benefit dual**  
13           **eligible rebate amount’ means, with**  
14           **respect to each dosage form and**  
15           **strength of a covered part D drug**  
16           **provided by a manufacturer for a re-**  
17           **bate period, the sum, for all PDP**  
18           **sponsors under part D and MA orga-**  
19           **nizations administering a MA-PD**  
20           **plan under part C, of—**

21           **“(i) the product, for each such**  
22           **sponsor or organization, of—**

23           **“(I) the sum of all rebates,**  
24           **discounts, or other price con-**  
25           **cessions (not taking into ac-**

1 count any rebate provided  
2 under paragraph (2) for such  
3 dosage form and strength of  
4 the drug dispensed, cal-  
5 culated on a per-unit basis,  
6 but only to the extent that  
7 any such rebate, discount, or  
8 other price concession applies  
9 equally to drugs dispensed to  
10 full-benefit dual eligible Medi-  
11 care drug plan enrollees and  
12 drugs dispensed to PDP and  
13 MA-PD enrollees who are not  
14 full-benefit dual eligible indi-  
15 viduals; and

16 “(II) the number of the  
17 units of such dosage and  
18 strength of the drug dis-  
19 pensed during the rebate pe-  
20 riod to full-benefit dual eligi-  
21 ble individuals enrolled in the  
22 prescription drug plans ad-  
23 ministered by the PDP spon-  
24 sor or the MA-PD plans ad-



1 ministered by the MA-PD or-  
2 ganization; divided by

3 “(ii) the total number of units  
4 of such dosage and strength of  
5 the drug dispensed during the re-  
6 bate period to full-benefit dual el-  
7 igible individuals enrolled in all  
8 prescription drug plans adminis-  
9 tered by PDP sponsors and all  
10 MA-PD plans administered by  
11 MA-PD organizations.

12 “(4) LENGTH OF AGREEMENT.—The pro-  
13 visions of paragraph (4) of section 1927(b)  
14 (other than clauses (iv) and (v) of sub-  
15 paragraph (B)) shall apply to rebate  
16 agreements under this subsection in the  
17 same manner as such paragraph applies  
18 to a rebate agreement under such sec-  
19 tion.

20 “(5) OTHER TERMS AND CONDITIONS.—  
21 The Secretary shall establish other terms  
22 and conditions of the rebate agreement  
23 under this subsection, including terms  
24 and conditions related to compliance,  
25 that are consistent with this subsection.

1           **“(6) DEFINITIONS.—In this subsection**  
2           **and section 1860D–12(b)(7):**

3           **“(A) FULL-BENEFIT DUAL ELIGIBLE**  
4           **INDIVIDUAL.—The term ‘full-benefit**  
5           **dual eligible individual’ has the**  
6           **meaning given such term in section**  
7           **1935(c)(6).**

8           **“(B) REBATE PERIOD.—The term**  
9           **‘rebate period’ has the meaning given**  
10           **such term in section 1927(k)(8).”.**

11           **(2) REPORTING REQUIREMENT FOR THE**  
12           **DETERMINATION AND PAYMENT OF REBATES**  
13           **BY MANUFACTURES RELATED TO REBATE FOR**  
14           **FULL-BENEFIT DUAL ELIGIBLE MEDICARE**  
15           **DRUG PLAN ENROLLEES.—**

16           **(A) REQUIREMENTS FOR PDP SPON-**  
17           **SORS.—Section 1860D–12(b) of the So-**  
18           **cial Security Act (42 U.S.C. 1395w-**  
19           **112(b)) is amended by adding at the**  
20           **end the following new paragraph:**

21           **“(7) REPORTING REQUIREMENT FOR THE**  
22           **DETERMINATION AND PAYMENT OF REBATES**  
23           **BY MANUFACTURERS RELATED TO REBATE**  
24           **FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE**  
25           **DRUG PLAN ENROLLEES.—**

1           **“(A) IN GENERAL.—For purposes of**  
2 **the rebate under section 1860D-2(f)**  
3 **for contract years beginning on or**  
4 **after January 1, 2011, each contract**  
5 **entered into with a PDP sponsor**  
6 **under this part with respect to a pre-**  
7 **scription drug plan shall require that**  
8 **the sponsor comply with subpara-**  
9 **graphs (B) and (C).**

10           **“(B) REPORT FORM AND CON-**  
11 **TENTS.—Not later than 60 days after**  
12 **the end of each rebate period (as de-**  
13 **fined in section 1860D-2(f)(6)(B))**  
14 **within such a contract year to which**  
15 **such section applies, a PDP sponsor**  
16 **of a prescription drug plan under this**  
17 **part shall report to each manufac-**  
18 **turer—**

19           **“(i) information (by National**  
20 **Drug Code number) on the total**  
21 **number of units of each dosage,**  
22 **form, and strength of each drug**  
23 **of such manufacturer dispensed**  
24 **to full-benefit dual eligible Medi-**  
25 **care drug plan enrollees under**

1           **any prescription drug plan oper-**  
2           **ated by the PDP sponsor during**  
3           **the rebate period;**

4           **“(ii) information on the price**  
5           **discounts, price concessions, and**  
6           **rebates for such drugs for such**  
7           **form, strength, and period;**

8           **“(iii) information on the ex-**  
9           **tent to which such price dis-**  
10           **counts, price concessions, and re-**  
11           **bates apply equally to full-benefit**  
12           **dual eligible Medicare drug plan**  
13           **enrollees and PDP enrollees who**  
14           **are not full-benefit dual eligible**  
15           **Medicare drug plan enrollees; and**

16           **“(iv) any additional informa-**  
17           **tion that the Secretary deter-**  
18           **mines is necessary to enable the**  
19           **Secretary to calculate the average**  
20           **Medicare drug program full-ben-**  
21           **efit dual eligible rebate amount**  
22           **(as defined in paragraph (3)(C) of**  
23           **such section), and to determine**  
24           **the amount of the rebate required**

1           under this section, for such form,  
2           strength, and period.

3           Such report shall be in a form con-  
4           sistent with a standard reporting for-  
5           mat established by the Secretary.

6           “(C) SUBMISSION TO SECRETARY.—  
7           Each PDP sponsor shall promptly  
8           transmit a copy of the information re-  
9           ported under subparagraph (B) to the  
10          Secretary for the purpose of audit  
11          oversight and evaluation.

12          “(D) CONFIDENTIALITY OF INFORMA-  
13          TION.—The provisions of subpara-  
14          graph (D) of section 1927(b)(3), relat-  
15          ing to confidentiality of information,  
16          shall apply to information reported  
17          by PDP sponsors under this para-  
18          graph in the same manner that such  
19          provisions apply to information dis-  
20          closed by manufacturers or whole-  
21          salers under such section, except—

22                  “(i) that any reference to ‘this  
23                  section’ in clause (i) of such sub-  
24                  paragraph shall be treated as  
25                  being a reference to this section;

1           “(ii) the reference to the Di-  
2           rector of the Congressional Budg-  
3           et Office in clause (iii) of such  
4           subparagraph shall be treated as  
5           including a reference to the Medi-  
6           care Payment Advisory Commis-  
7           sion; and

8           “(iii) clause (iv) of such sub-  
9           paragraph shall not apply.

10          “(E) OVERSIGHT.—Information re-  
11          ported under this paragraph may be  
12          used by the Inspector General of the  
13          Department of Health and Human  
14          Services for the statutorily author-  
15          ized purposes of audit, investigation,  
16          and evaluations.

17          “(F) PENALTIES FOR FAILURE TO  
18          PROVIDE TIMELY INFORMATION AND PRO-  
19          VISION OF FALSE INFORMATION.—In the  
20          case of a PDP sponsor—

21                 “(i) that fails to provide infor-  
22                 mation required under subpara-  
23                 graph (B) on a timely basis, the  
24                 sponsor is subject to a civil  
25                 money penalty in the amount of

1           **\$10,000 for each day in which**  
2           **such information has not been**  
3           **provided; or**

4           **“(ii) that knowingly (as de-**  
5           **defined in section 1128A(i)) provides**  
6           **false information under such sub-**  
7           **paragraph, the sponsor is subject**  
8           **to a civil money penalty in an**  
9           **amount not to exceed \$100,000 for**  
10           **each item of false information.**

11           **Such civil money penalties are in ad-**  
12           **dition to other penalties as may be**  
13           **prescribed by law. The provisions of**  
14           **section 1128A (other than subsections**  
15           **(a) and (b)) shall apply to a civil**  
16           **money penalty under this subpara-**  
17           **graph in the same manner as such**  
18           **provisions apply to a penalty or pro-**  
19           **ceeding under section 1128A(a).”.**

20           **(B) APPLICATION TO MA ORGANIZA-**  
21           **TIONS.—Section 1857(f)(3) of the Social**  
22           **Security Act (42 U.S.C. 1395w-27(f)(3))**  
23           **is amended by adding at the end the**  
24           **following:**

1           **“(D) REPORTING REQUIREMENT RE-**  
2           **LATED TO REBATE FOR FULL-BENEFIT**  
3           **DUAL ELIGIBLE MEDICARE DRUG PLAN**  
4           **ENROLLEES.—Section 1860D-12(b)(7).”.**

5           **(3) DEPOSIT OF REBATES INTO MEDICARE**  
6           **PRESCRIPTION DRUG ACCOUNT.—Section**  
7           **1860D-16(c) of such Act (42 U.S.C. 1395w-**  
8           **116(c)) is amended by adding at the end**  
9           **the following new paragraph:**

10           **“(6) REBATE FOR FULL-BENEFIT DUAL EL-**  
11           **IGIBLE MEDICARE DRUG PLAN ENROLLEES.—**  
12           **Amounts paid under a rebate agreement**  
13           **under section 1860D-2(f) shall be depos-**  
14           **ited into the Account and shall be used to**  
15           **pay for all or part of the gradual elimi-**  
16           **nation of the coverage gap under section**  
17           **1860D-2(b)(7).”.**

18           **SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN**  
19           **ORIGINAL COVERAGE GAP.**

20           **Section 1860D-2 of the Social Security Act**  
21           **(42 U.S.C. 1395w-102), as amended by section**  
22           **1181, is amended—**

23           **(1) in subsection (b)(4)(C)(ii), by in-**  
24           **serting “subject to subsection (g)(2)(C),”**  
25           **after “(ii)”;**



1           (2) in subsection (e)(1), in the matter  
2 before subparagraph (A), by striking  
3 “subsection (f)” and inserting “sub-  
4 sections (f) and (g)” after “this sub-  
5 section”; and

6           (3) by adding at the end the following  
7 new subsection:

8           “(g) REQUIREMENT FOR MANUFACTURER DIS-  
9 COUNT AGREEMENT FOR CERTAIN QUALIFYING  
10 DRUGS.—

11           “(1) IN GENERAL.—In this part, the  
12 term ‘covered part D drug’ does not in-  
13 clude any drug or biologic that is manu-  
14 factured by a manufacturer that has not  
15 entered into and have in effect for all  
16 qualifying drugs (as defined in paragraph  
17 (5)(A)) a discount agreement described in  
18 paragraph (2).

19           “(2) DISCOUNT AGREEMENT.—

20           “(A) PERIODIC DISCOUNTS.—A dis-  
21 count agreement under this para-  
22 graph shall require the manufacturer  
23 involved to provide, to each PDP  
24 sponsor with respect to a prescrip-  
25 tion drug plan or each MA organiza-

1           tion with respect to each MA-PD  
2           plan, a discount in an amount speci-  
3           fied in paragraph (3) for qualifying  
4           drugs (as defined in paragraph (5)(A))  
5           of the manufacturer dispensed to a  
6           qualifying enrollee after December  
7           31, 2010, insofar as the individual is  
8           in the original gap in coverage (as de-  
9           fined in paragraph (5)(E)).

10           “(B) DISCOUNT AGREEMENT.—Inso-  
11           far as not inconsistent with this sub-  
12           section, the Secretary shall establish  
13           terms and conditions of such agree-  
14           ment, including terms and conditions  
15           relating to compliance, similar to the  
16           terms and conditions for rebate  
17           agreements under paragraphs (2), (3),  
18           and (4) of section 1927(b), except  
19           that—

20                   “(i) discounts shall be applied  
21                   under this subsection to prescrip-  
22                   tion drug plans and MA-PD plans  
23                   instead of State plans under title  
24                   XIX;

1           “(ii) PDP sponsors and MA or-  
2           ganizations shall be responsible,  
3           instead of States, for provision of  
4           necessary utilization information  
5           to drug manufacturers; and

6           “(iii) sponsors and MA organi-  
7           zations shall be responsible for  
8           reporting information on drug-  
9           component negotiated price, in-  
10          stead of other manufacturer  
11          prices.

12          “(C) COUNTING DISCOUNT TOWARD  
13          TRUE OUT-OF-POCKET COSTS.—Under  
14          the discount agreement, in applying  
15          subsection (b)(4), with regard to sub-  
16          paragraph (C)(i) of such subsection, if  
17          a qualified enrollee purchases the  
18          qualified drug insofar as the enrollee  
19          is in an actual gap of coverage (as de-  
20          fined in paragraph (5)(D)), the  
21          amount of the discount under the  
22          agreement shall be treated and count-  
23          ed as costs incurred by the plan en-  
24          rollee.

1           **“(3) DISCOUNT AMOUNT.—The amount**  
2           **of the discount specified in this para-**  
3           **graph for a discount period for a plan is**  
4           **equal to 50 percent of the amount of the**  
5           **drug-component negotiated price (as de-**  
6           **finied in paragraph (5)(C)) for qualifying**  
7           **drugs for the period involved.**

8           **“(4) ADDITIONAL TERMS.—In the case of**  
9           **a discount provided under this sub-**  
10          **section with respect to a prescription**  
11          **drug plan offered by a PDP sponsor or an**  
12          **MA-PD plan offered by an MA organiza-**  
13          **tion, if a qualified enrollee purchases the**  
14          **qualified drug—**

15               **“(A) insofar as the enrollee is in**  
16               **an actual gap of coverage (as defined**  
17               **in paragraph (5)(D)), the sponsor or**  
18               **plan shall provide the discount to the**  
19               **enrollee at the time the enrollee pays**  
20               **for the drug; and**

21               **“(B) insofar as the enrollee is in**  
22               **the portion of the original gap in cov-**  
23               **erage (as defined in paragraph (5)(E))**  
24               **that is not in the actual gap in cov-**  
25               **erage, the discount shall not be ap-**

1           **plied against the negotiated price (as**  
2           **defined in subsection (d)(1)(B)) for**  
3           **the purpose of calculating the bene-**  
4           **ficiary payment.**

5           **“(5) DEFINITIONS.—In this subsection:**

6                   **“(A) QUALIFYING DRUG.—The term**  
7                   **‘qualifying drug’ means, with respect**  
8                   **to a prescription drug plan or MA–PD**  
9                   **plan, a drug or biological product**  
10                   **that—**

11                           **“(i)(I) is a drug produced or**  
12                           **distributed under an original new**  
13                           **drug application approved by the**  
14                           **Food and Drug Administration,**  
15                           **including a drug product mar-**  
16                           **keted by any cross-licensed pro-**  
17                           **ducers or distributors operating**  
18                           **under the new drug application;**

19                           **“(II) is a drug that was origi-**  
20                           **nally marketed under an original**  
21                           **new drug application approved**  
22                           **by the Food and Drug Adminis-**  
23                           **tration; or**

1           “(III) is a biological product  
2           as approved under Section 351(a)  
3           of the Public Health Services Act;

4           “(ii) is covered under the for-  
5           mulary of the plan; and

6           “(iii) is dispensed to an indi-  
7           vidual who is in the original gap  
8           in coverage.

9           “(B) **QUALIFYING ENROLLEE.**—The  
10          term ‘qualifying enrollee’ means an  
11          individual enrolled in a prescription  
12          drug plan or MA–PD plan other than  
13          such an individual who is a subsidy-  
14          eligible individual (as defined in sec-  
15          tion 1860D–14(a)(3)).

16          “(C) **DRUG-COMPONENT NEGOTIATED**  
17          **PRICE.**—The term ‘drug-component ne-  
18          gotiated price’ means, with respect to  
19          a qualifying drug, the negotiated  
20          price (as defined in subsection  
21          (d)(1)(B)), as determined without re-  
22          gard to any dispensing fee, of the  
23          drug under the prescription drug  
24          plan or MA–PD plan involved.

1           **“(D) ACTUAL GAP IN COVERAGE.—**  
2           **The term ‘actual gap in coverage’**  
3           **means the gap in prescription drug**  
4           **coverage that occurs between the ini-**  
5           **tial coverage limit (as modified under**  
6           **subparagraph (B) of subsection (b)(7))**  
7           **and the annual out-of-pocket thresh-**  
8           **old (as modified under subparagraph**  
9           **(C) of such subsection).**

10           **“(E) ORIGINAL GAP IN COVERAGE.—**  
11           **The term ‘original in gap coverage’**  
12           **means the gap in prescription drug**  
13           **coverage that would occur between**  
14           **the initial coverage limit (described**  
15           **in subsection (b)(3)) and the out-of-**  
16           **pocket threshold (as defined in sub-**  
17           **section (b)(4))(B) if subsection (b)(7)**  
18           **did not apply.”.**

19           **SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMIS-**  
20   **SION OF CLAIMS BY PHARMACIES LOCATED**  
21   **IN OR CONTRACTING WITH LONG-TERM CARE**  
22   **FACILITIES.**

23           **(a) PART D SUBMISSION.—Section 1860D-**  
24           **12(b) of the Social Security Act (42 U.S.C.**  
25           **1395w-112(b)), as amended by section**

1 **172(a)(1) of Public Law 110-275, is amended**  
2 **by striking paragraph (5) and redesignating**  
3 **paragraph (6) and paragraph (7), as added by**  
4 **section 1181(b)(2), as paragraph (5) and para-**  
5 **graph (6), respectively.**

6 **(b) SUBMISSION TO MA-PD PLANS.—Section**  
7 **1857(f)(3) of the Social Security Act (42 U.S.C.**  
8 **1395w-27(f)(3)), as added by section 171(b) of**  
9 **Public Law 110-275 and amended by section**  
10 **172(a)(2) of such Public Law and section 1181**  
11 **of this Act, is amended by striking subpara-**  
12 **graph (B) and redesignating subparagraphs**  
13 **(C) and (D) as subparagraphs (B) and (C) re-**  
14 **spectively.**

15 **(c) EFFECTIVE DATE.—The amendments**  
16 **made by this section shall apply for contract**  
17 **years beginning with 2010.**

18 **SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**  
19 **SISTANCE PROGRAMS AND INDIAN HEALTH**  
20 **SERVICE IN PROVIDING PRESCRIPTION**  
21 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**  
22 **ET THRESHOLD UNDER PART D.**

23 **(a) IN GENERAL.—Section 1860D-2(b)(4)(C)**  
24 **of the Social Security Act (42 U.S.C. 1395w-**  
25 **102(b)(4)(C)) is amended—**



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

3           (2) in clause (ii)—

4                 (A) by striking “such costs shall  
5                 be treated as incurred only if” and in-  
6                 serting “subject to clause (iii), such  
7                 costs shall be treated as incurred  
8                 only if”;

9                 (B) by striking “, under section  
10                1860D-14, or under a State Pharma-  
11                ceutical Assistance Program”; and

12                (C) by striking the period at the  
13                end and inserting “; and”; and

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

16                         “(iii) such costs shall be treat-  
17                         ed as incurred and shall not be  
18                         considered to be reimbursed  
19                         under clause (ii) if such costs are  
20                         borne or paid—

21                                 “(I) under section 1860D-  
22                                 14;

23                                 “(II) under a State Phar-  
24                                 maceutical Assistance Pro-  
25                                 gram;

1           **“(III) by the Indian Health**  
2           **Service, an Indian tribe or**  
3           **tribal organization, or an**  
4           **urban Indian organization (as**  
5           **defined in section 4 of the In-**  
6           **dian Health Care Improve-**  
7           **ment Act); or**

8           **“(IV) under an AIDS Drug**  
9           **Assistance Program under**  
10           **part B of title XXVI of the**  
11           **Public Health Service Act.”.**

12       **(b) EFFECTIVE DATE.—The amendments**  
13       **made by subsection (a) shall apply to costs in-**  
14       **curred on or after January 1, 2011.**

15       **SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLL-**  
16               **MENT FOR FORMULARY CHANGES THAT AD-**  
17               **VERSELY IMPACT AN ENROLLEE.**

18       **(a) IN GENERAL.—Section 1860D–1(b)(3) of**  
19       **the Social Security Act (42 U.S.C. 1395w-**  
20       **101(b)(3)) is amended by adding at the end the**  
21       **following new subparagraph:**

22               **“(F) CHANGE IN FORMULARY RE-**  
23               **SULTING IN INCREASE IN COST-SHAR-**  
24               **ING.—**

1           “(i) **IN GENERAL.**—Except as  
2           provided in clause (ii), in the case  
3           of an individual enrolled in a pre-  
4           scription drug plan (or MA-PD  
5           plan) who has been prescribed  
6           and is using a covered part D  
7           drug while so enrolled, if the for-  
8           mulary of the plan is materially  
9           changed (other than at the end of  
10          a contract year) so to reduce the  
11          coverage (or increase the cost-  
12          sharing) of the drug under the  
13          plan.

14          “(ii) **EXCEPTION.**—Clause (i)  
15          shall not apply in the case that a  
16          drug is removed from the for-  
17          mulary of a plan because of a re-  
18          call or withdrawal of the drug  
19          issued by the Food and Drug Ad-  
20          ministration, because the drug is  
21          replaced with a generic drug that  
22          is a therapeutic equivalent, or be-  
23          cause of utilization management  
24          applied to—

1           **“(I) a drug whose labeling**  
2           **includes a boxed warning re-**  
3           **quired by the Food and Drug**  
4           **Administration under section**  
5           **210.57(c)(1) of title 21, Code of**  
6           **Federal Regulations (or a suc-**  
7           **cessor regulation); or**

8           **“(II) a drug required**  
9           **under subsection (c)(2) of sec-**  
10           **tion 505–1 of the Federal**  
11           **Food, Drug, and Cosmetic Act**  
12           **to have a Risk Evaluation and**  
13           **Management Strategy that in-**  
14           **cludes elements under sub-**  
15           **section (f) of such section.”.**

16           **(b) EFFECTIVE DATE.—The amendment**  
17           **made by subsection (a) shall apply to contract**  
18           **years beginning on or after January 1, 2011.**

19           **Subtitle F—Medicare Rural Access**  
20           **Protections**

21           **SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.**

22           .

23           **(a) ADDITIONAL TELEHEALTH SITE.—**

24                   **(1) IN GENERAL.—Paragraph (4)(C)(ii)**  
25           **of section 1834(m) of the Social Security**

1 Act (42 U.S.C. 1395m(m)) is amended by  
2 adding at the end the following new sub-  
3 clause:

4 “(IX) A renal dialysis facil-  
5 ity.”

6 (2) EFFECTIVE DATE.—The amendment  
7 made by paragraph (1) shall apply to  
8 services furnished on or after January 1,  
9 2011.

10 (b) TELEHEALTH ADVISORY COMMITTEE.—

11 (1) ESTABLISHMENT.—Section 1868 of  
12 the Social Security Act (42 U.S.C. 1395ee)  
13 is amended—

14 (A) in the heading, by adding at  
15 the end the following: “TELEHEALTH  
16 ADVISORY COMMITTEE”; and

17 (B) by adding at the end the fol-  
18 lowing new subsection:

19 “(c) TELEHEALTH ADVISORY COMMITTEE.—

20 “(1) IN GENERAL.—The Secretary shall  
21 appoint a Telehealth Advisory Committee  
22 (in this subsection referred to as the ‘Ad-  
23 visory Committee’) to make recommenda-  
24 tions to the Secretary on policies of the  
25 Centers for Medicare & Medicaid Serv-

1 ices regarding telehealth services as es-  
2 tablished under section 1834(m), includ-  
3 ing the appropriate addition or deletion  
4 of services (and HCPCS codes) to those  
5 specified in paragraphs (4)(F)(i) and  
6 (4)(F)(ii) of such section and for author-  
7 ized payment under paragraph (1) of  
8 such section.

9 **“(2) MEMBERSHIP; TERMS.—**

10 **“(A) MEMBERSHIP.—**

11 **“(i) IN GENERAL.—**The Advi-  
12 sory Committee shall be com-  
13 posed of 9 members, to be ap-  
14 pointed by the Secretary, of  
15 whom—

16 **“(I) 5 shall be practicing**  
17 **physicians;**

18 **“(II) 2 shall be practicing**  
19 **non-physician health care**  
20 **practitioners; and**

21 **“(III) 2 shall be adminis-**  
22 **trators of telehealth pro-**  
23 **grams.**

24 **“(ii) REQUIREMENTS FOR AP-**  
25 **POINTING MEMBERS.—**In appointing

1           **members of the Advisory Com-**  
2           **mittee, the Secretary shall—**

3                   **“(I) ensure that each mem-**  
4                   **ber has prior experience with**  
5                   **the practice of telemedicine**  
6                   **or telehealth;**

7                   **“(II) give preference to in-**  
8                   **dividuals who are currently**  
9                   **providing telemedicine or**  
10                  **telehealth services or who are**  
11                  **involved in telemedicine or**  
12                  **telehealth programs;**

13                  **“(III) ensure that the**  
14                  **membership of the Advisory**  
15                  **Committee represents a bal-**  
16                  **ance of specialties and geo-**  
17                  **graphic regions; and**

18                  **“(IV) take into account the**  
19                  **recommendations of stake-**  
20                  **holders.**

21                  **“(B) TERMS.—The members of the**  
22                  **Advisory Committee shall serve for**  
23                  **such term as the Secretary may speci-**  
24                  **fy.**

1           **“(C) CONFLICTS OF INTEREST.—An**  
2           **advisory committee member may not**  
3           **participate with respect to a par-**  
4           **ticular matter considered in an advi-**  
5           **sory committee meeting if such mem-**  
6           **ber (or an immediate family member**  
7           **of such member) has a financial inter-**  
8           **est that could be affected by the ad-**  
9           **vice given to the Secretary with re-**  
10          **spect to such matter.**

11          **“(3) MEETINGS.—The Advisory Com-**  
12          **mittee shall meet twice each calendar**  
13          **year and at such other times as the Sec-**  
14          **retary may provide.**

15          **“(4) PERMANENT COMMITTEE.—Section**  
16          **14 of the Federal Advisory Committee Act**  
17          **(5 U.S.C. App.) shall not apply to the Ad-**  
18          **visory Committee.”**

19          **(2) FOLLOWING RECOMMENDATIONS.—**  
20          **Section 1834(m)(4)(F) of such Act (42**  
21          **U.S.C. 1395m(m)(4)(F)) is amended by**  
22          **adding at the end the following new**  
23          **clause:**

24                           **“(iii) RECOMMENDATIONS OF**  
25                           **THE TELEHEALTH ADVISORY COM-**



1           **MITTEE.—In making determina-**  
2           **tions under clauses (i) and (ii),**  
3           **the Secretary shall take into ac-**  
4           **count the recommendations of the**  
5           **Telehealth Advisory Committee**  
6           **(established under section**  
7           **1868(c)) when adding or deleting**  
8           **services (and HCPCS codes) and**  
9           **in establishing policies of the**  
10          **Centers for Medicare & Medicaid**  
11          **Services regarding the delivery of**  
12          **telehealth services. If the Sec-**  
13          **retary does not implement such a**  
14          **recommendation, the Secretary**  
15          **shall publish in the Federal Reg-**  
16          **ister a statement regarding the**  
17          **reason such recommendation was**  
18          **not implemented.”**

19           **(3) WAIVER OF ADMINISTRATIVE LIMITA-**  
20          **TION.—The Secretary of Health and**  
21          **Human Services shall establish the Tele-**  
22          **health Advisory Committee under the**  
23          **amendment made by paragraph (1) not-**  
24          **withstanding any limitation that may**  
25          **apply to the number of advisory commit-**

1        **tees that may be established (within the**  
2        **Department of Health and Human Serv-**  
3        **ices or otherwise).**

4        **(c) CREDENTIALING TELEMEDICINE PRACTI-**  
5        **TIONERS.—Section 1834(m) of such Act (42**  
6        **U.S.C. 1395m(m)) is amended by adding at the**  
7        **end the following new paragraph:**

8                **“(5) HOSPITAL CREDENTIALING OF TELE-**  
9        **MEDICINE PRACTITIONERS.—A telemedicine**  
10        **practitioner that is credentialed by a hos-**  
11        **pital in compliance with the Joint Com-**  
12        **mission Standards for Telemedicine shall**  
13        **be considered in compliance with condi-**  
14        **tions of participation and reimbursement**  
15        **credentialing requirements under this**  
16        **title for telemedicine services.”.**

17        **SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS**  
18                **PROVISION.**

19        **Section 1833(t)(7)(D)(i) of the Social Secu-**  
20        **rity Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amend-**  
21        **ed—**

22                **(1) in subclause (II)—**

23                        **(A) in the first sentence, by strik-**  
24                        **ing “2010” and inserting “2012”; and**

1           **(B) in the second sentence, by**  
2           **striking “or 2009” and inserting “,**  
3           **2009, 2010, or 2011”; and**

4           **(2) in subclause (III), by striking**  
5           **“January 1, 2010” and inserting “January**  
6           **1, 2012”.**

7 **SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLAS-**  
8           **SIFICATIONS.**

9           **Subsection (a) of section 106 of division B**  
10          **of the Tax Relief and Health Care Act of 2006**  
11          **(42 U.S.C. 1395 note), as amended by section**  
12          **117 of the Medicare, Medicaid, and SCHIP Ex-**  
13          **tension Act of 2007 (Public Law 110–173) and**  
14          **section 124 of the Medicare Improvements for**  
15          **Patients and Providers Act of 2008 (Public**  
16          **Law 110–275), is amended by striking “Sep-**  
17          **tember 30, 2009” and inserting “September 30,**  
18          **2011”.**

19 **SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.**

20          **Section 1848(e)(1)(E) of the Social Secu-**  
21          **rity Act (42 U.S.C. 1395w–4(e)(1)(E)) is amend-**  
22          **ed by striking “before January 1, 2010” and in-**  
23          **serting “before January 1, 2012”.**

1 SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COM-  
2 PONENT OF CERTAIN PHYSICIAN PATHOL-  
3 OGY SERVICES.

4 Section 542(c) of the Medicare, Medicaid,  
5 and SCHIP Benefits Improvement and Protec-  
6 tion Act of 2000 (as enacted into law by sec-  
7 tion 1(a)(6) of Public Law 106–554), as amend-  
8 ed by section 732 of the Medicare Prescription  
9 Drug, Improvement, and Modernization Act of  
10 2003 (42 U.S.C. 1395w–4 note), section 104 of  
11 division B of the Tax Relief and Health Care  
12 Act of 2006 (42 U.S.C. 1395w–4 note), section  
13 104 of the Medicare, Medicaid, and SCHIP Ex-  
14 tension Act of 2007 (Public Law 110–173), and  
15 section 136 of the Medicare Improvements for  
16 Patients and Providers Act of 1008 (Public  
17 Law 110–275), is amended by striking “and  
18 2009” and inserting “2009, 2010, and 2011”.

19 SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

20 (a) IN GENERAL.—Section 1834(l)(13) of the  
21 Social Security Act (42 U.S.C. 1395m(l)(13)) is  
22 amended—

23 (1) in subparagraph (A)—

24 (A) in the matter preceding clause

25 (i), by striking “before January 1,

1           **2010” and inserting “before January**  
2           **1, 2012”;** and

3                   **(B) in each of clauses (i) and (ii),**  
4           **by striking “before January 1, 2010”**  
5           **and inserting “before January 1,**  
6           **2012”.**

7           **(b) AIR AMBULANCE IMPROVEMENTS.—Sec-**  
8           **tion 146(b)(1) of the Medicare Improvements**  
9           **for Patients and Providers Act of 2008 (Public**  
10           **Law 110–275) is amended by striking “ending**  
11           **on December 31, 2009” and inserting “ending**  
12           **on December 31, 2011”.**

13                   **TITLE II—MEDICARE**  
14           **BENEFICIARY IMPROVEMENTS**  
15           **Subtitle A—Improving and Simpli-**  
16           **fyng Financial Assistance for**  
17           **Low Income Medicare Bene-**  
18           **ficiaries**

19           **SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**  
20                   **INGS PROGRAM AND LOW-INCOME SUBSIDY**  
21                   **PROGRAM.**

22                   **(a) APPLICATION OF HIGHEST LEVEL PER-**  
23           **MITTED UNDER LIS TO ALL SUBSIDY ELIGIBLE IN-**  
24           **DIVIDUALS.—**

1           **(1) IN GENERAL.—Section 1860D-**  
2           **14(a)(1) of the Social Security Act (42**  
3           **U.S.C. 1395w-114(a)(1)) is amended in the**  
4           **matter before subparagraph (A), by in-**  
5           **serting “(or, beginning with 2012, para-**  
6           **graph (3)(E))” after “paragraph (3)(D)”.**

7           **(2) ANNUAL INCREASE IN LIS RESOURCE**  
8           **TEST.—Section 1860D-14(a)(3)(E)(i) of**  
9           **such Act (42 U.S.C. 1395w-114(a)(3)(E)(i))**  
10           **is amended—**

11                   **(A) by striking “and” at the end of**  
12                   **subclause (I);**

13                   **(B) in subclause (II), by inserting**  
14                   **“(before 2012)” after “subsequent**  
15                   **year”;**

16                   **(C) by striking the period at the**  
17                   **end of subclause (II) and inserting a**  
18                   **semicolon;**

19                   **(D) by inserting after subclause**  
20                   **(II) the following new subclauses:**

21                           **“(III) for 2012, \$17,000 (or**  
22                           **\$34,000 in the case of the com-**  
23                           **bined value of the individual’s**  
24                           **assets or resources and the**

1           **assets or resources of the in-**  
2           **dividual’s spouse); and**

3           **“(IV) for a subsequent**  
4           **year, the dollar amounts spec-**  
5           **ified in this subclause (or sub-**  
6           **clause (III)) for the previous**  
7           **year increased by the annual**  
8           **percentage increase in the**  
9           **consumer price index (all**  
10          **items; U.S. city average) as of**  
11          **September of such previous**  
12          **year.”; and**

13           **(E) in the last sentence, by insert-**  
14          **ing “or (IV)” after “subclause (II)”.**

15          **(3) APPLICATION OF LIS TEST UNDER**  
16          **MEDICARE SAVINGS PROGRAM.—Section**  
17          **1905(p)(1)(C) of such Act (42 U.S.C.**  
18          **1396d(p)(1)(C)) is amended—**

19           **(A) by striking “effective begin-**  
20           **ning with January 1, 2010” and in-**  
21           **serting “effective for the period be-**  
22           **ginning with January 1, 2010, and**  
23           **ending with December 31, 2011”; and**

24           **(B) by inserting before the period**  
25          **at the end the following: “or, effective**

1           **beginning with January 1, 2012,**  
2           **whose resources (as so determined)**  
3           **do not exceed the maximum resource**  
4           **level applied for the year under sub-**  
5           **paragraph (E) of section 1860D-**  
6           **14(a)(3) (determined without regard**  
7           **to the life insurance policy exclusion**  
8           **provided under subparagraph (G) of**  
9           **such section) applicable to an indi-**  
10          **vidual or to the individual and the in-**  
11          **dividual’s spouse (as the case may**  
12          **be)”.**

13          **(b) EFFECTIVE DATE.—The amendments**  
14          **made by subsection (a) shall apply to eligi-**  
15          **bility determinations for income-related sub-**  
16          **sidies and medicare cost-sharing furnished**  
17          **for periods beginning on or after January 1,**  
18          **2012.**

19          **SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR**  
20                            **CERTAIN NON-INSTITUTIONALIZED FULL-**  
21                            **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

22          **(a) IN GENERAL.—Section 1860D-**  
23          **14(a)(1)(D)(i) of the Social Security Act (42**  
24          **U.S.C. 1395w-114(a)(1)(D)(i) is amended—**



1           (1) by striking “INSTITUTIONALIZED IN-  
2           DIVIDUALS.—In” and inserting “ELIMI-  
3           NATION OF COST-SHARING FOR CERTAIN  
4           FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

5                           “(I) INSTITUTIONALIZED IN-  
6                           DIVIDUALS.—In”; and

7           (2) by adding at the end the following  
8           new subclause:

9                           “(II) CERTAIN OTHER INDI-  
10                          VIDUALS.—In the case of an in-  
11                          dividual who is a full-benefit  
12                          dual eligible individual and  
13                          with respect to whom there  
14                          has been a determination that  
15                          but for the provision of home  
16                          and community based care  
17                          (whether under section 1915,  
18                          1932, or under a waiver under  
19                          section 1115) the individual  
20                          would require the level of  
21                          care provided in a hospital or  
22                          a nursing facility or inter-  
23                          mediate care facility for the  
24                          mentally retarded the cost of  
25                          which could be reimbursed

1           under the State plan under  
2           title XIX, the elimination of  
3           any beneficiary coinsurance  
4           described in section 1860D-  
5           2(b)(2) (for all amounts  
6           through the total amount of  
7           expenditures at which bene-  
8           fits are available under sec-  
9           tion 1860D-2(b)(4)).”.

10          **(b) EFFECTIVE DATE.**—The amendments  
11 made by subsection (a) shall apply to drugs  
12 dispensed on or after January 1, 2011.

13 SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

14          **(a) ADMINISTRATIVE VERIFICATION OF IN-**  
15 **COME AND RESOURCES UNDER THE LOW-INCOME**  
16 **SUBSIDY PROGRAM.**—

17           **(1) IN GENERAL.**—Clause (iii) of section  
18           1860D-14(a)(3)(E) of the Social Security  
19           Act (42 U.S.C. 1395w-114(a)(3)(E)) is  
20           amended to read as follows:

21                   **“(iii) CERTIFICATION OF INCOME**  
22                   **AND RESOURCES.**—For purposes of  
23                   applying this section—

24                           **“(I) an individual shall be**  
25                           permitted to apply on the

1           **basis of self-certification of in-**  
2           **come and resources; and**

3           **“(II) matters attested to in**  
4           **the application shall be sub-**  
5           **ject to appropriate methods of**  
6           **verification without the need**  
7           **of the individual to provide**  
8           **additional documentation, ex-**  
9           **cept in extraordinary situa-**  
10          **tions as determined by the**  
11          **Commissioner.”.**

12           **(2) EFFECTIVE DATE.—The amendment**  
13          **made by paragraph (1) shall apply begin-**  
14          **ning January 1, 2010.**

15          **(b) DISCLOSURES TO FACILITATE IDENTIFICA-**  
16          **TION OF INDIVIDUALS LIKELY TO BE INELIGIBLE**  
17          **FOR THE LOW-INCOME ASSISTANCE UNDER THE**  
18          **MEDICARE PRESCRIPTION DRUG PROGRAM TO AS-**  
19          **SIST SOCIAL SECURITY ADMINISTRATION’S OUT-**  
20          **REACH TO ELIGIBLE INDIVIDUALS.—For provi-**  
21          **sion authorizing disclosure of return informa-**  
22          **tion to facilitate identification of individuals**  
23          **likely to be ineligible for low-income sub-**  
24          **sidies under Medicare prescription drug pro-**  
25          **gram, see section 1801.**

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 retro-  
5 active LIS enrollment beneficiary who is en-  
6 rolled under a prescription drug plan under  
7 part D of title XVIII of the Social Security Act  
8 (or an MA–PD plan under part C of such title),  
9 the beneficiary (or any eligible third party) is  
10 entitled to reimbursement by the plan for cov-  
11 ered drug costs incurred by the beneficiary  
12 during the retroactive coverage period of the  
13 beneficiary in accordance with subsection (b)  
14 and in the case of such a beneficiary de-  
15 scribed in subsection (c)(4)(A)(i), such reim-  
16 bursement shall be made automatically by the  
17 plan upon receipt of appropriate notice the  
18 beneficiary is eligible for assistance described  
19 in such subsection (c)(4)(A)(i) without further  
20 information required to be filed with the plan  
21 by the beneficiary.

22 (b) **ADMINISTRATIVE REQUIREMENTS RELAT-**  
23 **ING TO REIMBURSEMENTS.**—

24 (1) **LINE-ITEM DESCRIPTION.**—Each re-  
25 imbursement made by a prescription  
26 drug plan or MA–PD plan under sub-

1 section (a) shall include a line-item de-  
2 scription of the items for which the reim-  
3 bursement is made.

4 (2) **TIMING OF REIMBURSEMENTS.**—A  
5 prescription drug plan or MA-PD plan  
6 must make a reimbursement under sub-  
7 section (a) to a retroactive LIS enroll-  
8 ment beneficiary, with respect to a claim,  
9 not later than 45 days after—

10 (A) in the case of a beneficiary de-  
11 scribed in subsection (c)(4)(A)(i), the  
12 date on which the plan receives no-  
13 tice from the Secretary that the bene-  
14 ficiary is eligible for assistance de-  
15 scribed in such subsection; or

16 (B) in the case of a beneficiary de-  
17 scribed in subsection (c)(4)(A)(ii), the  
18 date on which the beneficiary files  
19 the claim with the plan.

20 (3) **REPORTING REQUIREMENT.**—For  
21 each month beginning with January 2011,  
22 each prescription drug plan and each  
23 MA-PD plan shall report to the Secretary  
24 the following:

1           **(A) The number of claims the plan**  
2 **has readjudicated during the month**  
3 **due to a beneficiary becoming retro-**  
4 **actively eligible for subsidies avail-**  
5 **able under section 1860D-14 of the**  
6 **Social Security Act.**

7           **(B) The total value of the readju-**  
8 **dicated claim amount for the month.**

9           **(C) The Medicare Health Insur-**  
10 **ance Claims Number of beneficiaries**  
11 **for whom claims were readjudicated.**

12           **(D) For the claims described in**  
13 **subparagraphs (A) and (B), an attes-**  
14 **tation to the Administrator of the**  
15 **Centers for Medicare & Medicaid**  
16 **Services of the total amount of reim-**  
17 **bursement the plan has provided to**  
18 **beneficiaries for premiums and cost-**  
19 **sharing that the beneficiary overpaid**  
20 **for which the plan received payment**  
21 **from the Centers for Medicare & Med-**  
22 **icaid Services.**

23           **(c) DEFINITIONS.—For purposes of this sec-**  
24 **tion:**

1           **(1) COVERED DRUG COSTS.—**The term  
2           **“covered drug costs”** means, with respect  
3           to a retroactive LIS enrollment bene-  
4           ficiary enrolled under a prescription  
5           drug plan under part D of title XVIII of  
6           the Social Security Act (or an MA-PD  
7           plan under part C of such title), the  
8           amount by which—

9                   **(A)** the costs incurred by such  
10           beneficiary during the retroactive  
11           coverage period of the beneficiary for  
12           covered part D drugs, premiums, and  
13           cost-sharing under such title; exceeds

14                   **(B)** such costs that would have  
15           been incurred by such beneficiary  
16           during such period if the beneficiary  
17           had been both enrolled in the plan  
18           and recognized by such plan as quali-  
19           fied during such period for the low  
20           income subsidy under section 1860D-  
21           14 of the Social Security Act to which  
22           the individual is entitled.

23           **(2) ELIGIBLE THIRD PARTY.—**The term  
24           **“eligible third party”** means, with respect  
25           to a retroactive LIS enrollment bene-

1       **fiary, an organization or other third**  
2       **party that is owed payment on behalf of**  
3       **such beneficiary for covered drug costs**  
4       **incurred by such beneficiary during the**  
5       **retroactive coverage period of such bene-**  
6       **fiary.**

7           **(3) RETROACTIVE COVERAGE PERIOD.—**

8       **The term “retroactive coverage period”**  
9       **means—**

10           **(A) with respect to a retroactive**  
11           **LIS enrollment beneficiary described**  
12           **in paragraph (4)(A)(i), the period—**

13                   **(i) beginning on the effective**  
14                   **date of the assistance described**  
15                   **in such paragraph for which the**  
16                   **individual is eligible; and**

17                   **(ii) ending on the date the**  
18                   **plan effectuates the status of such**  
19                   **individual as so eligible; and**

20           **(B) with respect to a retroactive**  
21           **LIS enrollment beneficiary described**  
22           **in paragraph (4)(A)(ii), the period—**

23                   **(i) beginning on the date the**  
24                   **individual is both entitled to ben-**  
25                   **efits under part A, or enrolled**



1 under part B, of title XVIII of the  
2 Social Security Act and eligible  
3 for medical assistance under a  
4 State plan under title XIX of such  
5 Act; and

6 (ii) ending on the date the  
7 plan effectuates the status of such  
8 individual as a full-benefit dual  
9 eligible individual (as defined in  
10 section 1935(c)(6) of such Act).

11 (4) **RETROACTIVE LIS ENROLLMENT BEN-**  
12 **EFICIARY.—**

13 (A) **IN GENERAL.—**The term “retro-  
14 active LIS enrollment beneficiary”  
15 means an individual who—

16 (i) is enrolled in a prescrip-  
17 tion drug plan under part D of  
18 title XVIII of the Social Security  
19 Act (or an MA-PD plan under  
20 part C of such title) and subse-  
21 quently becomes eligible as a full-  
22 benefit dual eligible individual  
23 (as defined in section 1935(c)(6) of  
24 such Act), an individual receiving  
25 a low-income subsidy under sec-

1           **tion 1860D-14 of such Act, an in-**  
2           **dividual receiving assistance**  
3           **under the Medicare Savings Pro-**  
4           **gram implemented under clauses**  
5           **(i), (iii), and (iv) of section**  
6           **1902(a)(10)(E) of such Act, or an**  
7           **individual receiving assistance**  
8           **under the supplemental security**  
9           **income program under section**  
10           **1611 of such Act; or**

11           **(ii) subject to subparagraph**  
12           **(B)(i), is a full-benefit dual eligi-**  
13           **ble individual (as defined in sec-**  
14           **tion 1935(c)(6) of such Act) who is**  
15           **automatically enrolled in such a**  
16           **plan under section 1860D-**  
17           **1(b)(1)(C) of such Act.**

18           **(B) EXCEPTION FOR BENEFICIARIES**  
19           **ENROLLED IN RFP PLAN.—**

20           **(i) IN GENERAL.—In no case**  
21           **shall an individual described in**  
22           **subparagraph (A)(ii) include an**  
23           **individual who is enrolled, pursu-**  
24           **ant to a RFP contract described**  
25           **in clause (ii), in a prescription**

1           **drug plan offered by the sponsor**  
2           **of such plan awarded such con-**  
3           **tract.**

4           **(ii) RFP CONTRACT DE-**  
5           **SCRIBED.—The RFP contract de-**  
6           **scribed in this section is a con-**  
7           **tract entered into between the**  
8           **Secretary and a sponsor of a pre-**  
9           **scription drug plan pursuant to**  
10          **the Centers for Medicare & Med-**  
11          **icaid Services’ request for pro-**  
12          **posals issued on February 17,**  
13          **2009, relating to Medicare part D**  
14          **retroactive coverage for certain**  
15          **low income beneficiaries, or a**  
16          **similar subsequent request for**  
17          **proposals.**

18 **SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

19          **(a) IN GENERAL.—Section 1860D-1(b)(1)(C)**  
20          **of the Social Security Act (42 U.S.C. 1395w-**  
21          **101(b)(1)(C)) is amended by adding after “PDP**  
22          **region” the following: “or through use of an**  
23          **intelligent assignment process that is de-**  
24          **signed to maximize the access of such indi-**  
25          **vidual to necessary prescription drugs while**

1 **minimizing costs to such individual and to the**  
2 **program under this part to the greatest ex-**  
3 **tent possible. In the case the Secretary enrolls**  
4 **such individuals through use of an intelligent**  
5 **assignment process, such process shall take**  
6 **into account the extent to which prescription**  
7 **drugs necessary for the individual are cov-**  
8 **ered in the case of a PDP sponsor of a pre-**  
9 **scription drug plan that uses a formulary, the**  
10 **use of prior authorization or other restric-**  
11 **tions on access to coverage of such prescrip-**  
12 **tion drugs by such a sponsor, and the overall**  
13 **quality of a prescription drug plan as meas-**  
14 **ured by quality ratings established by the**  
15 **Secretary”**

16 **(b) EFFECTIVE DATE.—The amendment**  
17 **made by subsection (a) shall take effect for**  
18 **contract years beginning with 2012.**

19 **SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC**  
20 **ENROLLMENT PROCESS FOR CERTAIN SUB-**  
21 **SIDY ELIGIBLE INDIVIDUALS.**

22 **(a) SPECIAL ENROLLMENT PERIOD.—Section**  
23 **1860D–1(b)(3)(D) of the Social Security Act (42**  
24 **U.S.C. 1395w–101(b)(3)(D)) is amended to read**  
25 **as follows:**

1           **“(D) SUBSIDY ELIGIBLE INDIVID-**  
2           **UALS.—In the case of an individual (as**  
3           **determined by the Secretary) who is**  
4           **determined under subparagraph (B)**  
5           **of section 1860D–14(a)(3) to be a sub-**  
6           **sidy eligible individual.”.**

7           **(b) AUTOMATIC ENROLLMENT.—Section**  
8           **1860D–1(b)(1) of the Social Security Act (42**  
9           **U.S.C. 1395w–101(b)(1)) is amended by adding**  
10          **at the end the following new subparagraph:**

11           **“(D) SPECIAL RULE FOR SUBSIDY EL-**  
12           **IGIBLE INDIVIDUALS.—The process es-**  
13           **tablished under subparagraph (A)**  
14           **shall include, in the case of an indi-**  
15           **vidual described in section 1860D–**  
16           **1(b)(3)(D) who fails to enroll in a pre-**  
17           **scription drug plan or an MA–PD**  
18           **plan during the special enrollment es-**  
19           **tablished under such section applica-**  
20           **ble to such individual, the application**  
21           **of the assignment process described**  
22           **in subparagraph (C) to such indi-**  
23           **vidual in the same manner as such**  
24           **assignment process applies to a part**  
25           **D eligible individual described in**



1 determinations made for months beginning  
2 with January 2011.

3 **Subtitle B—Reducing Health**  
4 **Disparities**

5 SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN  
6 MEDICARE.

7 (a) ENSURING EFFECTIVE COMMUNICATION  
8 BY THE CENTERS FOR MEDICARE & MEDICAID  
9 SERVICES.—

10 (1) STUDY ON MEDICARE PAYMENTS FOR  
11 LANGUAGE SERVICES.—The Secretary of  
12 Health and Human Services shall conduct  
13 a study that examines the extent to  
14 which Medicare service providers utilize,  
15 offer, or make available language serv-  
16 ices for beneficiaries who are limited  
17 English proficient and ways that Medi-  
18 care should develop payment systems for  
19 language services.

20 (2) ANALYSES.—The study shall in-  
21 clude an analysis of each of the following:

22 (A) How to develop and structure  
23 appropriate payment systems for lan-  
24 guage services for all Medicare serv-  
25 ices providers.

1           **(B) The feasibility of adopting a**  
2           **payment methodology for on-site in-**  
3           **terpreters, including interpreters**  
4           **who work as independent contractors**  
5           **and interpreters who work for agen-**  
6           **cies that provide on-site interpreta-**  
7           **tion, pursuant to which such inter-**  
8           **preters could directly bill Medicare**  
9           **for services provided in support of**  
10          **physician office services for an LEP**  
11          **Medicare patient.**

12          **(C) The feasibility of Medicare**  
13          **contracting directly with agencies**  
14          **that provide off-site interpretation in-**  
15          **cluding telephonic and video inter-**  
16          **pretation pursuant to which such**  
17          **contractors could directly bill Medi-**  
18          **care for the services provided in sup-**  
19          **port of physician office services for**  
20          **an LEP Medicare patient.**

21          **(D) The feasibility of modifying**  
22          **the existing Medicare resource-based**  
23          **relative value scale (RBRVS) by using**  
24          **adjustments (such as multipliers or**  
25          **add-ons) when a patient is LEP.**



1           **(E) How each of options described**  
2 **in a previous paragraph would be**  
3 **funded and how such funding would**  
4 **affect physician payments, a physi-**  
5 **cian’s practice, and beneficiary cost-**  
6 **sharing.**

7           **(F) The extent to which providers**  
8 **under parts A and B of title XVIII of**  
9 **the Social Security Act, MA organiza-**  
10 **tions offering Medicare Advantage**  
11 **plans under part C of such title and**  
12 **PDP sponsors of a prescription drug**  
13 **plan under part D of such title utilize,**  
14 **offer, or make available language**  
15 **services for beneficiaries with limited**  
16 **English proficiency.**

17           **(G) The nature and type of lan-**  
18 **guage services provided by States**  
19 **under title XIX of the Social Security**  
20 **Act and the extent to which such**  
21 **services could be utilized by bene-**  
22 **ficiaries and providers under title**  
23 **XVIII of such Act.**

24           **(3) VARIATION IN PAYMENT SYSTEM DE-**  
25 **SCRIBED.—The payment systems described**

1       **in paragraph (2)(A) may allow variations**  
2       **based upon types of service providers,**  
3       **available delivery methods, and costs for**  
4       **providing language services including**  
5       **such factors as—**

6               **(A) the type of language services**  
7               **provided (such as provision of health**  
8               **care or health care related services**  
9               **directly in a non-English language by**  
10              **a bilingual provider or use of an in-**  
11              **terpreter);**

12              **(B) type of interpretation services**  
13              **provided (such as in-person, tele-**  
14              **phonic, video interpretation);**

15              **(C) the methods and costs of pro-**  
16              **viding language services (including**  
17              **the costs of providing language serv-**  
18              **ices with internal staff or through**  
19              **contract with external independent**  
20              **contractors or agencies, or both);**

21              **(D) providing services for lan-**  
22              **guages not frequently encountered in**  
23              **the United States; and**

24              **(E) providing services in rural**  
25              **areas.**

1           **(4) REPORT.—**The Secretary shall sub-  
2           **mit a report on the study conducted**  
3           **under subsection (a) to appropriate com-**  
4           **mittees of Congress not later than 12**  
5           **months after the date of the enactment of**  
6           **this Act.**

7           **(5) EXEMPTION FROM PAPERWORK RE-**  
8           **DUCTION ACT.—**Chapter 35 of title 44,  
9           **United States Code (commonly known as**  
10          **the “Paperwork Reduction Act” ), shall**  
11          **not apply for purposes of carrying out**  
12          **this subsection.**

13          **(6) AUTHORIZATION OF APPROPRIA-**  
14          **TIONS.—**There is authorized to be appro-  
15          **priated to carry out this subsection such**  
16          **sums as are necessary.**

17          **(b) HEALTH PLANS.—**Section 1857(g)(1) of  
18          **the Social Security Act (42 U.S.C. 1395w-**  
19          **27(g)(1)) is amended—**

20                **(1) by striking “or” at the end of sub-**  
21                **paragraph (F);**

22                **(2) by adding “or” at the end of sub-**  
23                **paragraph (G); and**

24                **(3) by inserting after subparagraph**  
25                **(G) the following new subparagraph:**

1           “(H) fails substantially to provide  
2           language services to limited English  
3           proficient beneficiaries enrolled in  
4           the plan that are required under  
5           law;”.

6   SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR  
7           MEDICARE BENEFICIARIES WITH LIMITED  
8           ENGLISH PROFICIENCY BY PROVIDING REIM-  
9           BURSEMENT FOR CULTURALLY AND LINGUIS-  
10          TICALLY APPROPRIATE SERVICES.

11        (a) IN GENERAL.—Not later than 6 months  
12   after the date of the completion of the study  
13   described in section 1221(a), the Secretary,  
14   acting through the Centers for Medicare &  
15   Medicaid Services, shall carry out a dem-  
16   onstration program under which the Sec-  
17   retary shall award not fewer than 24 3-year  
18   grants to eligible Medicare service providers  
19   (as described in subsection (b)(1)) to improve  
20   effective communication between such pro-  
21   viders and Medicare beneficiaries who are liv-  
22   ing in communities where racial and ethnic  
23   minorities, including populations that face  
24   language barriers, are underserved with re-  
25   spect to such services. In designing and car-

1 rying out the demonstration the Secretary  
2 shall take into consideration the results of the  
3 study conducted under section 1221(a) and  
4 adjust, as appropriate, the distribution of  
5 grants so as to better target Medicare bene-  
6 ficiaries who are in the greatest need of lan-  
7 guage services. The Secretary shall not au-  
8 thorize a grant larger than \$500,000 over  
9 three years for any grantee.

10 (b) **ELIGIBILITY; PRIORITY.—**

11 (1) **ELIGIBILITY.—**To be eligible to re-  
12 ceive a grant under subsection (a) an en-  
13 tity shall—

14 (A) be—

15 (i) a provider of services  
16 under part A of title XVIII of the  
17 Social Security Act;

18 (ii) a service provider under  
19 part B of such title;

20 (iii) a part C organization of-  
21 fering a Medicare part C plan  
22 under part C of such title; or

23 (iv) a PDP sponsor of a pre-  
24 scription drug plan under part D  
25 of such title; and

1           **(B) prepare and submit to the**  
2 **Secretary an application, at such**  
3 **time, in such manner, and accom-**  
4 **panied by such additional informa-**  
5 **tion as the Secretary may require.**

6 **(2) PRIORITY.—**

7           **(A) DISTRIBUTION.—To the extent**  
8 **feasible, in awarding grants under**  
9 **this section, the Secretary shall**  
10 **award—**

11                   **(i) at least 6 grants to pro-**  
12 **viders of services described in**  
13 **paragraph (1)(A)(i);**

14                   **(ii) at least 6 grants to service**  
15 **providers described in paragraph**  
16 **(1)(A)(ii);**

17                   **(iii) at least 6 grants to orga-**  
18 **nizations described in paragraph**  
19 **(1)(A)(iii); and**

20                   **(iv) at least 6 grants to spon-**  
21 **sors described in paragraph**  
22 **(1)(A)(iv).**

23           **(B) FOR COMMUNITY ORGANIZA-**  
24 **TIONS.—The Secretary shall give pri-**  
25 **ority to applicants that have devel-**

1           **oped partnerships with community**  
2           **organizations or with agencies with**  
3           **experience in language access.**

4           **(C) VARIATION IN GRANTEES.—The**  
5           **Secretary shall also ensure that the**  
6           **grantees under this section represent,**  
7           **among other factors, variations in—**

8                   **(i) different types of language**  
9                   **services provided and of service**  
10                  **providers and organizations**  
11                  **under parts A through D of title**  
12                  **XVIII of the Social Security Act;**

13                  **(ii) languages needed and**  
14                  **their frequency of use;**

15                  **(iii) urban and rural settings;**

16                  **(iv) at least two geographic**  
17                  **regions, as defined by the Sec-**  
18                  **retary; and**

19                  **(v) at least two large metro-**  
20                  **politan statistical areas with di-**  
21                  **verse populations.**

22           **(c) USE OF FUNDS.—**

23                   **(1) IN GENERAL.—A grantee shall use**  
24                   **grant funds received under this section**  
25                   **to pay for the provision of competent lan-**

1 **guage services to Medicare beneficiaries**  
2 **who are limited English proficient. Com-**  
3 **petent interpreter services may be pro-**  
4 **vided through on-site interpretation, tele-**  
5 **phonic interpretation, or video interpre-**  
6 **tation or direct provision of health care**  
7 **or health care related services by a bilin-**  
8 **gual health care provider. A grantee may**  
9 **use bilingual providers, staff, or contract**  
10 **interpreters. A grantee may use grant**  
11 **funds to pay for competent translation**  
12 **services. A grantee may use up to 10 per-**  
13 **cent of the grant funds to pay for admin-**  
14 **istrative costs associated with the provi-**  
15 **sion of competent language services and**  
16 **for reporting required under subsection**  
17 **(e).**

18 **(2) ORGANIZATIONS.—Grantees that are**  
19 **part C organizations or PDP sponsors**  
20 **must ensure that their network providers**  
21 **receive at least 50 percent of the grant**  
22 **funds to pay for the provision of com-**  
23 **petent language services to Medicare**  
24 **beneficiaries who are limited English**



1       **proficient, including physicians and**  
2       **pharmacies.**

3               **(3) DETERMINATION OF PAYMENTS FOR**  
4       **LANGUAGE SERVICES.—Payments to grant-**  
5       **ees shall be calculated based on the esti-**  
6       **mated numbers of limited English pro-**  
7       **ficient Medicare beneficiaries in a grant-**  
8       **ee’s service area utilizing—**

9               **(A) data on the numbers of lim-**  
10       **ited English proficient individuals**  
11       **who speak English less than “very**  
12       **well” from the most recently available**  
13       **data from the Bureau of the Census**  
14       **or other State-based study the Sec-**  
15       **retary determines likely to yield ac-**  
16       **curate data regarding the number of**  
17       **such individuals served by the grant-**  
18       **ee; or**

19               **(B) the grantee’s own data if the**  
20       **grantee routinely collects data on**  
21       **Medicare beneficiaries’ primary lan-**  
22       **guage in a manner determined by the**  
23       **Secretary to yield accurate data and**  
24       **such data shows greater numbers of**  
25       **limited English proficient individuals**

1           **than the data listed in subparagraph**  
2           **(A).**

3           **(4) LIMITATIONS.—**

4           **(A) REPORTING.—**Payments shall  
5           only be provided under this section  
6           to grantees that report their costs of  
7           providing language services as re-  
8           quired under subsection (e) and may  
9           be modified annually at the discre-  
10          tion of the Secretary. If a grantee  
11          fails to provide the reports under  
12          such section for the first year of a  
13          grant, the Secretary may terminate  
14          the grant and solicit applications  
15          from new grantees to participate in  
16          the subsequent two years of the dem-  
17          onstration program.

18          **(B) TYPE OF SERVICES.—**

19                **(i) IN GENERAL.—**Subject to  
20                clause (ii), payments shall be pro-  
21                vided under this section only to  
22                grantees that utilize competent  
23                bilingual staff or competent inter-  
24                preter or translation services  
25                which—

1           **(I) if the grantee operates**  
2           **in a State that has statewide**  
3           **health care interpreter stand-**  
4           **ards, meet the State stand-**  
5           **ards currently in effect; or**

6           **(II) if the grantee operates**  
7           **in a State that does not have**  
8           **statewide health care inter-**  
9           **preter standards, utilizes**  
10          **competent interpreters who**  
11          **follow the National Council**  
12          **on Interpreting in Health**  
13          **Care’s Code of Ethics and**  
14          **Standards of Practice.**

15          **(ii) EXEMPTIONS.—The require-**  
16          **ments of clause (i) shall not**  
17          **apply—**

18               **(I) in the case of a Medi-**  
19               **care beneficiary who is lim-**  
20               **ited English proficient (who**  
21               **has been informed in the**  
22               **beneficiary’s primary lan-**  
23               **guage of the availability of**  
24               **free interpreter and trans-**  
25               **lation services) and who re-**

1           **quests the use of family,**  
2           **friends, or other persons un-**  
3           **trained in interpretation or**  
4           **translation and the grantee**  
5           **documents the request in the**  
6           **beneficiary's record; and**

7                   **(II) in the case of a med-**  
8                   **ical emergency where the**  
9                   **delay directly associated with**  
10                  **obtaining a competent inter-**  
11                  **preter or translation services**  
12                  **would jeopardize the health**  
13                  **of the patient.**

14           **Nothing in clause (ii)(II) shall be**  
15           **construed to exempt emergency**  
16           **rooms or similar entities that reg-**  
17           **ularly provide health care serv-**  
18           **ices in medical emergencies from**  
19           **having in place systems to pro-**  
20           **vide competent interpreter and**  
21           **translation services without**  
22           **undue delay.**

23           **(d) ASSURANCES.—Grantees under this sec-**  
24           **tion shall—**

1           **(1) ensure that appropriate clinical**  
2           **and support staff receive ongoing edu-**  
3           **cation and training in linguistically ap-**  
4           **propriate service delivery;**

5           **(2) ensure the linguistic competence**  
6           **of bilingual providers;**

7           **(3) offer and provide appropriate lan-**  
8           **guage services at no additional charge to**  
9           **each patient with limited English pro-**  
10          **iciency at all points of contact, in a time-**  
11          **ly manner during all hours of operation;**

12          **(4) notify Medicare beneficiaries of**  
13          **their right to receive language services in**  
14          **their primary language;**

15          **(5) post signage in the languages of**  
16          **the commonly encountered group or**  
17          **groups present in the service area of the**  
18          **organization; and**

19          **(6) ensure that—**

20               **(A) primary language data are**  
21               **collected for recipients of language**  
22               **services; and**

23               **(B) consistent with the privacy**  
24               **protections provided under the regu-**  
25               **lations promulgated pursuant to sec-**

1           **tion 264(c) of the Health Insurance**  
2           **Portability and Accountability Act of**  
3           **1996 (42 U.S.C. 1320d-2 note), if the**  
4           **recipient of language services is a**  
5           **minor or is incapacitated, the pri-**  
6           **mary language of the parent or legal**  
7           **guardian is collected and utilized.**

8           **(e) REPORTING REQUIREMENTS.—Grantees**  
9           **under this section shall provide the Secretary**  
10          **with reports at the conclusion of the each**  
11          **year of a grant under this section. Each re-**  
12          **port shall include at least the following infor-**  
13          **mation:**

14               **(1) The number of Medicare bene-**  
15               **ficiaries to whom language services are**  
16               **provided.**

17               **(2) The languages of those Medicare**  
18               **beneficiaries.**

19               **(3) The types of language services**  
20               **provided (such as provision of services**  
21               **directly in non-English language by a bi-**  
22               **lingual health care provider or use of an**  
23               **interpreter).**

1           **(4) Type of interpretation (such as in-**  
2           **person, telephonic, or video interpreta-**  
3           **tion).**

4           **(5) The methods of providing lan-**  
5           **guage services (such as staff or contract**  
6           **with external independent contractors or**  
7           **agencies).**

8           **(6) The length of time for each inter-**  
9           **pretation encounter.**

10           **(7) The costs of providing language**  
11           **services (which may be actual or esti-**  
12           **mated, as determined by the Secretary).**

13           **(f) NO COST SHARING.—Limited English**  
14           **proficient Medicare beneficiaries shall not**  
15           **have to pay cost-sharing or co-pays for lan-**  
16           **guage services provided through this dem-**  
17           **onstration program.**

18           **(g) EVALUATION AND REPORT.—The Sec-**  
19           **retary shall conduct an evaluation of the dem-**  
20           **onstration program under this section and**  
21           **shall submit to the appropriate committees of**  
22           **Congress a report not later than 1 year after**  
23           **the completion of the program. The report**  
24           **shall include the following:**

1           **(1) An analysis of the patient out-**  
2           **comes and costs of furnishing care to the**  
3           **limited English proficient Medicare bene-**  
4           **ficiaries participating in the project as**  
5           **compared to such outcomes and costs for**  
6           **limited English proficient Medicare bene-**  
7           **ficiaries not participating.**

8           **(2) The effect of delivering culturally**  
9           **and linguistically appropriate services on**  
10          **beneficiary access to care, utilization of**  
11          **services, efficiency and cost-effectiveness**  
12          **of health care delivery, patient satisfac-**  
13          **tion, and select health outcomes.**

14          **(3) Recommendations, if any, regard-**  
15          **ing the extension of such project to the**  
16          **entire Medicare program.**

17          **(h) GENERAL PROVISIONS.—Nothing in this**  
18          **section shall be construed to limit otherwise**  
19          **existing obligations of recipients of Federal fi-**  
20          **nancial assistance under title VI of the Civil**  
21          **Rights Act of 1964 (42 U.S.C. 2000(d) et seq.)**  
22          **or any other statute.**

23          **(i) AUTHORIZATION OF APPROPRIATIONS.—**  
24          **There are authorized to be appropriated to**



1 carry out this section \$16,000,000 for each fis-  
2 cal year of the demonstration program.

3 SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS  
4 SERVICES.

5 (a) IN GENERAL.—The Secretary of Health  
6 and Human Services shall enter into an ar-  
7 rangement with the Institute of Medicine  
8 under which the Institute will prepare and  
9 publish, not later than 3 years after the date  
10 of the enactment of this Act, a report on the  
11 impact of language access services on the  
12 health and health care of limited English pro-  
13 ficient populations.

14 (b) CONTENTS.—Such report shall in-  
15 clude—

16 (1) recommendations on the develop-  
17 ment and implementation of policies and  
18 practices by health care organizations  
19 and providers for limited English pro-  
20 ficient patient populations;

21 (2) a description of the effect of pro-  
22 viding language access services on qual-  
23 ity of health care and access to care and  
24 reduced medical error; and

1           **(3) a description of the costs associ-**  
2           **ated with or savings related to provision**  
3           **of language access services.**

4 **SEC. 1224. DEFINITIONS.**

5           **In this subtitle:**

6           **(1) BILINGUAL.—The term “bilingual”**  
7           **with respect to an individual means a**  
8           **person who has sufficient degree of pro-**  
9           **ficiency in two languages and can ensure**  
10           **effective communication can occur in**  
11           **both languages.**

12           **(2) COMPETENT INTERPRETER SERV-**  
13           **ICES.—The term “competent interpreter**  
14           **services” means a trans-language ren-**  
15           **dition of a spoken message in which the**  
16           **interpreter comprehends the source lan-**  
17           **guage and can speak comprehensively in**  
18           **the target language to convey the mean-**  
19           **ing intended in the source language. The**  
20           **interpreter knows health and health-re-**  
21           **lated terminology and provides accurate**  
22           **interpretations by choosing equivalent**  
23           **expressions that convey the best match-**  
24           **ing and meaning to the source language**  
25           **and captures, to the greatest possible ex-**

1        **tent, all nuances intended in the source**  
2        **message.**

3            **(3) COMPETENT TRANSLATION SERV-**  
4        **ICES.—The term “competent translation**  
5        **services” means a trans-language ren-**  
6        **dition of a written document in which**  
7        **the translator comprehends the source**  
8        **language and can write comprehensively**  
9        **in the target language to convey the**  
10       **meaning intended in the source language.**  
11       **The translator knows health and health-**  
12       **related terminology and provides accu-**  
13       **rate translations by choosing equivalent**  
14       **expressions that convey the best match-**  
15       **ing and meaning to the source language**  
16       **and captures, to the greatest possible ex-**  
17       **tent, all nuances intended in the source**  
18       **document.**

19            **(4) EFFECTIVE COMMUNICATION.—The**  
20        **term “effective communication” means an**  
21        **exchange of information between the pro-**  
22        **vider of health care or health care-re-**  
23        **lated services and the limited English**  
24        **proficient recipient of such services that**  
25        **enables limited English proficient indi-**

1       **viduals to access, understand, and benefit**  
2       **from health care or health care-related**  
3       **services.**

4           **(5) INTERPRETING/INTERPRETATION.—**  
5       **The terms “interpreting” and “interpreta-**  
6       **tion” mean the transmission of a spoken**  
7       **message from one language into another,**  
8       **faithfully, accurately, and objectively.**

9           **(6) HEALTH CARE SERVICES.—The term**  
10       **“health care services” means services**  
11       **that address physical as well as mental**  
12       **health conditions in all care settings.**

13           **(7) HEALTH CARE-RELATED SERVICES.—**  
14       **The term “health care-related services”**  
15       **means human or social services programs**  
16       **or activities that provide access, referrals**  
17       **or links to health care.**

18           **(8) LANGUAGE ACCESS.—The term “lan-**  
19       **guage access” means the provision of lan-**  
20       **guage services to an LEP individual de-**  
21       **signed to enhance that individual’s ac-**  
22       **cess to, understanding of or benefit from**  
23       **health care or health care-related serv-**  
24       **ices.**

1           **(9) LANGUAGE SERVICES.—**The term  
2           **“language services”** means provision of  
3           **health care services directly in a non-**  
4           **English language, interpretation, trans-**  
5           **lation, and non-English signage.**

6           **(10) LIMITED ENGLISH PROFICIENT.—**  
7           **The term “limited English proficient” or**  
8           **“LEP” with respect to an individual**  
9           **means an individual who speaks a pri-**  
10           **mary language other than English and**  
11           **who cannot speak, read, write or under-**  
12           **stand the English language at a level that**  
13           **permits the individual to effectively com-**  
14           **municate with clinical or nonclinical**  
15           **staff at an entity providing health care or**  
16           **health care related services.**

17           **(11) MEDICARE BENEFICIARY.—**The term  
18           **“Medicare beneficiary”** means an indi-  
19           **vidual entitled to benefits under part A of**  
20           **title XVIII of the Social Security Act or**  
21           **enrolled under part B of such title.**

22           **(12) MEDICARE PROGRAM.—**The term  
23           **“Medicare program”** means the programs  
24           **under parts A through D of title XVIII of**  
25           **the Social Security Act.**

1           **(13) SERVICE PROVIDER.—**The term  
2           **“service provider”** includes all suppliers,  
3           **providers of services, or entities under**  
4           **contract to provide coverage, items or**  
5           **services under any part of title XVIII of**  
6           **the Social Security Act.**

7                           **Subtitle C—Miscellaneous**  
8                           **Improvements**

9           **SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS**  
10                           **PROCESS.**

11           **Section 1833(g)(5) of the Social Security**  
12           **Act (42 U.S.C. 1395l(g)(5)), as amended by sec-**  
13           **tion 141 of the Medicare Improvements for**  
14           **Patients and Providers Act of 2008 (Public**  
15           **Law 110–275), is amended by striking “Decem-**  
16           **ber 31, 2009” and inserting “December 31,**  
17           **2011”.**

18           **SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNO-**  
19                           **SUPPRESSIVE DRUGS FOR KIDNEY TRANS-**  
20                           **PLANT PATIENTS AND OTHER RENAL DIALY-**  
21                           **SIS PROVISIONS.**

22           **(a) PROVISION OF APPROPRIATE COVERAGE**  
23           **OF IMMUNOSUPPRESSIVE DRUGS UNDER THE**  
24           **MEDICARE PROGRAM FOR KIDNEY TRANSPLANT**  
25           **RECIPIENTS.—**

1           **(1) CONTINUED ENTITLEMENT TO IM-**  
2           **MUNOSUPPRESSIVE DRUGS.—**

3           **(A) KIDNEY TRANSPLANT RECIPI-**  
4           **ENTS.—Section 226A(b)(2) of the Social**  
5           **Security Act (42 U.S.C. 426–1(b)(2)) is**  
6           **amended by inserting “(except for**  
7           **coverage of immunosuppressive**  
8           **drugs under section 1861(s)(2)(J))” be-**  
9           **fore “, with the thirty-sixth month”.**

10           **(B) APPLICATION.—Section 1836 of**  
11           **such Act (42 U.S.C. 1395o) is amend-**  
12           **ed—**

13                   **(i) by striking “Every indi-**  
14                   **vidual who” and inserting “(a) IN**  
15                   **GENERAL.—Every individual who”;**  
16                   **and**

17                   **(ii) by adding at the end the**  
18                   **following new subsection:**

19           **“(b) SPECIAL RULES APPLICABLE TO INDIVID-**  
20           **UALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNO-**  
21           **SUPPRESSIVE DRUGS.—**

22                   **“(1) IN GENERAL.—In the case of an in-**  
23                   **dividual whose eligibility for benefits**  
24                   **under this title has ended on or after**  
25                   **January 1, 2012, except for the coverage**

1 of immunosuppressive drugs by reason of  
2 section 226A(b)(2), the following rules  
3 shall apply:

4 “(A) The individual shall be  
5 deemed to be enrolled under this part  
6 for purposes of receiving coverage of  
7 such drugs.

8 “(B) The individual shall be re-  
9 sponsible for providing for payment  
10 of the portion of the premium under  
11 section 1839 which is not covered  
12 under the Medicare savings program  
13 (as defined in section 1144(c)(7)) in  
14 order to receive such coverage.

15 “(C) The provision of such drugs  
16 shall be subject to the application  
17 of—

18 “(i) the deductible under sec-  
19 tion 1833(b); and

20 “(ii) the coinsurance amount  
21 applicable for such drugs (as de-  
22 termined under this part).

23 “(D) If the individual is an inpa-  
24 tient of a hospital or other entity, the



1 individual is entitled to receive cov-  
2 erage of such drugs under this part.

3 **“(2) ESTABLISHMENT OF PROCEDURES IN**  
4 **ORDER TO IMPLEMENT COVERAGE.—The Sec-**  
5 **retary shall establish procedures for—**

6 **“(A) identifying individuals that**  
7 **are entitled to coverage of immuno-**  
8 **suppressive drugs by reason of sec-**  
9 **tion 226A(b)(2); and**

10 **“(B) distinguishing such individ-**  
11 **uals from individuals that are en-**  
12 **rolled under this part for the com-**  
13 **plete package of benefits under this**  
14 **part.”.**

15 **(C) TECHNICAL AMENDMENT TO COR-**  
16 **RECT DUPLICATE SUBSECTION DESIGNA-**  
17 **TION.—Subsection (c) of section 226A**  
18 **of such Act (42 U.S.C. 426–1), as added**  
19 **by section 201(a)(3)(D)(ii) of the So-**  
20 **cial Security Independence and Pro-**  
21 **gram Improvements Act of 1994 (Pub-**  
22 **lic Law 103–296; 108 Stat. 1497), is re-**  
23 **designated as subsection (d).**

24 **(2) EXTENSION OF SECONDARY PAYER RE-**  
25 **QUIREMENTS FOR ESRD BENEFICIARIES.—**

1       **Section 1862(b)(1)(C) of such Act (42**  
2       **U.S.C. 1395y(b)(1)(C)) is amended by add-**  
3       **ing at the end the following new sen-**  
4       **tence: “With regard to immuno-**  
5       **suppressive drugs furnished on or after**  
6       **the date of the enactment of the Amer-**  
7       **ica’s Affordable Health Choices Act of**  
8       **2009, this subparagraph shall be applied**  
9       **without regard to any time limitation.”.**

10       **(b) MEDICARE COVERAGE FOR ESRD PA-**  
11       **TIENTS.—Section 1881 of such Act is further**  
12       **amended—**

13               **(1) in subsection (b)(14)(B)(iii), by in-**  
14               **serting “, including oral drugs that are**  
15               **not the oral equivalent of an intravenous**  
16               **drug (such as oral phosphate binders and**  
17               **calcimimetics),” after “other drugs and**  
18               **biologicals”;**

19               **(2) in subsection (b)(14)(E)(ii)—**

20                       **(A) in the first sentence—**

21                               **(i) by striking “a one-time**  
22                               **election to be excluded from the**  
23                               **phase-in” and inserting “an elec-**  
24                               **tion, with respect to 2011, 2012, or**  
25                               **2013, to be excluded from the**

1           **phase-in (or the remainder of the**  
2           **phase-in)”; and**

3           **(ii) by adding before the pe-**  
4           **riod at the end the following: “for**  
5           **such year and for each subse-**  
6           **quent year during the phase-in**  
7           **described in clause (i)”; and**

8           **(B) in the second sentence—**

9           **(i) by striking “January 1,**  
10           **2011” and inserting “the first date**  
11           **of such year”; and**

12           **(ii) by inserting “and at a**  
13           **time” after “form and manner”;**  
14           **and**

15           **(3) in subsection (h)(4)(E), by striking**  
16           **“lesser” and inserting “greater”.**

17 **SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.**

18           **(a) MEDICARE.—**

19           **(1) IN GENERAL.—Section 1861 of the**  
20           **Social Security Act (42 U.S.C. 1395x) is**  
21           **amended—**

22           **(A) in subsection (s)(2)—**

23           **(i) by striking “and” at the**  
24           **end of subparagraph (DD);**

1                   (ii) by adding “and” at the end  
2                   of subparagraph (EE); and

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

5                   “(FF) advance care planning con-  
6                   sultation (as defined in subsection  
7                   (hhh)(1));”; and

8                   (B) by adding at the end the fol-  
9                   lowing new subsection:

10                  “Advance Care Planning Consultation  
11                  “(hhh)(1) Subject to paragraphs (3) and  
12                  (4), the term ‘advance care planning consulta-  
13                  tion’ means a consultation between the indi-  
14                  vidual and a practitioner described in para-  
15                  graph (2) regarding advance care planning, if,  
16                  subject to paragraph (3), the individual in-  
17                  volved has not had such a consultation within  
18                  the last 5 years. Such consultation shall in-  
19                  clude the following:

20                  “(A) An explanation by the practi-  
21                  tioner of advance care planning, includ-  
22                  ing key questions and considerations, im-  
23                  portant steps, and suggested people to  
24                  talk to.

1           **“(B) An explanation by the practi-**  
2           **tioner of advance directives, including**  
3           **living wills and durable powers of attor-**  
4           **ney, and their uses.**

5           **“(C) An explanation by the practi-**  
6           **tioner of the role and responsibilities of a**  
7           **health care proxy.**

8           **“(D) The provision by the practitioner**  
9           **of a list of national and State-specific re-**  
10          **sources to assist consumers and their**  
11          **families with advance care planning, in-**  
12          **cluding the national toll-free hotline, the**  
13          **advance care planning clearinghouses,**  
14          **and State legal service organizations (in-**  
15          **cluding those funded through the Older**  
16          **Americans Act of 1965).**

17          **“(E) An explanation by the practi-**  
18          **tioner of the continuum of end-of-life**  
19          **services and supports available, includ-**  
20          **ing palliative care and hospice, and bene-**  
21          **fits for such services and supports that**  
22          **are available under this title.**

23          **“(F)(i) Subject to clause (ii), an expla-**  
24          **nation of orders regarding life sustaining**

1 treatment or similar orders, which shall  
2 include—

3 “(I) the reasons why the develop-  
4 ment of such an order is beneficial to  
5 the individual and the individual’s  
6 family and the reasons why such an  
7 order should be updated periodically  
8 as the health of the individual  
9 changes;

10 “(II) the information needed for  
11 an individual or legal surrogate to  
12 make informed decisions regarding  
13 the completion of such an order; and

14 “(III) the identification of re-  
15 sources that an individual may use to  
16 determine the requirements of the  
17 State in which such individual re-  
18 sides so that the treatment wishes of  
19 that individual will be carried out if  
20 the individual is unable to commu-  
21 nicate those wishes, including re-  
22 quirements regarding the designation  
23 of a surrogate decisionmaker (also  
24 known as a health care proxy).

1           “(ii) The Secretary shall limit the re-  
2           quirement for explanations under clause  
3           (i) to consultations furnished in a State—

4                   “(I) in which all legal barriers  
5                   have been addressed for enabling or-  
6                   ders for life sustaining treatment to  
7                   constitute a set of medical orders re-  
8                   spected across all care settings; and

9                   “(II) that has in effect a program  
10                  for orders for life sustaining treat-  
11                  ment described in clause (iii).

12           “(iii) A program for orders for life  
13           sustaining treatment for a States de-  
14           scribed in this clause is a program that—

15                   “(I) ensures such orders are  
16                   standardized and uniquely identifi-  
17                   able throughout the State;

18                   “(II) distributes or makes acces-  
19                   sible such orders to physicians and  
20                   other health professionals that (act-  
21                   ing within the scope of the profes-  
22                   sional’s authority under State law)  
23                   may sign orders for life sustaining  
24                   treatment;

1           **“(III) provides training for health**  
2           **care professionals across the con-**  
3           **tinuum of care about the goals and**  
4           **use of orders for life sustaining treat-**  
5           **ment; and**

6           **“(IV) is guided by a coalition of**  
7           **stakeholders includes representatives**  
8           **from emergency medical services,**  
9           **emergency department physicians or**  
10          **nurses, state long-term care associa-**  
11          **tion, state medical association, state**  
12          **surveyors, agency responsible for sen-**  
13          **ior services, state department of**  
14          **health, state hospital association,**  
15          **home health association, state bar as-**  
16          **sociation, and state hospice associa-**  
17          **tion.**

18          **“(2) A practitioner described in this para-**  
19          **graph is—**

20               **“(A) a physician (as defined in sub-**  
21               **section (r)(1)); and**

22               **“(B) a nurse practitioner or physician**  
23               **assistant who has the authority under**  
24               **State law to sign orders for life sus-**  
25               **taining treatments.**



1       **“(3)(A) An initial preventive physical ex-**  
2 **amination under subsection (WW), including**  
3 **any related discussion during such examina-**  
4 **tion, shall not be considered an advance care**  
5 **planning consultation for purposes of apply-**  
6 **ing the 5-year limitation under paragraph (1).**

7       **“(B) An advance care planning consulta-**  
8 **tion with respect to an individual may be con-**  
9 **ducted more frequently than provided under**  
10 **paragraph (1) if there is a significant change**  
11 **in the health condition of the individual, in-**  
12 **cluding diagnosis of a chronic, progressive,**  
13 **life-limiting disease, a life-threatening or ter-**  
14 **minal diagnosis or life-threatening injury, or**  
15 **upon admission to a skilled nursing facility,**  
16 **a long-term care facility (as defined by the**  
17 **Secretary), or a hospice program.**

18       **“(4) A consultation under this subsection**  
19 **may include the formulation of an order re-**  
20 **garding life sustaining treatment or a similar**  
21 **order.**

22       **“(5)(A) For purposes of this section, the**  
23 **term ‘order regarding life sustaining treat-**  
24 **ment’ means, with respect to an individual, an**

1 **actionable medical order relating to the treat-**  
2 **ment of that individual that—**

3           **“(i) is signed and dated by a physi-**  
4           **cian (as defined in subsection (r)(1)) or**  
5           **another health care professional (as spec-**  
6           **ified by the Secretary and who is acting**  
7           **within the scope of the professional’s au-**  
8           **thority under State law in signing such**  
9           **an order, including a nurse practitioner**  
10          **or physician assistant) and is in a form**  
11          **that permits it to stay with the individual**  
12          **and be followed by health care profes-**  
13          **sionals and providers across the con-**  
14          **tinuum of care;**

15           **“(ii) effectively communicates the in-**  
16           **dividual’s preferences regarding life sus-**  
17           **taining treatment, including an indica-**  
18           **tion of the treatment and care desired by**  
19           **the individual;**

20           **“(iii) is uniquely identifiable and**  
21           **standardized within a given locality, re-**  
22           **gion, or State (as identified by the Sec-**  
23           **retary); and**

1           “(iv) may incorporate any advance di-  
2           rective (as defined in section 1866(f)(3)) if  
3           executed by the individual.

4           “(B) The level of treatment indicated  
5           under subparagraph (A)(ii) may range from  
6           an indication for full treatment to an indica-  
7           tion to limit some or all or specified interven-  
8           tions. Such indicated levels of treatment may  
9           include indications respecting, among other  
10          items—

11           “(i) the intensity of medical interven-  
12           tion if the patient is pulse less, apneic, or  
13           has serious cardiac or pulmonary prob-  
14           lems;

15           “(ii) the individual’s desire regarding  
16           transfer to a hospital or remaining at the  
17           current care setting;

18           “(iii) the use of antibiotics; and

19           “(iv) the use of artificially adminis-  
20           tered nutrition and hydration.”.

21           (2) PAYMENT.—Section 1848(j)(3) of  
22           such Act (42 U.S.C. 1395w-4(j)(3)) is  
23           amended by inserting “(2)(FF),” after  
24           “(2)(EE),”.

1           **(3) FREQUENCY LIMITATION.—Section**  
2           **1862(a) of such Act (42 U.S.C. 1395y(a)) is**  
3           **amended—**

4                   **(A) in paragraph (1)—**

5                           **(i) in subparagraph (N), by**  
6                           **striking “and” at the end;**

7                           **(ii) in subparagraph (O) by**  
8                           **striking the semicolon at the end**  
9                           **and inserting “, and”; and**

10                           **(iii) by adding at the end the**  
11                           **following new subparagraph:**

12                           **“(P) in the case of advance care**  
13                           **planning consultations (as defined in**  
14                           **section 1861(hhh)(1)), which are per-**  
15                           **formed more frequently than is cov-**  
16                           **ered under such section;” and**

17                           **(B) in paragraph (7), by striking**  
18                           **“or (K)” and inserting “(K), or (P)”.**

19           **(4) EFFECTIVE DATE.—The amendments**  
20           **made by this subsection shall apply to**  
21           **consultations furnished on or after Janu-**  
22           **ary 1, 2011.**

23           **(b) EXPANSION OF PHYSICIAN QUALITY RE-**  
24           **PORTING INITIATIVE FOR END OF LIFE CARE.—**

1           **(1) PHYSICIAN’S QUALITY REPORTING INI-**  
2           **TIATIVE.—Section 1848(k)(2) of the Social**  
3           **Security Act (42 U.S.C. 1395w–4(k)(2)) is**  
4           **amended by adding at the end the fol-**  
5           **lowing new subparagraph:**

6                   **“(E) PHYSICIAN’S QUALITY REPORT-**  
7                   **ING INITIATIVE.—**

8                           **“(i) IN GENERAL.—For purposes**  
9                           **of reporting data on quality meas-**  
10                           **ures for covered professional**  
11                           **services furnished during 2011**  
12                           **and any subsequent year, to the**  
13                           **extent that measures are avail-**  
14                           **able, the Secretary shall include**  
15                           **quality measures on end of life**  
16                           **care and advanced care planning**  
17                           **that have been adopted or en-**  
18                           **dorsed by a consensus-based or-**  
19                           **ganization, if appropriate. Such**  
20                           **measures shall measure both the**  
21                           **creation of and adherence to or-**  
22                           **ders for life-sustaining treatment.**

23                           **“(ii) PROPOSED SET OF MEAS-**  
24                           **URES.—The Secretary shall pub-**  
25                           **lish in the Federal Register pro-**

1           posed quality measures on end of  
2           life care and advanced care plan-  
3           ning that the Secretary deter-  
4           mines are described in subpara-  
5           graph (A) and would be appro-  
6           priate for eligible professionals to  
7           use to submit data to the Sec-  
8           retary. The Secretary shall pro-  
9           vide for a period of public com-  
10          ment on such set of measures be-  
11          fore finalizing such proposed  
12          measures.”.

13           (c) **INCLUSION OF INFORMATION IN MEDICARE**  
14 **& YOU HANDBOOK.—**

15           (1) **MEDICARE & YOU HANDBOOK.—**

16           (A) **IN GENERAL.—**Not later than 1  
17           year after the date of the enactment  
18           of this Act, the Secretary of Health  
19           and Human Services shall update the  
20           online version of the Medicare & You  
21           Handbook to include the following:

22           (i) An explanation of advance  
23           care planning and advance direc-  
24           tives, including—

25                           (I) living wills;

1           **(II) durable power of at-**  
2           **torney;**

3           **(III) orders of life-sus-**  
4           **taining treatment; and**

5           **(IV) health care proxies.**

6           **(ii) A description of Federal**  
7           **and State resources available to**  
8           **assist individuals and their fami-**  
9           **lies with advance care planning**  
10           **and advance directives, includ-**  
11           **ing—**

12           **(I) available State legal**  
13           **service organizations to assist**  
14           **individuals with advance care**  
15           **planning, including those or-**  
16           **ganizations that receive fund-**  
17           **ing pursuant to the Older**  
18           **Americans Act of 1965 (42**  
19           **U.S.C. 93001 et seq.);**

20           **(II) website links or ad-**  
21           **resses for State-specific ad-**  
22           **vance directive forms; and**

23           **(III) any additional infor-**  
24           **mation, as determined by the**  
25           **Secretary.**

1           **(B) UPDATE OF PAPER AND SUBSE-**  
2           **QUENT VERSIONS.—The Secretary shall**  
3           **include the information described in**  
4           **subparagraph (A) in all paper and**  
5           **electronic versions of the Medicare &**  
6           **You Handbook that are published on**  
7           **or after the date that is 1 year after**  
8           **the date of the enactment of this Act.**

9 **SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND**  
10           **WAIVER OF LIMITED ENROLLMENT PENALTY**  
11           **FOR TRICARE BENEFICIARIES.**

12           **(a) PART B SPECIAL ENROLLMENT PERIOD.—**

13           **(1) IN GENERAL.—Section 1837 of the**  
14           **Social Security Act (42 U.S.C. 1395p) is**  
15           **amended by adding at the end the fol-**  
16           **lowing new subsection:**

17           **“(1)(1) In the case of any individual who is**  
18           **a covered beneficiary (as defined in section**  
19           **1072(5) of title 10, United States Code) at the**  
20           **time the individual is entitled to hospital in-**  
21           **surance benefits under part A under section**  
22           **226(b) or section 226A and who is eligible to**  
23           **enroll but who has elected not to enroll (or to**  
24           **be deemed enrolled) during the individual’s**  
25           **initial enrollment period, there shall be a spe-**



1 cial enrollment period described in para-  
2 graph (2).

3       “(2) The special enrollment period de-  
4 scribed in this paragraph, with respect to an  
5 individual, is the 12-month period beginning  
6 on the day after the last day of the initial en-  
7 rollment period of the individual or, if later,  
8 the 12-month period beginning with the  
9 month the individual is notified of enrollment  
10 under this section.

11       “(3) In the case of an individual who en-  
12 rolls during the special enrollment period  
13 provided under paragraph (1), the coverage  
14 period under this part shall begin on the first  
15 day of the month in which the individual en-  
16 rolls or, at the option of the individual, on the  
17 first day of the second month following the  
18 last month of the individual’s initial enroll-  
19 ment period.

20       “(4) The Secretary of Defense shall estab-  
21 lish a method for identifying individuals de-  
22 scribed in paragraph (1) and providing notice  
23 to them of their eligibility for enrollment dur-  
24 ing the special enrollment period described in  
25 paragraph (2).”.

1           **(2) EFFECTIVE DATE.—**The amendment  
2           made by paragraph (1) shall apply to  
3           elections made on or after the date of the  
4           enactment of this Act.

5           **(b) WAIVER OF INCREASE OF PREMIUM.—**

6           **(1) IN GENERAL.—**Section 1839(b) of  
7           the Social Security Act (42 U.S.C.  
8           1395r(b)) is amended by striking “section  
9           1837(i)(4)” and inserting “subsection (i)(4)  
10          or (l) of section 1837”.

11          **(2) EFFECTIVE DATE.—**

12          **(A) IN GENERAL.—**The amendment  
13          made by paragraph (1) shall apply  
14          with respect to elections made on or  
15          after the date of the enactment of this  
16          Act.

17          **(B) REBATES FOR CERTAIN DISABLED  
18          AND ESRD BENEFICIARIES.—**

19               **(i) IN GENERAL.—**With respect  
20               to premiums for months on or  
21               after January 2005 and before the  
22               month of the enactment of this  
23               Act, no increase in the premium  
24               shall be effected for a month in  
25               the case of any individual who is

1 a covered beneficiary (as defined  
2 in section 1072(5) of title 10,  
3 United States Code) at the time  
4 the individual is entitled to hos-  
5 pital insurance benefits under  
6 part A of title XVIII of the Social  
7 Security Act under section 226(b)  
8 or 226A of such Act, and who is el-  
9 igible to enroll, but who has elect-  
10 ed not to enroll (or to be deemed  
11 enrolled), during the individual's  
12 initial enrollment period, and  
13 who enrolls under this part with-  
14 in the 12-month period that be-  
15 gins on the first day of the month  
16 after the month of notification of  
17 entitlement under this part.

18 (ii) CONSULTATION WITH DE-  
19 PARTMENT OF DEFENSE.—The Sec-  
20 retary of Health and Human Serv-  
21 ices shall consult with the Sec-  
22 retary of Defense in identifying  
23 individuals described in this  
24 paragraph.

1                   **(iii) REBATES.—The Secretary**  
2                   **of Health and Human Services**  
3                   **shall establish a method for pro-**  
4                   **viding rebates of premium in-**  
5                   **creases paid for months on or**  
6                   **after January 1, 2005, and before**  
7                   **the month of the enactment of**  
8                   **this Act for which a penalty was**  
9                   **applied and collected.**

10 **SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX**  
11                   **YEAR IN CASE OF GAINS FROM SALE OF PRI-**  
12                   **MARY RESIDENCE IN COMPUTING PART B IN-**  
13                   **COME-RELATED PREMIUM.**

14                   **(a) IN GENERAL.—Section**  
15 **1839(i)(4)(C)(ii)(II) of the Social Security Act**  
16 **(42 U.S.C. 1395r(i)(4)(C)(ii)(II)) is amended by**  
17 **inserting “sale of primary residence,” after**  
18 **“divorce of such individual,”.**

19                   **(b) EFFECTIVE DATE.—The amendment**  
20 **made by subsection (a) shall apply to pre-**  
21 **miums and payments for years beginning**  
22 **with 2011.**

1 SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PA-  
2 TIENT DECISIONS AIDS.

3 (a) IN GENERAL.—The Secretary of Health  
4 and Human Services shall establish a shared  
5 decision making demonstration program (in  
6 this subsection referred to as the “program”)  
7 under the Medicare program using patient de-  
8 cision aids to meet the objective of improving  
9 the understanding by Medicare beneficiaries  
10 of their medical treatment options, as com-  
11 pared to comparable Medicare beneficiaries  
12 who do not participate in a shared decision  
13 making process using patient decision aids.

14 (b) SITES.—

15 (1) ENROLLMENT.—The Secretary shall  
16 enroll in the program not more than 30  
17 eligible providers who have experience in  
18 implementing, and have invested in the  
19 necessary infrastructure to implement,  
20 shared decision making using patient de-  
21 cision aids.

22 (2) APPLICATION.—An eligible provider  
23 seeking to participate in the program  
24 shall submit to the Secretary an applica-  
25 tion at such time and containing such in-  
26 formation as the Secretary may require.

1           **(3) PREFERENCE.—In enrolling eligible**  
2 **providers in the program, the Secretary**  
3 **shall give preference to eligible providers**  
4 **that—**

5           **(A) have documented experience**  
6 **in using patient decision aids for the**  
7 **conditions identified by the Secretary**  
8 **and in using shared decision making;**

9           **(B) have the necessary informa-**  
10 **tion technology infrastructure to col-**  
11 **lect the information required by the**  
12 **Secretary for reporting purposes; and**

13           **(C) are trained in how to use pa-**  
14 **tient decision aids and shared deci-**  
15 **sion making.**

16 **(c) FOLLOW-UP COUNSELING VISIT.—**

17           **(1) IN GENERAL.—An eligible provider**  
18 **participating in the program shall rou-**  
19 **tinely schedule Medicare beneficiaries**  
20 **for a counseling visit after the viewing of**  
21 **such a patient decision aid to answer any**  
22 **questions the beneficiary may have with**  
23 **respect to the medical care of the condi-**  
24 **tion involved and to assist the bene-**  
25 **ficiary in thinking through how their**

1 preferences and concerns relate to their  
2 medical care.

3 (2) PAYMENT FOR FOLLOW-UP COUN-  
4 SELING VISIT.—The Secretary shall estab-  
5 lish procedures for making payments for  
6 such counseling visits provided to Medi-  
7 care beneficiaries under the program.  
8 Such procedures shall provide for the es-  
9 tablishment—

10 (A) of a code (or codes) to rep-  
11 resent such services; and

12 (B) of a single payment amount  
13 for such service that includes the pro-  
14 fessional time of the health care pro-  
15 vider and a portion of the reasonable  
16 costs of the infrastructure of the eli-  
17 gible provider such as would be made  
18 under the applicable payment sys-  
19 tems to that provider for similar cov-  
20 ered services.

21 (d) COSTS OF AIDS.—An eligible provider  
22 participating in the program shall be respon-  
23 sible for the costs of selecting, purchasing,  
24 and incorporating such patient decision aids  
25 into the provider's practice, and reporting

1 **data on quality and outcome measures under**  
2 **the program.**

3 **(e) FUNDING.—The Secretary shall provide**  
4 **for the transfer from the Federal Supple-**  
5 **mentary Medical Insurance Trust Fund estab-**  
6 **lished under section 1841 of the Social Secu-**  
7 **rity Act (42 U.S.C. 1395t) of such funds as are**  
8 **necessary for the costs of carrying out the**  
9 **program.**

10 **(f) WAIVER AUTHORITY.—The Secretary**  
11 **may waive such requirements of titles XI and**  
12 **XVIII of the Social Security Act (42 U.S.C. 1301**  
13 **et seq. and 1395 et seq.) as may be necessary**  
14 **for the purpose of carrying out the program.**

15 **(g) REPORT.—Not later than 12 months**  
16 **after the date of completion of the program,**  
17 **the Secretary shall submit to Congress a re-**  
18 **port on such program, together with rec-**  
19 **ommendations for such legislation and ad-**  
20 **ministrative action as the Secretary deter-**  
21 **mines to be appropriate. The final report shall**  
22 **include an evaluation of the impact of the use**  
23 **of the program on health quality, utilization**  
24 **of health care services, and on improving the**  
25 **quality of life of such beneficiaries.**



1 **(h) DEFINITIONS.—In this section:**

2 **(1) ELIGIBLE PROVIDER.—The term “eli-**  
3 **gible provider” means the following:**

4 **(A) A primary care practice.**

5 **(B) A specialty practice.**

6 **(C) A multispecialty group prac-**  
7 **tice.**

8 **(D) A hospital.**

9 **(E) A rural health clinic.**

10 **(F) A Federally qualified health**  
11 **center (as defined in section**  
12 **1861(aa)(4) of the Social Security Act**  
13 **(42 U.S.C. 1395x(aa)(4)).**

14 **(G) An integrated delivery system.**

15 **(H) A State cooperative entity**  
16 **that includes the State government**  
17 **and at least one other health care**  
18 **provider which is set up for the pur-**  
19 **pose of testing shared decision mak-**  
20 **ing and patient decision aids.**

21 **(2) PATIENT DECISION AID.—The term**  
22 **“patient decision aid” means an edu-**  
23 **cational tool (such as the Internet, a**  
24 **video, or a pamphlet) that helps patients**  
25 **(or, if appropriate, the family caregiver of**

1 the patient) understand and commu-  
2 nicate their beliefs and preferences re-  
3 lated to their treatment options, and to  
4 decide with their health care provider  
5 what treatments are best for them based  
6 on their treatment options, scientific evi-  
7 dence, circumstances, beliefs, and pref-  
8 erences.

9 (3) SHARED DECISION MAKING.—The  
10 term “shared decision making” means a  
11 collaborative process between patient  
12 and clinician that engages the patient in  
13 decision making, provides patients with  
14 information about trade-offs among treat-  
15 ment options, and facilitates the incorpo-  
16 ration of patient preferences and values  
17 into the medical plan.

18 **TITLE III—PROMOTING PRI-**  
19 **MARY CARE, MENTAL**  
20 **HEALTH SERVICES, AND CO-**  
21 **ORDINATED CARE**

22 **SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT**  
23 **PROGRAM.**

24 **Title XVIII of the Social Security Act is**  
25 **amended by inserting after section 1866D, as**

1 added by section 1152(f) of this Act, the fol-  
 2 lowing new section:

3       **“ACCOUNTABLE CARE ORGANIZATION PILOT**  
 4                                   **PROGRAM**

5       **“SEC. 1866E. (a) IN GENERAL.—The Sec-**  
 6 **retary shall conduct a pilot program (in this**  
 7 **section referred to as the ‘pilot program’) to**  
 8 **test different payment incentive models, in-**  
 9 **cluding (to the extent practicable) the specific**  
 10 **payment incentive models described in sub-**  
 11 **section (c), designed to reduce the growth of**  
 12 **expenditures and improve health outcomes in**  
 13 **the provision of items and services under this**  
 14 **title to applicable beneficiaries (as defined in**  
 15 **subsection (d)) by qualifying accountable care**  
 16 **organizations (as defined in subsection (b)(1))**  
 17 **in order to—**

18               **“(1) promote accountability for a pa-**  
 19 **tient population and coordinate items**  
 20 **and services under parts A and B;**

21               **“(2) encourage investment in infra-**  
 22 **structure and redesigned care processes**  
 23 **for high quality and efficient service de-**  
 24 **livery; and**

25               **“(3) reward physician practices and**  
 26 **other physician organizational models for**

1       **the provision of high quality and efficient**  
2       **health care services.**

3       **“(b) QUALIFYING ACCOUNTABLE CARE ORGA-**  
4       **NIZATIONS (ACOs).—**

5               **“(1) QUALIFYING ACO DEFINED.—In this**  
6       **section:**

7               **“(A) IN GENERAL.—The terms**  
8               **‘qualifying accountable care organi-**  
9               **zation’ and ‘qualifying ACO’ mean a**  
10              **group of physicians or other physi-**  
11              **cian organizational model (as defined**  
12              **in subparagraph (D)) that—**

13                      **“(i) is organized at least in**  
14                      **part for the purpose of providing**  
15                      **physicians’ services; and**

16                      **“(ii) meets such criteria as the**  
17                      **Secretary determines to be appro-**  
18                      **priate to participate in the pilot**  
19                      **program, including the criteria**  
20                      **specified in paragraph (2).**

21               **“(B) INCLUSION OF OTHER PRO-**  
22               **VIDERS.—Nothing in this subsection**  
23               **shall be construed as preventing a**  
24               **qualifying ACO from including a hos-**  
25               **pital or any other provider of services**

1 or supplier furnishing items or serv-  
2 ices for which payment may be made  
3 under this title that is affiliated with  
4 the ACO under an arrangement struc-  
5 tured so that such provider or sup-  
6 plier participates in the pilot pro-  
7 gram and shares in any incentive  
8 payments under the pilot program.

9 “(C) PHYSICIAN.—The term ‘physi-  
10 cian’ includes, except as the Sec-  
11 retary may otherwise provide, any in-  
12 dividual who furnishes services for  
13 which payment may be made as phy-  
14 sicians’ services.

15 “(D) OTHER PHYSICIAN ORGANIZA-  
16 TIONAL MODEL.—The term ‘other phy-  
17 sician organization model’ means,  
18 with respect to a qualifying ACO any  
19 model of organization under which  
20 physicians enter into agreements  
21 with other providers for the purposes  
22 of participation in the pilot program  
23 in order to provide high quality and  
24 efficient health care services and

1 share in any incentive payments  
2 under such program

3 “(E) OTHER SERVICES.—Nothing in  
4 this paragraph shall be construed as  
5 preventing a qualifying ACO from  
6 furnishing items or services, for  
7 which payment may not be made  
8 under this title, for purposes of  
9 achieving performance goals under  
10 the pilot program.

11 “(2) QUALIFYING CRITERIA.—The fol-  
12 lowing are criteria described in this para-  
13 graph for an organized group of physi-  
14 cians to be a qualifying ACO:

15 “(A) The group has a legal struc-  
16 ture that would allow the group to re-  
17 ceive and distribute incentive pay-  
18 ments under this section.

19 “(B) The group includes a suffi-  
20 cient number of primary care physi-  
21 cians (regardless of specialty) for the  
22 applicable beneficiaries for whose  
23 care the group is accountable (as de-  
24 termined by the Secretary).

1           **“(C) The group reports on quality**  
2           **measures in such form, manner, and**  
3           **frequency as specified by the Sec-**  
4           **retary (which may be for the group,**  
5           **for providers of services and sup-**  
6           **pliers, or both).**

7           **“(D) The group reports to the Sec-**  
8           **retary (in a form, manner and fre-**  
9           **quency as specified by the Secretary)**  
10          **such data as the Secretary deter-**  
11          **mines appropriate to monitor and**  
12          **evaluate the pilot program.**

13          **“(E) The group provides notice to**  
14          **applicable beneficiaries regarding the**  
15          **pilot program (as determined appro-**  
16          **priate by the Secretary).**

17          **“(F) The group contributes to a**  
18          **best practices network or website,**  
19          **that shall be maintained by the Sec-**  
20          **retary for the purpose of sharing**  
21          **strategies on quality improvement,**  
22          **care coordination, and efficiency that**  
23          **the groups believe are effective.**

24          **“(G) The group utilizes patient-**  
25          **centered processes of care, including**

1           **those that emphasize patient and**  
2           **caregiver involvement in planning**  
3           **and monitoring of ongoing care man-**  
4           **agement plan.**

5           **“(H) The group meets other cri-**  
6           **teria determined to be appropriate by**  
7           **the Secretary.**

8           **“(c) SPECIFIC PAYMENT INCENTIVE MOD-**  
9           **ELS.—The specific payment incentive models**  
10          **described in this subsection are the following:**

11          **“(1) PERFORMANCE TARGET MODEL.—**  
12          **Under the performance target model**  
13          **under this paragraph (in this paragraph**  
14          **referred to as the ‘performance target**  
15          **model’):**

16               **“(A) IN GENERAL.—A qualifying**  
17               **ACO qualifies to receive an incentive**  
18               **payment if expenditures for applica-**  
19               **ble beneficiaries are less than a tar-**  
20               **get spending level or a target rate of**  
21               **growth. The incentive payment shall**  
22               **be made only if savings are greater**  
23               **than would result from normal vari-**  
24               **ation in expenditures for items and**  
25               **services covered under parts A and B.**



1           **“(B) COMPUTATION OF PERFORM-**  
2           **ANCE TARGET.—**

3           **“(i) IN GENERAL.—The Sec-**  
4           **retary shall establish a perform-**  
5           **ance target for each qualifying**  
6           **ACO comprised of a base amount**  
7           **(described in clause (ii)) in-**  
8           **creased to the current year by an**  
9           **adjustment factor (described in**  
10           **clause (iii)). Such a target may be**  
11           **established on a per capita basis,**  
12           **as the Secretary determines to be**  
13           **appropriate.**

14           **“(ii) BASE AMOUNT.—For pur-**  
15           **poses of clause (i), the base**  
16           **amount in this subparagraph is**  
17           **equal to the average total pay-**  
18           **ments (or allowed charges) under**  
19           **parts A and B (and may include**  
20           **part D, if the Secretary deter-**  
21           **mines appropriate) for applicable**  
22           **beneficiaries for whom the quali-**  
23           **ifying ACO furnishes items and**  
24           **services in a base period deter-**  
25           **mined by the Secretary. Such**

1           **base amount may be determined**  
2           **on a per capita basis.**

3           **“(iii) ADJUSTMENT FACTOR.—**

4           **For purposes of clause (i), the ad-**  
5           **justment factor in this clause may**  
6           **equal an annual per capita**  
7           **amount that reflects changes in**  
8           **expenditures from the period of**  
9           **the base amount to the current**  
10           **year that would represent an ap-**  
11           **propriate performance target for**  
12           **applicable beneficiaries (as deter-**  
13           **mined by the Secretary). Such ad-**  
14           **justment factor may be deter-**  
15           **mined as an amount or rate, may**  
16           **be determined on a national, re-**  
17           **gional, local, or organization-spe-**  
18           **cific basis, and may be deter-**  
19           **mined on a per capita basis. Such**  
20           **adjustment factor also may be ad-**  
21           **justed for risk as determined ap-**  
22           **propriate by the Secretary.**

23           **“(iv) REBASING.—Under this**  
24           **model the Secretary shall periodi-**

1 cally rebase the base expenditure  
2 amount described in clause (ii).

3 **“(C) MEETING TARGET.—**

4 **“(i) IN GENERAL.—Subject to**  
5 **clause (ii), a qualifying ACO that**  
6 **meet or exceeds annual quality**  
7 **and performance targets for a**  
8 **year shall receive an incentive**  
9 **payment for such year equal to a**  
10 **portion (as determined appro-**  
11 **priate by the Secretary) of the**  
12 **amount by which payments under**  
13 **this title for such year relative**  
14 **are estimated to be below the per-**  
15 **formance target for such year, as**  
16 **determined by the Secretary. The**  
17 **Secretary may establish a cap on**  
18 **incentive payments for a year for**  
19 **a qualifying ACO.**

20 **“(ii) LIMITATION.—The Sec-**  
21 **retary shall limit incentive pay-**  
22 **ments to each qualifying ACO**  
23 **under this paragraph as nec-**  
24 **essary to ensure that the aggre-**  
25 **gate expenditures with respect to**

1 applicable beneficiaries for such  
2 ACOs under this title (inclusive of  
3 incentive payments described in  
4 this subparagraph) do not exceed  
5 the amount that the Secretary es-  
6 timates would be expended for  
7 such ACO for such beneficiaries if  
8 the pilot program under this sec-  
9 tion were not implemented.

10 “(D) REPORTING AND OTHER RE-  
11 QUIREMENTS.—In carrying out such  
12 model, the Secretary may (as the Sec-  
13 retary determines to be appropriate)  
14 incorporate reporting requirements,  
15 incentive payments, and penalties re-  
16 lated to the physician quality report-  
17 ing initiative (PQRI), electronic pre-  
18 scribing, electronic health records,  
19 and other similar initiatives under  
20 section 1848, and may use alternative  
21 criteria than would otherwise apply  
22 under such section for determining  
23 whether to make such payments. The  
24 incentive payments described in this  
25 subparagraph shall not be included

1 in the limit described in subpara-  
2 graph (C)(ii) or in the performance  
3 target model described in this para-  
4 graph.

5 **“(2) PARTIAL CAPITATION MODEL.—**

6 **“(A) IN GENERAL.—**Subject to sub-  
7 paragraph (B), a partial capitation  
8 model described in this paragraph (in  
9 this paragraph referred to as a ‘par-  
10 tial capitation model’) is a model in  
11 which a qualifying ACO would be at  
12 financial risk for some, but not all, of  
13 the items and services covered under  
14 parts A and B, such as at risk for  
15 some or all physicians’ services or all  
16 items and services under part B. The  
17 Secretary may limit a partial capita-  
18 tion model to ACOs that are highly  
19 integrated systems of care and to  
20 ACOs capable of bearing risk, as de-  
21 termined to be appropriate by the  
22 Secretary.

23 **“(B) NO ADDITIONAL PROGRAM EX-**  
24 **PENDITURES.—**Payments to a quali-  
25 fying ACO for applicable bene-

1           **ficiaries for a year under the partial**  
2           **capitation model shall be established**  
3           **in a manner that does not result in**  
4           **spending more for such ACO for such**  
5           **beneficiaries than would otherwise**  
6           **be expended for such ACO for such**  
7           **beneficiaries for such year if the pilot**  
8           **program were not implemented, as**  
9           **estimated by the Secretary.**

10           **“(3) OTHER PAYMENT MODELS.—**

11                   **“(A) IN GENERAL.—Subject to sub-**  
12                   **paragraph (B), the Secretary may de-**  
13                   **velop other payment models that**  
14                   **meet the goals of this pilot program**  
15                   **to improve quality and efficiency.**

16                   **“(B) NO ADDITIONAL PROGRAM EX-**  
17                   **PENDITURES.—Subparagraph (B) of**  
18                   **paragraph (2) shall apply to a pay-**  
19                   **ment model under subparagraph (A)**  
20                   **in a similar manner as such subpara-**  
21                   **graph (B) applies to the payment**  
22                   **model under paragraph (2).**

23           **“(d) APPLICABLE BENEFICIARIES.—**

24                   **“(1) IN GENERAL.—In this section, the**  
25           **term ‘applicable beneficiary’ means, with**

1       **respect to a qualifying ACO, an indi-**  
2       **vidual who—**

3               **“(A) is enrolled under part B and**  
4               **entitled to benefits under part A;**

5               **“(B) is not enrolled in a Medicare**  
6               **Advantage plan under part C or a**  
7               **PACE program under section 1894;**  
8               **and**

9               **“(C) meets such other criteria as**  
10              **the Secretary determines appro-**  
11              **priate, which may include criteria re-**  
12              **lating to frequency of contact with**  
13              **physicians in the ACO**

14              **“(2) FOLLOWING APPLICABLE BENE-**  
15              **FICIARIES.—The Secretary may monitor**  
16              **data on expenditures and quality of serv-**  
17              **ices under this title after an applicable**  
18              **beneficiary discontinues receiving serv-**  
19              **ices under this title through a qualifying**  
20              **ACO.**

21              **“(e) IMPLEMENTATION.—**

22              **“(1) STARTING DATE.—The pilot pro-**  
23              **gram shall begin no later than January 1,**  
24              **2012. An agreement with a qualifying**  
25              **ACO under the pilot program may cover**

1       **a multi-year period of between 3 and 5**  
2       **years.**

3           **“(2) WAIVER.—The Secretary may**  
4       **waive such provisions of this title (in-**  
5       **cluding section 1877) and title XI in the**  
6       **manner the Secretary determines nec-**  
7       **essary in order implement the pilot pro-**  
8       **gram.**

9           **“(3) PERFORMANCE RESULTS REPORTS.—**  
10       **The Secretary shall report performance**  
11       **results to qualifying ACOs under the**  
12       **pilot program at least annually.**

13           **“(4) LIMITATIONS ON REVIEW.—There**  
14       **shall be no administrative or judicial re-**  
15       **view under section 1869, section 1878, or**  
16       **otherwise of—**

17                   **“(A) the elements, parameters,**  
18                   **scope, and duration of the pilot pro-**  
19                   **gram;**

20                   **“(B) the selection of qualifying**  
21                   **ACOs for the pilot program;**

22                   **“(C) the establishment of targets,**  
23                   **measurement of performance, deter-**  
24                   **minations with respect to whether**



1           **savings have been achieved and the**  
2           **amount of savings;**

3           **“(D) determinations regarding**  
4           **whether, to whom, and in what**  
5           **amounts incentive payments are paid;**  
6           **and**

7           **“(E) decisions about the extension**  
8           **of the program under subsection (g),**  
9           **expansion of the program under sub-**  
10          **section (h) or extensions under sub-**  
11          **section (i).**

12          **“(5) ADMINISTRATION.—Chapter 35 of**  
13          **title 44, United States Code shall not**  
14          **apply to this section.**

15          **“(f) EVALUATION; MONITORING.—**

16          **“(1) IN GENERAL.—The Secretary shall**  
17          **evaluate the payment incentive model for**  
18          **each qualifying ACO under the pilot pro-**  
19          **gram to assess impacts on beneficiaries,**  
20          **providers of services, suppliers and the**  
21          **program under this title. The Secretary**  
22          **shall make such evaluation publicly**  
23          **available within 60 days of the date of**  
24          **completion of such report.**

1           **“(2) MONITORING.—The Inspector Gen-**  
2           **eral of the Department of Health and**  
3           **Human Services shall provide for moni-**  
4           **toring of the operation of ACOs under the**  
5           **pilot program with regard to violations of**  
6           **section 1877 (popularly known as the**  
7           **‘Stark law’).**

8           **“(g) EXTENSION OF PILOT AGREEMENT WITH**  
9           **SUCCESSFUL ORGANIZATIONS.—**

10           **“(1) REPORTS TO CONGRESS.—Not later**  
11           **than 2 years after the date the first**  
12           **agreement is entered into under this sec-**  
13           **tion, and biennially thereafter for six**  
14           **years, the Secretary shall submit to Con-**  
15           **gress and make publicly available a re-**  
16           **port on the use of authorities under the**  
17           **pilot program. Each report shall address**  
18           **the impact of the use of those authorities**  
19           **on expenditures, access, and quality**  
20           **under this title.**

21           **“(2) EXTENSION.—Subject to the report**  
22           **provided under paragraph (1), with re-**  
23           **spect to a qualifying ACO, the Secretary**  
24           **may extend the duration of the agree-**  
25           **ment for such ACO under the pilot pro-**

1 **gram as the Secretary determines appro-**  
2 **priate if—**

3 **“(A) the ACO receives incentive**  
4 **payments with respect to any of the**  
5 **first 4 years of the pilot agreement**  
6 **and is consistently meeting quality**  
7 **standards or**

8 **“(B) the ACO is consistently ex-**  
9 **ceeding quality standards and is not**  
10 **increasing spending under the pro-**  
11 **gram.**

12 **“(3) TERMINATION.—The Secretary may**  
13 **terminate an agreement with a qualifying**  
14 **ACO under the pilot program if such ACO**  
15 **did not receive incentive payments or**  
16 **consistently failed to meet quality stand-**  
17 **ards in any of the first 3 years under the**  
18 **program.**

19 **“(h) EXPANSION TO ADDITIONAL ACOs.—**

20 **“(1) TESTING AND REFINEMENT OF PAY-**  
21 **MENT INCENTIVE MODELS.—Subject to the**  
22 **evaluation described in subsection (f), the**  
23 **Secretary may enter into agreements**  
24 **under the pilot program with additional**  
25 **qualifying ACOs to further test and re-**

1       **fine payment incentive models with re-**  
2       **spect to qualifying ACOs.**

3               **“(2) EXPANDING USE OF SUCCESSFUL**  
4       **MODELS TO PROGRAM IMPLEMENTATION.—**

5               **“(A) IN GENERAL.—Subject to sub-**  
6       **paragraph (B), the Secretary may**  
7       **issue regulations to implement, on a**  
8       **permanent basis, 1 or more models if,**  
9       **and to the extent that, such models**  
10       **are beneficial to the program under**  
11       **this title, as determined by the Sec-**  
12       **retary.**

13               **“(B) CERTIFICATION.—The Chief**  
14       **Actuary of the Centers for Medicare**  
15       **& Medicaid Services shall certify that**  
16       **1 or more of such models described in**  
17       **subparagraph (A) would result in es-**  
18       **timated spending that would be less**  
19       **than what spending would otherwise**  
20       **be estimated to be in the absence of**  
21       **such expansion.**

22               **“(i) TREATMENT OF PHYSICIAN GROUP PRAC-**  
23       **TICE DEMONSTRATION.—**

24               **“(1) EXTENSION.—The Secretary may**  
25       **enter in to an agreement with a quali-**

1 **fyng ACO under the demonstration**  
2 **under section 1866A, subject to rebasing**  
3 **and other modifications deemed appro-**  
4 **prate by the Secretary, until the pilot**  
5 **program under this section is oper-**  
6 **ational.**

7 **“(2) TRANSITION.—For purposes of ex-**  
8 **tension of an agreement with a qualifying**  
9 **ACO under subsection (g)(2), the Sec-**  
10 **retary shall treat receipt of an incentive**  
11 **payment for a year by an organization**  
12 **under the physician group practice dem-**  
13 **onstration pursuant to section 1866A as a**  
14 **year for which an incentive payment is**  
15 **made under such subsection, as long as**  
16 **such practice group practice organiza-**  
17 **tion meets the criteria under subsection**  
18 **(b)(2).**

19 **“(j) ADDITIONAL PROVISIONS.—**

20 **“(1) AUTHORITY FOR SEPARATE INCEN-**  
21 **TIVE ARRANGEMENTS.—The Secretary may**  
22 **create separate incentive arrangements**  
23 **(including using multiple years of data,**  
24 **varying thresholds, varying shared sav-**  
25 **ings amounts, and varying shared savings**

1 limits) for different categories of quali-  
2 fying ACOs to reflect natural variations  
3 in data availability, variation in average  
4 annual attributable expenditures, pro-  
5 gram integrity, and other matters the  
6 Secretary deems appropriate.

7 “(2) ENCOURAGEMENT OF PARTICIPATION  
8 OF SMALLER ORGANIZATIONS.—In order to  
9 encourage the participation of smaller  
10 accountable care organizations under the  
11 pilot program, the Secretary may limit a  
12 qualifying ACO’s exposure to high cost  
13 patients under the program.

14 “(3) INVOLVEMENT IN PRIVATE PAYER AR-  
15 RANGEMENTS.—Nothing in this section  
16 shall be construed as preventing quali-  
17 fying ACOs participating in the pilot pro-  
18 gram from negotiating similar contracts  
19 with private payers.

20 “(4) ANTIDISCRIMINATION LIMITATION.—  
21 The Secretary shall not enter into an  
22 agreement with an entity to provide  
23 health care items or services under the  
24 pilot program, or with an entity to ad-  
25 minister the program, unless such entity

1       **guarantees that it will not deny, limit, or**  
2       **condition the coverage or provision of**  
3       **benefits under the program, for individ-**  
4       **uals eligible to be enrolled under such**  
5       **program, based on any health status-re-**  
6       **lated factor described in section**  
7       **2702(a)(1) of the Public Health Service**  
8       **Act.**

9               **“(5) CONSTRUCTION.—Nothing in this**  
10       **section shall be construed to compel or**  
11       **require an organization to use an organi-**  
12       **zation-specific target growth rate for an**  
13       **accountable care organization under this**  
14       **section for purposes of section 1848.**

15               **“(6) FUNDING.—For purposes of ad-**  
16       **ministering and carrying out the pilot**  
17       **program, other than for payments for**  
18       **items and services furnished under this**  
19       **title and incentive payments under sub-**  
20       **section (c)(1), in addition to funds other-**  
21       **wise appropriated, there are appro-**  
22       **priated to the Secretary for the Center**  
23       **for Medicare & Medicaid Services Pro-**  
24       **gram Management Account \$25,000,000**  
25       **for each of fiscal years 2010 through 2014**

1       **and \$20,000,000 for fiscal year 2015.**  
2       **Amounts appropriated under this para-**  
3       **graph for a fiscal year shall be available**  
4       **until expended.”.**

5       **SEC. 1302. MEDICAL HOME PILOT PROGRAM.**

6       **(a) IN GENERAL.—Title XVIII of the Social**  
7       **Security Act is amended by inserting after**  
8       **section 1866E, as inserted by section 1301, the**  
9       **following new section:**

10               **“MEDICAL HOME PILOT PROGRAM**

11               **“SEC. 1866F. (a) ESTABLISHMENT AND MED-**  
12       **ICAL HOME MODELS.—**

13               **“(1) ESTABLISHMENT OF PILOT PRO-**  
14       **GRAM.—The Secretary shall establish a**  
15       **medical home pilot program (in this sec-**  
16       **tion referred to as the ‘pilot program’) for**  
17       **the purpose of evaluating the feasibility**  
18       **and advisability of reimbursing qualified**  
19       **patient-centered medical homes for fur-**  
20       **nishing medical home services (as de-**  
21       **defined under subsection (b)(1)) to high**  
22       **need beneficiaries (as defined in sub-**  
23       **section (d)(1)(C)) and to targeted high**  
24       **need beneficiaries (as defined in sub-**  
25       **section (c)(1)(C)).**



1           **“(2) SCOPE.—Subject to subsection (g),**  
2           **the pilot program shall include urban,**  
3           **rural, and underserved areas.**

4           **“(3) MODELS OF MEDICAL HOMES IN THE**  
5           **PILOT PROGRAM.—The pilot program shall**  
6           **evaluate each of the following medical**  
7           **home models:**

8                   **“(A) INDEPENDENT PATIENT-CEN-**  
9                   **TERED MEDICAL HOME MODEL.—Inde-**  
10                   **pendent patient-centered medical**  
11                   **home model under subsection (c).**

12                   **“(B) COMMUNITY-BASED MEDICAL**  
13                   **HOME MODEL.—Community-based med-**  
14                   **ical home model under subsection (d).**

15           **“(4) PARTICIPATION OF NURSE PRACTI-**  
16           **TIONERS AND PHYSICIAN ASSISTANTS.—**

17                   **“(A) Nothing in this section shall**  
18                   **be construed as preventing a nurse**  
19                   **practitioner from leading a patient**  
20                   **centered medical home so long as—**

21                           **“(i) all the requirements of**  
22                           **this section are met; and**

23                           **“(ii) the nurse practitioner is**  
24                           **acting consistently with State**  
25                           **law.**

1           **“(B) Nothing in this section shall**  
2           **be construed as preventing a physi-**  
3           **cian assistant from participating in a**  
4           **patient centered medical home so**  
5           **long as—**

6                   **“(i) all the requirements of**  
7                   **this section are met; and**

8                   **“(ii) the physician assistant is**  
9                   **acting consistently with State**  
10                  **law.**

11          **“(b) DEFINITIONS.—For purposes of this**  
12          **section:**

13                  **“(1) PATIENT-CENTERED MEDICAL HOME**  
14                  **SERVICES.—The term ‘patient-centered**  
15                  **medical home services’ means services**  
16                  **that—**

17                          **“(A) provide beneficiaries with di-**  
18                          **rect and ongoing access to a primary**  
19                          **care or principal care by a physician**  
20                          **or nurse practitioner who accepts re-**  
21                          **sponsibility for providing first con-**  
22                          **tact, continuous and comprehensive**  
23                          **care to such beneficiary;**

24                          **“(B) coordinate the care provided**  
25                          **to a beneficiary by a team of individ-**

1           **uals at the practice level across of-**  
2           **fi ce, institutional and home settings**  
3           **led by a primary care or principal**  
4           **care physician or nurse practitioner,**  
5           **as needed and appropriate;**

6           **“(C) provide for all the patient’s**  
7           **health care needs or take responsi-**  
8           **bility for appropriately arranging**  
9           **care with other qualified providers**  
10          **for all stages of life;**

11          **“(D) provide continuous access to**  
12          **care and communication with partici-**  
13          **pating beneficiaries;**

14          **“(E) provide support for patient**  
15          **self-management, proactive and reg-**  
16          **ular patient monitoring, support for**  
17          **family caregivers, use patient-cen-**  
18          **tered processes, and coordination**  
19          **with community resources;**

20          **“(F) integrate readily accessible,**  
21          **clinically useful information on par-**  
22          **ticipating patients that enables the**  
23          **practice to treat such patients com-**  
24          **prehensively and systematically; and**

1           “(G) implement evidence-based  
2           guidelines and apply such guidelines  
3           to the identified needs of bene-  
4           ficiaries over time and with the inten-  
5           sity needed by such beneficiaries.

6           “(2) PRIMARY CARE.—The term ‘pri-  
7           mary care’ means health care that is pro-  
8           vided by a physician, nurse practitioner,  
9           or physician assistant who practices in  
10          the field of family medicine, general in-  
11          ternal medicine, geriatric medicine, or  
12          pediatric medicine.

13          “(3) PRINCIPAL CARE.—The term ‘prin-  
14          cipal care’ means integrated, accessible  
15          health care that is provided by a physi-  
16          cian who is a medical subspecialist that  
17          addresses the majority of the personal  
18          health care needs of patients with chron-  
19          ic conditions requiring the subspecialist’s  
20          expertise, and for whom the subspecialist  
21          assumes care management.

22          “(c) INDEPENDENT PATIENT-CENTERED MED-  
23          ICAL HOME MODEL.—

24                 “(1) IN GENERAL.—

1           **“(A) PAYMENT AUTHORITY.—Under**  
2           **the independent patient-centered**  
3           **medical home model under this sub-**  
4           **section, the Secretary shall make pay-**  
5           **ments for medical home services fur-**  
6           **nished by an independent patient-**  
7           **centered medical home (as defined in**  
8           **subparagraph (B)) pursuant to para-**  
9           **graph (3)(B) for a targeted high need**  
10           **beneficiaries (as defined in subpara-**  
11           **graph (C)).**

12           **“(B) INDEPENDENT PATIENT-CEN-**  
13           **TERED MEDICAL HOME DEFINED.—In this**  
14           **section, the term ‘independent pa-**  
15           **tient-centered medical home’ means a**  
16           **physician-directed or nurse-practi-**  
17           **tioner-directed practice that is quali-**  
18           **fied under paragraph (2) as—**

19                   **“(i) providing beneficiaries**  
20                   **with patient-centered medical**  
21                   **home services; and**

22                   **“(ii) meets such other require-**  
23                   **ments as the Secretary may speci-**  
24                   **fy.**

1           **“(C) TARGETED HIGH NEED BENE-**  
2           **FICIARY DEFINED.—For purposes of**  
3           **this subsection, the term ‘targeted**  
4           **high need beneficiary’ means a high**  
5           **need beneficiary who, based on a risk**  
6           **score as specified by the Secretary, is**  
7           **generally within the upper 50th per-**  
8           **centile of Medicare beneficiaries.**

9           **“(D) BENEFICIARY ELECTION TO PAR-**  
10           **TICIPATE.—The Secretary shall deter-**  
11           **mine an appropriate method of ensur-**  
12           **ing that beneficiaries have agreed to**  
13           **participate in the pilot program.**

14           **“(E) IMPLEMENTATION.—The pilot**  
15           **program under this subsection shall**  
16           **begin no later than 6 months after**  
17           **the date of the enactment of this sec-**  
18           **tion.**

19           **“(2) STANDARD SETTING AND QUALIFICA-**  
20           **TION PROCESS FOR PATIENT-CENTERED MED-**  
21           **ICAL HOMES.—The Secretary shall review**  
22           **alternative models for standard setting**  
23           **and qualification, and shall establish a**  
24           **process—**

1           “(A) to establish standards to en-  
2           able medical practices to qualify as  
3           patient-centered medical homes; and

4           “(B) to initially provide for the re-  
5           view and certification of medical  
6           practices as meeting such standards.

7           “(3) PAYMENT.—

8           “(A) ESTABLISHMENT OF METHOD-  
9           OLOGY.—The Secretary shall establish  
10          a methodology for the payment for  
11          medical home services furnished by  
12          independent patient-centered medical  
13          homes. Under such methodology, the  
14          Secretary shall adjust payments to  
15          medical homes based on beneficiary  
16          risk scores to ensure that higher pay-  
17          ments are made for higher risk bene-  
18          ficiaries.

19          “(B) PER BENEFICIARY PER MONTH  
20          PAYMENTS.—Under such payment  
21          methodology, the Secretary shall pay  
22          independent patient-centered medical  
23          homes a monthly fee for each tar-  
24          geted high need beneficiary who con-

1           **sents to receive medical home serv-**  
2           **ices through such medical home.**

3           **“(C) PROSPECTIVE PAYMENT.—The**  
4           **fee under subparagraph (B) shall be**  
5           **paid on a prospective basis.**

6           **“(D) AMOUNT OF PAYMENT.—In de-**  
7           **termining the amount of such fee, the**  
8           **Secretary shall consider the fol-**  
9           **lowing:**

10           **“(i) The clinical work and**  
11           **practice expenses involved in pro-**  
12           **viding the medical home services**  
13           **provided by the independent pa-**  
14           **tient-centered medical home**  
15           **(such as providing increased ac-**  
16           **cess, care coordination, popu-**  
17           **lation disease management, and**  
18           **teaching self-care skills for man-**  
19           **aging chronic illnesses) for which**  
20           **payment is not made under this**  
21           **title as of the date of the enact-**  
22           **ment of this section.**

23           **“(ii) Allow for differential pay-**  
24           **ments based on capabilities of the**



1           **independent        patient-centered**  
2           **medical home.**

3           **“(iii) Use appropriate risk-ad-**  
4           **justment in determining the**  
5           **amount of the per beneficiary per**  
6           **month payment under this para-**  
7           **graph in a manner that ensures**  
8           **that higher payments are made**  
9           **for higher risk beneficiaries.**

10           **“(4) ENCOURAGING PARTICIPATION OF**  
11           **VARIETY OF PRACTICES.—The pilot program**  
12           **under this subsection shall be designed**  
13           **to include the participation of physicians**  
14           **in practices with fewer than 10 full-time**  
15           **equivalent physicians, as well as physi-**  
16           **cians in larger practices, particularly in**  
17           **underserved and rural areas, as well as**  
18           **federally qualified community health cen-**  
19           **ters, and rural health centers.**

20           **“(5) NO DUPLICATION IN PILOT PARTICI-**  
21           **PATION.—A physician in a group practice**  
22           **that participates in the accountable care**  
23           **organization pilot program under section**  
24           **1866D shall not be eligible to participate**  
25           **in the pilot program under this sub-**

1       **section, unless the pilot program under**  
2       **this section has been implemented on a**  
3       **permanent basis under subsection (e)(3).**

4       **“(d) COMMUNITY-BASED MEDICAL HOME**  
5       **MODEL.—**

6               **“(1) IN GENERAL.—**

7                       **“(A) AUTHORITY FOR PAYMENTS.—**  
8               **Under the community-based medical**  
9               **home model under this subsection (in**  
10              **this section referred to as the ‘CBMH**  
11              **model’), the Secretary shall make pay-**  
12              **ments for the furnishing of medical**  
13              **home services by a community-based**  
14              **medical home (as defined in subpara-**  
15              **graph (B)) pursuant to paragraph**  
16              **(5)(B) for high need beneficiaries.**

17                      **“(B) COMMUNITY-BASED MEDICAL**  
18              **HOME DEFINED.—In this section, the**  
19              **term ‘community-based medical**  
20              **home’ means a nonprofit community-**  
21              **based or State-based organization**  
22              **that is certified under paragraph (2)**  
23              **as meeting the following require-**  
24              **ments:**

1           “(i) The organization provides  
2 beneficiaries with medical home  
3 services.

4           “(ii) The organization pro-  
5 vides medical home services  
6 under the supervision of and in  
7 close collaboration with the pri-  
8 mary care or principal care physi-  
9 cian, nurse practitioner, or physi-  
10 cian assistant designated by the  
11 beneficiary as his or her commu-  
12 nity-based medical home pro-  
13 vider.

14           “(iii) The organization em-  
15 ploys community health workers,  
16 including nurses or other non-  
17 physician practitioners, lay  
18 health workers, or other persons  
19 as determined appropriate by the  
20 Secretary, that assist the primary  
21 or principal care physician, nurse  
22 practitioner, or physician assist-  
23 ant in chronic care management  
24 activities such as teaching self-  
25 care skills for managing chronic

1 illnesses, transitional care serv-  
2 ices, care plan setting, medication  
3 therapy management services for  
4 patients with multiple chronic  
5 diseases, or help beneficiaries ac-  
6 cess the health care and commu-  
7 nity-based resources in their local  
8 geographic area.

9 “(iv) The organization meets  
10 such other requirements as the  
11 Secretary may specify.

12 “(C) HIGH NEED BENEFICIARY.—In  
13 this section, the term ‘high need ben-  
14 eficiary’ means an individual who re-  
15 quires regular medical monitoring,  
16 advising, or treatment.

17 “(2) QUALIFICATION PROCESS FOR COM-  
18 MUNITY-BASED MEDICAL HOMES.—The Sec-  
19 retary shall establish a process—

20 “(A) for the initial qualification of  
21 community-based or State-based or-  
22 ganizations as community-based med-  
23 ical homes; and

24 “(B) to provide for the review and  
25 qualification of such community-

1           **based and State-based organizations**  
2           **pursuant to criteria established by**  
3           **the Secretary.**

4           **“(3) DURATION.—The pilot program for**  
5           **community-based medical homes under**  
6           **this subsection shall start no later than 2**  
7           **years after the date of the enactment of**  
8           **this section. Each demonstration site**  
9           **under the pilot program shall operate for**  
10          **a period of up to 5 years after the initial**  
11          **implementation phase, without regard to**  
12          **the receipt of a initial implementation**  
13          **funding under subsection (i).**

14          **“(4) PREFERENCE.—In selecting sites**  
15          **for the CBMH model, the Secretary may**  
16          **give preference to—**

17                  **“(A) applications from geographic**  
18                  **areas that propose to coordinate**  
19                  **health care services for chronically ill**  
20                  **beneficiaries across a variety of**  
21                  **health care settings, such as primary**  
22                  **care physician practices with fewer**  
23                  **than 10 physicians, specialty physi-**  
24                  **cians, nurse practitioner practices,**  
25                  **Federally qualified health centers,**

1 rural health clinics, and other set-  
2 tings;

3 “(B) applications that include  
4 other payors that furnish medical  
5 home services for chronically ill pa-  
6 tients covered by such payors; and

7 “(C) applications from States that  
8 propose to use the medical home  
9 model to coordinate health care serv-  
10 ices for individuals enrolled under  
11 this title, individuals enrolled under  
12 title XIX, and full-benefit dual eligible  
13 individuals (as defined in section  
14 1935(c)(6)) with chronic diseases  
15 across a variety of health care set-  
16 tings.

17 “(5) PAYMENTS.—

18 “(A) ESTABLISHMENT OF METHOD-  
19 OLOGY.—The Secretary shall establish  
20 a methodology for the payment for  
21 medical home services furnished  
22 under the CBMH model.

23 “(B) PER BENEFICIARY PER MONTH  
24 PAYMENTS.—Under such payment  
25 methodology, the Secretary shall

1           **make two separate monthly payments**  
2           **for each high need beneficiary who**  
3           **consents to receive medical home**  
4           **services through such medical home,**  
5           **as follows:**

6                   **“(i) PAYMENT TO COMMUNITY-**  
7                   **BASED ORGANIZATION.—One month-**  
8                   **ly payment to a community-based**  
9                   **or State-based organization.**

10                   **“(ii) PAYMENT TO PRIMARY OR**  
11                   **PRINCIPAL CARE PRACTICE.—One**  
12                   **monthly payment to the primary**  
13                   **or principal care practice for**  
14                   **such beneficiary.**

15                   **“(C) PROSPECTIVE PAYMENT.—The**  
16                   **payments under subparagraph (B)**  
17                   **shall be paid on a prospective basis.**

18                   **“(D) AMOUNT OF PAYMENT.—In de-**  
19                   **termining the amount of such pay-**  
20                   **ment, the Secretary shall consider the**  
21                   **following:**

22                           **“(i) The clinical work and**  
23                           **practice expenses involved in pro-**  
24                           **viding the medical home services**  
25                           **provided by the community-based**

1           **medical home (such as providing**  
2           **increased access, care coordina-**  
3           **tion, care plan setting, population**  
4           **disease management, and teach-**  
5           **ing self-care skills for managing**  
6           **chronic illnesses) for which pay-**  
7           **ment is not made under this title**  
8           **as of the date of the enactment of**  
9           **this section.**

10           **“(ii) Use appropriate risk-ad-**  
11           **justment in determining the**  
12           **amount of the per beneficiary per**  
13           **month payment under this para-**  
14           **graph.**

15           **“(6) INITIAL IMPLEMENTATION FUND-**  
16           **ING.—The Secretary may make available**  
17           **initial implementation funding to a com-**  
18           **munity based or State-based organization**  
19           **or a State that is participating in the**  
20           **pilot program under this subsection.**  
21           **Such organization shall provide the Sec-**  
22           **retary with a detailed implementation**  
23           **plan that includes how such funds will be**  
24           **used.**

25           **“(e) EXPANSION OF PROGRAM.—**



1           **“(1) EVALUATION OF COST AND QUAL-**  
2           **ITY.—The Secretary shall evaluate the**  
3           **pilot program to determine—**

4                   **“(A) the extent to which medical**  
5                   **homes result in—**

6                           **“(i) improvement in the qual-**  
7                           **ity and coordination of health**  
8                           **care services, particularly with**  
9                           **regard to the care of complex pa-**  
10                           **tients;**

11                           **“(ii) improvement in reducing**  
12                           **health disparities;**

13                           **“(iii) reductions in prevent-**  
14                           **able hospitalizations;**

15                           **“(iv) prevention of readmis-**  
16                           **sions;**

17                           **“(v) reductions in emergency**  
18                           **room visits;**

19                           **“(vi) improvement in health**  
20                           **outcomes, including patient func-**  
21                           **tional status where applicable;**

22                           **“(vii) improvement in patient**  
23                           **satisfaction;**

24                           **“(viii) improved efficiency of**  
25                           **care such as reducing duplicative**

1           **diagnostic tests and laboratory**  
2           **tests; and**

3           **“(ix) reductions in health care**  
4           **expenditures; and**

5           **“(B) the feasibility and advis-**  
6           **ability of reimbursing medical homes**  
7           **for medical home services under this**  
8           **title on a permanent basis.**

9           **“(2) REPORT.—Not later than 60 days**  
10          **after the date of completion of the eval-**  
11          **uation under paragraph (1), the Sec-**  
12          **retary shall submit to Congress and make**  
13          **available to the public a report on the**  
14          **findings of the evaluation under para-**  
15          **graph (1).**

16          **“(3) EXPANSION OF PROGRAM.—**

17                 **“(A) IN GENERAL.—Subject to the**  
18                 **results of the evaluation under para-**  
19                 **graph (1) and subparagraph (B), the**  
20                 **Secretary may issue regulations to**  
21                 **implement, on a permanent basis, one**  
22                 **or more models, if, and to the extent**  
23                 **that such model or models, are bene-**  
24                 **ficial to the program under this title,**  
25                 **including that such implementation**

1 will improve quality of care, as deter-  
2 mined by the Secretary.

3 “(B) CERTIFICATION REQUIRE-  
4 MENT.—The Secretary may not issue  
5 such regulations unless the Chief Ac-  
6 tuary of the Centers for Medicare &  
7 Medicaid Services certifies that the  
8 expansion of the components of the  
9 pilot program described in subpara-  
10 graph (A) would result in estimated  
11 spending under this title that would  
12 be no more than the level of spending  
13 that the Secretary estimates would  
14 otherwise be spent under this title in  
15 the absence of such expansion.

16 “(f) ADMINISTRATIVE PROVISIONS.—

17 “(1) NO DUPLICATION IN PAYMENTS.—  
18 During any month, the Secretary may not  
19 make payments under this section under  
20 more than one model or through more  
21 than one medical home under any model  
22 for the furnishing of medical home serv-  
23 ices to an individual.

24 “(2) NO EFFECT ON PAYMENT FOR EVAL-  
25 UATION AND MANAGEMENT SERVICES.—Pay-

1       **ments made under this section are in ad-**  
2       **dition to, and have no effect on the**  
3       **amount of, payment for evaluation and**  
4       **management services made under this**  
5       **title**

6               **“(3) ADMINISTRATION.—Chapter 35 of**  
7       **title 44, United States Code shall not**  
8       **apply to this section.**

9               **“(g) FUNDING.—**

10              **“(1) OPERATIONAL COSTS.—For pur-**  
11       **poses of administering and carrying out**  
12       **the pilot program (including the design,**  
13       **implementation, technical assistance for**  
14       **and evaluation of such program), in addi-**  
15       **tion to funds otherwise available, there**  
16       **shall be transferred from the Federal**  
17       **Supplementary Medical Insurance Trust**  
18       **Fund under section 1841 to the Secretary**  
19       **for the Centers for Medicare & Medicaid**  
20       **Services Program Management Account**  
21       **\$6,000,000 for each of fiscal years 2010**  
22       **through 2014. Amounts appropriated**  
23       **under this paragraph for a fiscal year**  
24       **shall be available until expended.**

1           **“(2) PATIENT-CENTERED MEDICAL HOME**  
2           **SERVICES.—In addition to funds otherwise**  
3           **available, there shall be available to the**  
4           **Secretary for the Centers for Medicare &**  
5           **Medicaid Services, from the Federal Sup-**  
6           **plementary Medical Insurance Trust**  
7           **Fund under section 1841—**

8                   **“(A) \$200,000,000 for each of fiscal**  
9                   **years 2010 through 2014 for payments**  
10                  **for medical home services under sub-**  
11                  **section (c)(3); and**

12                   **“(B) \$125,000,000 for each of fiscal**  
13                   **years 2012 through 2016, for pay-**  
14                   **ments under subsection (d)(5).**

15           **Amounts available under this paragraph**  
16           **for a fiscal year shall be available until**  
17           **expended.**

18           **“(3) INITIAL IMPLEMENTATION.—In addi-**  
19           **tion to funds otherwise available, there**  
20           **shall be available to the Secretary for the**  
21           **Centers for Medicare & Medicaid Serv-**  
22           **ices, from the Federal Supplementary**  
23           **Medical Insurance Trust Fund under sec-**  
24           **tion 1841, \$2,500,000 for each of fiscal**  
25           **years 2010 through 2012, under sub-**

1       **section (d)(6). Amounts available under**  
2       **this paragraph for a fiscal year shall be**  
3       **available until expended.**

4       **“(h) TREATMENT OF TRHCA MEDICARE MED-**  
5       **ICAL HOME DEMONSTRATION FUNDING.—**

6               **“(1) In addition to funds otherwise**  
7       **available for payment of medical home**  
8       **services under subsection (c)(3), there**  
9       **shall also be available the amount pro-**  
10       **vided in subsection (g) of section 204 of**  
11       **division B of the Tax Relief and Health**  
12       **Care Act of 2006 (42 U.S.C. 1395b–1 note).**

13               **“(2) Notwithstanding section 1302(c)**  
14       **of the America’s Affordable Health**  
15       **Choices Act of 2009, in addition to funds**  
16       **provided in paragraph (1) and subsection**  
17       **(g)(2)(A), the funding for medical home**  
18       **services that would otherwise have been**  
19       **available if such section 204 medical**  
20       **home demonstration had been imple-**  
21       **mented (without regard to subsection (g)**  
22       **of such section) shall be available to the**  
23       **independent patient-centered medical**  
24       **home model described in subsection (c).”.**

1       **(b) EFFECTIVE DATE.**—The amendment  
2 made by this section shall apply to services  
3 furnished on or after the date of the enact-  
4 ment of this Act.

5       **(c) CONFORMING REPEAL.**—Section 204 of  
6 division B of the Tax Relief and Health Care  
7 Act of 2006 (42 U.S.C. 1395b–1 note), as amend-  
8 ed by section 133(a)(2) of the Medicare Im-  
9 provements for Patients and Providers Act of  
10 2008 (Public Law 110–275), is repealed.

11 **SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY**  
12 **CARE SERVICES.**

13       **(a) IN GENERAL.**—Section 1833 of the So-  
14 cial Security Act is amended by inserting  
15 after subsection (o) the following new sub-  
16 section:

17       **“(p) PRIMARY CARE PAYMENT INCENTIVES.**—

18               **“(1) IN GENERAL.**—In the case of pri-  
19 mary care services (as defined in para-  
20 graph (2)) furnished on or after January  
21 1, 2011, by a primary care practitioner (as  
22 defined in paragraph (3)) for which  
23 amounts are payable under section 1848,  
24 in addition to the amount otherwise paid  
25 under this part there shall also be paid to

1       **the practitioner (or to an employer or fa-**  
2       **cility in the cases described in clause (A)**  
3       **of section 1842(b)(6)) (on a monthly or**  
4       **quarterly basis) from the Federal Supple-**  
5       **mentary Medical Insurance Trust Fund**  
6       **an amount equal 5 percent (or 10 percent**  
7       **if the practitioner predominately fur-**  
8       **nishes such services in an area that is**  
9       **designated (under section 332(a)(1)(A) of**  
10      **the Public Health Service Act) as a pri-**  
11      **mary care health professional shortage**  
12      **area.**

13           **“(2) PRIMARY CARE SERVICES DEFINED.—**  
14      **In this subsection, the term ‘primary care**  
15      **services’—**

16           **“(A) means services which are**  
17           **evaluation and management services**  
18           **as defined in section 1848(j)(5)(A);**  
19           **and**

20           **“(B) includes services furnished**  
21           **by another health care professional**  
22           **that would be described in subpara-**  
23           **graph (A) if furnished by a physician.**



1           **“(3) PRIMARY CARE PRACTITIONER DE-**  
2           **FINED.—In this subsection, the term ‘pri-**  
3           **mary care practitioner’—**

4                   **“(A) means a physician or other**  
5                   **health care practitioner (including a**  
6                   **nurse practitioner) who—**

7                           **“(i) specializes in family medi-**  
8                           **cine, general internal medicine,**  
9                           **general pediatrics, geriatrics, or**  
10                           **obstetrics and gynecology; and**

11                           **“(ii) has allowed charges for**  
12                           **primary care services that ac-**  
13                           **count for at least 50 percent of**  
14                           **the physician’s or practitioner’s**  
15                           **total allowed charges under sec-**  
16                           **tion 1848, as determined by the**  
17                           **Secretary for the most recent pe-**  
18                           **riod for which data are available;**  
19                           **and**

20                           **“(B) includes a physician assist-**  
21                           **ant who is under the supervision of a**  
22                           **physician described in subparagraph**  
23                           **(A).**

24           **“(4) LIMITATION ON REVIEW.—There**  
25           **shall be no administrative or judicial re-**

1 view under section 1869, section 1878, or  
2 otherwise, respecting—

3 “(A) any determination or des-  
4 ignation under this subsection;

5 “(B) the identification of services  
6 as primary care services under this  
7 subsection; and

8 “(C) the identification of a practi-  
9 tioner as a primary care practitioner  
10 under this subsection.

11 “(5) COORDINATION WITH OTHER PAY-  
12 MENTS.—

13 “(A) WITH OTHER PRIMARY CARE IN-  
14 CENTIVES.—The provisions of this sub-  
15 section shall not be taken into ac-  
16 count in applying subsections (m) and  
17 (u) and any payment under such sub-  
18 sections shall not be taken into ac-  
19 count in computing payments under  
20 this subsection.

21 “(B) WITH QUALITY INCENTIVES.—  
22 Payments under this subsection shall  
23 not be taken into account in deter-  
24 mining the amounts that would other-

1           **wise be paid under this part for pur-**  
2           **poses of section 1834(g)(2)(B).”.**

3           **(b) CONFORMING AMENDMENTS.—**

4           **(1) Section 1833(m) of such Act (42**  
5           **U.S.C. 1395l(m)) is amended by redesi-**  
6           **gnating paragraph (4) as paragraph (5)**  
7           **and by inserting after paragraph (3) the**  
8           **following new paragraph:**

9           **“(4) The provisions of this subsection shall**  
10          **not be taken into account in applying sub-**  
11          **sections (m) or (u) and any payment under**  
12          **such subsections shall not be taken into ac-**  
13          **count in computing payments under this sub-**  
14          **section.”.**

15          **(2) Section 1848(m)(5)(B) of such Act**  
16          **(42 U.S.C. 1395w-4(m)(5)(B)) is amended**  
17          **by inserting “, (p),” after “(m)”.**

18          **(3) Section 1848(o)(1)(B)(iv) of such**  
19          **Act (42 U.S.C. 1395w-4(o)(1)(B)(iv)) is**  
20          **amended by inserting “primary care” be-**  
21          **fore “health professional shortage area”.**

22          **SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CER-**  
23          **TIFIED NURSE-MIDWIVES.**

24          **(a) IN GENERAL.—Section 1833(a)(1)(K) of**  
25          **the Social Security Act (42**

1 **U.S.C.1395l(a)(1)(K)) is amended by striking**  
2 **“(but in no event” and all that follows through**  
3 **“performed by a physician)”.**

4 **(b) EFFECTIVE DATE.—The amendment**  
5 **made by subsection (a) shall apply to services**  
6 **furnished on or after January 1, 2011.**

7 **SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR**  
8 **PREVENTIVE SERVICES.**

9 **(a) MEDICARE COVERED PREVENTIVE SERV-**  
10 **ICES DEFINED.—Section 1861 of the Social Se-**  
11 **curity Act (42 U.S.C. 1395x), as amended by**  
12 **section 1233(a)(1)(B), is amended by adding at**  
13 **the end the following new subsection:**

14 **“Medicare Covered Preventive Services**  
15 **“(iii)(1) Subject to the succeeding provi-**  
16 **sions of this subsection, the term ‘Medicare**  
17 **covered preventive services’ means the fol-**  
18 **lowing:**

19 **“(A) Prostate cancer screening tests**  
20 **(as defined in subsection (oo)).**

21 **“(B) Colorectal cancer screening tests**  
22 **(as defined in subsection (pp)).**

23 **“(C) Diabetes outpatient self-manage-**  
24 **ment training services (as defined in sub-**  
25 **section (qq)).**

1           **“(D) Screening for glaucoma for cer-**  
2           **tain individuals (as described in sub-**  
3           **section (s)(2)(U)).**

4           **“(E) Medical nutrition therapy serv-**  
5           **ices for certain individuals (as described**  
6           **in subsection (s)(2)(V)).**

7           **“(F) An initial preventive physical ex-**  
8           **amination (as defined in subsection**  
9           **(ww)).**

10           **“(G) Cardiovascular screening blood**  
11           **tests (as defined in subsection (xx)(1)).**

12           **“(H) Diabetes screening tests (as de-**  
13           **finied in subsection (yy)).**

14           **“(I) Ultrasound screening for abdom-**  
15           **inal aortic aneurysm for certain individ-**  
16           **uals (as described in subsection**  
17           **(s)(2)(AA)).**

18           **“(J) Pneumococcal and influenza vac-**  
19           **cines and their administration (as de-**  
20           **scribed in subsection (s)(10)(A)) and hep-**  
21           **atitis B vaccine and its administration**  
22           **for certain individuals (as described in**  
23           **subsection (s)(10)(B)).**

24           **“(K) Screening mammography (as de-**  
25           **finied in subsection (jj)).**

1           **“(L) Screening pap smear and screen-**  
2           **ing pelvic exam (as defined in subsection**  
3           **(nn)).**

4           **“(M) Bone mass measurement (as de-**  
5           **fin ed in subsection (rr)).**

6           **“(N) Kidney disease education serv-**  
7           **ices (as defined in subsection (ggg)).**

8           **“(O) Additional preventive services**  
9           **(as defined in subsection (ddd)).**

10          **“(2) With respect to specific Medicare cov-**  
11          **ered preventive services, the limitations and**  
12          **conditions described in the provisions ref-**  
13          **erenced in paragraph (1) with respect to such**  
14          **services shall apply.”.**

15          **(b) PAYMENT AND ELIMINATION OF COST-**  
16          **SHARING.—**

17                  **(1) IN GENERAL.—**

18                          **(A) IN GENERAL.—Section 1833(a)**  
19                          **of the Social Security Act (42 U.S.C.**  
20                          **1395l(a)) is amended by adding after**  
21                          **and below paragraph (9) the fol-**  
22                          **lowing:**

23           **“With respect to Medicare covered preventive**  
24           **services, in any case in which the payment**  
25           **rate otherwise provided under this part is**

1 computed as a percent of less than 100 per-  
2 cent of an actual charge, fee schedule rate, or  
3 other rate, such percentage shall be increased  
4 to 100 percent.”.

5 (B) APPLICATION TO  
6 SIGMOIDOSCOPIES AND  
7 COLONOSCOPIES.—Section 1834(d) of  
8 such Act (42 U.S.C. 1395m(d)) is  
9 amended—

10 (i) in paragraph (2)(C), by  
11 amending clause (ii) to read as  
12 follows:

13 “(ii) NO COINSURANCE.—In the  
14 case of a beneficiary who receives  
15 services described in clause (i),  
16 there shall be no coinsurance ap-  
17 plied.”; and

18 (ii) in paragraph (3)(C), by  
19 amending clause (ii) to read as  
20 follows:

21 “(ii) NO COINSURANCE.—In the  
22 case of a beneficiary who receives  
23 services described in clause (i),  
24 there shall be no coinsurance ap-  
25 plied.”.

1           **(2) ELIMINATION OF COINSURANCE IN**  
2           **OUTPATIENT HOSPITAL SETTINGS.—**

3           **(A) EXCLUSION FROM OPD FEE**  
4           **SCHEDULE.—Section 1833(t)(1)(B)(iv) of**  
5           **the Social Security Act (42 U.S.C.**  
6           **1395l(t)(1)(B)(iv)) is amended by strik-**  
7           **ing “screening mammography (as de-**  
8           **defined in section 1861(jj)) and diag-**  
9           **nostic mammography” and inserting**  
10           **“diagnostic mammograms and Medi-**  
11           **care covered preventive services (as**  
12           **defined in section 1861(iii)(1))”.**

13           **(B) CONFORMING AMENDMENTS.—**  
14           **Section 1833(a)(2) of the Social Secu-**  
15           **rity Act (42 U.S.C. 1395l(a)(2)) is**  
16           **amended—**

17                   **(i) in subparagraph (F), by**  
18                   **striking “and” after the semicolon**  
19                   **at the end;**

20                   **(ii) in subparagraph (G), by**  
21                   **adding “and” at the end; and**

22                   **(iii) by adding at the end the**  
23                   **following new subparagraph:**

24                   **“(H) with respect to additional**  
25                   **preventive services (as defined in sec-**



1           **tion 1861(ddd)) furnished by an out-**  
2           **patient department of a hospital, the**  
3           **amount determined under paragraph**  
4           **(1)(W);”.**

5           **(3) WAIVER OF APPLICATION OF DEDUCT-**  
6           **IBLE FOR ALL PREVENTIVE SERVICES.—The**  
7           **first sentence of section 1833(b) of the So-**  
8           **cial Security Act (42 U.S.C. 1395l(b)) is**  
9           **amended—**

10                   **(A) in clause (1), by striking**  
11                   **“items and services described in sec-**  
12                   **tion 1861(s)(10)(A)” and inserting**  
13                   **“Medicare covered preventive serv-**  
14                   **ices (as defined in section 1861(iii))”;**

15                   **(B) by inserting “and” before**  
16                   **“(4)”;** and

17                   **(C) by striking clauses (5) through**  
18                   **(8).**

19           **(4) APPLICATION TO PROVIDERS OF SERV-**  
20           **ICES.—Section 1866(a)(2)(A)(ii) of such Act**  
21           **(42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended**  
22           **by inserting “other than for Medicare**  
23           **covered preventive services and” after**  
24           **“for such items and services (“.**

1       **(c) EFFECTIVE DATE.—**The amendments  
2 made by this section shall apply to services  
3 furnished on or after January 1, 2011.

4 SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL  
5                   CANCER SCREENING TESTS REGARDLESS OF  
6                   CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-  
7                   LARY TISSUE REMOVAL.

8       **(a) IN GENERAL.—**Section 1833 of the So-  
9 cial Security Act (42 U.S.C. 1395l(b)), as  
10 amended by section 1305(b), is further amend-  
11 ed—

12           (1) in subsection (a), in the sentence  
13 added by section 1305(b)(1)(A), by insert-  
14 ing “(including services described in the  
15 last sentence of section 1833(b))” after  
16 “preventive services”; and

17           (2) in subsection (b), by adding at the  
18 end the following new sentence: “Clause  
19 (1) of the first sentence of this subsection  
20 shall apply with respect to a colorectal  
21 cancer screening test regardless of the  
22 code that is billed for the establishment  
23 of a diagnosis as a result of the test, or  
24 for the removal of tissue or other matter  
25 or other procedure that is furnished in

1 connection with, as a result of, and in the  
2 same clinical encounter as, the screening  
3 test.”.

4 (b) EFFECTIVE DATE.—The amendment  
5 made by subsection (a) shall apply to items  
6 and services furnished on or after January 1,  
7 2011.

8 SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERV-  
9 ICES FROM COVERAGE UNDER THE MEDI-  
10 CARE SKILLED NURSING FACILITY PROSPEC-  
11 TIVE PAYMENT SYSTEM AND CONSOLIDATED  
12 PAYMENT.

13 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii)  
14 of the Social Security Act (42 U.S.C.  
15 1395yy(e)(2)(A)(ii)) is amended by inserting  
16 “clinical social worker services,” after “quali-  
17 fied psychologist services,”.

18 (b) CONFORMING AMENDMENT.—Section  
19 1861(hh)(2) of the Social Security Act (42  
20 U.S.C. 1395x(hh)(2)) is amended by striking  
21 “and other than services furnished to an inpa-  
22 tient of a skilled nursing facility which the fa-  
23 cility is required to provide as a requirement  
24 for participation”.

1       **(c) EFFECTIVE DATE.—The amendments**  
2 **made by this section shall apply to items and**  
3 **services furnished on or after July 1, 2010.**

4 **SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
5 **PIST SERVICES AND MENTAL HEALTH COUN-**  
6 **SELOR SERVICES.**

7       **(a) COVERAGE OF MARRIAGE AND FAMILY**  
8 **THERAPIST SERVICES.—**

9           **(1) COVERAGE OF SERVICES.—Section**  
10 **1861(s)(2) of the Social Security Act (42**  
11 **U.S.C. 1395x(s)(2)), as amended by section**  
12 **1235, is amended—**

13           **(A) in subparagraph (EE), by**  
14 **striking “and” at the end;**

15           **(B) in subparagraph (FF), by add-**  
16 **ing “and” at the end; and**

17           **(C) by adding at the end the fol-**  
18 **lowing new subparagraph:**

19           **“(GG) marriage and family thera-**  
20 **pist services (as defined in subsection**  
21 **(jjj));”.**

22           **(2) DEFINITION.—Section 1861 of the**  
23 **Social Security Act (42 U.S.C. 1395x), as**  
24 **amended by sections 1233 and 1305, is**

1       amended by adding at the end the fol-  
2       lowing new subsection:

3       **“Marriage and Family Therapist Services**

4       **“(jjj)(1) The term ‘marriage and family**  
5 **therapist services’ means services performed**  
6 **by a marriage and family therapist (as de-**  
7 **fin ed in paragraph (2)) for the diagnosis and**  
8 **treatment of mental illnesses, which the mar-**  
9 **riage and family therapist is legally author-**  
10 **ized to perform under State law (or the State**  
11 **regulatory mechanism provided by State law)**  
12 **of the State in which such services are per-**  
13 **formed, as would otherwise be covered if fur-**  
14 **nished by a physician or as incident to a phy-**  
15 **sician’s professional service, but only if no fa-**  
16 **cility or other provider charges or is paid any**  
17 **amounts with respect to the furnishing of**  
18 **such services.**

19       **“(2) The term ‘marriage and family thera-**  
20 **pist’ means an individual who—**

21               **“(A) possesses a master’s or doctoral**  
22 **degree which qualifies for licensure or**  
23 **certification as a marriage and family**  
24 **therapist pursuant to State law;**

1           **“(B) after obtaining such degree has**  
2           **performed at least 2 years of clinical su-**  
3           **pervised experience in marriage and fam-**  
4           **ily therapy; and**

5           **“(C) is licensed or certified as a mar-**  
6           **riage and family therapist in the State in**  
7           **which marriage and family therapist**  
8           **services are performed.”.**

9           **(3) PROVISION FOR PAYMENT UNDER**  
10          **PART B.—Section 1832(a)(2)(B) of the So-**  
11          **cial Security Act (42 U.S.C. 1395k(a)(2)(B))**  
12          **is amended by adding at the end the fol-**  
13          **lowing new clause:**

14                   **“(v) marriage and family ther-**  
15                   **apist services;”.**

16          **(4) AMOUNT OF PAYMENT.—**

17                   **(A) IN GENERAL.—Section**  
18                   **1833(a)(1) of the Social Security Act**  
19                   **(42 U.S.C. 1395l(a)(1)) is amended—**

20                           **(i) by striking “and” before**  
21                           **“(W)”;** and

22                           **(ii) by inserting before the**  
23                           **semicolon at the end the fol-**  
24                           **lowing: “, and (X) with respect to**  
25                           **marriage and family therapist**

1           **services under section**  
2           **1861(s)(2)(GG), the amounts paid**  
3           **shall be 80 percent of the lesser of**  
4           **the actual charge for the services**  
5           **or 75 percent of the amount de-**  
6           **termined for payment of a psy-**  
7           **chologist under clause (L)”.**

8           **(B) DEVELOPMENT OF CRITERIA**  
9           **WITH RESPECT TO CONSULTATION WITH A**  
10          **HEALTH CARE PROFESSIONAL.—The Sec-**  
11          **retary of Health and Human Services**  
12          **shall, taking into consideration con-**  
13          **cerns for patient confidentiality, de-**  
14          **velop criteria with respect to pay-**  
15          **ment for marriage and family thera-**  
16          **pist services for which payment may**  
17          **be made directly to the marriage and**  
18          **family therapist under part B of title**  
19          **XVIII of the Social Security Act (42**  
20          **U.S.C. 1395j et seq.) under which such**  
21          **a therapist must agree to consult**  
22          **with a patient’s attending or primary**  
23          **care physician or nurse practitioner**  
24          **in accordance with such criteria.**

1           **(5) EXCLUSION OF MARRIAGE AND FAM-**  
2           **ILY THERAPIST SERVICES FROM SKILLED**  
3           **NURSING FACILITY PROSPECTIVE PAYMENT**  
4           **SYSTEM.—Section 1888(e)(2)(A)(ii) of the**  
5           **Social Security Act (42 U.S.C.**  
6           **1395yy(e)(2)(A)(ii)), as amended by sec-**  
7           **tion 1307(a), is amended by inserting**  
8           **“marriage and family therapist services**  
9           **(as defined in subsection (jjj)(1)),” after**  
10           **“clinical social worker services,”.**

11           **(6) COVERAGE OF MARRIAGE AND FAMILY**  
12           **THERAPIST SERVICES PROVIDED IN RURAL**  
13           **HEALTH CLINICS AND FEDERALLY QUALIFIED**  
14           **HEALTH CENTERS.—Section 1861(aa)(1)(B)**  
15           **of the Social Security Act (42 U.S.C.**  
16           **1395x(aa)(1)(B)) is amended by striking**  
17           **“or by a clinical social worker (as defined**  
18           **in subsection (hh)(1)),” and inserting “, by**  
19           **a clinical social worker (as defined in**  
20           **subsection (hh)(1)), or by a marriage and**  
21           **family therapist (as defined in subsection**  
22           **(jjj)(2)),”.**

23           **(7) INCLUSION OF MARRIAGE AND FAMILY**  
24           **THERAPISTS AS PRACTITIONERS FOR ASSIGN-**  
25           **MENT OF CLAIMS.—Section 1842(b)(18)(C)**



1 of the Social Security Act (42 U.S.C.  
2 1395u(b)(18)(C)) is amended by adding at  
3 the end the following new clause:

4 “(vii) A marriage and family therapist  
5 (as defined in section 1861(jjj)(2)).”.

6 (b) COVERAGE OF MENTAL HEALTH COUN-  
7 SELOR SERVICES.—

8 (1) COVERAGE OF SERVICES.—Section  
9 1861(s)(2) of the Social Security Act (42  
10 U.S.C. 1395x(s)(2)), as previously amend-  
11 ed, is further amended—

12 (A) in subparagraph (FF), by  
13 striking “and” at the end;

14 (B) in subparagraph (GG), by in-  
15 sserting “and” at the end; and

16 (C) by adding at the end the fol-  
17 lowing new subparagraph:

18 “(HH) mental health counselor serv-  
19 ices (as defined in subsection (kkk)(1));”.

20 (2) DEFINITION.—Section 1861 of the  
21 Social Security Act (42 U.S.C. 1395x), as  
22 previously amended, is amended by add-  
23 ing at the end the following new sub-  
24 section:

1           **“Mental Health Counselor Services**

2           **“(kkk)(1) The term ‘mental health coun-**  
3 **selor services’ means services performed by a**  
4 **mental health counselor (as defined in para-**  
5 **graph (2)) for the diagnosis and treatment of**  
6 **mental illnesses which the mental health**  
7 **counselor is legally authorized to perform**  
8 **under State law (or the State regulatory**  
9 **mechanism provided by the State law) of the**  
10 **State in which such services are performed,**  
11 **as would otherwise be covered if furnished by**  
12 **a physician or as incident to a physician’s**  
13 **professional service, but only if no facility or**  
14 **other provider charges or is paid any**  
15 **amounts with respect to the furnishing of**  
16 **such services.**

17           **“(2) The term ‘mental health counselor’**  
18 **means an individual who—**

19                   **“(A) possesses a master’s or doctor’s**  
20                   **degree which qualifies the individual for**  
21                   **licensure or certification for the practice**  
22                   **of mental health counseling in the State**  
23                   **in which the services are performed;**

1           **“(B) after obtaining such a degree has**  
2           **performed at least 2 years of supervised**  
3           **mental health counselor practice; and**

4           **“(C) is licensed or certified as a men-**  
5           **tal health counselor or professional coun-**  
6           **selor by the State in which the services**  
7           **are performed.”.**

8           **(3) PROVISION FOR PAYMENT UNDER**  
9           **PART B.—Section 1832(a)(2)(B) of the So-**  
10          **cial Security Act (42 U.S.C.**  
11          **1395k(a)(2)(B)), as amended by subsection**  
12          **(a)(3), is further amended—**

13                 **(A) by striking “and” at the end of**  
14                 **clause (iv);**

15                 **(B) by adding “and” at the end of**  
16                 **clause (v); and**

17                 **(C) by adding at the end the fol-**  
18                 **lowing new clause:**

19                         **“(vi) mental health counselor**  
20                         **services;”.**

21          **(4) AMOUNT OF PAYMENT.—**

22                 **(A) IN GENERAL.—Section**  
23                 **1833(a)(1) of the Social Security Act**  
24                 **(42 U.S.C. 1395l(a)(1)), as amended by**  
25                 **subsection (a), is further amended—**

1           **(i) by striking “and” before**  
2           **“(X)”;** and

3           **(ii) by inserting before the**  
4           **semicolon at the end the fol-**  
5           **lowing: “, and (Y), with respect to**  
6           **mental health counselor services**  
7           **under section 1861(s)(2)(HH), the**  
8           **amounts paid shall be 80 percent**  
9           **of the lesser of the actual charge**  
10           **for the services or 75 percent of**  
11           **the amount determined for pay-**  
12           **ment of a psychologist under**  
13           **clause (L)”.**

14           **(B) DEVELOPMENT OF CRITERIA**  
15           **WITH RESPECT TO CONSULTATION WITH A**  
16           **PHYSICIAN.—The Secretary of Health**  
17           **and Human Services shall, taking**  
18           **into consideration concerns for pa-**  
19           **tient confidentiality, develop criteria**  
20           **with respect to payment for mental**  
21           **health counselor services for which**  
22           **payment may be made directly to the**  
23           **mental health counselor under part B**  
24           **of title XVIII of the Social Security**  
25           **Act (42 U.S.C. 1395j et seq.) under**

1           **which such a counselor must agree to**  
2           **consult with a patient’s attending or**  
3           **primary care physician in accordance**  
4           **with such criteria.**

5           **(5) EXCLUSION OF MENTAL HEALTH**  
6           **COUNSELOR SERVICES FROM SKILLED NURS-**  
7           **ING FACILITY PROSPECTIVE PAYMENT SYS-**  
8           **TEM.—Section 1888(e)(2)(A)(ii) of the So-**  
9           **cial Security Act (42 U.S.C.**  
10          **1395yy(e)(2)(A)(ii)), as amended by sec-**  
11          **tion 1307(a) and subsection (a), is amend-**  
12          **ed by inserting “mental health counselor**  
13          **services (as defined in section**  
14          **1861(kkk)(1)),” after “marriage and family**  
15          **therapist services (as defined in sub-**  
16          **section (jjj)(1)),”.**

17          **(6) COVERAGE OF MENTAL HEALTH COUN-**  
18          **SELOR SERVICES PROVIDED IN RURAL HEALTH**  
19          **CLINICS AND FEDERALLY QUALIFIED HEALTH**  
20          **CENTERS.—Section 1861(aa)(1)(B) of the**  
21          **Social Security Act (42 U.S.C.**  
22          **1395x(aa)(1)(B)), as amended by sub-**  
23          **section (a), is amended by striking “or by**  
24          **a marriage and family therapist (as de-**  
25          **defined in subsection (jjj)(2)),” and inserting**

1       **“by a marriage and family therapist (as**  
2       **defined in subsection (jjj)(2)), or a mental**  
3       **health counselor (as defined in sub-**  
4       **section (kkk)(2)).”.**

5               **(7) INCLUSION OF MENTAL HEALTH COUN-**  
6       **SELORS AS PRACTITIONERS FOR ASSIGNMENT**  
7       **OF CLAIMS.—Section 1842(b)(18)(C) of the**  
8       **Social Security Act (42 U.S.C.**  
9       **1395u(b)(18)(C)), as amended by sub-**  
10       **section (a)(7), is amended by adding at**  
11       **the end the following new clause:**

12               **“(viii) A mental health counselor (as**  
13       **defined in section 1861(kkk)(2)).”.**

14       **(c) EFFECTIVE DATE.—The amendments**  
15       **made by this section shall apply to items and**  
16       **services furnished on or after January 1, 2011.**

17       **SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**  
18       **TAL HEALTH ADD-ON.**

19       **Section 138(a)(1) of the Medicare Improve-**  
20       **ments for Patients and Providers Act of 2008**  
21       **(Public Law 110–275) is amended by striking**  
22       **“December 31, 2009” and inserting “December**  
23       **31, 2011”.**

1 **SEC. 1310. EXPANDING ACCESS TO VACCINES.**

2 **(a) IN GENERAL.—Paragraph (10) of section**  
3 **1861(s) of the Social Security Act (42 U.S.C.**  
4 **1395w(s)) is amended to read as follows:**

5 **“(10) federally recommended vaccines**  
6 **(as defined in subsection (III)) and their**  
7 **respective administration;”.**

8 **(b) FEDERALLY RECOMMENDED VACCINES**  
9 **DEFINED.—Section 1861 of such Act is further**  
10 **amended by adding at the end the following**  
11 **new subsection:**

12 **“Federally Recommended Vaccines**  
13 **“(III) The term ‘federally recommended**  
14 **vaccine’ means an approved vaccine rec-**  
15 **ommended by the Advisory Committee on Im-**  
16 **munization Practices (an advisory committee**  
17 **established by the Secretary, acting through**  
18 **the Director of the Centers for Disease Con-**  
19 **trol and Prevention).”.**

20 **(c) CONFORMING AMENDMENTS.—**

21 **(1) Section 1833 of such Act (42 U.S.C.**  
22 **1395l) is amended, in each of subsections**  
23 **(a)(1)(B), (a)(2)(G), and (a)(3)(A), by strik-**  
24 **ing “1861(s)(10)(A)” and inserting**  
25 **“1861(s)(10)” each place it appears.**

1           **(2) Section 1842(o)(1)(A)(iv) of such**  
2 **Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is**  
3 **amended—**

4           **(A) by striking “subparagraph (A)**  
5 **or (B) of”; and**

6           **(B) by inserting before the period**  
7 **the following: “and before January 1,**  
8 **2011, and influenza vaccines fur-**  
9 **nished on or after January 1, 2011”.**

10          **(3) Section 1847A(c)(6) of such Act (42**  
11 **U.S.C. 1395w-3a(c)(6)) is amended by**  
12 **striking subparagraph (G) and inserting**  
13 **the following:**

14           **“(G) IMPLEMENTATION.—Chapter 35**  
15 **of title 44, United States Code shall**  
16 **not apply to manufacturer provision**  
17 **of information pursuant to section**  
18 **1927(b)(3)(A)(iii) for purposes of im-**  
19 **plementation of this section.”.**

20          **(4) Section 1860D-2(e)(1) of such Act**  
21 **(42 U.S.C. 1395w-102(e)(1)) is amended by**  
22 **striking “such term includes a vaccine”**  
23 **and all that follows through “its adminis-**  
24 **tration) and”.**



1           **(5) Section 1861(ww)(2)(A) of such Act**  
2           **(42 U.S.C. 1395x(ww)(2)(A)) is amended**  
3           **by striking “Pneumococcal, influenza,**  
4           **and hepatitis B vaccine and administra-**  
5           **tion” and inserting “Federally rec-**  
6           **ommended vaccines (as defined in sub-**  
7           **section (lll)) and their respective adminis-**  
8           **tration”.**

9           **(6) Section 1861(iii)(1) of such Act, as**  
10           **added by section 1305(a), is amended by**  
11           **amending subparagraph (J) to read as**  
12           **follows:**

13           **“(J) Federally recommended vaccines**  
14           **(as defined in subsection (lll)) and their**  
15           **respective administration.”.**

16           **(7) Section 1927(b)(3)(A)(iii) of such**  
17           **Act (42 U.S.C. 1396r-8(b)(3)(A)(iii)) is**  
18           **amended, in the matter following sub-**  
19           **clause (III), by inserting “(A)(iv) (includ-**  
20           **ing influenza vaccines furnished on or**  
21           **after January 1, 2011),” after “described**  
22           **in subparagraph”**

23           **(d) EFFECTIVE DATES.—The amendments**  
24           **made by—**

1           **(1) this section (other than by sub-**  
2           **section (c)(7)) shall apply to vaccines ad-**  
3           **ministered on or after January 1, 2011;**  
4           **and**

5           **(2) by subsection (c)(7) shall apply to**  
6           **calendar quarters beginning on or after**  
7           **January 1, 2010.**

8 **SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVEN-**  
9           **TIVE SERVICES AT FEDERALLY QUALIFIED**  
10           **HEALTH CENTERS.**

11           **Section 1861(aa)(3)(A) of the Social Secu-**  
12           **rity Act (42 U.S.C. 1395w (aa)(3)(A)) is amend-**  
13           **ed to read as follows:**

14                   **“(A) services of the type described**  
15                   **subparagraphs (A) through (C) of**  
16                   **paragraph (1) and services described**  
17                   **in section 1861(iii); and”.**

18                   **TITLE IV—QUALITY**  
19                   **Subtitle A—Comparative**  
20                   **Effectiveness Research**

21 **SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.**

22           **(a) IN GENERAL.—Title XI of the Social Se-**  
23           **curity Act is amended by adding at the end**  
24           **the following new part:**

1       **“PART D—COMPARATIVE EFFECTIVENESS**  
2                           **RESEARCH**

3       **“COMPARATIVE EFFECTIVENESS RESEARCH**

4       **“SEC. 1181. (a) CENTER FOR COMPARATIVE**  
5 **EFFECTIVENESS RESEARCH ESTABLISHED.—**

6           **“(1) IN GENERAL.—The Secretary shall**  
7       **establish within the Agency for**  
8       **Healthcare Research and Quality a Cen-**  
9       **ter for Comparative Effectiveness Re-**  
10       **search (in this section referred to as the**  
11       **‘Center’) to conduct, support, and syn-**  
12       **thesize research (including research con-**  
13       **ducted or supported under section 1013**  
14       **of the Medicare Prescription Drug, Im-**  
15       **provement, and Modernization Act of**  
16       **2003) with respect to the outcomes, effec-**  
17       **tiveness, and appropriateness of health**  
18       **care services and procedures in order to**  
19       **identify the manner in which diseases,**  
20       **disorders, and other health conditions**  
21       **can most effectively and appropriately be**  
22       **prevented, diagnosed, treated, and man-**  
23       **aged clinically.**

24           **“(2) DUTIES.—The Center shall—**

1           **“(A) conduct, support, and syn-**  
2           **thesize research relevant to the com-**  
3           **parative effectiveness of the full spec-**  
4           **trum of health care items, services**  
5           **and systems, including pharma-**  
6           **ceuticals, medical devices, medical**  
7           **and surgical procedures, and other**  
8           **medical interventions;**

9           **“(B) conduct and support system-**  
10           **atic reviews of clinical research, in-**  
11           **cluding original research conducted**  
12           **subsequent to the date of the enact-**  
13           **ment of this section;**

14           **“(C) continuously develop rig-**  
15           **orous scientific methodologies for**  
16           **conducting comparative effectiveness**  
17           **studies, and use such methodologies**  
18           **appropriately;**

19           **“(D) submit to the Comparative**  
20           **Effectiveness Research Commission,**  
21           **the Secretary, and Congress appro-**  
22           **priate relevant reports described in**  
23           **subsection (d)(2); and**

24           **“(E) encourage, as appropriate,**  
25           **the development and use of clinical**

1 registries and the development of  
2 clinical effectiveness research data  
3 networks from electronic health  
4 records, post marketing drug and  
5 medical device surveillance efforts,  
6 and other forms of electronic health  
7 data.

8 **“(3) POWERS.—**

9 **“(A) OBTAINING OFFICIAL DATA.—**

10 The Center may secure directly from  
11 any department or agency of the  
12 United States information necessary  
13 to enable it to carry out this section.  
14 Upon request of the Center, the head  
15 of that department or agency shall  
16 furnish that information to the Cen-  
17 ter on an agreed upon schedule.

18 **“(B) DATA COLLECTION.—**In order  
19 to carry out its functions, the Center  
20 shall—

21 **“(i) utilize existing informa-**  
22 **tion, both published and unpub-**  
23 **lished, where possible, collected**  
24 **and assessed either by its own**  
25 **staff or under other arrangements**

1           **made in accordance with this sec-**  
2           **tion,**

3           **“(ii) carry out, or award**  
4           **grants or contracts for, original**  
5           **research and experimentation,**  
6           **where existing information is in-**  
7           **adequate, and**

8           **“(iii) adopt procedures allow-**  
9           **ing any interested party to submit**  
10           **information for the use by the**  
11           **Center and Commission under**  
12           **subsection (b) in making reports**  
13           **and recommendations.**

14           **“(C) ACCESS OF GAO TO INFORMA-**  
15           **TION.—The Comptroller General shall**  
16           **have unrestricted access to all delib-**  
17           **erations, records, and nonproprietary**  
18           **data of the Center and Commission**  
19           **under subsection (b), immediately**  
20           **upon request.**

21           **“(D) PERIODIC AUDIT.—The Center**  
22           **and Commission under subsection (b)**  
23           **shall be subject to periodic audit by**  
24           **the Comptroller General.**

1       **“(b) OVERSIGHT BY COMPARATIVE EFFEC-**  
2 **TIVENESS RESEARCH COMMISSION.—**

3           **“(1) IN GENERAL.—The Secretary shall**  
4 **establish an independent Comparative**  
5 **Effectiveness Research Commission (in**  
6 **this section referred to as the ‘Commis-**  
7 **sion’) to oversee and evaluate the activi-**  
8 **ties carried out by the Center under sub-**  
9 **section (a), subject to the authority of the**  
10 **Secretary, to ensure such activities result**  
11 **in highly credible research and informa-**  
12 **tion resulting from such research.**

13           **“(2) DUTIES.—The Commission shall—**

14           **“(A) determine national priorities**  
15 **for research described in subsection**  
16 **(a) and in making such determina-**  
17 **tions consult with a broad array of**  
18 **public and private stakeholders, in-**  
19 **cluding patients and health care pro-**  
20 **viders and payers;**

21           **“(B) monitor the appropriateness**  
22 **of use of the CERTF described in sub-**  
23 **section (g) with respect to the timely**  
24 **production of comparative effective-**  
25 **ness research determined to be a na-**

1           **tional priority under subparagraph**  
2           **(A);**

3           **“(C) identify highly credible re-**  
4           **search methods and standards of evi-**  
5           **dence for such research to be consid-**  
6           **ered by the Center;**

7           **“(D) review the methodologies de-**  
8           **veloped by the center under sub-**  
9           **section (a)(2)(C);**

10           **“(E) not later than one year after**  
11           **the date of the enactment of this sec-**  
12           **tion, enter into an arrangement**  
13           **under which the Institute of Medicine**  
14           **of the National Academy of Sciences**  
15           **shall conduct an evaluation and re-**  
16           **port on standards of evidence for**  
17           **such research;**

18           **“(F) support forums to increase**  
19           **stakeholder awareness and permit**  
20           **stakeholder feedback on the efforts of**  
21           **the Center to advance methods and**  
22           **standards that promote highly cred-**  
23           **ible research;**

24           **“(G) make recommendations for**  
25           **policies that would allow for public**



1 access of data produced under this  
2 section, in accordance with appro-  
3 priate privacy and proprietary prac-  
4 tices, while ensuring that the infor-  
5 mation produced through such data  
6 is timely and credible;

7 “(H) appoint a clinical perspective  
8 advisory panel for each research pri-  
9 ority determined under subpara-  
10 graph (A), which shall consult with  
11 patients and advise the Center on re-  
12 search questions, methods, and evi-  
13 dence gaps in terms of clinical out-  
14 comes for the specific research in-  
15 quiry to be examined with respect to  
16 such priority to ensure that the infor-  
17 mation produced from such research  
18 is clinically relevant to decisions  
19 made by clinicians and patients at  
20 the point of care;

21 “(I) make recommendations for  
22 the priority for periodic reviews of  
23 previous comparative effectiveness  
24 research and studies conducted by  
25 the Center under subsection (a);

1           “(J) routinely review processes of  
2           the Center with respect to such re-  
3           search to confirm that the informa-  
4           tion produced by such research is ob-  
5           jective, credible, consistent with  
6           standards of evidence established  
7           under this section, and developed  
8           through a transparent process that  
9           includes consultations with appro-  
10          priate stakeholders; and

11          “(K) make recommendations to  
12          the center for the broad dissemina-  
13          tion of the findings of research con-  
14          ducted and supported under this sec-  
15          tion that enables clinicians, patients,  
16          consumers, and payers to make more  
17          informed health care decisions that  
18          improve quality and value.

19          “(3) COMPOSITION OF COMMISSION.—

20                 “(A) IN GENERAL.—The members of  
21                 the Commission shall consist of—

22                         “(i) the Director of the Agency  
23                         for Healthcare Research and  
24                         Quality;

1           “(ii) the Chief Medical Officer  
2           of the Centers for Medicare &  
3           Medicaid Services; and

4           “(iii) 15 additional members  
5           who shall represent broad con-  
6           stituencies of stakeholders includ-  
7           ing clinicians, patients, research-  
8           ers, third-party payers, con-  
9           sumers of Federal and State bene-  
10          ficiary programs.

11          Of such members, at least 9 shall be  
12          practicing physicians, health care  
13          practitioners, consumers, or patients.

14          “(B) QUALIFICATIONS.—

15               “(i) DIVERSE REPRESENTATION  
16               OF PERSPECTIVES.—The members  
17               of the Commission shall represent  
18               a broad range of perspectives and  
19               shall collectively have experience  
20               in the following areas:

21                       “(I) Epidemiology.

22                       “(II) Health services re-  
23                       search.

24                       “(III) Bioethics.

25                       “(IV) Decision sciences.

1                   **“(V) Health disparities.**

2                   **“(VI) Economics.**

3                   **“(ii) DIVERSE REPRESENTATION**  
4                   **OF HEALTH CARE COMMUNITY.—At**  
5                   **least one member shall represent**  
6                   **each of the following health care**  
7                   **communities:**

8                   **“(I) Patients.**

9                   **“(II) Health care con-**  
10                   **sumers.**

11                   **“(III) Practicing Physi-**  
12                   **cians, including surgeons.**

13                   **“(IV) Other health care**  
14                   **practitioners engaged in clin-**  
15                   **ical care.**

16                   **“(V) Employers.**

17                   **“(VI) Public payers.**

18                   **“(VII) Insurance plans.**

19                   **“(VIII) Clinical research-**  
20                   **ers who conduct research on**  
21                   **behalf of pharmaceutical or**  
22                   **device manufacturers.**

23                   **“(C) LIMITATION.—No more than 3**  
24                   **of the Members of the Commission**  
25                   **may be representatives of pharma-**

1           **ceutical or device manufacturers and**  
2           **such representatives shall be clinical**  
3           **researchers described under subpara-**  
4           **graph (B)(ii)(VIII).**

5           **“(4) APPOINTMENT.—**

6                   **“(A) IN GENERAL.—The Secretary**  
7                   **shall appoint the members of the**  
8                   **Commission.**

9                   **“(B) CONSULTATION.—In consid-**  
10                   **ering candidates for appointment to**  
11                   **the Commission, the Secretary may**  
12                   **consult with the Government Ac-**  
13                   **countability Office and the Institute**  
14                   **of Medicine of the National Academy**  
15                   **of Sciences.**

16           **“(5) CHAIRMAN; VICE CHAIRMAN.—The**  
17           **Secretary shall designate a member of**  
18           **the Commission, at the time of appoint-**  
19           **ment of the member, as Chairman and a**  
20           **member as Vice Chairman for that term**  
21           **of appointment, except that in the case of**  
22           **vacancy of the Chairmanship or Vice**  
23           **Chairmanship, the Secretary may des-**  
24           **ignate another member for the remainder**  
25           **of that member’s term. The Chairman**

1 shall serve as an ex officio member of the  
2 National Advisory Council of the Agency  
3 for Health Care Research and Quality  
4 under section 931(c)(3)(B) of the Public  
5 Health Service Act.

6 **“(6) TERMS.—**

7 **“(A) IN GENERAL.—**Except as pro-  
8 vided in subparagraph (B), each  
9 member of the Commission shall be  
10 appointed for a term of 4 years.

11 **“(B) TERMS OF INITIAL AP-**  
12 **POINTEES.—**Of the members first ap-  
13 pointed—

14 **“(i) 8 shall be appointed for a**  
15 **term of 4 years; and**

16 **“(ii) 7 shall be appointed for a**  
17 **term of 3 years.**

18 **“(7) COORDINATION.—**To enhance effec-  
19 tiveness and coordination, the Secretary  
20 is encouraged, to the greatest extent pos-  
21 sible, to seek coordination between the  
22 Commission and the National Advisory  
23 Council of the Agency for Healthcare Re-  
24 search and Quality.

25 **“(8) CONFLICTS OF INTEREST.—**

1           **“(A) IN GENERAL.—In appointing**  
2           **the members of the Commission or a**  
3           **clinical perspective advisory panel**  
4           **described in paragraph (2)(H), the**  
5           **Secretary or the Commission, respec-**  
6           **tively, shall take into consideration**  
7           **any financial interest (as defined in**  
8           **subparagraph (D)), consistent with**  
9           **this paragraph, and develop a plan**  
10           **for managing any identified conflicts.**

11           **“(B) EVALUATION AND CRITERIA.—**  
12           **When considering an appointment to**  
13           **the Commission or a clinical perspec-**  
14           **tive advisory panel described para-**  
15           **graph (2)(H) the Secretary or the**  
16           **Commission shall review the exper-**  
17           **tise of the individual and the finan-**  
18           **cial disclosure report filed by the in-**  
19           **dividual pursuant to the Ethics in**  
20           **Government Act of 1978 for each indi-**  
21           **vidual under consideration for the**  
22           **appointment, so as to reduce the like-**  
23           **lihood that an appointed individual**  
24           **will later require a written deter-**  
25           **mination as referred to in section**

1           **208(b)(1) of title 18, United States**  
2           **Code, a written certification as re-**  
3           **ferred to in section 208(b)(3) of title**  
4           **18, United States Code, or a waiver as**  
5           **referred to in subparagraph (D)(iii)**  
6           **for service on the Commission at a**  
7           **meeting of the Commission.**

8           **“(C) DISCLOSURES; PROHIBITIONS ON**  
9           **PARTICIPATION; WAIVERS.—**

10           **“(i) DISCLOSURE OF FINANCIAL**  
11           **INTEREST.—Prior to a meeting of**  
12           **the Commission or a clinical per-**  
13           **spective advisory panel described**  
14           **in paragraph (2)(H) regarding a**  
15           **‘particular matter’ (as that term is**  
16           **used in section 208 of title 18,**  
17           **United States Code), each mem-**  
18           **ber of the Commission or the clin-**  
19           **ical perspective advisory panel**  
20           **who is a full-time Government**  
21           **employee or special Government**  
22           **employee shall disclose to the**  
23           **Secretary financial interests in**  
24           **accordance with subsection (b) of**  
25           **such section 208.**



1           “(ii) PROHIBITIONS ON PARTICI-  
2           PATION.—Except as provided  
3           under clause (iii), a member of  
4           the Commission or a clinical per-  
5           spective advisory panel described  
6           in paragraph (2)(H) may not par-  
7           ticipate with respect to a par-  
8           ticular matter considered in  
9           meeting of the Commission or the  
10          clinical perspective advisory  
11          panel if such member (or an im-  
12          mediate family member of such  
13          member) has a financial interest  
14          that could be affected by the ad-  
15          vice given to the Secretary with  
16          respect to such matter, excluding  
17          interests exempted in regulations  
18          issued by the Director of the Of-  
19          fice of Government Ethics as too  
20          remote or inconsequential to af-  
21          fect the integrity of the services  
22          of the Government officers or em-  
23          ployees to which such regulations  
24          apply.

1           “(iii) **WAIVER.**—If the Sec-  
2           retary determines it necessary to  
3           afford the Commission or a clin-  
4           ical perspective advisory panel  
5           described in paragraph 2(H) es-  
6           sential expertise, the Secretary  
7           may grant a waiver of the prohi-  
8           bition in clause (ii) to permit a  
9           member described in such sub-  
10          paragraph to—

11                   “(I) participate as a non-  
12                   voting member with respect  
13                   to a particular matter consid-  
14                   ered in a Commission or a  
15                   clinical perspective advisory  
16                   panel meeting; or

17                   “(II) participate as a vot-  
18                   ing member with respect to a  
19                   particular matter considered  
20                   in a Commission or a clinical  
21                   perspective advisory panel  
22                   meeting.

23           “(iv) **LIMITATION ON WAIVERS**  
24           **AND OTHER EXCEPTIONS.**—

1           **“(I) DETERMINATION OF AL-**  
2           **LOWABLE EXCEPTIONS FOR THE**  
3           **COMMISSION.—The number of**  
4           **waivers granted to members**  
5           **of the Commission cannot ex-**  
6           **ceed one-half of the total**  
7           **number of members for the**  
8           **Commission.**

9           **“(II) PROHIBITION ON VOT-**  
10          **ING STATUS ON CLINICAL PER-**  
11          **SPECTIVE ADVISORY PANELS.—**  
12          **No voting member of any clin-**  
13          **ical perspective advisory**  
14          **panel shall be in receipt of a**  
15          **waiver. No more than two**  
16          **nonvoting members of any**  
17          **clinical perspective advisory**  
18          **panel shall receive a waiver.**

19          **“(D) FINANCIAL INTEREST DE-**  
20          **FINED.—For purposes of this para-**  
21          **graph, the term ‘financial interest’**  
22          **means a financial interest under sec-**  
23          **tion 208(a) of title 18, United States**  
24          **Code.**

1           **“(9) COMPENSATION.—While serving on**  
2           **the business of the Commission (includ-**  
3           **ing travel time), a member of the Com-**  
4           **mission shall be entitled to compensation**  
5           **at the per diem equivalent of the rate**  
6           **provided for level IV of the Executive**  
7           **Schedule under section 5315 of title 5,**  
8           **United States Code; and while so serving**  
9           **away from home and the member’s reg-**  
10           **ular place of business, a member may be**  
11           **allowed travel expenses, as authorized by**  
12           **the Director of the Commission.**

13           **“(10) AVAILABILITY OF REPORTS.—The**  
14           **Commission shall transmit to the Sec-**  
15           **retary a copy of each report submitted**  
16           **under this subsection and shall make**  
17           **such reports available to the public.**

18           **“(11) DIRECTOR AND STAFF; EXPERTS**  
19           **AND CONSULTANTS.—Subject to such re-**  
20           **view as the Secretary deems necessary to**  
21           **assure the efficient administration of the**  
22           **Commission, the Commission may—**

23                   **“(A) appoint an Executive Direc-**  
24                   **tor (subject to the approval of the**  
25                   **Secretary) and such other personnel**

1 as Federal employees under section  
2 2105 of title 5, United States Code, as  
3 may be necessary to carry out its du-  
4 ties (without regard to the provisions  
5 of title 5, United States Code, gov-  
6 erning appointments in the competi-  
7 tive service);

8 “(B) seek such assistance and sup-  
9 port as may be required in the per-  
10 formance of its duties from appro-  
11 priate Federal departments and agen-  
12 cies;

13 “(C) enter into contracts or make  
14 other arrangements, as may be nec-  
15 essary for the conduct of the work of  
16 the Commission (without regard to  
17 section 3709 of the Revised Statutes  
18 (41 U.S.C. 5));

19 “(D) make advance, progress, and  
20 other payments which relate to the  
21 work of the Commission;

22 “(E) provide transportation and  
23 subsistence for persons serving with-  
24 out compensation; and

1           **“(F) prescribe such rules and reg-**  
2           **ulations as it deems necessary with**  
3           **respect to the internal organization**  
4           **and operation of the Commission.**

5           **“(c) RESEARCH REQUIREMENTS.—Any re-**  
6           **search conducted, supported, or synthesized**  
7           **under this section shall meet the following re-**  
8           **quirements:**

9           **“(1) ENSURING TRANSPARENCY, CREDI-**  
10          **BILITY, AND ACCESS.—**

11           **“(A) The establishment of the**  
12           **agenda and conduct of the research**  
13           **shall be insulated from inappropriate**  
14           **political or stakeholder influence.**

15           **“(B) Methods of conducting such**  
16           **research shall be scientifically based.**

17           **“(C) All aspects of the**  
18           **prioritization of research, conduct of**  
19           **the research, and development of con-**  
20           **clusions based on the research shall**  
21           **be transparent to all stakeholders.**

22           **“(D) The process and methods for**  
23           **conducting such research shall be**  
24           **publicly documented and available to**  
25           **all stakeholders.**

1           **“(E) Throughout the process of**  
2           **such research, the Center shall pro-**  
3           **vide opportunities for all stake-**  
4           **holders involved to review and pro-**  
5           **vide public comment on the methods**  
6           **and findings of such research.**

7           **“(2) USE OF CLINICAL PERSPECTIVE AD-**  
8           **VISORY PANELS.—The research shall meet**  
9           **a national research priority determined**  
10          **under subsection (b)(2)(A) and shall con-**  
11          **sider advice given to the Center by the**  
12          **clinical perspective advisory panel for**  
13          **the national research priority.**

14          **“(3) STAKEHOLDER INPUT.—**

15               **“(A) IN GENERAL.—The Commis-**  
16               **sion shall consult with patients,**  
17               **health care providers, health care**  
18               **consumer representatives, and other**  
19               **appropriate stakeholders with an in-**  
20               **terest in the research through a**  
21               **transparent process recommended by**  
22               **the Commission.**

23               **“(B) SPECIFIC AREAS OF CONSULTA-**  
24               **TION.—Consultation shall include**

1           **where deemed appropriate by the**  
2           **Commission—**

3                   **“(i) recommending research**  
4                   **priorities and questions;**

5                   **“(ii) recommending research**  
6                   **methodologies; and**

7                   **“(iii) advising on and assisting**  
8                   **with efforts to disseminate re-**  
9                   **search findings.**

10           **“(C) OMBUDSMAN.—The Secretary**  
11           **shall designate a patient ombudsman.**

12           **The ombudsman shall—**

13                   **“(i) serve as an available point**  
14                   **of contact for any patients with**  
15                   **an interest in proposed compara-**  
16                   **tive effectiveness studies by the**  
17                   **Center; and**

18                   **“(ii) ensure that any com-**  
19                   **ments from patients regarding**  
20                   **proposed comparative effective-**  
21                   **ness studies are reviewed by the**  
22                   **Commission.**

23           **“(4) TAKING INTO ACCOUNT POTENTIAL**  
24           **DIFFERENCES.—Research shall—**



1           “(A) be designed, as appropriate,  
2           to take into account the potential for  
3           differences in the effectiveness of  
4           health care items and services used  
5           with various subpopulations such as  
6           racial and ethnic minorities, women,  
7           different age groups (including chil-  
8           dren, adolescents, adults, and sen-  
9           iors), and individuals with different  
10          comorbidities; and—

11           “(B) seek, as feasible and appro-  
12          priate, to include members of such  
13          subpopulations as subjects in the re-  
14          search.

15          “(d) PUBLIC ACCESS TO COMPARATIVE EF-  
16          FECTIVENESS INFORMATION.—

17           “(1) IN GENERAL.—Not later than 90  
18          days after receipt by the Center or Com-  
19          mission, as applicable, of a relevant re-  
20          port described in paragraph (2) made by  
21          the Center, Commission, or clinical per-  
22          spective advisory panel under this sec-  
23          tion, appropriate information contained  
24          in such report shall be posted on the offi-

1       **cial public Internet site of the Center and**  
2       **of the Commission, as applicable.**

3               **“(2) RELEVANT REPORTS DESCRIBED.—**

4       **For purposes of this section, a relevant**  
5       **report is each of the following submitted**  
6       **by the Center or a grantee or contractor**  
7       **of the Center:**

8               **“(A) Any interim or progress re-**  
9               **ports as deemed appropriate by the**  
10              **Secretary.**

11              **“(B) Stakeholder comments.**

12              **“(C) A final report.**

13              **“(e) DISSEMINATION AND INCORPORATION OF**  
14       **COMPARATIVE EFFECTIVENESS INFORMATION.—**

15              **“(1) DISSEMINATION.—The Center shall**  
16       **provide for the dissemination of appro-**  
17       **priate findings produced by research**  
18       **supported, conducted, or synthesized**  
19       **under this section to health care pro-**  
20       **viders, patients, vendors of health infor-**  
21       **mation technology focused on clinical de-**  
22       **cision support, appropriate professional**  
23       **associations, and Federal and private**  
24       **health plans, and other relevant stake-**

1       **holders. In disseminating such findings**  
2       **the Center shall—**

3               **“(A) convey findings of research**  
4               **so that they are comprehensible and**  
5               **useful to patients and providers in**  
6               **making health care decisions;**

7               **“(B) discuss findings and other**  
8               **considerations specific to certain sub-**  
9               **populations, risk factors, and**  
10              **comorbidities as appropriate;**

11              **“(C) include considerations such**  
12              **as limitations of research and what**  
13              **further research may be needed, as**  
14              **appropriate;**

15              **“(D) not include any data that the**  
16              **dissemination of which would violate**  
17              **the privacy of research participants**  
18              **or violate any confidentiality agree-**  
19              **ments made with respect to the use of**  
20              **data under this section; and**

21              **“(E) assist the users of health in-**  
22              **formation technology focused on clin-**  
23              **ical decision support to promote the**  
24              **timely incorporation of such findings**

1           into clinical practices and promote  
2           the ease of use of such incorporation.

3           “(2) **DISSEMINATION PROTOCOLS AND**  
4           **STRATEGIES.**—The Center shall develop  
5           protocols and strategies for the appro-  
6           priate dissemination of research findings  
7           in order to ensure effective communica-  
8           tion of findings and the use and incorpo-  
9           ration of such findings into relevant ac-  
10          tivities for the purpose of informing high-  
11          er quality and more effective and effi-  
12          cient decisions regarding medical items  
13          and services. In developing and adopting  
14          such protocols and strategies, the Center  
15          shall consult with stakeholders con-  
16          cerning the types of dissemination that  
17          will be most useful to the end users of in-  
18          formation and may provide for the utili-  
19          zation of multiple formats for conveying  
20          findings to different audiences, including  
21          dissemination to individuals with limited  
22          English proficiency.

23          “(f) **REPORTS TO CONGRESS.**—

24                 “(1) **ANNUAL REPORTS.**—Beginning not  
25          later than one year after the date of the

1       enactment of this section, the Director of  
2       the Agency of Healthcare Research and  
3       Quality and the Commission shall submit  
4       to Congress an annual report on the ac-  
5       tivities of the Center and the Commis-  
6       sion, as well as the research, conducted  
7       under this section. Each such report shall  
8       include a discussion of the Center’s com-  
9       pliance with subsection (c)(4)(B), includ-  
10      ing any reasons for lack of compliance  
11      with such subsection.

12           “(2) RECOMMENDATION FOR FAIR SHARE  
13      PER CAPITA AMOUNT FOR ALL-PAYER FINANC-  
14      ING.—Beginning not later than December  
15      31, 2011, the Secretary shall submit to  
16      Congress an annual recommendation for  
17      a fair share per capita amount described  
18      in subsection (c)(1) of section 9511 of the  
19      Internal Revenue Code of 1986 for pur-  
20      poses of funding the CERTF under such  
21      section.

22           “(3) ANALYSIS AND REVIEW.—Not later  
23      than December 31, 2013, the Secretary, in  
24      consultation with the Commission, shall  
25      submit to Congress a report on all activi-

1        **ties conducted or supported under this**  
2        **section as of such date. Such report shall**  
3        **include an evaluation of the overall costs**  
4        **of such activities and an analysis of the**  
5        **backlog of any research proposals ap-**  
6        **proved by the Commission but not fund-**  
7        **ed.**

8        **“(g) FUNDING OF COMPARATIVE EFFECTIVE-**  
9        **NESS RESEARCH.—For fiscal year 2010 and**  
10       **each subsequent fiscal year, amounts in the**  
11       **Comparative Effectiveness Research Trust**  
12       **Fund (referred to in this section as the**  
13       **‘CERTF’) under section 9511 of the Internal**  
14       **Revenue Code of 1986 shall be available, with-**  
15       **out the need for further appropriations and**  
16       **without fiscal year limitation, to the Sec-**  
17       **retary to carry out this section.**

18       **“(h) CONSTRUCTION.—Nothing in this sec-**  
19       **tion shall be construed to permit the Commis-**  
20       **sion or the Center to mandate coverage, reim-**  
21       **bursement, or other policies for any public or**  
22       **private payer.”.**

23       **(b) COMPARATIVE EFFECTIVENESS RESEARCH**  
24       **TRUST FUND; FINANCING FOR THE TRUST**  
25       **FUND.—For provision establishing a Compara-**

1 **tive Effectiveness Research Trust Fund and**  
2 **financing such Trust Fund, see section 1802.**

3 **Subtitle B—Nursing Home**  
4 **Transparency**

5 **PART 1—IMPROVING TRANSPARENCY OF INFOR-**  
6 **MATION ON SKILLED NURSING FACILITIES**  
7 **AND NURSING FACILITIES**

8 **SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND**  
9 **ADDITIONAL DISCLOSABLE PARTIES INFOR-**  
10 **MATION.**

11 **(a) IN GENERAL.—Section 1124 of the So-**  
12 **cial Security Act (42 U.S.C. 1320a-3) is amend-**  
13 **ed by adding at the end the following new**  
14 **subsection:**

15 **“(c) REQUIRED DISCLOSURE OF OWNERSHIP**  
16 **AND ADDITIONAL DISCLOSABLE PARTIES INFOR-**  
17 **MATION.—**

18 **“(1) DISCLOSURE.—A facility (as de-**  
19 **finied in paragraph (7)(B)) shall have the**  
20 **information described in paragraph (3)**  
21 **available—**

22 **“(A) during the period beginning**  
23 **on the date of the enactment of this**  
24 **subsection and ending on the date**  
25 **such information is made available to**

1           **the public under section 1411(b) of**  
2           **the America’s Affordable Health**  
3           **Choices Act of 2009, for submission to**  
4           **the Secretary, the Inspector General**  
5           **of the Department of Health and**  
6           **Human Services, the State in which**  
7           **the facility is located, and the State**  
8           **long-term care ombudsman in the**  
9           **case where the Secretary, the Inspec-**  
10          **tor General, the State, or the State**  
11          **long-term care ombudsman requests**  
12          **such information; and**

13               **“(B) beginning on the effective**  
14               **date of the final regulations promul-**  
15               **gated under paragraph (4)(A), for re-**  
16               **porting such information in accord-**  
17               **ance with such final regulations.**

18          **Nothing in subparagraph (A) shall be**  
19          **construed as authorizing a facility to dis-**  
20          **pose of or delete information described in**  
21          **such subparagraph after the effective**  
22          **date of the final regulations promulgated**  
23          **under paragraph (4)(A).**



1           **“(2) PUBLIC AVAILABILITY OF INFORMA-**  
2           **TION.—During the period described in**  
3           **paragraph (1)(A), a facility shall—**

4                   **“(A) make the information de-**  
5                   **scribed in paragraph (3) available to**  
6                   **the public upon request and update**  
7                   **such information as may be necessary**  
8                   **to reflect changes in such informa-**  
9                   **tion; and**

10                   **“(B) post a notice of the avail-**  
11                   **ability of such information in the**  
12                   **lobby of the facility in a prominent**  
13                   **manner.**

14           **“(3) INFORMATION DESCRIBED.—**

15                   **“(A) IN GENERAL.—The following**  
16                   **information is described in this para-**  
17                   **graph:**

18                           **“(i) The information described**  
19                           **in subsections (a) and (b), subject**  
20                           **to subparagraph (C).**

21                           **“(ii) The identity of and infor-**  
22                           **mation on—**

23                                   **“(I) each member of the**  
24                                   **governing body of the facility,**  
25                                   **including the name, title, and**

1           **period of service of each such**  
2           **member;**

3           **“(II) each person or entity**  
4           **who is an officer, director,**  
5           **member, partner, trustee, or**  
6           **managing employee of the fa-**  
7           **cility, including the name,**  
8           **title, and date of start of serv-**  
9           **ice of each such person or en-**  
10          **tity; and**

11          **“(III) each person or enti-**  
12          **ty who is an additional**  
13          **disclosable party of the facil-**  
14          **ity.**

15          **“(iii) The organizational struc-**  
16          **ture of each person and entity de-**  
17          **scribed in subclauses (II) and (III)**  
18          **of clause (ii) and a description of**  
19          **the relationship of each such per-**  
20          **son or entity to the facility and to**  
21          **one another.**

22          **“(B) SPECIAL RULE WHERE INFORMA-**  
23          **TION IS ALREADY REPORTED OR SUB-**  
24          **MITTED.—To the extent that informa-**  
25          **tion reported by a facility to the In-**

1           **ternal Revenue Service on Form 990,**  
2           **information submitted by a facility to**  
3           **the Securities and Exchange Commis-**  
4           **sion, or information otherwise sub-**  
5           **mitted to the Secretary or any other**  
6           **Federal agency contains the informa-**  
7           **tion described in clauses (i), (ii), or**  
8           **(iii) of subparagraph (A), the Sec-**  
9           **retary may allow, to the extent prac-**  
10           **ticable, such Form or such informa-**  
11           **tion to meet the requirements of**  
12           **paragraph (1) and to be submitted in**  
13           **a manner specified by the Secretary.**

14           **“(C) SPECIAL RULE.—In applying**  
15           **subparagraph (A)(i)—**

16                   **“(i) with respect to sub-**  
17                   **sections (a) and (b), ‘ownership or**  
18                   **control interest’ shall include di-**  
19                   **rect or indirect interests, includ-**  
20                   **ing such interests in intermediate**  
21                   **entities; and**

22                   **“(ii) subsection (a)(3)(A)(ii)**  
23                   **shall include the owner of a**  
24                   **whole or part interest in any**  
25                   **mortgage, deed of trust, note, or**

1           other obligation secured, in whole  
2           or in part, by the entity or any of  
3           the property or assets thereof, if  
4           the interest is equal to or exceeds  
5           5 percent of the total property or  
6           assets of the entirety.

7           “(4) REPORTING.—

8           “(A) IN GENERAL.—Not later than  
9           the date that is 2 years after the date  
10          of the enactment of this subsection,  
11          the Secretary shall promulgate regu-  
12          lations requiring, effective on the  
13          date that is 90 days after the date on  
14          which such final regulations are pub-  
15          lished in the Federal Register, a facil-  
16          ity to report the information de-  
17          scribed in paragraph (3) to the Sec-  
18          retary in a standardized format, and  
19          such other regulations as are nec-  
20          essary to carry out this subsection.  
21          Such final regulations shall ensure  
22          that the facility certifies, as a condi-  
23          tion of participation and payment  
24          under the program under title XVIII  
25          or XIX, that the information reported

1 by the facility in accordance with  
2 such final regulations is accurate and  
3 current.

4 “(B) GUIDANCE.—The Secretary  
5 shall provide guidance and technical  
6 assistance to States on how to adopt  
7 the standardized format under sub-  
8 paragraph (A).

9 “(5) NO EFFECT ON EXISTING REPORTING  
10 REQUIREMENTS.—Nothing in this sub-  
11 section shall reduce, diminish, or alter  
12 any reporting requirement for a facility  
13 that is in effect as of the date of the en-  
14 actment of this subsection.

15 “(6) DEFINITIONS.—In this subsection:

16 “(A) ADDITIONAL DISCLOSABLE  
17 PARTY.—The term ‘additional  
18 disclosable party’ means, with respect  
19 to a facility, any person or entity  
20 who—

21 “(i) exercises operational, fi-  
22 nancial, or managerial control  
23 over the facility or a part thereof,  
24 or provides policies or procedures  
25 for any of the operations of the

1 facility, or provides financial or  
2 cash management services to the  
3 facility;

4 “(ii) leases or subleases real  
5 property to the facility, or owns a  
6 whole or part interest equal to or  
7 exceeding 5 percent of the total  
8 value of such real property;

9 “(iii) lends funds or provides a  
10 financial guarantee to the facility  
11 in an amount which is equal to or  
12 exceeds \$50,000; or

13 “(iv) provides management or  
14 administrative services, clinical  
15 consulting services, or accounting  
16 or financial services to the facil-  
17 ity.

18 “(B) FACILITY.—The term ‘facility’  
19 means a disclosing entity which is—

20 “(i) a skilled nursing facility  
21 (as defined in section 1819(a)); or

22 “(ii) a nursing facility (as de-  
23 fined in section 1919(a)).

24 “(C) MANAGING EMPLOYEE.—The  
25 term ‘managing employee’ means,

1 with respect to a facility, an indi-  
2 vidual (including a general manager,  
3 business manager, administrator, di-  
4 rector, or consultant) who directly or  
5 indirectly manages, advises, or super-  
6 vises any element of the practices, fi-  
7 nances, or operations of the facility.

8 “(D) ORGANIZATIONAL STRUCTURE.—  
9 The term ‘organizational structure’  
10 means, in the case of—

11 “(i) a corporation, the officers,  
12 directors, and shareholders of the  
13 corporation who have an owner-  
14 ship interest in the corporation  
15 which is equal to or exceeds 5  
16 percent;

17 “(ii) a limited liability com-  
18 pany, the members and managers  
19 of the limited liability company  
20 (including, as applicable, what  
21 percentage each member and  
22 manager has of the ownership in-  
23 terest in the limited liability com-  
24 pany);

1           “(iii) a general partnership,  
2           the partners of the general part-  
3           nership;

4           “(iv) a limited partnership,  
5           the general partners and any lim-  
6           ited partners of the limited part-  
7           nership who have an ownership  
8           interest in the limited partner-  
9           ship which is equal to or exceeds  
10          10 percent;

11          “(v) a trust, the trustees of the  
12          trust;

13          “(vi) an individual, contact in-  
14          formation for the individual; and

15          “(vii) any other person or en-  
16          tity, such information as the Sec-  
17          retary determines appropriate.”.

18          **(b) PUBLIC AVAILABILITY OF INFORMATION.—**

19                 **(1) IN GENERAL.—**Not later than the  
20                 date that is 1 year after the date on  
21                 which the final regulations promulgated  
22                 under section 1124(c)(4)(A) of the Social  
23                 Security Act, as added by subsection (a),  
24                 are published in the Federal Register, the  
25                 information reported in accordance with



1 such final regulations shall be made  
2 available to the public in accordance  
3 with procedures established by the Sec-  
4 retary.

5 (2) DEFINITIONS.—In this subsection:

6 (A) NURSING FACILITY.—The term  
7 “nursing facility” has the meaning  
8 given such term in section 1919(a) of  
9 the Social Security Act (42 U.S.C.  
10 1396r(a)).

11 (B) SECRETARY.—The term “Sec-  
12 retary” means the Secretary of Health  
13 and Human Services.

14 (C) SKILLED NURSING FACILITY.—  
15 The term “skilled nursing facility”  
16 has the meaning given such term in  
17 section 1819(a) of the Social Security  
18 Act (42 U.S.C. 1395i-3(a)).

19 (c) CONFORMING AMENDMENTS.—

20 (1) SKILLED NURSING FACILITIES.—Sec-  
21 tion 1819(d)(1) of the Social Security Act  
22 (42 U.S.C. 1395i-3(d)(1)) is amended by  
23 striking subparagraph (B) and redesign-  
24 ating subparagraph (C) as subpara-  
25 graph (B).

1           **(2) NURSING FACILITIES.—Section**  
2           **1919(d)(1) of the Social Security Act (42**  
3           **U.S.C. 1396r(d)(1)) is amended by striking**  
4           **subparagraph (B) and redesignating sub-**  
5           **paragraph (C) as subparagraph (B).**

6 **SEC. 1412. ACCOUNTABILITY REQUIREMENTS.**

7           **(a) EFFECTIVE COMPLIANCE AND ETHICS**  
8           **PROGRAMS.—**

9           **(1) SKILLED NURSING FACILITIES.—Sec-**  
10           **tion 1819(d)(1) of the Social Security Act**  
11           **(42 U.S.C. 1395i-3(d)(1)), as amended by**  
12           **section 1411(c)(1), is amended by adding**  
13           **at the end the following new subpara-**  
14           **graph:**

15                   **“(C) COMPLIANCE AND ETHICS PRO-**  
16                   **GRAMS.—**

17                           **“(i) REQUIREMENT.—On or**  
18                           **after the date that is 36 months**  
19                           **after the date of the enactment of**  
20                           **this subparagraph, a skilled nurs-**  
21                           **ing facility shall, with respect to**  
22                           **the entity that operates the facil-**  
23                           **ity (in this subparagraph referred**  
24                           **to as the ‘operating organization’**  
25                           **or ‘organization’), have in oper-**

1           **ation a compliance and ethics**  
2           **program that is effective in pre-**  
3           **venting and detecting criminal,**  
4           **civil, and administrative viola-**  
5           **tions under this Act and in pro-**  
6           **moting quality of care consistent**  
7           **with regulations developed under**  
8           **clause (ii).**

9           **“(ii) DEVELOPMENT OF REGULA-**  
10          **TIONS.—**

11           **“(I) IN GENERAL.—Not later**  
12           **than the date that is 2 years**  
13           **after such date of the enact-**  
14           **ment, the Secretary, in con-**  
15           **sultation with the Inspector**  
16           **General of the Department of**  
17           **Health and Human Services,**  
18           **shall promulgate regulations**  
19           **for an effective compliance**  
20           **and ethics program for oper-**  
21           **ating organizations, which**  
22           **may include a model compli-**  
23           **ance program.**

24           **“(II) DESIGN OF REGULA-**  
25          **TIONS.—Such regulations with**

1           **respect to specific elements or**  
2           **formality of a program may**  
3           **vary with the size of the orga-**  
4           **nization, such that larger or-**  
5           **ganizations should have a**  
6           **more formal and rigorous pro-**  
7           **gram and include established**  
8           **written policies defining the**  
9           **standards and procedures to**  
10          **be followed by its employees.**  
11          **Such requirements shall spe-**  
12          **cifically apply to the cor-**  
13          **porate level management of**  
14          **multi-unit nursing home**  
15          **chains.**

16                 **“(III) EVALUATION.—Not**  
17                 **later than 3 years after the**  
18                 **date of promulgation of regu-**  
19                 **lations under this clause, the**  
20                 **Secretary shall complete an**  
21                 **evaluation of the compliance**  
22                 **and ethics programs required**  
23                 **to be established under this**  
24                 **subparagraph. Such evalua-**  
25                 **tion shall determine if such**

1           **programs led to changes in**  
2           **deficiency citations, changes**  
3           **in quality performance, or**  
4           **changes in other metrics of**  
5           **resident quality of care. The**  
6           **Secretary shall submit to Con-**  
7           **gress a report on such evalua-**  
8           **tion and shall include in such**  
9           **report such recommendations**  
10          **regarding changes in the re-**  
11          **quirements for such programs**  
12          **as the Secretary determines**  
13          **appropriate.**

14           **“(iii) REQUIREMENTS FOR COM-**  
15          **PLIANCE AND ETHICS PROGRAMS.—In**  
16          **this subparagraph, the term ‘com-**  
17          **pliance and ethics program’**  
18          **means, with respect to a skilled**  
19          **nursing facility, a program of the**  
20          **operating organization that—**

21                   **“(I) has been reasonably**  
22                   **designed, implemented, and**  
23                   **enforced so that it generally**  
24                   **will be effective in preventing**  
25                   **and detecting criminal, civil,**

1           **and administrative violations**  
2           **under this Act and in pro-**  
3           **moting quality of care; and**

4           **“(II) includes at least the**  
5           **required components speci-**  
6           **fied in clause (iv).**

7           **“(iv) REQUIRED COMPONENTS OF**  
8           **PROGRAM.—The required compo-**  
9           **nents of a compliance and ethics**  
10           **program of an organization are**  
11           **the following:**

12           **“(I) The organization must**  
13           **have established compliance**  
14           **standards and procedures to**  
15           **be followed by its employees,**  
16           **contractors, and other agents**  
17           **that are reasonably capable of**  
18           **reducing the prospect of**  
19           **criminal, civil, and adminis-**  
20           **trative violations under this**  
21           **Act.**

22           **“(II) Specific individuals**  
23           **within high-level personnel of**  
24           **the organization must have**  
25           **been assigned overall respon-**

1           **sibility to oversee compliance**  
2           **with such standards and pro-**  
3           **cedures and have sufficient**  
4           **resources and authority to as-**  
5           **sure such compliance.**

6           **“(III) The organization**  
7           **must have used due care not**  
8           **to delegate substantial discre-**  
9           **tionary authority to individ-**  
10          **uals whom the organization**  
11          **knew, or should have known**  
12          **through the exercise of due**  
13          **diligence, had a propensity to**  
14          **engage in criminal, civil, and**  
15          **administrative violations**  
16          **under this Act.**

17          **“(IV) The organization**  
18          **must have taken steps to com-**  
19          **municate effectively its stand-**  
20          **ards and procedures to all em-**  
21          **ployees and other agents,**  
22          **such as by requiring partici-**  
23          **pation in training programs**  
24          **or by disseminating publica-**

1           **tions that explain in a prac-**  
2           **tical manner what is required.**

3           **“(V) The organization**  
4           **must have taken reasonable**  
5           **steps to achieve compliance**  
6           **with its standards, such as by**  
7           **utilizing monitoring and au-**  
8           **diting systems reasonably de-**  
9           **signed to detect criminal,**  
10          **civil, and administrative vio-**  
11          **lations under this Act by its**  
12          **employees and other agents**  
13          **and by having in place and**  
14          **publicizing a reporting sys-**  
15          **tem whereby employees and**  
16          **other agents could report vio-**  
17          **lations by others within the**  
18          **organization without fear of**  
19          **retribution.**

20          **“(VI) The standards must**  
21          **have been consistently en-**  
22          **forced through appropriate**  
23          **disciplinary mechanisms, in-**  
24          **cluding, as appropriate, dis-**  
25          **cipline of individuals respon-**



1           **sible for the failure to detect**  
2           **an offense.**

3           **“(VII) After an offense has**  
4           **been detected, the organiza-**  
5           **tion must have taken all rea-**  
6           **sonable steps to respond ap-**  
7           **propriately to the offense and**  
8           **to prevent further similar of-**  
9           **fenses, including repayment**  
10           **of any funds to which it was**  
11           **not entitled and any nec-**  
12           **essary modification to its pro-**  
13           **gram to prevent and detect**  
14           **criminal, civil, and adminis-**  
15           **trative violations under this**  
16           **Act.**

17           **“(VIII) The organization**  
18           **must periodically undertake**  
19           **reassessment of its compli-**  
20           **ance program to identify**  
21           **changes necessary to reflect**  
22           **changes within the organiza-**  
23           **tion and its facilities.**

24           **“(v) COORDINATION.—The pro-**  
25           **visions of this subparagraph shall**

1           **apply with respect to a skilled**  
2           **nursing facility in lieu of section**  
3           **1874(d).”.**

4           **(2) NURSING FACILITIES.—Section**  
5           **1919(d)(1) of the Social Security Act (42**  
6           **U.S.C. 1396r(d)(1)), as amended by section**  
7           **1411(c)(2), is amended by adding at the**  
8           **end the following new subparagraph:**

9                   **“(C) COMPLIANCE AND ETHICS PRO-**  
10                   **GRAM.—**

11                           **“(i) REQUIREMENT.—On or**  
12                           **after the date that is 36 months**  
13                           **after the date of the enactment of**  
14                           **this subparagraph, a nursing fa-**  
15                           **ility shall, with respect to the en-**  
16                           **tity that operates the facility (in**  
17                           **this subparagraph referred to as**  
18                           **the ‘operating organization’ or**  
19                           **‘organization’), have in operation**  
20                           **a compliance and ethics program**  
21                           **that is effective in preventing and**  
22                           **detecting criminal, civil, and ad-**  
23                           **ministrative violations under this**  
24                           **Act and in promoting quality of**

1           **care consistent with regulations**  
2           **developed under clause (ii).**

3           **“(ii) DEVELOPMENT OF REGULA-**  
4           **TIONS.—**

5                   **“(I) IN GENERAL.—Not later**  
6                   **than the date that is 2 years**  
7                   **after such date of the enact-**  
8                   **ment, the Secretary, in con-**  
9                   **sultation with the Inspector**  
10                   **General of the Department of**  
11                   **Health and Human Services,**  
12                   **shall develop regulations for**  
13                   **an effective compliance and**  
14                   **ethics program for operating**  
15                   **organizations, which may in-**  
16                   **clude a model compliance**  
17                   **program.**

18                   **“(II) DESIGN OF REGULA-**  
19                   **TIONS.—Such regulations with**  
20                   **respect to specific elements or**  
21                   **formality of a program may**  
22                   **vary with the size of the orga-**  
23                   **nization, such that larger or-**  
24                   **ganizations should have a**  
25                   **more formal and rigorous pro-**

1           **gram and include established**  
2           **written policies defining the**  
3           **standards and procedures to**  
4           **be followed by its employees.**  
5           **Such requirements may spe-**  
6           **cifically apply to the cor-**  
7           **porate level management of**  
8           **multi-unit nursing home**  
9           **chains.**

10           **“(III) EVALUATION.—Not**  
11           **later than 3 years after the**  
12           **date of promulgation of regu-**  
13           **lations under this clause the**  
14           **Secretary shall complete an**  
15           **evaluation of the compliance**  
16           **and ethics programs required**  
17           **to be established under this**  
18           **subparagraph. Such evalua-**  
19           **tion shall determine if such**  
20           **programs led to changes in**  
21           **deficiency citations, changes**  
22           **in quality performance, or**  
23           **changes in other metrics of**  
24           **resident quality of care. The**  
25           **Secretary shall submit to Con-**

1           **gress a report on such evalua-**  
2           **tion and shall include in such**  
3           **report such recommendations**  
4           **regarding changes in the re-**  
5           **quirements for such programs**  
6           **as the Secretary determines**  
7           **appropriate.**

8           **“(iii) REQUIREMENTS FOR COM-**  
9           **PLIANCE AND ETHICS PROGRAMS.—In**  
10          **this subparagraph, the term ‘com-**  
11          **pliance and ethics program’**  
12          **means, with respect to a nursing**  
13          **facility, a program of the oper-**  
14          **ating organization that—**

15               **“(I) has been reasonably**  
16               **designed, implemented, and**  
17               **enforced so that it generally**  
18               **will be effective in preventing**  
19               **and detecting criminal, civil,**  
20               **and administrative violations**  
21               **under this Act and in pro-**  
22               **moting quality of care; and**

23               **“(II) includes at least the**  
24               **required components speci-**  
25               **fied in clause (iv).**

1           **“(iv) REQUIRED COMPONENTS OF**  
2           **PROGRAM.—The required compo-**  
3           **nents of a compliance and ethics**  
4           **program of an organization are**  
5           **the following:**

6                   **“(I) The organization must**  
7                   **have established compliance**  
8                   **standards and procedures to**  
9                   **be followed by its employees**  
10                  **and other agents that are rea-**  
11                  **sonably capable of reducing**  
12                  **the prospect of criminal, civil,**  
13                  **and administrative violations**  
14                  **under this Act.**

15                   **“(II) Specific individuals**  
16                   **within high-level personnel of**  
17                   **the organization must have**  
18                   **been assigned overall respon-**  
19                   **sibility to oversee compliance**  
20                   **with such standards and pro-**  
21                   **cedures and has sufficient re-**  
22                   **sources and authority to as-**  
23                   **sure such compliance.**

24                   **“(III) The organization**  
25                   **must have used due care not**

1 to delegate substantial discre-  
2 tionary authority to individ-  
3 uals whom the organization  
4 knew, or should have known  
5 through the exercise of due  
6 diligence, had a propensity to  
7 engage in criminal, civil, and  
8 administrative violations  
9 under this Act.

10 “(IV) The organization  
11 must have taken steps to com-  
12 municate effectively its stand-  
13 ards and procedures to all em-  
14 ployees and other agents,  
15 such as by requiring partici-  
16 pation in training programs  
17 or by disseminating publica-  
18 tions that explain in a prac-  
19 tical manner what is required.

20 “(V) The organization  
21 must have taken reasonable  
22 steps to achieve compliance  
23 with its standards, such as by  
24 utilizing monitoring and au-  
25 diting systems reasonably de-

1 signed to detect criminal,  
2 civil, and administrative vio-  
3 lations under this Act by its  
4 employees and other agents  
5 and by having in place and  
6 publicizing a reporting sys-  
7 tem whereby employees and  
8 other agents could report vio-  
9 lations by others within the  
10 organization without fear of  
11 retribution.

12 “(VI) The standards must  
13 have been consistently en-  
14 forced through appropriate  
15 disciplinary mechanisms, in-  
16 cluding, as appropriate, dis-  
17 cipline of individuals respon-  
18 sible for the failure to detect  
19 an offense.

20 “(VII) After an offense has  
21 been detected, the organiza-  
22 tion must have taken all rea-  
23 sonable steps to respond ap-  
24 propriately to the offense and  
25 to prevent further similar of-



1           **fenses, including repayment**  
2           **of any funds to which it was**  
3           **not entitled and any nec-**  
4           **essary modification to its pro-**  
5           **gram to prevent and detect**  
6           **criminal, civil, and adminis-**  
7           **trative violations under this**  
8           **Act.**

9           **“(VIII) The organization**  
10           **must periodically undertake**  
11           **reassessment of its compli-**  
12           **ance program to identify**  
13           **changes necessary to reflect**  
14           **changes within the organiza-**  
15           **tion and its facilities.**

16           **“(v) COORDINATION.—The pro-**  
17           **visions of this subparagraph shall**  
18           **apply with respect to a nursing**  
19           **facility in lieu of section**  
20           **1902(a)(77).”.**

21           **(b) QUALITY ASSURANCE AND PERFORMANCE**  
22           **IMPROVEMENT PROGRAM.—**

23           **(1) SKILLED NURSING FACILITIES.—Sec-**  
24           **tion 1819(b)(1)(B) of the Social Security**

1       **Act (42 U.S.C. 1396r(b)(1)(B)) is amend-**  
2       **ed—**

3               **(A) by striking “ASSURANCE” and**  
4               **inserting “ASSURANCE AND QUALITY AS-**  
5               **SURANCE AND PERFORMANCE IMPROVE-**  
6               **MENT PROGRAM”;**

7               **(B) by designating the matter be-**  
8               **ginning with “A skilled nursing facil-**  
9               **ity” as a clause (i) with the heading**  
10              **“IN GENERAL.—” and the appropriate**  
11              **indentation;**

12              **(C) in clause (i) (as so designated**  
13              **by subparagraph (B)), by redesign-**  
14              **ating clauses (i) and (ii) as sub-**  
15              **clauses (I) and (II), respectively; and**

16              **(D) by adding at the end the fol-**  
17              **lowing new clause:**

18                      **“(ii) QUALITY ASSURANCE AND**  
19                      **PERFORMANCE IMPROVEMENT PRO-**  
20                      **GRAM.—**

21                              **“(I) IN GENERAL.—Not later**  
22                              **than December 31, 2011, the**  
23                              **Secretary shall establish and**  
24                              **implement a quality assur-**  
25                              **ance and performance im-**

1           **provement program (in this**  
2           **clause referred to as the**  
3           **‘QAPI program’) for skilled**  
4           **nursing facilities, including**  
5           **multi-unit chains of such fa-**  
6           **ilities. Under the QAPI pro-**  
7           **gram, the Secretary shall es-**  
8           **tablish standards relating to**  
9           **such facilities and provide**  
10          **technical assistance to such**  
11          **facilities on the development**  
12          **of best practices in order to**  
13          **meet such standards. Not**  
14          **later than 1 year after the**  
15          **date on which the regulations**  
16          **are promulgated under sub-**  
17          **clause (II), a skilled nursing**  
18          **facility must submit to the**  
19          **Secretary a plan for the facil-**  
20          **ity to meet such standards**  
21          **and implement such best**  
22          **practices, including how to**  
23          **coordinate the implementa-**  
24          **tion of such plan with quality**  
25          **assessment and assurance ac-**

1            **tivities conducted under**  
2            **clause (i).**

3            **“(II) REGULATIONS.—The**  
4            **Secretary shall promulgate**  
5            **regulations to carry out this**  
6            **clause.”.**

7            **(2) NURSING FACILITIES.—Section**  
8            **1919(b)(1)(B) of the Social Security Act**  
9            **(42 U.S.C. 1396r(b)(1)(B)) is amended—**

10            **(A) by striking “ASSURANCE” and**  
11            **inserting “ASSURANCE AND QUALITY AS-**  
12            **SURANCE AND PERFORMANCE IMPROVE-**  
13            **MENT PROGRAM”;**

14            **(B) by designating the matter be-**  
15            **ginning with “A nursing facility” as a**  
16            **clause (i) with the heading “IN GEN-**  
17            **ERAL.—” and the appropriate indenta-**  
18            **tion; and**

19            **(C) by adding at the end the fol-**  
20            **lowing new clause:**

21            **“(ii) QUALITY ASSURANCE AND**  
22            **PERFORMANCE IMPROVEMENT PRO-**  
23            **GRAM.—**

24            **“(I) IN GENERAL.—Not later**  
25            **than December 31, 2011, the**

1           **Secretary shall establish and**  
2           **implement a quality assur-**  
3           **ance and performance im-**  
4           **provement program (in this**  
5           **clause referred to as the**  
6           **‘QAPI program’) for nursing**  
7           **facilities, including multi-unit**  
8           **chains of such facilities.**  
9           **Under the QAPI program, the**  
10          **Secretary shall establish**  
11          **standards relating to such fa-**  
12          **cilities and provide technical**  
13          **assistance to such facilities on**  
14          **the development of best prac-**  
15          **tices in order to meet such**  
16          **standards. Not later than 1**  
17          **year after the date on which**  
18          **the regulations are promul-**  
19          **gated under subclause (II), a**  
20          **nursing facility must submit**  
21          **to the Secretary a plan for the**  
22          **facility to meet such stand-**  
23          **ards and implement such best**  
24          **practices, including how to**  
25          **coordinate the implementa-**

1           **tion of such plan with quality**  
2           **assessment and assurance ac-**  
3           **tivities conducted under**  
4           **clause (i).**

5           **“(II) REGULATIONS.—The**  
6           **Secretary shall promulgate**  
7           **regulations to carry out this**  
8           **clause.”.**

9           **(3) PROPOSAL TO REVISE QUALITY AS-**  
10          **SURANCE AND PERFORMANCE IMPROVEMENT**  
11          **PROGRAMS.—The Secretary shall include**  
12          **in the proposed rule published under sec-**  
13          **tion 1888(e) of the Social Security Act (42**  
14          **U.S.C. 1395yy(e)(5)(A)) for the subsequent**  
15          **fiscal year to the extent otherwise au-**  
16          **thorized under section 1819(b)(1)(B) or**  
17          **1819(d)(1)(C) of the Social Security Act or**  
18          **other statutory or regulatory authority,**  
19          **one or more proposals for skilled nursing**  
20          **facilities to modify and strengthen qual-**  
21          **ity assurance and performance improve-**  
22          **ment programs in such facilities. At the**  
23          **time of publication of such proposed rule**  
24          **and to the extent otherwise authorized**  
25          **under section 1919(b)(1)(B) or**

1 **1919(d)(1)(C) of such Act or other regu-**  
2 **latory authority.**

3 **(4) FACILITY PLAN.—Not later than 1**  
4 **year after the date on which the regula-**  
5 **tions are promulgated under subclause**  
6 **(II) of clause (ii) of sections 1819(b)(1)(B)**  
7 **and 1919(b)(1)(B) of the Social Security**  
8 **Act, as added by paragraphs (1) and (2), a**  
9 **skilled nursing facility and a nursing fa-**  
10 **ility must submit to the Secretary a plan**  
11 **for the facility to meet the standards**  
12 **under such regulations and implement**  
13 **such best practices, including how to co-**  
14 **ordinate the implementation of such plan**  
15 **with quality assessment and assurance**  
16 **activities conducted under clause (i) of**  
17 **such sections.**

18 **(c) GAO STUDY ON NURSING FACILITY**  
19 **UNDERCAPITALIZATION.—**

20 **(1) IN GENERAL.—The Comptroller**  
21 **General of the United States shall con-**  
22 **duct a study that examines the following:**

23 **(A) The extent to which corpora-**  
24 **tions that own or operate large num-**  
25 **bers of nursing facilities, taking into**

1           **account ownership type (including**  
2           **private equity and control interests),**  
3           **are undercapitalizing such facilities.**

4           **(B) The effects of such under-**  
5           **capitalization on quality of care, in-**  
6           **cluding staffing and food costs, at**  
7           **such facilities.**

8           **(C) Options to address such**  
9           **undercapitalization, such as require-**  
10          **ments relating to surety bonds, liabil-**  
11          **ity insurance, or minimum capitaliza-**  
12          **tion.**

13          **(2) REPORT.—Not later than 18 months**  
14          **after the date of the enactment of this**  
15          **Act, the Comptroller General shall submit**  
16          **to Congress a report on the study con-**  
17          **ducted under paragraph (1).**

18          **(3) NURSING FACILITY.—In this sub-**  
19          **section, the term “nursing facility” in-**  
20          **cludes a skilled nursing facility.**

21 **SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.**

22          **(a) SKILLED NURSING FACILITIES.—**

23               **(1) IN GENERAL.—Section 1819 of the**  
24               **Social Security Act (42 U.S.C. 1395i-3) is**  
25               **amended—**



1           **(A) by redesignating subsection**  
2           **(i) as subsection (j); and**

3           **(B) by inserting after subsection**  
4           **(h) the following new subsection:**

5           **“(i) NURSING HOME COMPARE WEBSITE.—**

6           **“(1) INCLUSION OF ADDITIONAL INFORMA-**  
7           **TION.—**

8           **“(A) IN GENERAL.—The Secretary**  
9           **shall ensure that the Department of**  
10           **Health and Human Services includes,**  
11           **as part of the information provided**  
12           **for comparison of nursing homes on**  
13           **the official Internet website of the**  
14           **Federal Government for Medicare**  
15           **beneficiaries (commonly referred to**  
16           **as the ‘Nursing Home Compare’ Medi-**  
17           **care website) (or a successor**  
18           **website), the following information in**  
19           **a manner that is prominent, easily ac-**  
20           **cessible, readily understandable to**  
21           **consumers of long-term care services,**  
22           **and searchable:**

23           **“(i) Information that is re-**  
24           **ported to the Secretary under sec-**  
25           **tion 1124(c)(4).**

1           “(ii) Information on the ‘Spe-  
2           cial Focus Facility program’ (or a  
3           successor program) established  
4           by the Centers for Medicare and  
5           Medicaid Services, according to  
6           procedures established by the  
7           Secretary. Such procedures shall  
8           provide for the inclusion of infor-  
9           mation with respect to, and the  
10          names and locations of, those fa-  
11          cilities that, since the previous  
12          quarter—

13                   “(I) were newly enrolled  
14                   in the program;

15                   “(II) are enrolled in the  
16                   program and have failed to  
17                   significantly improve;

18                   “(III) are enrolled in the  
19                   program and have signifi-  
20                   cantly improved;

21                   “(IV) have graduated from  
22                   the program; and

23                   “(V) have closed volun-  
24                   tarily or no longer participate  
25                   under this title.

1           “(iii) Staffing data for each fa-  
2           cility (including resident census  
3           data and data on the hours of  
4           care provided per resident per  
5           day) based on data submitted  
6           under subsection (b)(8)(C), includ-  
7           ing information on staffing turn-  
8           over and tenure, in a format that  
9           is clearly understandable to con-  
10          sumers of long-term care services  
11          and allows such consumers to  
12          compare differences in staffing  
13          between facilities and State and  
14          national averages for the facili-  
15          ties. Such format shall include—

16               “(I) concise explanations  
17               of how to interpret the data  
18               (such as a plain English expla-  
19               nation of data reflecting  
20               ‘nursing home staff hours per  
21               resident day’);

22               “(II) differences in types  
23               of staff (such as training asso-  
24               ciated with different cat-  
25               egories of staff);

1           **“(III) the relationship be-**  
2           **tween nurse staffing levels**  
3           **and quality of care; and**

4           **“(IV) an explanation that**  
5           **appropriate staffing levels**  
6           **vary based on patient case**  
7           **mix.**

8           **“(iv) Links to State Internet**  
9           **websites with information regard-**  
10           **ing State survey and certification**  
11           **programs, links to Form 2567**  
12           **State inspection reports (or a suc-**  
13           **cessor form) on such websites, in-**  
14           **formation to guide consumers in**  
15           **how to interpret and understand**  
16           **such reports, and the facility plan**  
17           **of correction or other response to**  
18           **such report.**

19           **“(v) The standardized com-**  
20           **plaint form developed under sub-**  
21           **section (f)(8), including explana-**  
22           **tory material on what complaint**  
23           **forms are, how they are used, and**  
24           **how to file a complaint with the**  
25           **State survey and certification**

1           **program and the State long-term**  
2           **care ombudsman program.**

3           **“(vi) Summary information on**  
4           **the number, type, severity, and**  
5           **outcome of substantiated com-**  
6           **plaints.**

7           **“(vii) The number of adju-**  
8           **dicated instances of criminal vio-**  
9           **lations by employees of a nursing**  
10          **facility—**

11           **“(I) that were committed**  
12           **inside the facility;**

13           **“(II) with respect to such**  
14           **instances of violations or**  
15           **crimes committed inside of**  
16           **the facility that were the vio-**  
17           **lations or crimes of abuse, ne-**  
18           **glect, and exploitation, crimi-**  
19           **nal sexual abuse, or other vio-**  
20           **lations or crimes that resulted**  
21           **in serious bodily injury; and**

22           **“(III) the number of civil**  
23           **monetary penalties levied**  
24           **against the facility, employ-**

1           ees, contractors, and other  
2           agents.

3           **“(B) DEADLINE FOR PROVISION OF**  
4           **INFORMATION.—**

5           **“(i) IN GENERAL.—**Except as  
6           provided in clause (ii), the Sec-  
7           retary shall ensure that the infor-  
8           mation described in subpara-  
9           graph (A) is included on such  
10          website (or a successor website)  
11          not later than 1 year after the  
12          date of the enactment of this sub-  
13          section.

14          **“(ii) EXCEPTION.—**The Sec-  
15          retary shall ensure that the infor-  
16          mation described in subpara-  
17          graph (A)(i) and (A)(iii) is in-  
18          cluded on such website (or a suc-  
19          cessor website) not later than the  
20          date on which the requirements  
21          under section 1124(c)(4) and sub-  
22          section (b)(8)(C)(ii) are imple-  
23          mented.

24          **“(2) REVIEW AND MODIFICATION OF**  
25          **WEBSITE.—**

1           **“(A) IN GENERAL.—The Secretary**  
2           **shall establish a process—**

3                   **“(i) to review the accuracy,**  
4                   **clarity of presentation, timeliness,**  
5                   **and comprehensiveness of infor-**  
6                   **mation reported on such website**  
7                   **as of the day before the date of**  
8                   **the enactment of this subsection;**  
9                   **and**

10                   **“(ii) not later than 1 year after**  
11                   **the date of the enactment of this**  
12                   **subsection, to modify or revamp**  
13                   **such website in accordance with**  
14                   **the review conducted under**  
15                   **clause (i).**

16           **“(B) CONSULTATION.—In con-**  
17           **ducting the review under subpara-**  
18           **graph (A)(i), the Secretary shall con-**  
19           **sult with—**

20                   **“(i) State long-term care om-**  
21                   **budsman programs;**

22                   **“(ii) consumer advocacy**  
23                   **groups;**

24                   **“(iii) provider stakeholder**  
25                   **groups; and**

1           “(iv) any other representa-  
2           tives of programs or groups the  
3           Secretary determines appro-  
4           priate.”.

5           (2) TIMELINESS OF SUBMISSION OF SUR-  
6           VEY AND CERTIFICATION INFORMATION.—

7           (A) IN GENERAL.—Section  
8           1819(g)(5) of the Social Security Act  
9           (42 U.S.C. 1395i-3(g)(5)) is amended  
10          by adding at the end the following  
11          new subparagraph:

12          “(E) SUBMISSION OF SURVEY AND  
13          CERTIFICATION INFORMATION TO THE  
14          SECRETARY.—In order to improve the  
15          timeliness of information made avail-  
16          able to the public under subpara-  
17          graph (A) and provided on the Nurs-  
18          ing Home Compare Medicare website  
19          under subsection (i), each State shall  
20          submit information respecting any  
21          survey or certification made respect-  
22          ing a skilled nursing facility (includ-  
23          ing any enforcement actions taken by  
24          the State) to the Secretary not later  
25          than the date on which the State



1 sends such information to the facility.  
2 The Secretary shall use the informa-  
3 tion submitted under the preceding  
4 sentence to update the information  
5 provided on the Nursing Home Com-  
6 pare Medicare website as expedi-  
7 tiously as practicable but not less fre-  
8 quently than quarterly.”.

9 (B) EFFECTIVE DATE.—The amend-  
10 ment made by this paragraph shall  
11 take effect 1 year after the date of the  
12 enactment of this Act.

13 (3) SPECIAL FOCUS FACILITY PROGRAM.—  
14 Section 1819(f) of such Act is amended by  
15 adding at the end the following new  
16 paragraph:

17 “(8) SPECIAL FOCUS FACILITY PRO-  
18 GRAM.—

19 “(A) IN GENERAL.—The Secretary  
20 shall conduct a special focus facility  
21 program for enforcement of require-  
22 ments for skilled nursing facilities  
23 that the Secretary has identified as  
24 having substantially failed to meet  
25 applicable requirement of this Act.

1           **“(B) PERIODIC SURVEYS.—Under**  
2           **such program the Secretary shall**  
3           **conduct surveys of each facility in**  
4           **the program not less than once every**  
5           **6 months.”.**

6           **(b) NURSING FACILITIES.—**

7           **(1) IN GENERAL.—Section 1919 of the**  
8           **Social Security Act (42 U.S.C. 1396r) is**  
9           **amended—**

10           **(A) by redesignating subsection**  
11           **(i) as subsection (j); and**

12           **(B) by inserting after subsection**  
13           **(h) the following new subsection:**

14           **“(i) NURSING HOME COMPARE WEBSITE.—**

15           **“(1) INCLUSION OF ADDITIONAL INFORMA-**  
16           **TION.—**

17           **“(A) IN GENERAL.—The Secretary**  
18           **shall ensure that the Department of**  
19           **Health and Human Services includes,**  
20           **as part of the information provided**  
21           **for comparison of nursing homes on**  
22           **the official Internet website of the**  
23           **Federal Government for Medicare**  
24           **beneficiaries (commonly referred to**  
25           **as the ‘Nursing Home Compare’ Medi-**

1           care website) (or a successor  
2           website), the following information in  
3           a manner that is prominent, easily ac-  
4           cessible, readily understandable to  
5           consumers of long-term care services,  
6           and searchable:

7                   “(i) Staffing data for each fa-  
8                   cility (including resident census  
9                   data and data on the hours of  
10                  care provided per resident per  
11                  day) based on data submitted  
12                  under subsection (b)(8)(C)(ii), in-  
13                  cluding information on staffing  
14                  turnover and tenure, in a format  
15                  that is clearly understandable to  
16                  consumers of long-term care serv-  
17                  ices and allows such consumers to  
18                  compare differences in staffing  
19                  between facilities and State and  
20                  national averages for the facili-  
21                  ties. Such format shall include—

22                           “(I) concise explanations  
23                           of how to interpret the data  
24                           (such as plain English expla-  
25                           nation of data reflecting

1           **‘nursing home staff hours per**  
2           **resident day’);**

3           **“(II) differences in types**  
4           **of staff (such as training asso-**  
5           **ciated with different cat-**  
6           **egories of staff);**

7           **“(III) the relationship be-**  
8           **tween nurse staffing levels**  
9           **and quality of care; and**

10          **“(IV) an explanation that**  
11          **appropriate staffing levels**  
12          **vary based on patient case**  
13          **mix.**

14          **“(ii) Links to State Internet**  
15          **websites with information regard-**  
16          **ing State survey and certification**  
17          **programs, links to Form 2567**  
18          **State inspection reports (or a suc-**  
19          **cessor form) on such websites, in-**  
20          **formation to guide consumers in**  
21          **how to interpret and understand**  
22          **such reports, and the facility plan**  
23          **of correction or other response to**  
24          **such report.**

1           “(iii) The standardized com-  
2           plaint form developed under sub-  
3           section (f)(10), including explana-  
4           tory material on what complaint  
5           forms are, how they are used, and  
6           how to file a complaint with the  
7           State survey and certification  
8           program and the State long-term  
9           care ombudsman program.

10           “(iv) Summary information on  
11           the number, type, severity, and  
12           outcome of substantiated com-  
13           plaints.

14           “(v) The number of adju-  
15           dicated instances of criminal vio-  
16           lations by employees of a nursing  
17           facility—

18                   “(I) that were committed  
19                   inside of the facility; and

20                   “(II) with respect to such  
21                   instances of violations or  
22                   crimes committed outside of  
23                   the facility, that were the vio-  
24                   lations or crimes that resulted

1           **in the serious bodily injury of**  
2           **an elder.**

3           **“(B) DEADLINE FOR PROVISION OF**  
4           **INFORMATION.—**

5           **“(i) IN GENERAL.—Except as**  
6           **provided in clause (ii), the Sec-**  
7           **retary shall ensure that the infor-**  
8           **mation described in subpara-**  
9           **graph (A) is included on such**  
10          **website (or a successor website)**  
11          **not later than 1 year after the**  
12          **date of the enactment of this sub-**  
13          **section.**

14          **“(ii) EXCEPTION.—The Sec-**  
15          **retary shall ensure that the infor-**  
16          **mation described in subpara-**  
17          **graph (A)(i) and (A)(iii) is in-**  
18          **cluded on such website (or a suc-**  
19          **cessor website) not later than the**  
20          **date on which the requirements**  
21          **under section 1124(c)(4) and sub-**  
22          **section (b)(8)(C)(ii) are imple-**  
23          **mented.**

24          **“(2) REVIEW AND MODIFICATION OF**  
25          **WEBSITE.—**

1           **“(A) IN GENERAL.—The Secretary**  
2           **shall establish a process—**

3                   **“(i) to review the accuracy,**  
4                   **clarity of presentation, timeliness,**  
5                   **and comprehensiveness of infor-**  
6                   **mation reported on such website**  
7                   **as of the day before the date of**  
8                   **the enactment of this subsection;**  
9                   **and**

10                   **“(ii) not later than 1 year after**  
11                   **the date of the enactment of this**  
12                   **subsection, to modify or revamp**  
13                   **such website in accordance with**  
14                   **the review conducted under**  
15                   **clause (i).**

16           **“(B) CONSULTATION.—In con-**  
17           **ducting the review under subpara-**  
18           **graph (A)(i), the Secretary shall con-**  
19           **sult with—**

20                   **“(i) State long-term care om-**  
21                   **budsman programs;**

22                   **“(ii) consumer advocacy**  
23                   **groups;**

24                   **“(iii) provider stakeholder**  
25                   **groups;**

1           “(iv) skilled nursing facility  
2           employees and their representa-  
3           tives; and

4           “(v) any other representatives  
5           of programs or groups the Sec-  
6           retary determines appropriate.”.

7           **(2) TIMELINESS OF SUBMISSION OF SUR-**  
8           **VEY AND CERTIFICATION INFORMATION.—**

9           **(A) IN GENERAL.—Section**  
10          **1919(g)(5) of the Social Security Act**  
11          **(42 U.S.C. 1396r(g)(5)) is amended by**  
12          **adding at the end the following new**  
13          **subparagraph:**

14          **“(E) SUBMISSION OF SURVEY AND**  
15          **CERTIFICATION INFORMATION TO THE**  
16          **SECRETARY.—In order to improve the**  
17          **timeliness of information made avail-**  
18          **able to the public under subpara-**  
19          **graph (A) and provided on the Nurs-**  
20          **ing Home Compare Medicare website**  
21          **under subsection (i), each State shall**  
22          **submit information respecting any**  
23          **survey or certification made respect-**  
24          **ing a nursing facility (including any**  
25          **enforcement actions taken by the**



1           **State) to the Secretary not later than**  
2           **the date on which the State sends**  
3           **such information to the facility. The**  
4           **Secretary shall use the information**  
5           **submitted under the preceding sen-**  
6           **tence to update the information pro-**  
7           **vided on the Nursing Home Compare**  
8           **Medicare website as expeditiously as**  
9           **practicable but not less frequently**  
10          **than quarterly.”.**

11           **(B) EFFECTIVE DATE.—The amend-**  
12          **ment made by this paragraph shall**  
13          **take effect 1 year after the date of the**  
14          **enactment of this Act.**

15           **(3) SPECIAL FOCUS FACILITY PROGRAM.—**  
16          **Section 1919(f) of such Act is amended by**  
17          **adding at the end of the following new**  
18          **paragraph:**

19           **“(10) SPECIAL FOCUS FACILITY PRO-**  
20          **GRAM.—**

21           **“(A) IN GENERAL.—The Secretary**  
22          **shall conduct a special focus facility**  
23          **program for enforcement of require-**  
24          **ments for nursing facilities that the**  
25          **Secretary has identified as having**

1           **substantially failed to meet applica-**  
2           **ble requirements of this Act.**

3           **“(B) PERIODIC SURVEYS.—Under**  
4           **such program the Secretary shall**  
5           **conduct surveys of each facility in**  
6           **the program not less often than once**  
7           **every 6 months.”.**

8           **(c) AVAILABILITY OF REPORTS ON SURVEYS,**  
9           **CERTIFICATIONS, AND COMPLAINT INVESTIGA-**  
10          **TIONS.—**

11           **(1) SKILLED NURSING FACILITIES.—Sec-**  
12          **tion 1819(d)(1) of the Social Security Act**  
13          **(42 U.S.C. 1395i-3(d)(1)), as amended by**  
14          **sections 1411 and 1412, is amended by**  
15          **adding at the end the following new sub-**  
16          **paragraph:**

17           **“(D) AVAILABILITY OF SURVEY, CER-**  
18           **TIFICATION, AND COMPLAINT INVESTIGA-**  
19           **TION REPORTS.—A skilled nursing fa-**  
20           **cility must—**

21           **“(i) have reports with respect**  
22           **to any surveys, certifications, and**  
23           **complaint investigations made re-**  
24           **specting the facility during the 3**  
25           **preceding years available for any**

1 individual to review upon re-  
2 quest; and

3 “(ii) post notice of the avail-  
4 ability of such reports in areas of  
5 the facility that are prominent  
6 and accessible to the public.

7 The facility shall not make available  
8 under clause (i) identifying informa-  
9 tion about complainants or resi-  
10 dents.”.

11 (2) NURSING FACILITIES.—Section  
12 1919(d)(1) of the Social Security Act (42  
13 U.S.C. 1396r(d)(1)), as amended by sec-  
14 tions 1411 and 1412, is amended by add-  
15 ing at the end the following new subpara-  
16 graph:

17 “(D) AVAILABILITY OF SURVEY, CER-  
18 TIFICATION, AND COMPLAINT INVESTIGA-  
19 TION REPORTS.—A nursing facility  
20 must—

21 “(i) have reports with respect  
22 to any surveys, certifications, and  
23 complaint investigations made re-  
24 specting the facility during the 3  
25 preceding years available for any

1 individual to review upon re-  
2 quest; and

3 “(ii) post notice of the avail-  
4 ability of such reports in areas of  
5 the facility that are prominent  
6 and accessible to the public.

7 The facility shall not make available  
8 under clause (i) identifying informa-  
9 tion about complainants or resi-  
10 dents.”.

11 (3) EFFECTIVE DATE.—The amendments  
12 made by this subsection shall take effect  
13 1 year after the date of the enactment of  
14 this Act.

15 (d) GUIDANCE TO STATES ON FORM 2567  
16 STATE INSPECTION REPORTS AND COMPLAINT IN-  
17 VESTIGATION REPORTS.—

18 (1) GUIDANCE.—The Secretary of  
19 Health and Human Services (in this sub-  
20 title referred to as the “Secretary”) shall  
21 provide guidance to States on how States  
22 can establish electronic links to Form  
23 2567 State inspection reports (or a suc-  
24 cessor form), complaint investigation re-  
25 ports, and a facility’s plan of correction

1 or other response to such Form 2567  
2 State inspection reports (or a successor  
3 form) on the Internet website of the State  
4 that provides information on skilled  
5 nursing facilities and nursing facilities  
6 and the Secretary shall, if possible, in-  
7 clude such information on Nursing Home  
8 Compare.

9 (2) REQUIREMENT.—Section 1902(a)(9)  
10 of the Social Security Act (42 U.S.C.  
11 1396a(a)(9)) is amended—

12 (A) by striking “and” at the end of  
13 subparagraph (B);

14 (B) by striking the semicolon at  
15 the end of subparagraph (C) and in-  
16 sserting “, and”; and

17 (C) by adding at the end the fol-  
18 lowing new subparagraph:

19 “(D) that the State maintain a  
20 consumer-oriented website providing  
21 useful information to consumers re-  
22 garding all skilled nursing facilities  
23 and all nursing facilities in the State,  
24 including for each facility, Form 2567  
25 State inspection reports (or a suc-

1           cessor form), complaint investigation  
2           reports, the facility’s plan of correc-  
3           tion, and such other information that  
4           the State or the Secretary considers  
5           useful in assisting the public to assess  
6           the quality of long term care options  
7           and the quality of care provided by  
8           individual facilities;”.

9           **(3) DEFINITIONS.—In this subsection:**

10           **(A) NURSING FACILITY.—The term**  
11           **“nursing facility” has the meaning**  
12           **given such term in section 1919(a) of**  
13           **the Social Security Act (42 U.S.C.**  
14           **1396r(a)).**

15           **(B) SECRETARY.—The term “Sec-**  
16           **retary” means the Secretary of Health**  
17           **and Human Services.**

18           **(C) SKILLED NURSING FACILITY.—**  
19           **The term “skilled nursing facility”**  
20           **has the meaning given such term in**  
21           **section 1819(a) of the Social Security**  
22           **Act (42 U.S.C. 1395i-3(a)).**

1 SEC. 1414. REPORTING OF EXPENDITURES.

2 Section 1888 of the Social Security Act (42  
3 U.S.C. 1395yy) is amended by adding at the  
4 end the following new subsection:

5 “(f) REPORTING OF DIRECT CARE EXPENDI-  
6 TURES.—

7 “(1) IN GENERAL.—For cost reports  
8 submitted under this title for cost report-  
9 ing periods beginning on or after the  
10 date that is 3 years after the date of the  
11 enactment of this subsection, skilled  
12 nursing facilities shall separately report  
13 expenditures for wages and benefits for  
14 direct care staff (breaking out (at a min-  
15 imum) registered nurses, licensed profes-  
16 sional nurses, certified nurse assistants,  
17 and other medical and therapy staff).

18 “(2) MODIFICATION OF FORM.—The Sec-  
19 retary, in consultation with private sec-  
20 tor accountants experienced with skilled  
21 nursing facility cost reports, shall rede-  
22 sign such reports to meet the require-  
23 ment of paragraph (1) not later than 1  
24 year after the date of the enactment of  
25 this subsection.

1           **“(3) CATEGORIZATION BY FUNCTIONAL**  
2           **ACCOUNTS.—Not later than 30 months**  
3           **after the date of the enactment of this**  
4           **subsection, the Secretary, working in**  
5           **consultation with the Medicare Payment**  
6           **Advisory Commission, the Inspector Gen-**  
7           **eral of the Department of Health and**  
8           **Human Services, and other expert parties**  
9           **the Secretary determines appropriate,**  
10          **shall take the expenditures listed on cost**  
11          **reports, as modified under paragraph (1),**  
12          **submitted by skilled nursing facilities**  
13          **and categorize such expenditures, re-**  
14          **gardless of any source of payment for**  
15          **such expenditures, for each skilled nurs-**  
16          **ing facility into the following functional**  
17          **accounts on an annual basis:**

18                   **“(A) Spending on direct care serv-**  
19                   **ices (including nursing, therapy, and**  
20                   **medical services).**

21                   **“(B) Spending on indirect care**  
22                   **(including housekeeping and dietary**  
23                   **services).**

24                   **“(C) Capital assets (including**  
25                   **building and land costs).**



1           **“(D) Administrative services**  
2           **costs.**

3           **“(4) AVAILABILITY OF INFORMATION SUB-**  
4           **MITTED.—The Secretary shall establish**  
5           **procedures to make information on ex-**  
6           **penditures submitted under this sub-**  
7           **section readily available to interested**  
8           **parties upon request, subject to such re-**  
9           **quirements as the Secretary may specify**  
10          **under the procedures established under**  
11          **this paragraph.”.**

12 **SEC. 1415. STANDARDIZED COMPLAINT FORM.**

13           **(a) SKILLED NURSING FACILITIES.—**

14           **(1) DEVELOPMENT BY THE SECRETARY.—**  
15           **Section 1819(f) of the Social Security Act**  
16           **(42 U.S.C. 1395i-3(f)), as amended by sec-**  
17           **tion 1413(a)(3), is amended by adding at**  
18           **the end the following new paragraph:**

19           **“(9) STANDARDIZED COMPLAINT FORM.—**  
20           **The Secretary shall develop a standard-**  
21           **ized complaint form for use by a resident**  
22           **(or a person acting on the resident’s be-**  
23           **half) in filing a complaint with a State**  
24           **survey and certification agency and a**  
25           **State long-term care ombudsman pro-**

1 **gram with respect to a skilled nursing fa-**  
2 **cility.”.**

3 **(2) STATE REQUIREMENTS.—Section**  
4 **1819(e) of the Social Security Act (42**  
5 **U.S.C. 1395i-3(e)) is amended by adding**  
6 **at the end the following new paragraph:**

7 **“(6) COMPLAINT PROCESSES AND WHIS-**  
8 **TLE-BLOWER PROTECTION.—**

9 **“(A) COMPLAINT FORMS.—The State**  
10 **must make the standardized com-**  
11 **plaint form developed under sub-**  
12 **section (f)(9) available upon request**  
13 **to—**

14 **“(i) a resident of a skilled**  
15 **nursing facility;**

16 **“(ii) any person acting on the**  
17 **resident’s behalf; and**

18 **“(iii) any person who works at**  
19 **a skilled nursing facility or is a**  
20 **representative of such a worker.**

21 **“(B) COMPLAINT RESOLUTION PROC-**  
22 **ESS.—The State must establish a com-**  
23 **plaint resolution process in order to**  
24 **ensure that a resident, the legal rep-**  
25 **resentative of a resident of a skilled**

1           nursing facility, or other responsible  
2           party is not retaliated against if the  
3           resident, legal representative, or re-  
4           sponsible party has complained, in  
5           good faith, about the quality of care  
6           or other issues relating to the skilled  
7           nursing facility, that the legal rep-  
8           resentative of a resident of a skilled  
9           nursing facility or other responsible  
10          party is not denied access to such  
11          resident or otherwise retaliated  
12          against if such representative party  
13          has complained, in good faith, about  
14          the quality of care provided by the fa-  
15          cility or other issues relating to the  
16          facility, and that a person who works  
17          at a skilled nursing facility is not re-  
18          taliated against if the worker has  
19          complained, in good faith, about qual-  
20          ity of care or services or an issue re-  
21          lating to the quality of care or serv-  
22          ices provided at the facility, whether  
23          the resident, legal representative,  
24          other responsible party, or worker  
25          used the form developed under sub-

1 section (f)(9) or some other method  
2 for submitting the complaint. Such  
3 complaint resolution process shall in-  
4 clude—

5 “(i) procedures to assure accu-  
6 rate tracking of complaints re-  
7 ceived, including notification to  
8 the complainant that a complaint  
9 has been received;

10 “(ii) procedures to determine  
11 the likely severity of a complaint  
12 and for the investigation of the  
13 complaint;

14 “(iii) deadlines for responding  
15 to a complaint and for notifying  
16 the complainant of the outcome of  
17 the investigation; and

18 “(iv) procedures to ensure  
19 that the identity of the complain-  
20 ant will be kept confidential.

21 “(C) WHISTLEBLOWER PROTEC-  
22 TION.—

23 “(i) PROHIBITION AGAINST RE-  
24 TALIACTION.—No person who works  
25 at a skilled nursing facility may

1           **be penalized, discriminated, or re-**  
2           **taliated against with respect to**  
3           **any aspect of employment, includ-**  
4           **ing discharge, promotion, com-**  
5           **ensation, terms, conditions, or**  
6           **privileges of employment, or have**  
7           **a contract for services termi-**  
8           **nated, because the person (or**  
9           **anyone acting at the person’s re-**  
10          **quest) complained, in good faith,**  
11          **about the quality of care or serv-**  
12          **ices provided by a nursing facility**  
13          **or about other issues relating to**  
14          **quality of care or services, wheth-**  
15          **er using the form developed**  
16          **under subsection (f)(9) or some**  
17          **other method for submitting the**  
18          **complaint.**

19           **“(ii) RETALIATORY REPORT-**  
20           **ING.—A skilled nursing facility**  
21           **may not file a complaint or a re-**  
22           **port against a person who works**  
23           **(or has worked at the facility with**  
24           **the appropriate State profes-**  
25           **sional disciplinary agency be-**

1           **cause the person (or anyone act-**  
2           **ing at the person's request) com-**  
3           **plained in good faith, as de-**  
4           **scribed in clause (i).**

5           **“(iii) COMMENCEMENT OF AC-**  
6           **TION.—Any person who believes**  
7           **the person has been penalized,**  
8           **discriminated , or retaliated**  
9           **against or had a contract for serv-**  
10           **ices terminated in violation of**  
11           **clause (i) or against whom a com-**  
12           **plaint has been filed in violation**  
13           **of clause (ii) may bring an action**  
14           **at law or equity in the appro-**  
15           **priate district court of the United**  
16           **States, which shall have jurisdic-**  
17           **tion over such action without re-**  
18           **gard to the amount in con-**  
19           **troversy or the citizenship of the**  
20           **parties, and which shall have ju-**  
21           **risdiction to grant complete re-**  
22           **lief, including, but not limited to,**  
23           **injunctive relief (such as rein-**  
24           **statement, compensatory damages**  
25           **(which may include reimburse-**

1           **ment of lost wages, compensation,**  
2           **and benefits), costs of litigation**  
3           **(including reasonable attorney**  
4           **and expert witness fees), exem-**  
5           **plary damages where appro-**  
6           **priate, and such other relief as**  
7           **the court deems just and proper.**

8           **“(iv) RIGHTS NOT WAIVABLE.—**  
9           **The rights protected by this para-**  
10          **graph may not be diminished by**  
11          **contract or other agreement, and**  
12          **nothing in this paragraph shall be**  
13          **construed to diminish any greater**  
14          **or additional protection provided**  
15          **by Federal or State law or by con-**  
16          **tract or other agreement.**

17          **“(v) REQUIREMENT TO POST NO-**  
18          **TICE OF EMPLOYEE RIGHTS.—Each**  
19          **skilled nursing facility shall post**  
20          **conspicuously in an appropriate**  
21          **location a sign (in a form speci-**  
22          **fied by the Secretary) specifying**  
23          **the rights of persons under this**  
24          **paragraph and including a state-**  
25          **ment that an employee may file a**

1           complaint with the Secretary  
2           against a skilled nursing facility  
3           that violates the provisions of this  
4           paragraph and information with  
5           respect to the manner of filing  
6           such a complaint.

7           “(D) RULE OF CONSTRUCTION.—  
8           Nothing in this paragraph shall be  
9           construed as preventing a resident of  
10          a skilled nursing facility (or a person  
11          acting on the resident’s behalf) from  
12          submitting a complaint in a manner  
13          or format other than by using the  
14          standardized complaint form devel-  
15          oped under subsection (f)(9) (includ-  
16          ing submitting a complaint orally).

17          “(E) GOOD FAITH DEFINED.—For  
18          purposes of this paragraph, an indi-  
19          vidual shall be deemed to be acting in  
20          good faith with respect to the filing of  
21          a complaint if the individual reason-  
22          ably believes—

23                  “(i) the information reported  
24                  or disclosed in the complaint is  
25                  true; and



1                   “(ii) the violation of this title  
2                   has occurred or may occur in re-  
3                   lation to such information.”.

4           **(b) NURSING FACILITIES.—**

5                   **(1) DEVELOPMENT BY THE SECRETARY.—**  
6           **Section 1919(f) of the Social Security Act**  
7           **(42 U.S.C. 1395i-3(f)), as amended by sec-**  
8           **tion 1413(b), is amended by adding at the**  
9           **end the following new paragraph:**

10                   **“(11) STANDARDIZED COMPLAINT**  
11                   **FORM.—The Secretary shall develop a**  
12                   **standardized complaint form for use by a**  
13                   **resident (or a person acting on the resi-**  
14                   **dent’s behalf) in filing a complaint with a**  
15                   **State survey and certification agency and**  
16                   **a State long-term care ombudsman pro-**  
17                   **gram with respect to a nursing facility.”.**

18                   **(2) STATE REQUIREMENTS.—Section**  
19                   **1919(e) of the Social Security Act (42**  
20                   **U.S.C. 1395i-3(e)) is amended by adding**  
21                   **at the end the following new paragraph:**

22                   **“(8) COMPLAINT PROCESSES AND WHIS-**  
23                   **TLEBLOWER PROTECTION.—**

24                   **“(A) COMPLAINT FORMS.—The State**  
25                   **must make the standardized com-**

1           **plaint form developed under sub-**  
2           **section (f)(11) available upon request**  
3           **to—**

4                   **“(i) a resident of a nursing fa-**  
5                   **cility;**

6                   **“(ii) any person acting on the**  
7                   **resident’s behalf; and**

8                   **“(iii) any person who works at**  
9                   **a nursing facility or a representa-**  
10                   **tive of such a worker.**

11           **“(B) COMPLAINT RESOLUTION PROC-**  
12           **ESS.—The State must establish a com-**  
13           **plaint resolution process in order to**  
14           **ensure that a resident, the legal rep-**  
15           **resentative of a resident of a nursing**  
16           **facility, or other responsible party is**  
17           **not retaliated against if the resident,**  
18           **legal representative, or responsible**  
19           **party has complained, in good faith,**  
20           **about the quality of care or other**  
21           **issues relating to the nursing facility,**  
22           **that the legal representative of a resi-**  
23           **dent of a nursing facility or other re-**  
24           **sponsible party is not denied access**  
25           **to such resident or otherwise retali-**

1           ated against if such representative  
2           party has complained, in good faith,  
3           about the quality of care provided by  
4           the facility or other issues relating to  
5           the facility, and that a person who  
6           works at a nursing facility is not re-  
7           taliated against if the worker has  
8           complained, in good faith, about qual-  
9           ity of care or services or an issue re-  
10          lating to the quality of care or serv-  
11          ices provided at the facility, whether  
12          the resident, legal representative,  
13          other responsible party, or worker  
14          used the form developed under sub-  
15          section (f)(11) or some other method  
16          for submitting the complaint. Such  
17          complaint resolution process shall in-  
18          clude—

19                   “(i) procedures to assure accu-  
20                   rate tracking of complaints re-  
21                   ceived, including notification to  
22                   the complainant that a complaint  
23                   has been received;

24                   “(ii) procedures to determine  
25                   the likely severity of a complaint

1           **and for the investigation of the**  
2           **complaint;**

3           **“(iii) deadlines for responding**  
4           **to a complaint and for notifying**  
5           **the complainant of the outcome of**  
6           **the investigation; and**

7           **“(iv) procedures to ensure**  
8           **that the identity of the complain-**  
9           **ant will be kept confidential.**

10           **“(C) WHISTLEBLOWER PROTEC-**  
11           **TION.—**

12           **“(i) PROHIBITION AGAINST RE-**  
13           **TALIATION.—No person who works**  
14           **at a nursing facility may be penal-**  
15           **ized, discriminated, or retaliated**  
16           **against with respect to any aspect**  
17           **of employment, including dis-**  
18           **charge, promotion, compensation,**  
19           **terms, conditions, or privileges of**  
20           **employment, or have a contract**  
21           **for services terminated, because**  
22           **the person (or anyone acting at**  
23           **the person’s request) complained,**  
24           **in good faith, about the quality of**  
25           **care or services provided by a**

1           nursing facility or about other  
2           issues relating to quality of care  
3           or services, whether using the  
4           form developed under subsection  
5           (f)(11) or some other method for  
6           submitting the complaint.

7           “(ii) RETALIATORY REPORT-  
8           ING.—A nursing facility may not  
9           file a complaint or a report  
10          against a person who works (or  
11          has worked at the facility with  
12          the appropriate State profes-  
13          sional disciplinary agency be-  
14          cause the person (or anyone act-  
15          ing at the person’s request) com-  
16          plained in good faith, as de-  
17          scribed in clause (i).

18          “(iii) COMMENCEMENT OF AC-  
19          TION.—Any person who believes  
20          the person has been penalized,  
21          discriminated, or retaliated  
22          against or had a contract for serv-  
23          ices terminated in violation of  
24          clause (i) or against whom a com-  
25          plaint has been filed in violation

1 of clause (ii) may bring an action  
2 at law or equity in the appro-  
3 priate district court of the United  
4 States, which shall have jurisdic-  
5 tion over such action without re-  
6 gard to the amount in con-  
7 troversy or the citizenship of the  
8 parties, and which shall have ju-  
9 risdiction to grant complete re-  
10 lief, including, but not limited to,  
11 injunctive relief (such as rein-  
12 statement, compensatory damages  
13 (which may include reimburse-  
14 ment of lost wages, compensation,  
15 and benefits), costs of litigation  
16 (including reasonable attorney  
17 and expert witness fees), exem-  
18 plary damages where appro-  
19 priate, and such other relief as  
20 the court deems just and proper.

21 “(iv) RIGHTS NOT WAIVABLE.—  
22 The rights protected by this para-  
23 graph may not be diminished by  
24 contract or other agreement, and  
25 nothing in this paragraph shall be

1           **construed to diminish any greater**  
2           **or additional protection provided**  
3           **by Federal or State law or by con-**  
4           **tract or other agreement.**

5           **“(v) REQUIREMENT TO POST NO-**  
6           **TICE OF EMPLOYEE RIGHTS.—Each**  
7           **nursing facility shall post con-**  
8           **spicuously in an appropriate loca-**  
9           **tion a sign (in a form specified by**  
10          **the Secretary) specifying the**  
11          **rights of persons under this para-**  
12          **graph and including a statement**  
13          **that an employee may file a com-**  
14          **plaint with the Secretary against**  
15          **a nursing facility that violates the**  
16          **provisions of this paragraph and**  
17          **information with respect to the**  
18          **manner of filing such a com-**  
19          **plaint.**

20          **“(D) RULE OF CONSTRUCTION.—**  
21          **Nothing in this paragraph shall be**  
22          **construed as preventing a resident of**  
23          **a nursing facility (or a person acting**  
24          **on the resident’s behalf) from submit-**  
25          **ting a complaint in a manner or for-**

1 mat other than by using the stand-  
2 ardized complaint form developed  
3 under subsection (f)(11) (including  
4 submitting a complaint orally).

5 “(E) GOOD FAITH DEFINED.—For  
6 purposes of this paragraph, an indi-  
7 vidual shall be deemed to be acting in  
8 good faith with respect to the filing of  
9 a complaint if the individual reason-  
10 ably believes—

11 “(i) the information reported  
12 or disclosed in the complaint is  
13 true; and

14 “(ii) the violation of this title  
15 has occurred or may occur in re-  
16 lation to such information.”.

17 (c) EFFECTIVE DATE.—The amendments  
18 made by this section shall take effect 1 year  
19 after the date of the enactment of this Act.

20 SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.

21 (a) SKILLED NURSING FACILITIES.—Section  
22 1819(b)(8) of the Social Security Act (42 U.S.C.  
23 1395i-3(b)(8)) is amended by adding at the end  
24 the following new subparagraph:



1           **“(C) SUBMISSION OF STAFFING IN-**  
2           **FORMATION BASED ON PAYROLL DATA IN**  
3           **A UNIFORM FORMAT.—Beginning not**  
4           **later than 2 years after the date of**  
5           **the enactment of this subparagraph,**  
6           **and after consulting with State long-**  
7           **term care ombudsman programs, con-**  
8           **sumer advocacy groups, provider**  
9           **stakeholder groups, employees and**  
10           **their representatives, and other par-**  
11           **ties the Secretary deems appropriate,**  
12           **the Secretary shall require a skilled**  
13           **nursing facility to electronically sub-**  
14           **mit to the Secretary direct care staff-**  
15           **ing information (including informa-**  
16           **tion with respect to agency and con-**  
17           **tract staff) based on payroll and**  
18           **other verifiable and auditable data in**  
19           **a uniform format (according to speci-**  
20           **fications established by the Secretary**  
21           **in consultation with such programs,**  
22           **groups, and parties). Such specifica-**  
23           **tions shall require that the informa-**  
24           **tion submitted under the preceding**  
25           **sentence—**

1           “(i) specify the category of  
2           work a certified employee per-  
3           forms (such as whether the em-  
4           ployee is a registered nurse, li-  
5           censed practical nurse, licensed  
6           vocational nurse, certified nurs-  
7           ing assistant, therapist, or other  
8           medical personnel);

9           “(ii) include resident census  
10          data and information on resident  
11          case mix;

12          “(iii) include a regular report-  
13          ing schedule; and

14          “(iv) include information on  
15          employee turnover and tenure  
16          and on the hours of care provided  
17          by each category of certified em-  
18          ployees referenced in clause (i)  
19          per resident per day.

20          Nothing in this subparagraph shall be  
21          construed as preventing the Sec-  
22          retary from requiring submission of  
23          such information with respect to spe-  
24          cific categories, such as nursing staff,  
25          before other categories of certified

1           **employees. Information under this**  
2           **subparagraph with respect to agency**  
3           **and contract staff shall be kept sepa-**  
4           **rate from information on employee**  
5           **staffing.”.**

6           **(b)       NURSING       FACILITIES.—Section**  
7           **1919(b)(8) of the Social Security Act (42 U.S.C.**  
8           **1396r(b)(8)) is amended by adding at the end**  
9           **the following new subparagraph:**

10                   **“(C) SUBMISSION OF STAFFING IN-**  
11                   **FORMATION BASED ON PAYROLL DATA IN**  
12                   **A UNIFORM FORMAT.—Beginning not**  
13                   **later than 2 years after the date of**  
14                   **the enactment of this subparagraph,**  
15                   **and after consulting with State long-**  
16                   **term care ombudsman programs, con-**  
17                   **sumer advocacy groups, provider**  
18                   **stakeholder groups, employees and**  
19                   **their representatives, and other par-**  
20                   **ties the Secretary deems appropriate,**  
21                   **the Secretary shall require a nursing**  
22                   **facility to electronically submit to the**  
23                   **Secretary direct care staffing infor-**  
24                   **mation (including information with**  
25                   **respect to agency and contract staff)**

1 based on payroll and other verifiable  
2 and auditable data in a uniform for-  
3 mat (according to specifications es-  
4 tablished by the Secretary in con-  
5 sultation with such programs, groups,  
6 and parties). Such specifications shall  
7 require that the information sub-  
8 mitted under the preceding sen-  
9 tence—

10 “(i) specify the category of  
11 work a certified employee per-  
12 forms (such as whether the em-  
13 ployee is a registered nurse, li-  
14 censed practical nurse, licensed  
15 vocational nurse, certified nurs-  
16 ing assistant, therapist, or other  
17 medical personnel);

18 “(ii) include resident census  
19 data and information on resident  
20 case mix;

21 “(iii) include a regular report-  
22 ing schedule; and

23 “(iv) include information on  
24 employee turnover and tenure  
25 and on the hours of care provided

1           by each category of certified em-  
2           ployees referenced in clause (i)  
3           per resident per day.

4           Nothing in this subparagraph shall be  
5           construed as preventing the Sec-  
6           retary from requiring submission of  
7           such information with respect to spe-  
8           cific categories, such as nursing staff,  
9           before other categories of certified  
10          employees. Information under this  
11          subparagraph with respect to agency  
12          and contract staff shall be kept sepa-  
13          rate from information on employee  
14          staffing.”.

15           **PART 2—TARGETING ENFORCEMENT**

16   **SEC. 1421. CIVIL MONEY PENALTIES.**

17           **(a) SKILLED NURSING FACILITIES.—**

18           (1)           IN           GENERAL.—Section  
19           1819(h)(2)(B)(ii) of the Social Security Act  
20           (42 U.S.C. 1395i-3(h)(2)(B)(ii)) is amended  
21           to read as follows:

22                   **“(ii) AUTHORITY WITH RESPECT**  
23                   **TO CIVIL MONEY PENALTIES.—**

24                           **“(I) AMOUNT.—The Sec-**  
25                           **retary may impose a civil**

1 money penalty in the applica-  
2 ble per instance or per day  
3 amount (as defined in sub-  
4 clause (II) and (III)) for each  
5 day or instance, respectively,  
6 of noncompliance (as deter-  
7 mined appropriate by the Sec-  
8 retary).

9 “(II) APPLICABLE PER IN-  
10 STANCE AMOUNT.—In this  
11 clause, the term ‘applicable  
12 per instance amount’ means—

13 “(aa) in the case  
14 where the deficiency is  
15 found to be a direct proxi-  
16 mate cause of death of a  
17 resident of the facility, an  
18 amount not to exceed  
19 \$100,000.

20 “(bb) in each case of a  
21 deficiency where the facil-  
22 ity is cited for actual  
23 harm or immediate jeop-  
24 ardy, an amount not less

1975

1 than \$3,050 and not more  
2 than \$25,000; and

3 “(cc) in each case of  
4 any other deficiency, an  
5 amount not less than \$250  
6 and not to exceed \$3050.

7 “(III) APPLICABLE PER DAY  
8 AMOUNT.—In this clause, the  
9 term ‘applicable per day  
10 amount’ means—

11 “(aa) in each case of a  
12 deficiency where the facil-  
13 ity is cited for actual  
14 harm or immediate jeop-  
15 ardy, an amount not less  
16 than \$3,050 and not more  
17 than \$25,000 and

18 “(bb) in each case of  
19 any other deficiency, an  
20 amount not less than \$250  
21 and not to exceed \$3,050.

22 “(IV) REDUCTION OF CIVIL  
23 MONEY PENALTIES IN CERTAIN  
24 CIRCUMSTANCES.—Subject to  
25 subclauses (V) and (VI), in the

1 case where a facility self-re-  
2 ports and promptly corrects a  
3 deficiency for which a penalty  
4 was imposed under this  
5 clause not later than 10 cal-  
6 endar days after the date of  
7 such imposition, the Sec-  
8 retary may reduce the  
9 amount of the penalty im-  
10 posed by not more than 50  
11 percent.

12 “(V) PROHIBITION ON RE-  
13 DUCATION FOR CERTAIN DEFICI-  
14 CIENCIES.—

15 “(aa) REPEAT DEFICI-  
16 CIENCIES.—The Secretary  
17 may not reduce under  
18 subclause (IV) the amount  
19 of a penalty if the defi-  
20 ciency is a repeat defi-  
21 ciency.

22 “(bb) CERTAIN OTHER  
23 DEFICIENCIES.—The Sec-  
24 retary may not reduce  
25 under subclause (IV) the



1 amount of a penalty if the  
2 penalty is imposed for a  
3 deficiency described in  
4 subclause (II)(aa) or  
5 (III)(aa) and the actual  
6 harm or widespread harm  
7 immediately jeopardizes  
8 the health or safety of a  
9 resident or residents of  
10 the facility, or if the pen-  
11 alty is imposed for a defi-  
12 ciency described in sub-  
13 clause (II)(bb).

14 “(VI) LIMITATION ON AGGRE-  
15 GATE REDUCTIONS.—The aggre-  
16 gate reduction in a penalty  
17 under subclause (IV) may not  
18 exceed 35 percent on the basis  
19 of self-reporting, on the basis  
20 of a waiver or an appeal (as  
21 provided for under regula-  
22 tions under section 488.436 of  
23 title 42, Code of Federal Regu-  
24 lations), or on the basis of  
25 both.

1           **“(VII) COLLECTION OF CIVIL**  
2           **MONEY PENALTIES.—In the case**  
3           **of a civil money penalty im-**  
4           **posed under this clause, the**  
5           **Secretary—**

6                   **“(aa) subject to item**  
7                   **(cc), shall, not later than**  
8                   **30 days after the date of**  
9                   **imposition of the penalty,**  
10                  **provide the opportunity**  
11                  **for the facility to partici-**  
12                  **pate in an independent in-**  
13                  **formal dispute resolution**  
14                  **process which generates a**  
15                  **written record prior to**  
16                  **the collection of such pen-**  
17                  **alty, but such opportunity**  
18                  **shall not affect the re-**  
19                  **sponsibility of the State**  
20                  **survey agency for making**  
21                  **final recommendations for**  
22                  **such penalties;**

23                   **“(bb) in the case**  
24                   **where the penalty is im-**  
25                   **posed for each day of non-**

1 compliance, shall not im-  
2 pose a penalty for any day  
3 during the period begin-  
4 ning on the initial day of  
5 the imposition of the pen-  
6 alty and ending on the  
7 day on which the informal  
8 dispute resolution process  
9 under item (aa) is com-  
10 pleted;

11 “(cc) may provide for  
12 the collection of such civil  
13 money penalty and the  
14 placement of such  
15 amounts collected in an  
16 escrow account under the  
17 direction of the Secretary  
18 on the earlier of the date  
19 on which the informal dis-  
20 pute resolution process  
21 under item (aa) is com-  
22 pleted or the date that is  
23 90 days after the date of  
24 the imposition of the pen-  
25 alty;

1           “(dd) may provide that  
2 such amounts collected  
3 are kept in such account  
4 pending the resolution of  
5 any subsequent appeals;

6           “(ee) in the case where  
7 the facility successfully  
8 appeals the penalty, may  
9 provide for the return of  
10 such amounts collected  
11 (plus interest) to the facil-  
12 ity; and

13           “(ff) in the case where  
14 all such appeals are un-  
15 successful, may provide  
16 that some portion of such  
17 amounts collected may be  
18 used to support activities  
19 that benefit residents, in-  
20 cluding assistance to sup-  
21 port and protect residents  
22 of a facility that closes  
23 (voluntarily or involun-  
24 tarily) or is decertified  
25 (including offsetting costs

1 of relocating residents to  
2 home and community-  
3 based settings or another  
4 facility), projects that sup-  
5 port resident and family  
6 councils and other con-  
7 sumer involvement in as-  
8 suring quality care in fa-  
9 cilities, and facility im-  
10 provement initiatives ap-  
11 proved by the Secretary  
12 (including joint training  
13 of facility staff and sur-  
14 veyors, technical assist-  
15 ance for facilities under  
16 quality assurance pro-  
17 grams, the appointment of  
18 temporary management,  
19 and other activities ap-  
20 proved by the Secretary).

21 “(VIII) PROCEDURE.—The  
22 provisions of section 1128A  
23 (other than subsections (a)  
24 and (b) and except to the ex-  
25 tent that such provisions re-

1           **quire a hearing prior to the**  
2           **imposition of a civil money**  
3           **penalty) shall apply to a civil**  
4           **money penalty under this**  
5           **clause in the same manner as**  
6           **such provisions apply to a**  
7           **penalty or proceeding under**  
8           **section 1128A(a).”.**

9           **(2) CONFORMING AMENDMENT.—The**  
10          **second sentence of section 1819(h)(5) of**  
11          **the Social Security Act (42 U.S.C. 1395i-**  
12          **3(h)(5)) is amended by inserting**  
13          **“(ii),”after “(i),”.**

14          **(b) NURSING FACILITIES.—**

15               **(1) PENALTIES IMPOSED BY THE STATE.—**

16                       **(A) IN GENERAL.—Section**  
17                       **1919(h)(2) of the Social Security Act**  
18                       **(42 U.S.C. 1396r(h)(2)) is amended—**

19                               **(i) in subparagraph (A)(ii), by**  
20                               **striking the first sentence and in-**  
21                               **serting the following: “A civil**  
22                               **money penalty in accordance**  
23                               **with subparagraph (G).”;** and

24                               **(ii) by adding at the end the**  
25                               **following new subparagraph:**

1           **“(G) CIVIL MONEY PENALTIES.—**

2           **“(i) IN GENERAL.—The State**  
3           **may impose a civil money penalty**  
4           **under subparagraph (A)(ii) in the**  
5           **applicable per instance or per**  
6           **day amount (as defined in sub-**  
7           **clause (II) and (III)) for each day**  
8           **or instance, respectively, of non-**  
9           **compliance (as determined appro-**  
10           **priate by the Secretary).**

11           **“(ii) APPLICABLE PER INSTANCE**  
12           **AMOUNT.—In this subparagraph,**  
13           **the term ‘applicable per instance**  
14           **amount’ means—**

15           **“(I) in the case where the**  
16           **deficiency is found to be a di-**  
17           **rect proximate cause of death**  
18           **of a resident of the facility, an**  
19           **amount not to exceed**  
20           **\$100,000.**

21           **“(II) in each case of a defi-**  
22           **ciency where the facility is**  
23           **cited for actual harm or im-**  
24           **mediate jeopardy, an amount**

1 not less than \$3,050 and not  
2 more than \$25,000; and

3 “(III) in each case of any  
4 other deficiency, an amount  
5 not less than \$250 and not to  
6 exceed \$3050.

7 “(iii) APPLICABLE PER DAY  
8 AMOUNT.—In this subparagraph,  
9 the term ‘applicable per day  
10 amount’ means—

11 “(I) in each case of a defi-  
12 ciency where the facility is  
13 cited for actual harm or im-  
14 mediate jeopardy, an amount  
15 not less than \$3,050 and not  
16 more than \$25,000 and

17 “(II) in each case of any  
18 other deficiency, an amount  
19 not less than \$250 and not to  
20 exceed \$3,050.

21 “(iv) REDUCTION OF CIVIL  
22 MONEY PENALTIES IN CERTAIN CIR-  
23 CUMSTANCES.—Subject to clauses  
24 (v) and (vi), in the case where a  
25 facility self-reports and promptly



1           **corrects a deficiency for which a**  
2           **penalty was imposed under sub-**  
3           **paragraph (A)(ii) not later than 10**  
4           **calendar days after the date of**  
5           **such imposition, the State may re-**  
6           **duce the amount of the penalty**  
7           **imposed by not more than 50 per-**  
8           **cent.**

9           **“(v) PROHIBITION ON REDUC-**  
10          **TION FOR CERTAIN DEFICIENCIES.—**

11           **“(I) REPEAT DEFICI-**  
12          **ENCIES.—The State may not**  
13          **reduce under clause (iv) the**  
14          **amount of a penalty if the**  
15          **State had reduced a penalty**  
16          **imposed on the facility in the**  
17          **preceding year under such**  
18          **clause with respect to a re-**  
19          **peat deficiency.**

20           **“(II) CERTAIN OTHER DEFICI-**  
21          **ENCIES.—The State may not**  
22          **reduce under clause (iv) the**  
23          **amount of a penalty if the**  
24          **penalty is imposed for a defi-**  
25          **ciency described in clause**

1           (ii)(II) or (iii)(I) and the actual  
2           harm or widespread harm  
3           that immediately jeopardizes  
4           the health or safety of a resi-  
5           dent or residents of the facil-  
6           ity, or if the penalty is im-  
7           posed for a deficiency de-  
8           scribed in clause (ii)(I).

9           “(III) LIMITATION ON AG-  
10          GREGATE REDUCTIONS.—The ag-  
11          gregate reduction in a penalty  
12          under clause (iv) may not ex-  
13          ceed 35 percent on the basis  
14          of self-reporting, on the basis  
15          of a waiver or an appeal (as  
16          provided for under regula-  
17          tions under section 488.436 of  
18          title 42, Code of Federal Regu-  
19          lations), or on the basis of  
20          both.

21          “(vi) COLLECTION OF CIVIL  
22          MONEY PENALTIES.—In the case of  
23          a civil money penalty imposed  
24          under subparagraph (A)(ii), the  
25          State—

1           **“(I) subject to subclause**  
2           **(III), shall, not later than 30**  
3           **days after the date of imposi-**  
4           **tion of the penalty, provide**  
5           **the opportunity for the facil-**  
6           **ity to participate in an inde-**  
7           **pendent informal dispute res-**  
8           **olution process which gen-**  
9           **erates a written record prior**  
10          **to the collection of such pen-**  
11          **alty, but such opportunity**  
12          **shall not affect the responsi-**  
13          **bility of the State survey**  
14          **agency for making final rec-**  
15          **ommendations for such pen-**  
16          **alties;**

17           **“(II) in the case where the**  
18           **penalty is imposed for each**  
19           **day of noncompliance, shall**  
20           **not impose a penalty for any**  
21           **day during the period begin-**  
22           **ning on the initial day of the**  
23           **imposition of the penalty and**  
24           **ending on the day on which**  
25           **the informal dispute resolu-**

1           **tion process under subclause**  
2           **(I) is completed;**

3           **“(III) may provide for the**  
4           **collection of such civil money**  
5           **penalty and the placement of**  
6           **such amounts collected in an**  
7           **escrow account under the di-**  
8           **rection of the State on the**  
9           **earlier of the date on which**  
10          **the informal dispute resolu-**  
11          **tion process under subclause**  
12          **(I) is completed or the date**  
13          **that is 90 days after the date**  
14          **of the imposition of the pen-**  
15          **alty;**

16          **“(IV) may provide that**  
17          **such amounts collected are**  
18          **kept in such account pending**  
19          **the resolution of any subse-**  
20          **quent appeals;**

21          **“(V) in the case where the**  
22          **facility successfully appeals**  
23          **the penalty, may provide for**  
24          **the return of such amounts**

1 collected (plus interest) to the  
2 facility; and

3 “(VI) in the case where all  
4 such appeals are unsuccessful,  
5 may provide that such  
6 funds collected shall be used  
7 for the purposes described in  
8 the second sentence of sub-  
9 paragraph (A)(ii).”.

10 (B) CONFORMING AMENDMENT.—The  
11 second sentence of section  
12 1919(h)(2)(A)(ii) of the Social Security  
13 Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is  
14 amended by inserting before the pe-  
15 riod at the end the following: “, and  
16 some portion of such funds may be  
17 used to support activities that benefit  
18 residents, including assistance to sup-  
19 port and protect residents of a facil-  
20 ity that closes (voluntarily or involun-  
21 tarily) or is decertified (including off-  
22 setting costs of relocating residents to  
23 home and community-based settings  
24 or another facility), projects that sup-  
25 port resident and family councils and

1           **other consumer involvement in assur-**  
2           **ing quality care in facilities, and fa-**  
3           **ility improvement initiatives ap-**  
4           **proved by the Secretary (including**  
5           **joint training of facility staff and sur-**  
6           **veyors, providing technical assistance**  
7           **to facilities under quality assurance**  
8           **programs, the appointment of tem-**  
9           **porary management, and other activi-**  
10          **ties approved by the Secretary)”.**

11           **(2) PENALTIES IMPOSED BY THE SEC-**  
12          **RETARY.—**

13                   **(A)        IN        GENERAL.—Section**  
14                   **1919(h)(3)(C)(ii) of the Social Security**  
15                   **Act (42 U.S.C. 1396r(h)(3)(C)) is**  
16                   **amended to read as follows:**

17                           **“(ii) AUTHORITY WITH RESPECT**  
18                           **TO CIVIL MONEY PENALTIES.—**

19                                   **“(I) AMOUNT.—Subject to**  
20                                   **subclause (II), the Secretary**  
21                                   **may impose a civil money**  
22                                   **penalty in an amount not to**  
23                                   **exceed \$10,000 for each day or**  
24                                   **each instance of noncompli-**

1           **ance (as determined appro-**  
2           **priate by the Secretary).**

3           **“(II) REDUCTION OF CIVIL**  
4           **MONEY PENALTIES IN CERTAIN**  
5           **CIRCUMSTANCES.—Subject to**  
6           **subclause (III), in the case**  
7           **where a facility self-reports**  
8           **and promptly corrects a defi-**  
9           **ciency for which a penalty**  
10           **was imposed under this**  
11           **clause not later than 10 cal-**  
12           **endar days after the date of**  
13           **such imposition, the Sec-**  
14           **retary may reduce the**  
15           **amount of the penalty im-**  
16           **posed by not more than 50**  
17           **percent.**

18           **“(III) PROHIBITION ON RE-**  
19           **DUCTION FOR REPEAT DEFI-**  
20           **CIENCIES.—The Secretary may**  
21           **not reduce the amount of a**  
22           **penalty under subclause (II) if**  
23           **the Secretary had reduced a**  
24           **penalty imposed on the facil-**  
25           **ity in the preceding year**

1           **under such subclause with re-**  
2           **spect to a repeat deficiency.**

3           **“(IV) COLLECTION OF CIVIL**  
4           **MONEY PENALTIES.—In the case**  
5           **of a civil money penalty im-**  
6           **posed under this clause, the**  
7           **Secretary—**

8                   **“(aa) subject to item**  
9                   **(bb), shall, not later than**  
10                  **30 days after the date of**  
11                  **imposition of the penalty,**  
12                  **provide the opportunity**  
13                  **for the facility to partici-**  
14                  **pate in an independent in-**  
15                  **formal dispute resolution**  
16                  **process which generates a**  
17                  **written record prior to**  
18                  **the collection of such pen-**  
19                  **alty;**

20                   **“(bb) in the case**  
21                   **where the penalty is im-**  
22                   **posed for each day of non-**  
23                   **compliance, shall not im-**  
24                   **pose a penalty for any day**  
25                   **during the period begin-**



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1           **ning on the initial day of**  
2           **the imposition of the pen-**  
3           **alty and ending on the**  
4           **day on which the informal**  
5           **dispute resolution process**  
6           **under item (aa) is com-**  
7           **pleted;**

8           **“(cc) may provide for**  
9           **the collection of such civil**  
10          **money penalty and the**  
11          **placement of such**  
12          **amounts collected in an**  
13          **escrow account under the**  
14          **direction of the Secretary**  
15          **on the earlier of the date**  
16          **on which the informal dis-**  
17          **pute resolution process**  
18          **under item (aa) is com-**  
19          **pleted or the date that is**  
20          **90 days after the date of**  
21          **the imposition of the pen-**  
22          **alty;**

23          **“(dd) may provide that**  
24          **such amounts collected**  
25          **are kept in such account**

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**pending the resolution of any subsequent appeals;**

**“(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and**

**“(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another**

1 facility), projects that sup-  
2 port resident and family  
3 councils and other con-  
4 sumer involvement in as-  
5 suring quality care in fa-  
6 cilities, and facility im-  
7 provement initiatives ap-  
8 proved by the Secretary  
9 (including joint training  
10 of facility staff and sur-  
11 veyors, technical assist-  
12 ance for facilities under  
13 quality assurance pro-  
14 grams, the appointment of  
15 temporary management,  
16 and other activities ap-  
17 proved by the Secretary).

18 “(V) PROCEDURE.—The pro-  
19 visions of section 1128A (other  
20 than subsections (a) and (b)  
21 and except to the extent that  
22 such provisions require a  
23 hearing prior to the imposi-  
24 tion of a civil money penalty)  
25 shall apply to a civil money

1           penalty under this clause in  
2           the same manner as such pro-  
3           visions apply to a penalty or  
4           proceeding under section  
5           1128A(a).”.

6           **(B) CONFORMING AMENDMENT.—**  
7           **Section 1919(h)(8) of the Social Secu-**  
8           **urity Act (42 U.S.C. 1396r(h)(5)(8)) is**  
9           **amended by inserting “and in para-**  
10          **graph (3)(C)(ii)” after “paragraph**  
11          **(2)(A)”.**

12          **(c) EFFECTIVE DATE.—The amendments**  
13          **made by this section shall take effect 1 year**  
14          **after the date of the enactment of this Act.**

15          **SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PRO-**  
16          **GRAM.**

17          **(a) ESTABLISHMENT.—**

18                 **(1) IN GENERAL.—The Secretary, in**  
19                 **consultation with the Inspector General**  
20                 **of the Department of Health and Human**  
21                 **Services, shall establish a pilot program**  
22                 **(in this section referred to as the “pilot**  
23                 **program”) to develop, test, and imple-**  
24                 **ment use of an independent monitor to**  
25                 **oversee interstate and large intrastate**

1 chains of skilled nursing facilities and  
2 nursing facilities.

3 (2) SELECTION.—The Secretary shall  
4 select chains of skilled nursing facilities  
5 and nursing facilities described in para-  
6 graph (1) to participate in the pilot pro-  
7 gram from among those chains that sub-  
8 mit an application to the Secretary at  
9 such time, in such manner, and con-  
10 taining such information as the Secretary  
11 may require.

12 (3) DURATION.—The Secretary shall  
13 conduct the pilot program for a two-year  
14 period.

15 (4) IMPLEMENTATION.—The Secretary  
16 shall implement the pilot program not  
17 later than one year after the date of the  
18 enactment of this Act.

19 (b) REQUIREMENTS.—The Secretary shall  
20 evaluate chains selected to participate in the  
21 pilot program based on criteria selected by  
22 the Secretary, including where evidence sug-  
23 gests that one or more facilities of the chain  
24 are experiencing serious safety and quality of  
25 care problems. Such criteria may include the

1 evaluation of a chain that includes one or  
2 more facilities participating in the “Special  
3 Focus Facility” program (or a successor pro-  
4 gram) or one or more facilities with a record  
5 of repeated serious safety and quality of care  
6 deficiencies.

7 (c) **RESPONSIBILITIES OF THE INDEPENDENT**  
8 **MONITOR.**—An independent monitor that en-  
9 ters into a contract with the Secretary to par-  
10 ticipate in the conduct of such program  
11 shall—

12 (1) conduct periodic reviews and pre-  
13 pare root-cause quality and deficiency  
14 analyses of a chain to assess if facilities  
15 of the chain are in compliance with State  
16 and Federal laws and regulations appli-  
17 cable to the facilities;

18 (2) undertake sustained oversight of  
19 the chain, whether publicly or privately  
20 held, to involve the owners of the chain  
21 and the principal business partners of  
22 such owners in facilitating compliance by  
23 facilities of the chain with State and Fed-  
24 eral laws and regulations applicable to  
25 the facilities;

1           **(3) analyze the management struc-**  
2           **ture, distribution of expenditures, and**  
3           **nurse staffing levels of facilities of the**  
4           **chain in relation to resident census, staff**  
5           **turnover rates, and tenure;**

6           **(4) report findings and recommenda-**  
7           **tions with respect to such reviews, anal-**  
8           **yses, and oversight to the chain and fa-**  
9           **ilities of the chain, to the Secretary and**  
10          **to relevant States; and**

11          **(5) publish the results of such re-**  
12          **views, analyses, and oversight.**

13          **(d) IMPLEMENTATION OF RECOMMENDA-**  
14          **TIONS.—**

15               **(1) RECEIPT OF FINDING BY CHAIN.—Not**  
16               **later than 10 days after receipt of a find-**  
17               **ing of an independent monitor under sub-**  
18               **section (c)(4), a chain participating in the**  
19               **pilot program shall submit to the inde-**  
20               **pendent monitor a report—**

21                       **(A) outlining corrective actions**  
22                       **the chain will take to implement the**  
23                       **recommendations in such report; or**

1           **(B) indicating that the chain will**  
2           **not implement such recommenda-**  
3           **tions and why it will not do so.**

4           **(2) RECEIPT OF REPORT BY INDE-**  
5           **PENDENT MONITOR.—Not later than 10 days**  
6           **after the date of receipt of a report sub-**  
7           **mitted by a chain under paragraph (1),**  
8           **an independent monitor shall finalize its**  
9           **recommendations and submit a report to**  
10          **the chain and facilities of the chain, the**  
11          **Secretary, and the State (or States) in-**  
12          **volved, as appropriate, containing such**  
13          **final recommendations.**

14          **(e) COST OF APPOINTMENT.—A chain shall**  
15          **be responsible for a portion of the costs asso-**  
16          **ciated with the appointment of independent**  
17          **monitors under the pilot program. The chain**  
18          **shall pay such portion to the Secretary (in an**  
19          **amount and in accordance with procedures**  
20          **established by the Secretary).**

21          **(f) WAIVER AUTHORITY.—The Secretary**  
22          **may waive such requirements of titles XVIII**  
23          **and XIX of the Social Security Act (42 U.S.C.**  
24          **1395 et seq.; 1396 et seq.) as may be necessary**



1 for the purpose of carrying out the pilot pro-  
2 gram.

3 (g) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated such  
5 sums as may be necessary to carry out this  
6 section.

7 (h) DEFINITIONS.—In this section:

8 (1) FACILITY.—The term “facility”  
9 means a skilled nursing facility or a nurs-  
10 ing facility.

11 (2) NURSING FACILITY.—The term  
12 “nursing facility” has the meaning given  
13 such term in section 1919(a) of the Social  
14 Security Act (42 U.S.C. 1396r(a)).

15 (3) SECRETARY.—The term “Secretary”  
16 means the Secretary of Health and  
17 Human Services, acting through the As-  
18 sistant Secretary for Planning and Eval-  
19 uation.

20 (4) SKILLED NURSING FACILITY.—The  
21 term “skilled nursing facility” has the  
22 meaning given such term in section  
23 1819(a) of the Social Security Act (42  
24 U.S.C. 1395(a)).

25 (i) EVALUATION AND REPORT.—

1           **(1) EVALUATION.—**The Inspector Gen-  
2           eral of the Department of Health and  
3           Human Services shall evaluate the pilot  
4           program. Such evaluation shall—

5                   **(A)** determine whether the inde-  
6                   pendent monitor program should be  
7                   established on a permanent basis;  
8                   and

9                   **(B)** if the Inspector General deter-  
10                  mines that the independent monitor  
11                  program should be established on a  
12                  permanent basis, recommend appro-  
13                  priate procedures and mechanisms  
14                  for such establishment.

15           **(2) REPORT.—**Not later than 180 days  
16           after the completion of the pilot program,  
17           the Inspector General shall submit to  
18           Congress and the Secretary a report con-  
19           taining the results of the evaluation con-  
20           ducted under paragraph (1), together  
21           with recommendations for such legisla-  
22           tion and administrative action as the In-  
23           spector General determines appropriate.

24   **SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.**

25           **(a) SKILLED NURSING FACILITIES.—**

1           **(1) IN GENERAL.—Section 1819(c) of the**  
2           **Social Security Act (42 U.S.C. 1395i-3(c))**  
3           **is amended by adding at the end the fol-**  
4           **lowing new paragraph:**

5           **“(7) NOTIFICATION OF FACILITY CLO-**  
6           **SURE.—**

7           **“(A) IN GENERAL.—Any individual**  
8           **who is the administrator of a skilled**  
9           **nursing facility must—**

10           **“(i) submit to the Secretary,**  
11           **the State long-term care ombuds-**  
12           **man, residents of the facility, and**  
13           **the legal representatives of such**  
14           **residents or other responsible**  
15           **parties, written notification of an**  
16           **impending closure—**

17           **“(I) subject to subclause**  
18           **(II), not later than the date**  
19           **that is 60 days prior to the**  
20           **date of such closure; and**

21           **“(II) in the case of a facil-**  
22           **ity where the Secretary termi-**  
23           **nates the facility’s participa-**  
24           **tion under this title, not later**  
25           **than the date that the Sec-**

1           retary determines appro-  
2           priate;

3           “(ii) ensure that the facility  
4           does not admit any new residents  
5           on or after the date on which  
6           such written notification is sub-  
7           mitted; and

8           “(iii) include in the notice a  
9           plan for the transfer and ade-  
10          quate relocation of the residents  
11          of the facility by a specified date  
12          prior to closure that has been ap-  
13          proved by the State, including as-  
14          surances that the residents will  
15          be transferred to the most appro-  
16          priate facility or other setting in  
17          terms of quality, services, and lo-  
18          cation, taking into consideration  
19          the needs and best interests of  
20          each resident.

21          “(B) RELOCATION.—

22                 “(i) IN GENERAL.—The State  
23                 shall ensure that, before a facility  
24                 closes, all residents of the facility  
25                 have been successfully relocated

1           to another facility or an alter-  
2           native home and community-  
3           based setting.

4           “(ii) CONTINUATION OF PAY-  
5           MENTS UNTIL RESIDENTS RELO-  
6           CATED.—The Secretary may, as the  
7           Secretary determines appro-  
8           priate, continue to make pay-  
9           ments under this title with re-  
10          spect to residents of a facility that  
11          has submitted a notification  
12          under subparagraph (A) during  
13          the period beginning on the date  
14          such notification is submitted and  
15          ending on the date on which the  
16          resident is successfully relo-  
17          cated.”.

18          (2) CONFORMING AMENDMENTS.—Sec-  
19          tion 1819(h)(4) of the Social Security Act  
20          (42 U.S.C. 1395i-3(h)(4)) is amended—

21                 (A) in the first sentence, by strik-  
22                 ing “the Secretary shall terminate”  
23                 and inserting “the Secretary, subject  
24                 to subsection (c)(7), shall terminate”;  
25                 and

1           **(B) in the second sentence, by**  
2           **striking “subsection (c)(2)” and in-**  
3           **serting “paragraphs (2) and (7) of sub-**  
4           **section (c)”.**

5           **(b) NURSING FACILITIES.—**

6           **(1) IN GENERAL.—Section 1919(c) of the**  
7           **Social Security Act (42 U.S.C. 1396r(c)) is**  
8           **amended by adding at the end the fol-**  
9           **lowing new paragraph:**

10           **“(9) NOTIFICATION OF FACILITY CLO-**  
11           **SURE.—**

12           **“(A) IN GENERAL.—Any individual**  
13           **who is an administrator of a nursing**  
14           **facility must—**

15           **“(i) submit to the Secretary,**  
16           **the State long-term care ombuds-**  
17           **man, residents of the facility, and**  
18           **the legal representatives of such**  
19           **residents or other responsible**  
20           **parties, written notification of an**  
21           **impending closure—**

22           **“(I) subject to subclause**  
23           **(II), not later than the date**  
24           **that is 60 days prior to the**  
25           **date of such closure; and**

1                   **“(II) in the case of a facil-**  
2                   **ity where the Secretary termi-**  
3                   **nates the facility’s participa-**  
4                   **tion under this title, not later**  
5                   **than the date that the Sec-**  
6                   **retary determines appro-**  
7                   **priate;**

8                   **“(ii) ensure that the facility**  
9                   **does not admit any new residents**  
10                  **on or after the date on which**  
11                  **such written notification is sub-**  
12                  **mitted; and**

13                  **“(iii) include in the notice a**  
14                  **plan for the transfer and ade-**  
15                  **quate relocation of the residents**  
16                  **of the facility by a specified date**  
17                  **prior to closure that has been ap-**  
18                  **proved by the State, including as-**  
19                  **surances that the residents will**  
20                  **be transferred to the most appro-**  
21                  **priate facility or other setting in**  
22                  **terms of quality, services, and lo-**  
23                  **cation, taking into consideration**  
24                  **the needs and best interests of**  
25                  **each resident.**

1           **“(B) RELOCATION.—**

2                   **“(i) IN GENERAL.—The State**  
3                   **shall ensure that, before a facility**  
4                   **closes, all residents of the facility**  
5                   **have been successfully relocated**  
6                   **to another facility or an alter-**  
7                   **native home and community-**  
8                   **based setting.**

9                   **“(ii) CONTINUATION OF PAY-**  
10                   **MENTS UNTIL RESIDENTS RELO-**  
11                   **CATED.—The Secretary may, as the**  
12                   **Secretary determines appro-**  
13                   **priate, continue to make pay-**  
14                   **ments under this title with re-**  
15                   **spect to residents of a facility that**  
16                   **has submitted a notification**  
17                   **under subparagraph (A) during**  
18                   **the period beginning on the date**  
19                   **such notification is submitted and**  
20                   **ending on the date on which the**  
21                   **resident is successfully relo-**  
22                   **cated.”.**

23           **(c) EFFECTIVE DATE.—The amendments**  
24           **made by this section shall take effect 1 year**  
25           **after the date of the 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**  
5   **U.S.C. 1395i-3(f)(2)(A)(i)(I)) is amended by in-**  
6   **serting “(including, in the case of initial train-**  
7   **ing and, if the Secretary determines appro-**  
8   **priate, in the case of ongoing training, demen-**  
9   **tia management training and resident abuse**  
10 **prevention training)” after “curriculum”.**

11          **(b) NURSING FACILITIES.—Section**  
12 **1919(f)(2)(A)(i)(I) of the Social Security Act (42**  
13 **U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by in-**  
14 **serting “(including, in the case of initial train-**  
15 **ing and, if the Secretary determines appro-**  
16 **priate, in the case of ongoing training, demen-**  
17 **tia management training and resident abuse**  
18 **prevention training)” after “curriculum”.**

19          **(c) EFFECTIVE DATE.—The amendments**  
20 **made by this section shall take effect 1 year**  
21 **after the date of the enactment of this Act.**

22   **SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED**  
23                   **FOR CERTIFIED NURSE AIDES AND SUPER-**  
24                   **VISORY STAFF.**

25          **(a) STUDY.—**



1           **recommendations for the content of**  
2           **such training.**

3           **(2) CONSULTATION.—In conducting the**  
4           **analysis under paragraph (1)(A), the Sec-**  
5           **retary shall consult with States that, as of**  
6           **the date of the enactment of this Act, re-**  
7           **quire more than 75 hours of training for**  
8           **certified nurse aides.**

9           **(3) DEFINITIONS.—In this section:**

10           **(A) NURSING FACILITY.—The term**  
11           **“nursing facility” has the meaning**  
12           **given such term in section 1919(a) of**  
13           **the Social Security Act (42 U.S.C.**  
14           **1396r(a)).**

15           **(B) SECRETARY.—The term “Sec-**  
16           **retary” means the Secretary of Health**  
17           **and Human Services, acting through**  
18           **the Assistant Secretary for Planning**  
19           **and Evaluation.**

20           **(C) SKILLED NURSING FACILITY.—**  
21           **The term “skilled nursing facility”**  
22           **has the meaning given such term in**  
23           **section 1819(a) of the Social Security**  
24           **Act (42 U.S.C. 1395(a)).**



1       **“(b) RECOMMENDATIONS FOR NATIONAL PRI-**  
2 **ORITIES.—In establishing and updating na-**  
3 **tional priorities under subsection (a), the Sec-**  
4 **retary shall solicit and consider recommenda-**  
5 **tions from multiple outside stakeholders.**

6       **“(c) CONSIDERATIONS IN SETTING NATIONAL**  
7 **PRIORITIES.—With respect to such priorities,**  
8 **the Secretary shall ensure that priority is**  
9 **given to areas in the delivery of health care**  
10 **services in the United States that—**

11           **“(1) contribute to a large burden of**  
12 **disease, including those that address the**  
13 **health care provided to patients with**  
14 **prevalent, high-cost chronic diseases;**

15           **“(2) have the greatest potential to de-**  
16 **crease morbidity and mortality in this**  
17 **country, including those that are de-**  
18 **signed to eliminate harm to patients;**

19           **“(3) have the greatest potential for**  
20 **improving the performance, affordability,**  
21 **and patient-centeredness of health care,**  
22 **including those due to variations in care;**

23           **“(4) address health disparities across**  
24 **groups and areas; and**

1           **“(5) have the potential for rapid im-**  
2           **provement due to existing evidence,**  
3           **standards of care or other reasons.**

4           **“(d) DEFINITIONS.—In this part:**

5           **“(1) CONSENSUS-BASED ENTITY.—The**  
6           **term ‘consensus-based entity’ means an**  
7           **entity with a contract with the Secretary**  
8           **under section 1890.**

9           **“(2) QUALITY MEASURE.—The term**  
10          **‘quality measure’ means a national con-**  
11          **sensus standard for measuring the per-**  
12          **formance and improvement of population**  
13          **health, or of institutional providers of**  
14          **services, physicians, and other health**  
15          **care practitioners in the delivery of**  
16          **health care services.**

17          **“(e) FUNDING.—**

18          **“(1) IN GENERAL.—The Secretary shall**  
19          **provide for the transfer, from the Federal**  
20          **Hospital Insurance Trust Fund under**  
21          **section 1817 and the Federal Supple-**  
22          **mentary Medical Insurance Trust Fund**  
23          **under section 1841 (in such proportion as**  
24          **the Secretary determines appropriate), of**  
25          **\$2,000,000, for the activities under this**

1       **section for each of the fiscal years 2010**  
2       **through 2014.**

3               **“(2) AUTHORIZATION OF APPROPRIA-**  
4       **TIONS.—For purposes of carrying out the**  
5       **provisions of this section, in addition to**  
6       **funds otherwise available, out of any**  
7       **funds in the Treasury not otherwise ap-**  
8       **propriated, there are appropriated to the**  
9       **Secretary of Health and Human Services**  
10       **\$2,000,000 for each of the fiscal years 2010**  
11       **through 2014.”.**

12       **SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES;**  
13               **GAO EVALUATION OF DATA COLLECTION**  
14               **PROCESS FOR QUALITY MEASUREMENT.**

15       **Part E of title XI of the Social Security**  
16       **Act, as added by section 1441, is amended by**  
17       **adding at the end the following new sections:**

18       **“SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.**

19               **“(a) AGREEMENTS WITH QUALIFIED ENTI-**  
20       **TIES.—**

21               **“(1) IN GENERAL.—The Secretary shall**  
22       **enter into agreements with qualified enti-**  
23       **ties to develop quality measures for the**  
24       **delivery of health care services in the**  
25       **United States.**

1           **“(2) FORM OF AGREEMENTS.—The Sec-**  
2           **retary may carry out paragraph (1) by**  
3           **contract, grant, or otherwise.**

4           **“(3) RECOMMENDATIONS OF CONSENSUS-**  
5           **BASED ENTITY.—In carrying out this sec-**  
6           **tion, the Secretary shall—**

7                   **“(A) seek public input; and**

8                   **“(B) take into consideration rec-**  
9                   **ommendations of the consensus-based**  
10                  **entity with a contract with the Sec-**  
11                  **retary under section 1890(a).**

12           **“(b) DETERMINATION OF AREAS WHERE**  
13           **QUALITY MEASURES ARE REQUIRED.—Con-**  
14           **sistent with the national priorities estab-**  
15           **lished under this part and with the programs**  
16           **administered by the Centers for Medicare &**  
17           **Medicaid Services and in consultation with**  
18           **other relevant Federal agencies, the Sec-**  
19           **retary shall determine areas in which quality**  
20           **measures for assessing health care services in**  
21           **the United States are needed.**

22           **“(c) DEVELOPMENT OF QUALITY MEASURES.—**

23                   **“(1) PATIENT-CENTERED AND POPU-**  
24                   **LATION-BASED MEASURES.—Quality meas-**



1 ures developed under agreements under  
2 subsection (a) shall be designed—

3 “(A) to assess outcomes and func-  
4 tional status of patients;

5 “(B) to assess the continuity and  
6 coordination of care and care transi-  
7 tions for patients across providers  
8 and health care settings, including  
9 end of life care;

10 “(C) to assess patient experience  
11 and patient engagement;

12 “(D) to assess the safety, effective-  
13 ness, and timeliness of care;

14 “(E) to assess health disparities  
15 including those associated with indi-  
16 vidual race, ethnicity, age, gender,  
17 place of residence or language;

18 “(F) to assess the efficiency and  
19 resource use in the provision of care;

20 “(G) to the extent feasible, to be  
21 collected as part of health informa-  
22 tion technologies supporting better  
23 delivery of health care services;

1           **“(H) to be available free of charge**  
2           **to users for the use of such measures;**  
3           **and**

4           **“(I) to assess delivery of health**  
5           **care services to individuals regard-**  
6           **less of age.**

7           **“(2) AVAILABILITY OF MEASURES.—The**  
8           **Secretary shall make quality measures**  
9           **developed under this section available to**  
10          **the public.**

11          **“(3) TESTING OF PROPOSED MEASURES.—**  
12          **The Secretary may use amounts made**  
13          **available under subsection (f) to fund the**  
14          **testing of proposed quality measures by**  
15          **qualified entities. Testing funded under**  
16          **this paragraph shall include testing of**  
17          **the feasibility and usability of proposed**  
18          **measures.**

19          **“(4) UPDATING OF ENDORSED MEAS-**  
20          **URES.—The Secretary may use amounts**  
21          **made available under subsection (f) to**  
22          **fund the updating (and testing, if applica-**  
23          **ble) by consensus-based entities of qual-**  
24          **ity measures that have been previously**  
25          **endorsed by such an entity as new evi-**

1        **dence is developed, in a manner con-**  
2        **sistent with section 1890(b)(3).**

3        **“(d) QUALIFIED ENTITIES.—Before entering**  
4        **into agreements with a qualified entity, the**  
5        **Secretary shall ensure that the entity is a**  
6        **public, nonprofit or academic institution with**  
7        **technical expertise in the area of health qual-**  
8        **ity measurement.**

9        **“(e) APPLICATION FOR GRANT.—A grant may**  
10       **be made under this section only if an applica-**  
11       **tion for the grant is submitted to the Sec-**  
12       **retary and the application is in such form, is**  
13       **made in such manner, and contains such**  
14       **agreements, assurances, and information as**  
15       **the Secretary determines to be necessary to**  
16       **carry out this section.**

17       **“(f) FUNDING.—**

18                **“(1) IN GENERAL.—The Secretary shall**  
19        **provide for the transfer, from the Federal**  
20        **Hospital Insurance Trust Fund under**  
21        **section 1817 and the Federal Supple-**  
22        **mentary Medical Insurance Trust Fund**  
23        **under section 1841 (in such proportion as**  
24        **the Secretary determines appropriate), of**  
25        **\$25,000,000, to the Secretary for purposes**

1 of carrying out this section for each of  
2 the fiscal years 2010 through 2014.

3 “(2) AUTHORIZATION OF APPROPRIA-  
4 TIONS.—For purposes of carrying out the  
5 provisions of this section, in addition to  
6 funds otherwise available, out of any  
7 funds in the Treasury not otherwise ap-  
8 propriated, there are appropriated to the  
9 Secretary of Health and Human Services  
10 \$25,000,000 for each of the fiscal years  
11 2010 through 2014.

12 “SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROC-  
13 ESS FOR QUALITY MEASUREMENT.

14 “(a) GAO EVALUATIONS.—The Comptroller  
15 General of the United States shall conduct  
16 periodic evaluations of the implementation of  
17 the data collection processes for quality meas-  
18 ures used by the Secretary.

19 “(b) CONSIDERATIONS.—In carrying out the  
20 evaluation under subsection (a), the Comp-  
21 troller General shall determine—

22 “(1) whether the system for the collec-  
23 tion of data for quality measures pro-  
24 vides for validation of data as relevant  
25 and scientifically credible;

1           **“(2) whether data collection efforts**  
2           **under the system use the most efficient**  
3           **and cost-effective means in a manner**  
4           **that minimizes administrative burden on**  
5           **persons required to collect data and that**  
6           **adequately protects the privacy of pa-**  
7           **tients’ personal health information and**  
8           **provides data security;**

9           **“(3) whether standards under the sys-**  
10          **tem provide for an appropriate oppor-**  
11          **tunity for physicians and other clinicians**  
12          **and institutional providers of services to**  
13          **review and correct findings; and**

14          **“(4) the extent to which quality meas-**  
15          **ures are consistent with section**  
16          **1192(c)(1) or result in direct or indirect**  
17          **costs to users of such measures.**

18          **“(c) REPORT.—The Comptroller General**  
19          **shall submit reports to Congress and to the**  
20          **Secretary containing a description of the find-**  
21          **ings and conclusions of the results of each**  
22          **such evaluation.”.**

1 SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT  
2 INTO SELECTION OF QUALITY MEASURES.

3 Section 1808 of the Social Security Act (42  
4 U.S.C. 1395b–9) is amended by adding at the  
5 end the following new subsection:

6 “(d) MULTI-STAKEHOLDER PRE-RULEMAKING  
7 INPUT INTO SELECTION OF QUALITY MEASURES.—

8 “(1) LIST OF MEASURES.—Not later than  
9 December 1 before each year (beginning  
10 with 2011), the Secretary shall make pub-  
11 lic a list of measures being considered for  
12 selection for quality measurement by the  
13 Secretary in rulemaking with respect to  
14 payment systems under this title begin-  
15 ning in the payment year beginning in  
16 such year and for payment systems be-  
17 ginning in the calendar year following  
18 such year, as the case may be.

19 “(2) CONSULTATION ON SELECTION OF  
20 ENDORSED QUALITY MEASURES.—A con-  
21 sensus-based entity that has entered into  
22 a contract under section 1890 shall, as  
23 part of such contract, convene multi-  
24 stakeholder groups to provide rec-  
25 ommendations on the selection of indi-  
26 vidual or composite quality measures, for

1 use in reporting performance informa-  
2 tion to the public or for use in public  
3 health care programs.

4 “(3) **MULTI-STAKEHOLDER INPUT.**—Not  
5 later than February 1 of each year (be-  
6 ginning with 2011), the consensus-based  
7 entity described in paragraph (2) shall  
8 transmit to the Secretary the rec-  
9 ommendations of multi-stakeholder  
10 groups provided under paragraph (2).  
11 Such recommendations shall be included  
12 in the transmissions the consensus-based  
13 entity makes to the Secretary under the  
14 contract provided for under section 1890.

15 “(4) **REQUIREMENT FOR TRANSPARENCY**  
16 **IN PROCESS.**—

17 “(A) **IN GENERAL.**—In convening  
18 multi-stakeholder groups under para-  
19 graph (2) with respect to the selection  
20 of quality measures, the consensus-  
21 based entity described in such para-  
22 graph shall provide for an open and  
23 transparent process for the activities  
24 conducted pursuant to such con-  
25 vening.

1           **“(B) SELECTION OF ORGANIZATIONS**  
2           **PARTICIPATING IN MULTI-STAKEHOLDER**  
3           **GROUPS.—The process under para-**  
4           **graph (2) shall ensure that the selec-**  
5           **tion of representatives of multi-stake-**  
6           **holder groups includes provision for**  
7           **public nominations for, and the op-**  
8           **portunity for public comment on,**  
9           **such selection.**

10           **“(5) USE OF INPUT.—The respective**  
11           **proposed rule shall contain a summary of**  
12           **the recommendations made by the multi-**  
13           **stakeholder groups under paragraph (2),**  
14           **as well as other comments received re-**  
15           **garding the proposed measures, and the**  
16           **extent to which such proposed rule fol-**  
17           **lows such recommendations and the ra-**  
18           **tionale for not following such rec-**  
19           **ommendations.**

20           **“(6) MULTI-STAKEHOLDER GROUPS.—For**  
21           **purposes of this subsection, the term**  
22           **‘multi-stakeholder groups’ means, with**  
23           **respect to a quality measure, a voluntary**  
24           **collaborative of organizations rep-**  
25           **resenting persons interested in or af-**



1       **ected by the use of such quality meas-**  
2       **ure, such as the following:**

3               **“(A) Hospitals and other institu-**  
4               **tional providers.**

5               **“(B) Physicians.**

6               **“(C) Health care quality alliances.**

7               **“(D) Nurses and other health care**  
8               **practitioners.**

9               **“(E) Health plans.**

10              **“(F) Patient advocates and con-**  
11              **sumer groups.**

12              **“(G) Employers.**

13              **“(H) Public and private pur-**  
14              **chasers of health care items and serv-**  
15              **ices.**

16              **“(I) Labor organizations.**

17              **“(J) Relevant departments or**  
18              **agencies of the United States.**

19              **“(K) Biopharmaceutical compa-**  
20              **nies and manufacturers of medical**  
21              **devices.**

22              **“(L) Licensing, credentialing, and**  
23              **accrediting bodies.**

24              **“(7) FUNDING.—**

1           “(A) IN GENERAL.—The Secretary  
2 shall provide for the transfer, from  
3 the Federal Hospital Insurance Trust  
4 Fund under section 1817 and the Fed-  
5 eral Supplementary Medical Insur-  
6 ance Trust Fund under section 1841  
7 (in such proportion as the Secretary  
8 determines appropriate), of  
9 \$1,000,000, to the Secretary for pur-  
10 poses of carrying out this subsection  
11 for each of the fiscal years 2010  
12 through 2014.

13           “(B) AUTHORIZATION OF APPROPRIA-  
14 TIONS.—For purposes of carrying out  
15 the provisions of this subsection, in  
16 addition to funds otherwise available,  
17 out of any funds in the Treasury not  
18 otherwise appropriated, there are ap-  
19 propriated to the Secretary of Health  
20 and Human Services \$1,000,000 for  
21 each of the fiscal years 2010 through  
22 2014.”.

23 SEC. 1444. APPLICATION OF QUALITY MEASURES.

24           (a) INPATIENT HOSPITAL SERVICES.—Section  
25 1886(b)(3)(B) of such Act (42 U.S.C.

1 **1395ww(b)(3)(B)) is amended by adding at the**  
2 **end the following new clause:**

3 **“(x)(I) Subject to subclause (II), for pur-**  
4 **poses of reporting data on quality measures**  
5 **for inpatient hospital services furnished dur-**  
6 **ing fiscal year 2012 and each subsequent fis-**  
7 **cal year, the quality measures specified under**  
8 **clause (viii) shall be measures selected by the**  
9 **Secretary from measures that have been en-**  
10 **dorsed by the entity with a contract with the**  
11 **Secretary under section 1890(a).**

12 **“(II) In the case of a specified area or med-**  
13 **ical topic determined appropriate by the Sec-**  
14 **retary for which a feasible and practical qual-**  
15 **ity measure has not been endorsed by the en-**  
16 **tity with a contract under section 1890(a), the**  
17 **Secretary may specify a measure that is not**  
18 **so endorsed as long as due consideration is**  
19 **given to measures that have been endorsed or**  
20 **adopted by a consensus organization identi-**  
21 **fied by the Secretary. The Secretary shall sub-**  
22 **mit such a non-endorsed measure to the enti-**  
23 **ty for consideration for endorsement. If the**  
24 **entity considers but does not endorse such a**  
25 **measure and if the Secretary does not phase-**

1 out use of such measure, the Secretary shall  
2 include the rationale for continued use of  
3 such a measure in rulemaking.”.

4 (b) **OUTPATIENT HOSPITAL SERVICES.—Section**  
5 **tion 1833(t)(17) of such Act (42 U.S.C.**  
6 **1395l(t)(17)) is amended by adding at the end**  
7 **the following new subparagraph:**

8 (F) **USE OF ENDORSED QUALITY**  
9 **MEASURES.—The provisions of clause**  
10 **(x) of section 1886(b)(3)(C) shall apply**  
11 **to quality measures for covered OPD**  
12 **services under this paragraph in the**  
13 **same manner as such provisions**  
14 **apply to quality measures for inpa-**  
15 **tient hospital services.”.**

16 (c) **PHYSICIANS’ SERVICES.—Section**  
17 **1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-**  
18 **4(k)(2)(C)(ii)) is amended by adding at the end**  
19 **the following: “The Secretary shall submit**  
20 **such a non-endorsed measure to the entity for**  
21 **consideration for endorsement. If the entity**  
22 **considers but does not endorse such a meas-**  
23 **ure and if the Secretary does not phase-out**  
24 **use of such measure, the Secretary shall in-**

1 **clude the rationale for continued use of such**  
2 **a measure in rulemaking.”.**

3 **(d) RENAL DIALYSIS SERVICES.—Section**  
4 **1881(h)(2)(B)(ii) of such Act (42 U.S.C.**  
5 **1395rr(h)(2)(B)(ii)) is amended by adding at**  
6 **the end the following: “The Secretary shall**  
7 **submit such a non-endorsed measure to the**  
8 **entity for consideration for endorsement. If**  
9 **the entity considers but does not endorse**  
10 **such a measure and if the Secretary does not**  
11 **phase-out use of such measure, the Secretary**  
12 **shall include the rationale for continued use**  
13 **of such a measure in rulemaking.”.**

14 **(e) ENDORSEMENT OF STANDARDS.—Section**  
15 **1890(b)(2) of the Social Security Act (42 U.S.C.**  
16 **1395aaa(b)(2)) is amended by adding after and**  
17 **below subparagraph (B) the following:**

18 **“If the entity does not endorse a measure,**  
19 **such entity shall explain the reasons and**  
20 **provide suggestions about changes to**  
21 **such measure that might make it a poten-**  
22 **tially endorsable measure.”.**

23 **(f) EFFECTIVE DATE.—Except as otherwise**  
24 **provided, the amendments made by this sec-**  
25 **tion shall apply to quality measures applied**

1 for payment years beginning with 2012 or fis-  
2 cal year 2012, as the case may be.

3 SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

4 Section 1890(d) of the Social Security Act  
5 (42 U.S.C. 1395aaa(d)) is amended by striking  
6 “for each of fiscal years 2009 through 2012”  
7 and inserting “for fiscal year 2009, and  
8 \$12,000,000 for each of the fiscal years 2010  
9 through 2012”

10 **Subtitle D—Physician Payments**  
11 **Sunshine Provision**

12 SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BE-  
13 TWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES,  
14 TORS OF COVERED DRUGS, DEVICES,  
15 BIOLOGICALS, OR MEDICAL SUPPLIES  
16 UNDER MEDICARE, MEDICAID, OR CHIP AND  
17 PHYSICIANS AND OTHER HEALTH CARE ENTI-  
18 TIES AND BETWEEN PHYSICIANS AND OTHER  
19 HEALTH CARE ENTITIES.

20 (a) IN GENERAL.—Part A of title XI of the  
21 Social Security Act (42 U.S.C. 1301 et seq.), as  
22 amended by section 1631(a), is further amend-  
23 ed by inserting after section 1128G the fol-  
24 lowing new section:

1 “SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS’ FINAN-  
2 CIAL RELATIONSHIPS WITH MANUFACTUR-  
3 ERS AND DISTRIBUTORS OF COVERED  
4 DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL  
5 SUPPLIES UNDER MEDICARE, MEDICAID, OR  
6 CHIP AND WITH ENTITIES THAT BILL FOR  
7 SERVICES UNDER MEDICARE.

8 “(a) REPORTING OF PAYMENTS OR OTHER  
9 TRANSFERS OF VALUE.—

10 “(1) IN GENERAL.—Except as provided  
11 in this subsection, not later than March  
12 31, 2011 and annually thereafter, each ap-  
13 plicable manufacturer or distributor that  
14 provides a payment or other transfer of  
15 value to a covered recipient, or to an en-  
16 tity or individual at the request of or des-  
17 ignated on behalf of a covered recipient,  
18 shall submit to the Secretary, in such  
19 electronic form as the Secretary shall re-  
20 quire, the following information with re-  
21 spect to the preceding calendar year:

22 “(A) With respect to the covered  
23 recipient, the recipient’s name, busi-  
24 ness address, physician specialty, and  
25 national provider identifier.

1           **“(B) With respect to the payment**  
2           **or other transfer of value, other than**  
3           **a drug sample—**

4                   **“(i) its value and date;**

5                   **“(ii) the name of the related**  
6                   **drug, device, or supply, if avail-**  
7                   **able; and**

8                   **“(iii) a description of its form,**  
9                   **indicated (as appropriate for all**  
10                   **that apply) as—**

11                   **“(I) cash or a cash equiva-**  
12                   **lent;**

13                   **“(II) in-kind items or serv-**  
14                   **ices;**

15                   **“(III) stock, a stock option,**  
16                   **or any other ownership inter-**  
17                   **est, dividend, profit, or other**  
18                   **return on investment; or**

19                   **“(IV) any other form (as**  
20                   **defined by the Secretary).**

21           **“(C) With respect to a drug sam-**  
22           **ple, the name, number, date, and dos-**  
23           **age units of the sample.**

24           **“(2) AGGREGATE REPORTING.—Informa-**  
25           **tion submitted by an applicable manufac-**



1        **turer or distributor under paragraph (1)**  
2        **shall include the aggregate amount of all**  
3        **payments or other transfers of value pro-**  
4        **vided by the manufacturer or distributor**  
5        **to covered recipients (and to entities or**  
6        **individuals at the request of or des-**  
7        **ignated on behalf of a covered recipient)**  
8        **during the year involved, including all**  
9        **payments and transfers of value regard-**  
10       **less of whether such payments or trans-**  
11       **fer of value were individually disclosed.**

12            **“(3) SPECIAL RULE FOR CERTAIN PAY-**  
13        **MENTS OR OTHER TRANSFERS OF VALUE.—In**  
14        **the case where an applicable manufac-**  
15        **turer or distributor provides a payment**  
16        **or other transfer of value to an entity or**  
17        **individual at the request of or designated**  
18        **on behalf of a covered recipient, the man-**  
19        **ufacturer or distributor shall disclose**  
20        **that payment or other transfer of value**  
21        **under the name of the covered recipient.**

22            **“(4) DELAYED REPORTING FOR PAYMENTS**  
23        **MADE PURSUANT TO PRODUCT DEVELOPMENT**  
24        **AGREEMENTS.—In the case of a payment or**  
25        **other transfer of value made to a covered**

1 recipient by an applicable manufacturer  
2 or distributor pursuant to a product de-  
3 velopment agreement for services fur-  
4 nished in connection with the develop-  
5 ment of a new drug, device, biological, or  
6 medical supply, the applicable manufac-  
7 turer or distributor may report the value  
8 and recipient of such payment or other  
9 transfer of value in the first reporting pe-  
10 riod under this subsection in the next re-  
11 porting deadline after the earlier of the  
12 following:

13 “(A) The date of the approval or  
14 clearance of the covered drug, device,  
15 biological, or medical supply by the  
16 Food and Drug Administration.

17 “(B) Two calendar years after the  
18 date such payment or other transfer  
19 of value was made.

20 “(5) DELAYED REPORTING FOR PAYMENTS  
21 MADE PURSUANT TO CLINICAL INVESTIGA-  
22 TIONS.—In the case of a payment or other  
23 transfer of value made to a covered re-  
24 cipient by an applicable manufacturer or  
25 distributor in connection with a clinical

1 investigation regarding a new drug, de-  
2 vice, biological, or medical supply, the  
3 applicable manufacturer or distributor  
4 may report as required under this section  
5 in the next reporting period under this  
6 subsection after the earlier of the fol-  
7 lowing:

8 “(A) The date that the clinical in-  
9 vestigation is registered on the  
10 website maintained by the National  
11 Institutes of Health pursuant to sec-  
12 tion 671 of the Food and Drug Admin-  
13 istration Amendments Act of 2007.

14 “(B) Two calendar years after the  
15 date such payment or other transfer  
16 of value was made.

17 “(6) **CONFIDENTIALITY.**—Information  
18 described in paragraph (4) or (5) shall be  
19 considered confidential and shall not be  
20 subject to disclosure under section 552 of  
21 title 5, United States Code, or any other  
22 similar Federal, State, or local law, until  
23 or after the date on which the informa-  
24 tion is made available to the public under  
25 such paragraph.

1       **“(b) REPORTING OF OWNERSHIP INTEREST BY**  
2 **PHYSICIANS IN HOSPITALS AND OTHER ENTITIES**  
3 **THAT BILL MEDICARE.—Not later than March**  
4 **31 of each year (beginning with 2011), each**  
5 **hospital or other health care entity (not in-**  
6 **cluding a Medicare Advantage organization)**  
7 **that bills the Secretary under part A or part**  
8 **B of title XVIII for services shall report on the**  
9 **ownership shares (other than ownership**  
10 **shares described in section 1877(c)) of each**  
11 **physician who, directly or indirectly, owns an**  
12 **interest in the entity. In this subsection, the**  
13 **term ‘physician’ includes a physician’s imme-**  
14 **diately family members (as defined for purposes**  
15 **of section 1877(a)).**

16       **“(c) PUBLIC AVAILABILITY.—**

17           **“(1) IN GENERAL.—The Secretary shall**  
18 **establish procedures to ensure that, not**  
19 **later than September 30, 2011, and on**  
20 **June 30 of each year beginning there-**  
21 **after, the information submitted under**  
22 **subsections (a) and (b), other than infor-**  
23 **mation regard drug samples, with respect**  
24 **to the preceding calendar year is made**

1 available through an Internet website  
2 that—

3 “(A) is searchable and is in a for-  
4 mat that is clear and understandable;

5 “(B) contains information that is  
6 presented by the name of the applica-  
7 ble manufacturer or distributor, the  
8 name of the covered recipient, the  
9 business address of the covered re-  
10 cipient, the specialty (if applicable) of  
11 the covered recipient, the value of the  
12 payment or other transfer of value,  
13 the date on which the payment or  
14 other transfer of value was provided  
15 to the covered recipient, the form of  
16 the payment or other transfer of  
17 value, indicated (as appropriate)  
18 under subsection (a)(1)(B)(ii), the na-  
19 ture of the payment or other transfer  
20 of value, indicated (as appropriate)  
21 under subsection (a)(1)(B)(iii), and  
22 the name of the covered drug, device,  
23 biological, or medical supply, as ap-  
24 plicable;

1           **“(C) contains information that is**  
2           **able to be easily aggregated and**  
3           **downloaded;**

4           **“(D) contains a description of any**  
5           **enforcement actions taken to carry**  
6           **out this section, including any pen-**  
7           **alties imposed under subsection (d),**  
8           **during the preceding year;**

9           **“(E) contains background infor-**  
10          **mation on industry-physician rela-**  
11          **tionships;**

12          **“(F) in the case of information**  
13          **submitted with respect to a payment**  
14          **or other transfer of value described**  
15          **in subsection (a)(5), lists such infor-**  
16          **mation separately from the other in-**  
17          **formation submitted under sub-**  
18          **section (a) and designates such sepa-**  
19          **rately listed information as funding**  
20          **for clinical research;**

21          **“(G) contains any other informa-**  
22          **tion the Secretary determines would**  
23          **be helpful to the average consumer;**  
24          **and**

1           “(H) provides the covered recipi-  
2           ent an opportunity to submit correc-  
3           tions to the information made avail-  
4           able to the public with respect to the  
5           covered recipient.

6           “(2) ACCURACY OF REPORTING.—The ac-  
7           curacy of the information that is sub-  
8           mitted under subsections (a) and (b) and  
9           made available under paragraph (1) shall  
10          be the responsibility of the applicable  
11          manufacturer or distributor of a covered  
12          drug, device, biological, or medical sup-  
13          ply reporting under subsection (a) or hos-  
14          pital or other health care entity report-  
15          ing physician ownership under sub-  
16          section (b). The Secretary shall establish  
17          procedures to ensure that the covered re-  
18          cipient is provided with an opportunity  
19          to submit corrections to the manufac-  
20          turer, distributor, hospital, or other enti-  
21          ty reporting under subsection (a) or (b)  
22          with regard to information made public  
23          with respect to the covered recipient and,  
24          under such procedures, the corrections  
25          shall be transmitted to the Secretary.

1           **“(3) SPECIAL RULE FOR DRUG SAM-**  
2           **PLES.—Information relating to drug sam-**  
3           **ples provided under subsection (a) shall**  
4           **not be made available to the public by**  
5           **the Secretary but may be made available**  
6           **outside the Department of Health and**  
7           **Human Services by the Secretary for re-**  
8           **search or legitimate business purposes**  
9           **pursuant to data use agreements.**

10           **“(4) SPECIAL RULE FOR NATIONAL PRO-**  
11           **VIDER IDENTIFIERS.—Information relating**  
12           **to national provider identifiers provided**  
13           **under subsection (a) shall not be made**  
14           **available to the public by the Secretary**  
15           **but may be made available outside the**  
16           **Department of Health and Human Serv-**  
17           **ices by the Secretary for research or le-**  
18           **gitimate business purposes pursuant to**  
19           **data use agreements.**

20           **“(d) PENALTIES FOR NONCOMPLIANCE.—**

21           **“(1) FAILURE TO REPORT.—**

22           **“(A) IN GENERAL.—Subject to sub-**  
23           **paragraph (B), except as provided in**  
24           **paragraph (2), any applicable manu-**  
25           **facturer or distributor that fails to**



1       **submit information required under**  
2       **subsection (a) in a timely manner in**  
3       **accordance with regulations promul-**  
4       **gated to carry out such subsection,**  
5       **and any hospital or other entity that**  
6       **fails to submit information required**  
7       **under subsection (b) in a timely man-**  
8       **ner in accordance with regulations**  
9       **promulgated to carry out such sub-**  
10       **section shall be subject to a civil**  
11       **money penalty of not less than \$1,000,**  
12       **but not more than \$10,000, for each**  
13       **payment or other transfer of value or**  
14       **ownership or investment interest not**  
15       **reported as required under such sub-**  
16       **section. Such penalty shall be im-**  
17       **posed and collected in the same man-**  
18       **ner as civil money penalties under**  
19       **subsection (a) of section 1128A are**  
20       **imposed and collected under that sec-**  
21       **tion.**

22               **“(B)       LIMITATION.—The       total**  
23       **amount of civil money penalties im-**  
24       **posed under subparagraph (A) with**  
25       **respect to each annual submission of**

1 information under subsection (a) by  
2 an applicable manufacturer or dis-  
3 tributor or other entity shall not ex-  
4 ceed \$150,000.

5 “(2) KNOWING FAILURE TO REPORT.—

6 “(A) IN GENERAL.—Subject to sub-  
7 paragraph (B), any applicable manu-  
8 facturer or distributor that know-  
9 ingly fails to submit information re-  
10 quired under subsection (a) in a time-  
11 ly manner in accordance with regula-  
12 tions promulgated to carry out such  
13 subsection and any hospital or other  
14 entity that fails to submit information  
15 required under subsection (b) in a  
16 timely manner in accordance with  
17 regulations promulgated to carry out  
18 such subsection, shall be subject to a  
19 civil money penalty of not less than  
20 \$10,000, but not more than \$100,000,  
21 for each payment or other transfer of  
22 value or ownership or investment in-  
23 terest not reported as required under  
24 such subsection. Such penalty shall  
25 be imposed and collected in the same

1           **manner as civil money penalties**  
2           **under subsection (a) of section 1128A**  
3           **are imposed and collected under that**  
4           **section.**

5           **“(B) LIMITATION.—The total**  
6           **amount of civil money penalties im-**  
7           **posed under subparagraph (A) with**  
8           **respect to each annual submission of**  
9           **information under subsection (a) or**  
10          **(b) by an applicable manufacturer,**  
11          **distributor, or entity shall not exceed**  
12          **\$1,000,000, or, if greater, 0.1 percent-**  
13          **age of the total annual revenues of**  
14          **the manufacturer, distributor, or en-**  
15          **tity.**

16          **“(3) USE OF FUNDS.—Funds collected**  
17          **by the Secretary as a result of the imposi-**  
18          **tion of a civil money penalty under this**  
19          **subsection shall be used to carry out this**  
20          **section.**

21          **“(4) ENFORCEMENT THROUGH STATE AT-**  
22          **TORNEYS GENERAL.—The attorney general**  
23          **of a State, after providing notice to the**  
24          **Secretary of an intent to proceed under**  
25          **this paragraph in a specific case and pro-**

1        **viding the Secretary with an opportunity**  
2        **to bring an action under this subsection**  
3        **and the Secretary declining such oppor-**  
4        **tunity, may proceed under this sub-**  
5        **section against a manufacturer or dis-**  
6        **tributor in the State.**

7        **“(e) ANNUAL REPORT TO CONGRESS.—Not**  
8        **later than April 1 of each year beginning with**  
9        **2011, the Secretary shall submit to Congress**  
10       **a report that includes the following:**

11            **“(1) The information submitted under**  
12            **this section during the preceding year,**  
13            **aggregated for each applicable manufac-**  
14            **turer or distributor of a covered drug, de-**  
15            **vice, biological, or medical supply that**  
16            **submitted such information during such**  
17            **year.**

18            **“(2) A description of any enforcement**  
19            **actions taken to carry out this section, in-**  
20            **cluding any penalties imposed under sub-**  
21            **section (d), during the preceding year.**

22        **“(f) DEFINITIONS.—In this section:**

23            **“(1) APPLICABLE MANUFACTURER; APPLI-**  
24            **CABLE DISTRIBUTOR.—The term ‘applicable**  
25            **manufacturer’ means a manufacturer of a**

1 covered drug, device, biological, or med-  
2 ical supply, and the term ‘applicable dis-  
3 tributor’ means a distributor of a covered  
4 drug, device, or medical supply.

5 “(2) CLINICAL INVESTIGATION.—The  
6 term ‘clinical investigation’ means any  
7 experiment involving one or more human  
8 subjects, or materials derived from  
9 human subjects, in which a drug or de-  
10 vice is administered, dispensed, or used.

11 “(3) COVERED DRUG, DEVICE, BIOLOGI-  
12 CAL, OR MEDICAL SUPPLY.—The term ‘cov-  
13 ered’ means, with respect to a drug, de-  
14 vice, biological, or medical supply, such a  
15 drug, device, biological, or medical sup-  
16 ply for which payment is available under  
17 title XVIII or a State plan under title XIX  
18 or XXI (or a waiver of such a plan).

19 “(4) COVERED RECIPIENT.—The term  
20 ‘covered recipient’ means the following:

21 “(A) A physician.

22 “(B) A physician group practice.

23 “(C) Any other prescriber of a  
24 covered drug, device, biological, or  
25 medical supply.

1           **“(D) A pharmacy or pharmacist.**

2           **“(E) A health insurance issuer,**  
3           **group health plan, or other entity of-**  
4           **fering a health benefits plan, includ-**  
5           **ing any employee of such an issuer,**  
6           **plan, or entity.**

7           **“(F) A pharmacy benefit manager,**  
8           **including any employee of such a**  
9           **manager.**

10          **“(G) A hospital.**

11          **“(H) A medical school.**

12          **“(I) A sponsor of a continuing**  
13          **medical education program.**

14          **“(J) A patient advocacy or disease**  
15          **specific group.**

16          **“(K) A organization of health care**  
17          **professionals.**

18          **“(L) A biomedical researcher.**

19          **“(M) A group purchasing organi-**  
20          **zation.**

21          **“(5) DISTRIBUTOR OF A COVERED DRUG,**  
22          **DEVICE, OR MEDICAL SUPPLY.—The term**  
23          **‘distributor of a covered drug, device, or**  
24          **medical supply’ means any entity which**  
25          **is engaged in the marketing or distribu-**

1       **tion of a covered drug, device, or medical**  
2       **supply (or any subsidiary of or entity af-**  
3       **filiated with such entity), but does not in-**  
4       **clude a wholesale pharmaceutical dis-**  
5       **tributor.**

6           **“(6) EMPLOYEE.—The term ‘employee’**  
7       **has the meaning given such term in sec-**  
8       **tion 1877(h)(2).**

9           **“(7) KNOWINGLY.—The term ‘know-**  
10       **ingly’ has the meaning given such term in**  
11       **section 3729(b) of title 31, United States**  
12       **Code.**

13           **“(8) MANUFACTURER OF A COVERED**  
14       **DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUP-**  
15       **PLY.—The term ‘manufacturer of a cov-**  
16       **ered drug, device, biological, or medical**  
17       **supply’ means any entity which is en-**  
18       **gaged in the production, preparation,**  
19       **propagation, compounding, conversion,**  
20       **processing, marketing, or distribution of**  
21       **a covered drug, device, biological, or**  
22       **medical supply (or any subsidiary of or**  
23       **entity affiliated with such entity).**

24           **“(9) PAYMENT OR OTHER TRANSFER OF**  
25       **VALUE.—**

1           **“(A) IN GENERAL.—The term ‘pay-**  
2           **ment or other transfer of value’**  
3           **means a transfer of anything of value**  
4           **for or of any of the following:**

5                   **“(i) Gift, food, or entertain-**  
6                   **ment.**

7                   **“(ii) Travel or trip.**

8                   **“(iii) Honoraria.**

9                   **“(iv) Research funding or**  
10                  **grant.**

11                  **“(v) Education or conference**  
12                  **funding.**

13                  **“(vi) Consulting fees.**

14                  **“(vii) Ownership or invest-**  
15                  **ment interest and royalties or li-**  
16                  **cence fee.**

17           **“(B) INCLUSIONS.—Subject to sub-**  
18           **paragraph (C), the term ‘payment or**  
19           **other transfer of value’ includes any**  
20           **compensation, gift, honorarium,**  
21           **speaking fee, consulting fee, travel,**  
22           **services, dividend, profit distribution,**  
23           **stock or stock option grant, or any**  
24           **ownership or investment interest**  
25           **held by a physician in a manufac-**



1           **turer (excluding a dividend or other**  
2           **profit distribution from, or ownership**  
3           **or investment interest in, a publicly**  
4           **traded security or mutual fund (as**  
5           **described in section 1877(c)).**

6           **“(C) EXCLUSIONS.—The term ‘pay-**  
7           **ment or other transfer of value’ does**  
8           **not include the following:**

9                   **“(i) Any payment or other**  
10                   **transfer of value provided by an**  
11                   **applicable manufacturer or dis-**  
12                   **tributor to a covered recipient**  
13                   **where the amount transferred to,**  
14                   **requested by, or designated on**  
15                   **behalf of the covered recipient**  
16                   **does not exceed \$5.**

17                   **“(ii) The loan of a covered de-**  
18                   **vice for a short-term trial period,**  
19                   **not to exceed 90 days, to permit**  
20                   **evaluation of the covered device**  
21                   **by the covered recipient.**

22                   **“(iii) Items or services pro-**  
23                   **vided under a contractual war-**  
24                   **ranty, including the replacement**  
25                   **of a covered device, where the**

1 terms of the warranty are set  
2 forth in the purchase or lease  
3 agreement for the covered device.

4 “(iv) A transfer of anything of  
5 value to a covered recipient when  
6 the covered recipient is a patient  
7 and not acting in the professional  
8 capacity of a covered recipient.

9 “(v) In-kind items used for the  
10 provision of charity care.

11 “(vi) A dividend or other prof-  
12 it distribution from, or ownership  
13 or investment interest in, a pub-  
14 licly traded security and mutual  
15 fund (as described in section  
16 1877(c)).

17 “(vii) Compensation paid by a  
18 manufacturer or distributor of a  
19 covered drug, device, biological,  
20 or medical supply to a covered re-  
21 cipient who is directly employed  
22 by and works solely for such man-  
23 ufacturer or distributor.

24 “(viii) Any discount or cash  
25 rebate.

1           **“(10) PHYSICIAN.—**The term ‘physician’  
2           **has the meaning given that term in sec-**  
3           **tion 1861(r). For purposes of this section,**  
4           **such term does not include a physician**  
5           **who is an employee of the applicable**  
6           **manufacturer that is required to submit**  
7           **information under subsection (a).**

8           **“(g) ANNUAL REPORTS TO STATES.—**Not  
9           **later than April 1 of each year beginning with**  
10          **2011, the Secretary shall submit to States a re-**  
11          **port that includes a summary of the informa-**  
12          **tion submitted under subsections (a) and (d)**  
13          **during the preceding year with respect to**  
14          **covered recipients or other hospitals and en-**  
15          **tities in the State.**

16          **“(h) RELATION TO STATE LAWS.—**

17               **“(1) IN GENERAL.—**Effective on Janu-  
18               **ary 1, 2011, subject to paragraph (2), the**  
19               **provisions of this section shall preempt**  
20               **any law or regulation of a State or of a**  
21               **political subdivision of a State that re-**  
22               **quires an applicable manufacturer and**  
23               **applicable distributor (as such terms are**  
24               **defined in subsection (f)) to disclose or**  
25               **report, in any format, the type of infor-**

1        **mation (described in subsection (a)) re-**  
2        **garding a payment or other transfer of**  
3        **value provided by the manufacturer to a**  
4        **covered recipient (as so defined).**

5            **“(2) NO PREEMPTION OF ADDITIONAL RE-**  
6        **QUIREMENTS.—Paragraph (1) shall not pre-**  
7        **empt any law or regulation of a State or**  
8        **of a political subdivision of a State that**  
9        **requires any of the following:**

10            **“(A) The disclosure or reporting**  
11            **of information not of the type re-**  
12            **quired to be disclosed or reported**  
13            **under this section.**

14            **“(B) The disclosure or reporting,**  
15            **in any format, of the type of informa-**  
16            **tion required to be disclosed or re-**  
17            **ported under this section to a Fed-**  
18            **eral, State, or local governmental**  
19            **agency for public health surveillance,**  
20            **investigation, or other public health**  
21            **purposes or health oversight pur-**  
22            **poses.**

23            **“(C) The discovery or admissi-**  
24            **bility of information described in this**

1           section in a criminal, civil, or admin-  
2           istrative proceeding.”.

3           **(b) AVAILABILITY OF INFORMATION FROM THE**  
4 **DISCLOSURE OF FINANCIAL RELATIONSHIP RE-**  
5 **PORT (DFRR).—The Secretary of Health and**  
6 **Human Services shall submit to Congress a**  
7 **report on the full results of the Disclosure of**  
8 **Physician Financial Relationships surveys re-**  
9 **quired pursuant to section 5006 of the Deficit**  
10 **Reduction Act of 2005. Such report shall be**  
11 **submitted to Congress not later than the date**  
12 **that is 6 months after the date such surveys**  
13 **are collected and shall be made publicly avail-**  
14 **able on an Internet website of the Department**  
15 **of Health and Human Services.**

16           **Subtitle E—Public Reporting on**  
17 **Health Care-Associated Infections**

18 **SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY**  
19                           **HOSPITALS AND AMBULATORY SURGICAL**  
20                           **CENTERS ON HEALTH CARE-ASSOCIATED IN-**  
21                           **FECTIONS.**

22           **(a) IN GENERAL.—Title XI of the Social Se-**  
23 **curity Act is amended by inserting after sec-**  
24 **tion 1138 the following section:**

1 “SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY  
2 HOSPITALS AND AMBULATORY SURGICAL  
3 CENTERS ON HEALTH CARE-ASSOCIATED IN-  
4 FECTIONS.

5 “(a) REPORTING REQUIREMENT.—

6 “(1) IN GENERAL.—The Secretary shall  
7 provide that a hospital (as defined in sub-  
8 section (g)) or ambulatory surgical center  
9 meeting the requirements of titles XVIII  
10 or XIX may participate in the programs  
11 established under such titles (pursuant to  
12 the applicable provisions of law, includ-  
13 ing sections 1866(a)(1) and  
14 1832(a)(1)(F)(i)) only if, in accordance  
15 with this section, the hospital or center  
16 reports such information on health care-  
17 associated infections that develop in the  
18 hospital or center (and such demographic  
19 information associated with such infec-  
20 tions) as the Secretary specifies.

21 “(2) REPORTING PROTOCOLS.—Such in-  
22 formation shall be reported in accord-  
23 ance with reporting protocols established  
24 by the Secretary through the Director of  
25 the Centers for Disease Control and Pre-  
26 vention (in this section referred to as the

1       **‘CDC’) and to the National Healthcare**  
2       **Safety Network of the CDC or under such**  
3       **another reporting system of such Centers**  
4       **as determined appropriate by the Sec-**  
5       **retary in consultation with such Director.**

6           **“(3) COORDINATION WITH HIT.—The Sec-**  
7       **retary, through the Director of the CDC**  
8       **and the Office of the National Coordi-**  
9       **nator for Health Information Technology,**  
10       **shall ensure that the transmission of in-**  
11       **formation under this subsection is co-**  
12       **ordinated with systems established under**  
13       **the HITECH Act, where appropriate.**

14           **“(4) PROCEDURES TO ENSURE THE VALID-**  
15       **ITY OF INFORMATION.—The Secretary shall**  
16       **establish procedures regarding the valid-**  
17       **ity of the information submitted under**  
18       **this subsection in order to ensure that**  
19       **such information is appropriately com-**  
20       **pared across hospitals and centers. Such**  
21       **procedures shall address failures to re-**  
22       **port as well as errors in reporting.**

23           **“(5) IMPLEMENTATION.—Not later than**  
24       **1 year after the date of enactment of this**  
25       **section, the Secretary, through the Direc-**

1        **tor of CDC, shall promulgate regulations**  
2        **to carry out this section.**

3        **“(b) PUBLIC POSTING OF INFORMATION.—The**  
4        **Secretary shall promptly post, on the official**  
5        **public Internet site of the Department of**  
6        **Health and Human Services, the information**  
7        **reported under subsection (a). Such informa-**  
8        **tion shall be set forth in a manner that allows**  
9        **for the comparison of information on health**  
10       **care-associated infections—**

11            **“(1) among hospitals and ambulatory**  
12            **surgical centers; and**

13            **“(2) by demographic information.**

14        **“(c) ANNUAL REPORT TO CONGRESS.—On an**  
15        **annual basis the Secretary shall submit to the**  
16        **Congress a report that summarizes each of**  
17        **the following:**

18            **“(1) The number and types of health**  
19            **care-associated infections reported under**  
20            **subsection (a) in hospitals and ambula-**  
21            **tory surgical centers during such year.**

22            **“(2) Factors that contribute to the oc-**  
23            **currence of such infections, including**  
24            **health care worker immunization rates.**



1           **“(3) Based on the most recent infor-**  
2           **mation available to the Secretary on the**  
3           **composition of the professional staff of**  
4           **hospitals and ambulatory surgical cen-**  
5           **ters, the number of certified infection**  
6           **control professionals on the staff of hos-**  
7           **pitals and ambulatory surgical centers.**

8           **“(4) The total increases or decreases**  
9           **in health care costs that resulted from in-**  
10          **creases or decreases in the rates of occur-**  
11          **rence of each such type of infection dur-**  
12          **ing such year.**

13          **“(5) Recommendations, in coordina-**  
14          **tion with the Center for Quality Improve-**  
15          **ment established under section 931 of the**  
16          **Public Health Service Act, for best prac-**  
17          **tices to eliminate the rates of occurrence**  
18          **of each such type of infection in hospitals**  
19          **and ambulatory surgical centers.**

20          **“(d) NON-PREEMPTION OF STATE LAWS.—**  
21          **Nothing in this section shall be construed as**  
22          **preempting or otherwise affecting any provi-**  
23          **sion of State law relating to the disclosure of**  
24          **information on health care-associated infec-**

1 tions or patient safety procedures for a hos-  
2 pital or ambulatory surgical center.

3 **“(e) HEALTH CARE-ASSOCIATED INFECTION.—**  
4 **For purposes of this section:**

5 **“(1) IN GENERAL.—The term ‘health**  
6 **care-associated infection’ means an infec-**  
7 **tion that develops in a patient who has**  
8 **received care in any institutional setting**  
9 **where health care is delivered and is re-**  
10 **lated to receiving health care.**

11 **“(2) RELATED TO RECEIVING HEALTH**  
12 **CARE.—The term ‘related to receiving**  
13 **health care’, with respect to an infection,**  
14 **means that the infection was not incu-**  
15 **bating or present at the time health care**  
16 **was provided.**

17 **“(f) APPLICATION TO CRITICAL ACCESS HOS-**  
18 **PITALS.—For purposes of this section, the term**  
19 **‘hospital’ includes a critical access hospital,**  
20 **as defined in section 1861(mm)(1).”.**

21 **(b) EFFECTIVE DATE.—With respect to sec-**  
22 **tion 1138A of the Social Security Act (as in-**  
23 **serted by subsection (a) of this section), the**  
24 **requirement under such section that hos-**  
25 **pitals and ambulatory surgical centers submit**

1 reports takes effect on such date (not later  
2 than 2 years after the date of the enactment  
3 of this Act) as the Secretary of Health and  
4 Human Services shall specify. In order to  
5 meet such deadline, the Secretary may imple-  
6 ment such section through guidance or other  
7 instructions.

8 (c) GAO REPORT.—Not later than 18  
9 months after the date of the enactment of this  
10 Act, the Comptroller General of the United  
11 States shall submit to Congress a report on  
12 the program established under section 1138A  
13 of the Social Security Act, as inserted by sub-  
14 section (a). Such report shall include an anal-  
15 ysis of the appropriateness of the types of in-  
16 formation required for submission, compli-  
17 ance with reporting requirements, the suc-  
18 cess of the validity procedures established,  
19 and any conflict or overlap between the re-  
20 porting required under such section and any  
21 other reporting systems mandated by either  
22 the States or the Federal Government.

23 (d) REPORT ON ADDITIONAL DATA.—Not  
24 later than 18 months after the date of the en-  
25 actment of this Act, the Secretary of Health

1 and Human Services shall submit to the Con-  
2 gress a report on the appropriateness of ex-  
3 panding the requirements under such section  
4 to include additional information (such as  
5 health care worker immunization rates), in  
6 order to improve health care quality and pa-  
7 tient safety.

8 **TITLE V—MEDICARE GRADUATE**  
9 **MEDICAL EDUCATION**

10 **SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSI-**  
11 **TIONS.**

12 (a) **IN GENERAL.—Section 1886(h) of the So-**  
13 **cial Security Act (42 U.S.C. 1395ww(h)) is**  
14 **amended—**

15 (1) **in paragraph (4)(F)(i), by striking**  
16 **“paragraph (7)” and inserting “para-**  
17 **graphs (7) and (8)”;**

18 (2) **in paragraph (4)(H)(i), by striking**  
19 **“paragraph (7)” and inserting “para-**  
20 **graphs (7) and (8)”;**

21 (3) **in paragraph (7)(E), by inserting**  
22 **“and paragraph (8)” after “this para-**  
23 **graph”;** and

24 (4) **by adding at the end the following**  
25 **new paragraph:**

1           **“(8) ADDITIONAL REDISTRIBUTION OF UN-**  
2           **USED RESIDENCY POSITIONS.—**

3           **“(A) REDUCTIONS IN LIMIT BASED ON**  
4           **UNUSED POSITIONS.—**

5           **“(i) PROGRAMS SUBJECT TO RE-**  
6           **DUCTION.—If a hospital’s reference**  
7           **resident level (specified in clause**  
8           **(ii)) is less than the otherwise ap-**  
9           **licable resident limit (as defined**  
10           **in subparagraph (C)(ii)), effective**  
11           **for portions of cost reporting pe-**  
12           **riods occurring on or after July 1,**  
13           **2011, the otherwise applicable**  
14           **resident limit shall be reduced by**  
15           **90 percent of the difference be-**  
16           **tween such otherwise applicable**  
17           **resident limit and such reference**  
18           **resident level.**

19           **“(ii) REFERENCE RESIDENT**  
20           **LEVEL.—**

21           **“(I) IN GENERAL.—Except**  
22           **as otherwise provided in a**  
23           **subsequent subclause, the ref-**  
24           **erence resident level specified**  
25           **in this clause for a hospital is**

1           **the highest resident level for**  
2           **any of the 3 most recent cost**  
3           **reporting periods (ending be-**  
4           **fore the date of the enactment**  
5           **of this paragraph) of the hos-**  
6           **pital for which a cost report**  
7           **has been settled (or, if not,**  
8           **submitted (subject to audit)),**  
9           **as determined by the Sec-**  
10          **retary.**

11           **“(II) USE OF MOST RECENT**  
12          **ACCOUNTING PERIOD TO RECOG-**  
13          **NIZE EXPANSION OF EXISTING**  
14          **PROGRAMS.—If a hospital sub-**  
15          **mits a timely request to in-**  
16          **crease its resident level due**  
17          **to an expansion, or planned**  
18          **expansion, of an existing resi-**  
19          **dency training program that**  
20          **is not reflected on the most**  
21          **recent settled or submitted**  
22          **cost report, after audit and**  
23          **subject to the discretion of**  
24          **the Secretary, subject to sub-**  
25          **clause (IV), the reference resi-**

1           **dent level for such hospital is**  
2           **the resident level that in-**  
3           **cludes the additional resi-**  
4           **dents attributable to such ex-**  
5           **pansion or establishment, as**  
6           **determined by the Secretary.**  
7           **The Secretary is authorized to**  
8           **determine an alternative ref-**  
9           **erence resident level for a**  
10          **hospital that submitted to the**  
11          **Secretary a timely request,**  
12          **before the start of the 2009–**  
13          **2010 academic year, for an in-**  
14          **crease in its reference resi-**  
15          **dent level due to a planned**  
16          **expansion.**

17           **“(III) SPECIAL PROVIDER**  
18           **AGREEMENT.—In the case of a**  
19           **hospital described in para-**  
20           **graph (4)(H)(v), the reference**  
21           **resident level specified in this**  
22           **clause is the limitation appli-**  
23           **cable under subclause (I) of**  
24           **such paragraph.**

1                   **“(IV) PREVIOUS REDISTRIBU-**  
2                   **TION.—The reference resident**  
3                   **level specified in this clause**  
4                   **for a hospital shall be in-**  
5                   **creased to the extent required**  
6                   **to take into account an in-**  
7                   **crease in resident positions**  
8                   **made available to the hospital**  
9                   **under paragraph (7)(B) that**  
10                  **are not otherwise taken into**  
11                  **account under a previous sub-**  
12                  **clause.**

13                  **“(iii) AFFILIATION.—The provi-**  
14                  **sions of clause (i) shall be applied**  
15                  **to hospitals which are members**  
16                  **of the same affiliated group (as**  
17                  **defined by the Secretary under**  
18                  **paragraph (4)(H)(ii)) and to the**  
19                  **extent the hospitals can dem-**  
20                  **onstrate that they are filling any**  
21                  **additional resident slots allo-**  
22                  **cated to other hospitals through**  
23                  **an affiliation agreement, the Sec-**  
24                  **retary shall adjust the determina-**  
25                  **tion of available slots accordingly,**



1 or which the Secretary otherwise  
2 has permitted the resident posi-  
3 tions (under section 402 of the So-  
4 cial Security Amendments of  
5 1967) to be aggregated for pur-  
6 poses of applying the resident po-  
7 sition limitations under this sub-  
8 section.

9 **“(B) REDISTRIBUTION.—**

10 **“(i) IN GENERAL.—**The Sec-  
11 retary shall increase the other-  
12 wise applicable resident limit for  
13 each qualifying hospital that sub-  
14 mits an application under this  
15 subparagraph by such number as  
16 the Secretary may approve for  
17 portions of cost reporting periods  
18 occurring on or after July 1, 2011.  
19 The estimated aggregate number  
20 of increases in the otherwise ap-  
21 plicable resident limit under this  
22 subparagraph may not exceed the  
23 Secretary’s estimate of the aggre-  
24 gate reduction in such limits at-  
25 tributable to subparagraph (A).

1           **“(ii) REQUIREMENTS FOR QUALI-**  
2           **FYING HOSPITALS.—A hospital is**  
3           **not a qualifying hospital for pur-**  
4           **poses of this paragraph unless the**  
5           **following requirements are met:**

6                   **“(I) MAINTENANCE OF PRI-**  
7                   **MARY CARE RESIDENT LEVEL.—**  
8                   **The hospital maintains the**  
9                   **number of primary care resi-**  
10                  **dents at a level that is not less**  
11                  **than the base level of primary**  
12                  **care residents increased by**  
13                  **the number of additional pri-**  
14                  **mary care resident positions**  
15                  **provided to the hospital**  
16                  **under this subparagraph. For**  
17                  **purposes of this subpara-**  
18                  **graph, the ‘base level of pri-**  
19                  **mary care residents’ for a hos-**  
20                  **pital is the level of such resi-**  
21                  **dents as of a base period**  
22                  **(specified by the Secretary),**  
23                  **determined without regard to**  
24                  **whether such positions were**  
25                  **in excess of the otherwise ap-**

1            **plicable resident limit for**  
2            **such period but taking into**  
3            **account the application of**  
4            **subclauses (II) and (III) of**  
5            **subparagraph (A)(ii).**

6            **“(II) DEDICATED ASSIGN-**  
7            **MENT OF ADDITIONAL RESIDENT**  
8            **POSITIONS TO PRIMARY CARE.—**  
9            **The hospital assigns all such**  
10           **additional resident positions**  
11           **for primary care residents.**

12           **“(III) ACCREDITATION.—The**  
13           **hospital’s residency programs**  
14           **in primary care are fully ac-**  
15           **credited or, in the case of a**  
16           **residency training program**  
17           **not in operation as of the base**  
18           **year, the hospital is actively**  
19           **applying for such accredita-**  
20           **tion for the program for such**  
21           **additional resident positions**  
22           **(as determined by the Sec-**  
23           **retary).**

24           **“(iii) CONSIDERATIONS IN REDIS-**  
25           **TRIBUTION.—In determining for**

1           **which qualifying hospitals the in-**  
2           **crease in the otherwise applicable**  
3           **resident limit is provided under**  
4           **this subparagraph, the Secretary**  
5           **shall take into account the dem-**  
6           **onstrated likelihood of the hos-**  
7           **pital filling the positions within**  
8           **the first 3 cost reporting periods**  
9           **beginning on or after July 1, 2011,**  
10          **made available under this sub-**  
11          **paragraph, as determined by the**  
12          **Secretary.**

13           **“(iv) PRIORITY FOR CERTAIN**  
14           **HOSPITALS.—In determining for**  
15           **which qualifying hospitals the in-**  
16           **crease in the otherwise applicable**  
17           **resident limit is provided under**  
18           **this subparagraph, the Secretary**  
19           **shall distribute the increase to**  
20           **qualifying hospitals based on the**  
21           **following criteria:**

22                   **“(I) The Secretary shall**  
23                   **give preference to hospitals**  
24                   **that had a reduction in resi-**

1           **dent training positions under**  
2           **subparagraph (A).**

3           **“(II) The Secretary shall**  
4           **give preference to hospitals**  
5           **with 3-year primary care resi-**  
6           **dency training programs,**  
7           **such as family practice and**  
8           **general internal medicine.**

9           **“(III) The Secretary shall**  
10          **give preference to hospitals**  
11          **insofar as they have in effect**  
12          **formal arrangements (as de-**  
13          **termined by the Secretary)**  
14          **that place greater emphasis**  
15          **upon training in Federally**  
16          **qualified health centers, rural**  
17          **health clinics, and other non-**  
18          **provider settings, and to hos-**  
19          **pitals that receive additional**  
20          **payments under subsection**  
21          **(d)(5)(F) and emphasize train-**  
22          **ing in an outpatient depart-**  
23          **ment.**

24          **“(IV) The Secretary shall**  
25          **give preference to hospitals**

1 with a number of positions (as  
2 of July 1, 2009) in excess of  
3 the otherwise applicable resi-  
4 dent limit for such period.

5 “(V) The Secretary shall  
6 give preference to hospitals  
7 that place greater emphasis  
8 upon training in a health pro-  
9 fessional shortage area (des-  
10 ignated under section 332 of  
11 the Public Health Service Act)  
12 or a health professional needs  
13 area (designated under sec-  
14 tion 2211 of such Act).

15 “(VI) The Secretary shall  
16 give preference to hospitals in  
17 States that have low resident-  
18 to-population ratios (includ-  
19 ing a greater preference for  
20 those States with lower resi-  
21 dent-to-population ratios).

22 “(v) LIMITATION.—In no case  
23 shall more than 20 full-time  
24 equivalent additional residency  
25 positions be made available under

1           **this subparagraph with respect to**  
2           **any hospital.**

3           **“(vi) APPLICATION OF PER RESI-**  
4           **DENT AMOUNTS FOR PRIMARY**  
5           **CARE.—With respect to additional**  
6           **residency positions in a hospital**  
7           **attributable to the increase pro-**  
8           **vided under this subparagraph,**  
9           **the approved FTE resident**  
10           **amounts are deemed to be equal**  
11           **to the hospital per resident**  
12           **amounts for primary care and**  
13           **nonprimary care computed under**  
14           **paragraph (2)(D) for that hospital.**

15           **“(vii) DISTRIBUTION.—The Sec-**  
16           **retary shall distribute the in-**  
17           **crease in resident training posi-**  
18           **tions to qualifying hospitals**  
19           **under this subparagraph not later**  
20           **than July 1, 2011.**

21           **“(C) RESIDENT LEVEL AND LIMIT DE-**  
22           **FINED.—In this paragraph:**

23           **“(i) The term ‘resident level’**  
24           **has the meaning given such term**  
25           **in paragraph (7)(C)(i).**

1           “(ii) The term ‘otherwise ap-  
2           plicable resident limit’ means,  
3           with respect to a hospital, the  
4           limit otherwise applicable under  
5           subparagraphs (F)(i) and (H) of  
6           paragraph (4) on the resident  
7           level for the hospital determined  
8           without regard to this paragraph  
9           but taking into account para-  
10          graph (7)(A).

11          “(D) MAINTENANCE OF PRIMARY  
12          CARE RESIDENT LEVEL.—In carrying  
13          out this paragraph, the Secretary  
14          shall require hospitals that receive  
15          additional resident positions under  
16          subparagraph (B)—

17                 “(i) to maintain records, and  
18                 periodically report to the Sec-  
19                 retary, on the number of primary  
20                 care residents in its residency  
21                 training programs; and

22                 “(ii) as a condition of payment  
23                 for a cost reporting period under  
24                 this subsection for such positions,



1           to maintain the level of such posi-  
2           tions at not less than the sum of—

3                   “(I) the base level of pri-  
4                   mary care resident positions  
5                   (as determined under sub-  
6                   paragraph (B)(ii)(I)) before re-  
7                   ceiving such additional posi-  
8                   tions; and

9                   “(II) the number of such  
10                  additional positions.”.

11       (b) **IME.**—

12           (1)           **IN           GENERAL.**—Section  
13       **1886(d)(5)(B)(v) of the Social Security Act**  
14       **(42 U.S.C. 1395ww(d)(5)(B)(v)), in the**  
15       **third sentence, is amended—**

16                   (A) by striking “subsection (h)(7)”  
17                   and inserting “subsections (h)(7) and  
18                   (h)(8)”; and

19                   (B) by striking “it applies” and in-  
20                   serting “they apply”.

21           (2) **CONFORMING PROVISION.**—Section  
22       **1886(d)(5)(B) of the Social Security Act**  
23       **(42 U.S.C. 1395ww(d)(5)(B)) is amended by**  
24       **adding at the end the following clause:**

1       “(x) For discharges occurring on or after  
2 July 1, 2011, insofar as an additional payment  
3 amount under this subparagraph is attrib-  
4 utable to resident positions distributed to a  
5 hospital under subsection (h)(8)(B), the indi-  
6 rect teaching adjustment factor shall be com-  
7 puted in the same manner as provided under  
8 clause (ii) with respect to such resident posi-  
9 tions.”.

10       (c) CONFORMING AMENDMENT.—Section  
11 422(b)(2) of the Medicare Prescription Drug,  
12 Improvement, and Modernization Act of 2003  
13 (Public Law 108–173) is amended by striking  
14 “section 1886(h)(7)” and all that follows and  
15 inserting “paragraphs (7) and (8) of sub-  
16 section (h) of section 1886 of the Social Secu-  
17 rity Act.”.

18 SEC. 1502. INCREASING TRAINING IN NONPROVIDER SET-  
19 TINGS.

20       (a) DIRECT GME.—Section 1886(h)(4)(E) of  
21 the Social Security Act (42 U.S.C. 1395ww(h))  
22 is amended—

23               (1) by designating the first sentence  
24 as a clause (i) with the heading “IN GEN-  
25 ERAL.—” and appropriate indentation;

1           **(2) by striking “shall be counted and**  
2           **that all the time” and inserting “shall be**  
3           **counted and that—**

4                       **“(I) effective for cost re-**  
5                       **porting periods beginning be-**  
6                       **fore July 1, 2009, all the time”;**

7           **(3) in subclause (I), as inserted by**  
8           **paragraph (1), by striking the period at**  
9           **the end and inserting “; and”; and**

10                      **(A) by inserting after subclause**  
11                      **(I), as so inserted, the following:**

12                      **“(II) effective for cost re-**  
13                      **porting periods beginning on**  
14                      **or after July 1, 2009, all the**  
15                      **time so spent by a resident**  
16                      **shall be counted towards the**  
17                      **determination of full-time**  
18                      **equivalency, without regard**  
19                      **to the setting in which the ac-**  
20                      **tivities are performed, if the**  
21                      **hospital incurs the costs of**  
22                      **the stipends and fringe bene-**  
23                      **fits of the resident during the**  
24                      **time the resident spends in**  
25                      **that setting.**

1           **Any hospital claiming under this**  
2           **subparagraph for time spent in a**  
3           **nonprovider setting shall main-**  
4           **tain and make available to the**  
5           **Secretary records regarding the**  
6           **amount of such time and such**  
7           **amount in comparison with**  
8           **amounts of such time in such**  
9           **base year as the Secretary shall**  
10          **specify.”.**

11          **(b) IME.—Section 1886(d)(5)(B)(iv) of the**  
12          **Social Security Act (42 U.S.C.**  
13          **1395ww(d)(5)(B)(iv)) is amended—**

14                 **(1) by striking “(iv) Effective for dis-**  
15                 **charges occurring on or after October 1,**  
16                 **1997” and inserting “(iv)(I) Effective for**  
17                 **discharges occurring on or after October**  
18                 **1, 1997, and before July 1, 2009”; and**

19                 **(2) by inserting after subclause (I), as**  
20                 **inserted by paragraph (1), the following**  
21                 **new subclause:**

22                         **“(II) Effective for discharges occur-**  
23                         **ring on or after July 1, 2009, all the time**  
24                         **spent by an intern or resident in patient**  
25                         **care activities at an entity in a nonpro-**

1 vider setting shall be counted towards  
2 the determination of full-time equiva-  
3 lency if the hospital incurs the costs of  
4 the stipends and fringe benefits of the in-  
5 tern or resident during the time the in-  
6 tern or resident spends in that setting.”.

7 (c) **OIG STUDY ON IMPACT ON TRAINING.—**  
8 **The Inspector General of the Department of**  
9 **Health and Human Services shall analyze the**  
10 **data collected by the Secretary of Health and**  
11 **Human Services from the records made avail-**  
12 **able to the Secretary under section**  
13 **1886(h)(4)(E) of the Social Security Act, as**  
14 **amended by subsection (a), in order to assess**  
15 **the extent to which there is an increase in**  
16 **time spent by medical residents in training in**  
17 **nonprovider settings as a result of the amend-**  
18 **ments made by this section. Not later than 4**  
19 **years after the date of the enactment of this**  
20 **Act, the Inspector General shall submit a re-**  
21 **port to Congress on such analysis and assess-**  
22 **ment.**

23 (d) **DEMONSTRATION PROJECT FOR AP-**  
24 **PROVED TEACHING HEALTH CENTERS.—**

1           **(1) IN GENERAL.—**The Secretary of  
2           **Health and Human Services shall conduct**  
3           **a demonstration project under which an**  
4           **approved teaching health center (as de-**  
5           **finied in paragraph (3)) would be eligible**  
6           **for payment under subsections (h) and**  
7           **(k) of section 1886 of the Social Security**  
8           **Act (42 U.S.C. 1395ww) of amounts for its**  
9           **own direct costs of graduate medical edu-**  
10          **cation activities for primary care resi-**  
11          **dents, as well as for the direct costs of**  
12          **graduate medical education activities of**  
13          **its contracting hospital for such resi-**  
14          **dents, in a manner similar to the manner**  
15          **in which such payments would be made**  
16          **to a hospital if the hospital were to oper-**  
17          **ate such a program.**

18          **(2) CONDITIONS.—**Under the dem-  
19          **onstration project—**

20               **(A) an approved teaching health**  
21               **center shall contract with an accred-**  
22               **ited teaching hospital to carry out**  
23               **the inpatient responsibilities of the**  
24               **primary care residency program of**  
25               **the hospital involved and is respon-**

1           sible for payment to the hospital for  
2           the hospital's costs of the salary and  
3           fringe benefits for residents in the  
4           program;

5           (B) the number of primary care  
6           residents of the center shall not count  
7           against the contracting hospital's  
8           resident limit; and

9           (C) the contracting hospital shall  
10          agree not to diminish the number of  
11          residents in its primary care resi-  
12          dency training program.

13          (3) **APPROVED TEACHING HEALTH CEN-**  
14          **TER DEFINED.**—In this subsection, the  
15          term “approved teaching health center”  
16          means a nonprovider setting, such as a  
17          Federally qualified health center or rural  
18          health clinic (as defined in section  
19          1861(aa) of the Social Security Act), that  
20          develops and operates an accredited pri-  
21          mary care residency program for which  
22          funding would be available if it were op-  
23          erated by a hospital.

1 SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DI-  
2 DACTIC AND SCHOLARLY ACTIVITIES AND  
3 OTHER ACTIVITIES.

4 (a) DIRECT GME.—Section 1886(h) of the  
5 Social Security Act (42 U.S.C. 1395ww(h)) is  
6 amended—

7 (1) in paragraph (4)(E), as amended  
8 by section 1502(a)—

9 (A) in clause (i), by striking “Such  
10 rules” and inserting “Subject to  
11 clause (ii), such rules”; and

12 (B) by adding at the end the fol-  
13 lowing new clause:

14 “(ii) TREATMENT OF CERTAIN  
15 NONPROVIDER AND DIDACTIC ACTIVI-  
16 TIES.—Such rules shall provide  
17 that all time spent by an intern or  
18 resident in an approved medical  
19 residency training program in a  
20 nonprovider setting that is pri-  
21 marily engaged in furnishing pa-  
22 tient care (as defined in para-  
23 graph (5)(K)) in nonpatient care  
24 activities, such as didactic con-  
25 ferences and seminars, but not in-  
26 cluding research not associated



1           with the treatment or diagnosis of  
2           a particular patient, as such time  
3           and activities are defined by the  
4           Secretary, shall be counted to-  
5           ward the determination of full-  
6           time equivalency.”;

7           (2) in paragraph (4), by adding at the  
8           end the following new subparagraph:

9                   “(I) TREATMENT OF CERTAIN TIME IN  
10           APPROVED MEDICAL RESIDENCY TRAIN-  
11           ING PROGRAMING.—In determining the  
12           hospital’s number of full-time equiva-  
13           lent residents for purposes of this  
14           subsection, all the time that is spent  
15           by an intern or resident in an ap-  
16           proved medical residency training  
17           program on vacation, sick leave, or  
18           other approved leave, as such time is  
19           defined by the Secretary, and that  
20           does not prolong the total time the  
21           resident is participating in the ap-  
22           proved program beyond the normal  
23           duration of the program shall be  
24           counted toward the determination of  
25           full-time equivalency.”; and

1           **(3) in paragraph (5), by adding at the**  
2           **end the following new subparagraph:**

3           **“(K) NONPROVIDER SETTING THAT IS**  
4           **PRIMARILY ENGAGED IN FURNISHING PA-**  
5           **TIENT CARE.—The term ‘nonprovider**  
6           **setting that is primarily engaged in**  
7           **furnishing patient care’ means a non-**  
8           **provider setting in which the primary**  
9           **activity is the care and treatment of**  
10           **patients, as defined by the Sec-**  
11           **retary.”.**

12           **(b)     IME     DETERMINATIONS.—Section**  
13           **1886(d)(5)(B) of such Act (42 U.S.C.**  
14           **1395ww(d)(5)(B)), as amended by section**  
15           **1501(b), is amended by adding at the end the**  
16           **following new clause:**

17           **“(xi)(I) The provisions of subparagraph (I)**  
18           **of subsection (h)(4) shall apply under this sub-**  
19           **paragraph in the same manner as they apply**  
20           **under such subsection.**

21           **“(II) In determining the hospital’s number**  
22           **of full-time equivalent residents for purposes**  
23           **of this subparagraph, all the time spent by an**  
24           **intern or resident in an approved medical**  
25           **residency training program in nonpatient**

1 **care activities, such as didactic conferences**  
2 **and seminars, as such time and activities are**  
3 **defined by the Secretary, that occurs in the**  
4 **hospital shall be counted toward the deter-**  
5 **mination of full-time equivalency if the hos-**  
6 **pital—**

7 **“(aa) is recognized as a subsection (d)**  
8 **hospital;**

9 **“(bb) is recognized as a subsection (d)**  
10 **Puerto Rico hospital;**

11 **“(cc) is reimbursed under a reim-**  
12 **bursement system authorized under sec-**  
13 **tion 1814(b)(3); or**

14 **“(dd) is a provider-based hospital out-**  
15 **patient department.**

16 **“(III) In determining the hospital’s num-**  
17 **ber of full-time equivalent residents for pur-**  
18 **poses of this subparagraph, all the time spent**  
19 **by an intern or resident in an approved med-**  
20 **ical residency training program in research**  
21 **activities that are not associated with the**  
22 **treatment or diagnosis of a particular patient,**  
23 **as such time and activities are defined by the**  
24 **Secretary, shall not be counted toward the de-**  
25 **termination of full-time equivalency.”.**

1           **(c) EFFECTIVE DATES; APPLICATION.—**

2           **(1) IN GENERAL.—Except as otherwise**  
3           **provided, the Secretary of Health and**  
4           **Human Services shall implement the**  
5           **amendments made by this section in a**  
6           **manner so as to apply to cost reporting**  
7           **periods beginning on or after January 1,**  
8           **1983.**

9           **(2)           DIRECT           GME.—Section**  
10          **1886(h)(4)(E)(ii) of the Social Security**  
11          **Act, as added by subsection (a)(1)(B),**  
12          **shall apply to cost reporting periods be-**  
13          **ginning on or after July 1, 2008.**

14          **(3) IME.—Section 1886(d)(5)(B)(x)(III)**  
15          **of the Social Security Act, as added by**  
16          **subsection (b), shall apply to cost report-**  
17          **ing periods beginning on or after October**  
18          **1, 2001. Such section, as so added, shall**  
19          **not give rise to any inference on how the**  
20          **law in effect prior to such date should be**  
21          **interpreted.**

22          **(4) APPLICATION.—The amendments**  
23          **made by this section shall not be applied**  
24          **in a manner that requires reopening of**  
25          **any settled hospital cost reports as to**

1       **which there is not a jurisdictionally prop-**  
2       **er appeal pending as of the date of the**  
3       **enactment of this Act on the issue of pay-**  
4       **ment for indirect costs of medical edu-**  
5       **cation under section 1886(d)(5)(B) of the**  
6       **Social Security Act or for direct graduate**  
7       **medical education costs under section**  
8       **1886(h) of such Act.**

9       **SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS**  
10               **FROM CLOSED HOSPITALS.**

11       **(a) DIRECT GME.—Section 1886(h)(4)(H) of**  
12       **the Social Security Act (42 U.S.C. Section**  
13       **1395ww(h)(4)(H)) is amended by adding at the**  
14       **end the following new clause:**

15                       **“(vi) REDISTRIBUTION OF RESI-**  
16                       **DENCY SLOTS AFTER A HOSPITAL**  
17                       **CLOSES.—**

18                       **“(I) IN GENERAL.—The Sec-**  
19                       **retary shall, by regulation, es-**  
20                       **tablish a process consistent**  
21                       **with subclauses (II) and (III)**  
22                       **under which, in the case**  
23                       **where a hospital (other than a**  
24                       **hospital described in clause**  
25                       **(v)) with an approved medical**

1           **residency program in a State**  
2           **closes on or after the date**  
3           **that is 2 years before the date**  
4           **of the enactment of this**  
5           **clause, the Secretary shall in-**  
6           **crease the otherwise applica-**  
7           **ble resident limit under this**  
8           **paragraph for other hospitals**  
9           **in the State in accordance**  
10          **with this clause.**

11           **“(II) PROCESS FOR HOS-**  
12          **PITALS IN CERTAIN AREAS.—In**  
13          **determining for which hos-**  
14          **pitals the increase in the oth-**  
15          **erwise applicable resident**  
16          **limit described in subclause**  
17          **(I) is provided, the Secretary**  
18          **shall establish a process to**  
19          **provide for such increase to**  
20          **one or more hospitals located**  
21          **in the State. Such process**  
22          **shall take into consideration**  
23          **the recommendations sub-**  
24          **mitted to the Secretary by the**  
25          **senior health official (as des-**

1           **ignated by the chief executive**  
2           **officer of such State) if such**  
3           **recommendations are sub-**  
4           **mitted not later than 180 days**  
5           **after the date of the hospital**  
6           **closure involved (or, in the**  
7           **case of a hospital that closed**  
8           **after the date that is 2 years**  
9           **before the date of the enact-**  
10          **ment of this clause, 180 days**  
11          **after such date of enactment).**

12           **“(III) LIMITATION.—The es-**  
13          **timated aggregate number of**  
14          **increases in the otherwise ap-**  
15          **licable resident limits for**  
16          **hospitals under this clause**  
17          **shall be equal to the esti-**  
18          **mated number of resident po-**  
19          **sitions in the approved med-**  
20          **ical residency programs that**  
21          **closed on or after the date de-**  
22          **scribed in subclause (I).”.**

23           **(b) NO EFFECT ON TEMPORARY FTE CAP AD-**  
24          **JUSTMENTS.—The amendments made by this**  
25          **section shall not effect any temporary adjust-**

1 ment to a hospital’s FTE cap under section  
2 413.79(h) of title 42, Code of Federal Regula-  
3 tions (as in effect on the date of enactment of  
4 this Act) and shall not affect the application  
5 of section 1886(h)(4)(H)(v) of the Social Secu-  
6 rity Act.

7 (c) CONFORMING AMENDMENTS.—

8 (1) Section 422(b)(2) of the Medicare  
9 Prescription Drug, Improvement, and  
10 Modernization Act of 2003 (Public Law  
11 108–173), as amended by section 1501(c),  
12 is amended by striking “(7) and” and in-  
13 serting “(4)(H)(vi), (7), and”.

14 (2) Section 1886(h)(7)(E) of the Social  
15 Security Act (42 U.S.C. 1395ww(h)(7)(E))  
16 is amended by inserting “or under para-  
17 graph (4)(H)(vi)” after “under this para-  
18 graph”.

19 SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED  
20 MEDICAL RESIDENCY TRAINING.

21 (a) SPECIFICATION OF GOALS FOR APPROVED  
22 MEDICAL RESIDENCY TRAINING PROGRAMS.—  
23 Section 1886(h)(1) of the Social Security Act  
24 (42 U.S.C. 1395ww(h)(1)) is amended—



1           (1) by designating the matter begin-  
2           ning with “Notwithstanding” as a sub-  
3           paragraph (A) with the heading “IN GEN-  
4           ERAL.—” and with appropriate indenta-  
5           tion; and

6           (2) by adding at the end the following  
7           new subparagraph:

8                   “(B) GOALS AND ACCOUNTABILITY  
9                   FOR APPROVED MEDICAL RESIDENCY  
10                   TRAINING PROGRAMS.—The goals of  
11                   medical residency training programs  
12                   are to foster a physician workforce so  
13                   that physicians are trained to be able  
14                   to do the following:

15                           “(i) Work effectively in var-  
16                           ious health care delivery settings,  
17                           such as nonprovider settings.

18                           “(ii) Coordinate patient care  
19                           within and across settings rel-  
20                           evant to their specialties.

21                           “(iii) Understand the relevant  
22                           cost and value of various diag-  
23                           nostic and treatment options.

24                           “(iv) Work in inter-profes-  
25                           sional teams and multi-discipli-

1 nary team-based models in pro-  
2 vider and nonprovider settings to  
3 enhance safety and improve qual-  
4 ity of patient care.

5 “(v) Be knowledgeable in  
6 methods of identifying systematic  
7 errors in health care delivery and  
8 in implementing systematic solu-  
9 tions in case of such errors, in-  
10 cluding experience and participa-  
11 tion in continuous quality im-  
12 provement projects to improve  
13 health outcomes of the population  
14 the physicians serve.

15 “(vi) Be meaningful EHR  
16 users (as determined under sec-  
17 tion 1848(o)(2)) in the delivery of  
18 care and in improving the quality  
19 of the health of the community  
20 and the individuals that the hos-  
21 pital serves.”

22 (b) GAO STUDY ON EVALUATION OF TRAIN-  
23 ING PROGRAMS.—

24 (1) IN GENERAL.—The Comptroller  
25 General of the United States shall con-

1       **duct a study to evaluate the extent to**  
2       **which medical residency training pro-**  
3       **grams—**

4               **(A) are meeting the goals de-**  
5               **scribed in section 1886(h)(1)(B) of the**  
6               **Social Security Act, as added by sub-**  
7               **section (a), in a range of residency**  
8               **programs, including primary care**  
9               **and other specialties; and**

10              **(B) have the appropriate faculty**  
11              **expertise to teach the topics required**  
12              **to achieve such goals.**

13       **(2) REPORT.—Not later than 18 months**  
14       **after the date of the enactment of this**  
15       **Act, the Comptroller General shall submit**  
16       **to Congress a report on such study and**  
17       **shall include in such report recommenda-**  
18       **tions as to how medical residency train-**  
19       **ing programs could be further encour-**  
20       **aged to meet such goals through means**  
21       **such as—**

22              **(A) development of curriculum re-**  
23              **quirements; and**

24              **(B) assessment of the accredita-**  
25              **tion processes of the Accreditation**

1           **Council for Graduate Medical Edu-**  
2           **cation and the American Osteopathic**  
3           **Association and effectiveness of those**  
4           **processes in accrediting medical resi-**  
5           **dency programs that meet the goals**  
6           **referred to in paragraph (1)(A).**

7           **TITLE VI—PROGRAM INTEGRITY**  
8           **Subtitle A—Increased Funding to**  
9           **Fight Waste, Fraud, and Abuse**

10          **SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO**  
11                                   **FIGHT FRAUD AND ABUSE.**

12           **(a) IN GENERAL.—Section 1817(k) of the So-**  
13          **cial Security Act (42 U.S.C. 1395i(k)) is amend-**  
14          **ed—**

15                   **(1) by adding at the end the following**  
16           **new paragraph:**

17                   **“(7) ADDITIONAL FUNDING.—In addition**  
18           **to the funds otherwise appropriated to**  
19           **the Account from the Trust Fund under**  
20           **paragraphs (3) and (4) and for purposes**  
21           **described in paragraphs (3)(C) and (4)(A),**  
22           **there are hereby appropriated an addi-**  
23           **tional \$100,000,000 to such Account from**  
24           **such Trust Fund for each fiscal year be-**  
25           **ginning with 2011. The funds appro-**

1        **priated under this paragraph shall be al-**  
2        **located in the same proportion as the**  
3        **total funding appropriated with respect**  
4        **to paragraphs (3)(A) and (4)(A) was allo-**  
5        **cated with respect to fiscal year 2010, and**  
6        **shall be available without further appro-**  
7        **priation until expended.”.**

8                **(2) in paragraph (4)(A)—**

9                        **(A) by inserting “for activities de-**  
10                        **scribed in paragraph (3)(C) and” after**  
11                        **“necessary”; and**

12                        **(B) by inserting “until expended”**  
13                        **after “appropriation”.**

14        **(b) FLEXIBILITY IN PURSUING FRAUD AND**  
15        **ABUSE.—Section 1893(a) of the Social Security**  
16        **Act (42 U.S.C. 1395ddd(a)) is amended by in-**  
17        **serting “, or otherwise,” after “entities”.**

18        **Subtitle B—Enhanced Penalties for**  
19                **Fraud and Abuse**

20        **SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS**  
21                        **ON PROVIDER OR SUPPLIER ENROLLMENT**  
22                        **APPLICATIONS.**

23        **(a) IN GENERAL.—Section 1128A(a) of the**  
24        **Social Security Act (42 U.S.C. 1320a-7a(a)) is**  
25        **amended—**

1           **(1) in paragraph (1)(D), by striking all**  
2           **that follows “in which the person was ex-**  
3           **cluded” and inserting “under Federal law**  
4           **from the Federal health care program**  
5           **under which the claim was made, or”;**

6           **(2) by striking “or” at the end of para-**  
7           **graph (6);**

8           **(3) in paragraph (7), by inserting at**  
9           **the end “or”;**

10           **(4) by inserting after paragraph (7)**  
11           **the following new paragraph:**

12           **“(8) knowingly makes or causes to be**  
13           **made any false statement, omission, or**  
14           **misrepresentation of a material fact in**  
15           **any application, agreement, bid, or con-**  
16           **tract to participate or enroll as a pro-**  
17           **vider of services or supplier under a Fed-**  
18           **eral health care program, including man-**  
19           **aged care organizations under title XIX,**  
20           **Medicare Advantage organizations under**  
21           **part C of title XVIII, prescription drug**  
22           **plan sponsors under part D of title XVIII,**  
23           **and entities that apply to participate as**  
24           **providers of services or suppliers in such**

1 managed care organizations and such  
2 plans;”;

3 (5) in the matter following paragraph  
4 (8), as inserted by paragraph (4), by strik-  
5 ing “or in cases under paragraph (7),  
6 \$50,000 for each such act)” and inserting  
7 “in cases under paragraph (7), \$50,000 for  
8 each such act, or in cases under para-  
9 graph (8), \$50,000 for each false state-  
10 ment, omission, or misrepresentation of a  
11 material fact)”;

12 (6) in the second sentence, by striking  
13 “for a lawful purpose)” and inserting “for  
14 a lawful purpose, or in cases under para-  
15 graph (8), an assessment of not more than  
16 3 times the amount claimed as the result  
17 of the false statement, omission, or mis-  
18 representation of material fact claimed  
19 by a provider of services or supplier  
20 whose application to participate con-  
21 tained such false statement, omission, or  
22 misrepresentation)”.

23 (b) **EFFECTIVE DATE.**—The amendments  
24 made by subsection (a) shall apply to acts  
25 committed on or after January 1, 2010.

1 SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF  
2 FALSE STATEMENTS MATERIAL TO A FALSE  
3 CLAIM.

4 (a) IN GENERAL.—Section 1128A(a) of the  
5 Social Security Act (42 U.S.C. 1320a-7a(a)), as  
6 amended by section 1611, is further amend-  
7 ed—

8 (1) in paragraph (7), by striking “or”  
9 at the end;

10 (2) in paragraph (8), by inserting “or”  
11 at the end; and

12 (3) by inserting after paragraph (8),  
13 the following new paragraph:

14 “(9) knowingly makes, uses, or causes  
15 to be made or used, a false record or  
16 statement material to a false or fraudu-  
17 lent claim for payment for items and  
18 services furnished under a Federal  
19 health care program;” and

20 (4) in the matter following paragraph  
21 (9), as inserted by paragraph (3)—

22 (A) by striking “or in cases under  
23 paragraph (8)” and inserting “in cases  
24 under paragraph (8)”; and

25 (B) by striking “a material fact”  
26 and inserting “a material fact, in





1       **Inspector General of the Department of**  
2       **Health and Human Services;”**; and

3               **(4) in the matter following paragraph**  
4       **(10), as inserted by paragraph (3), by in-**  
5       **serting “, or in cases under paragraph**  
6       **(10), \$15,000 for each day of the failure**  
7       **described in such paragraph” after “false**  
8       **record or statement”.**

9       **(b) ENSURING TIMELY INSPECTIONS RELAT-**  
10       **ING TO CONTRACTS WITH MA ORGANIZATIONS.—**  
11       **Section 1857(d)(2) of such Act (42 U.S.C.**  
12       **1395w-27(d)(2)) is amended—**

13               **(1) in subparagraph (A), by inserting**  
14       **“timely” before “inspect”; and**

15               **(2) in subparagraph (B), by inserting**  
16       **“timely” before “audit and inspect”.**

17       **(c) EFFECTIVE DATE.—The amendments**  
18       **made by subsection (a) shall apply to viola-**  
19       **tions committed on or after January 1, 2010.**

20       **SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.**

21       **(a) MEDICARE.—Part A of title XVIII of the**  
22       **Social Security Act is amended by inserting**  
23       **after section 1819 the following new section:**

1 “SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE  
2 CARE.

3 “(a) IN GENERAL.—If the Secretary deter-  
4 mines on the basis of a survey or otherwise,  
5 that a hospice program that is certified for  
6 participation under this title has dem-  
7 onstrated a substandard quality of care and  
8 failed to meet such other requirements as the  
9 Secretary may find necessary in the interest  
10 of the health and safety of the individuals  
11 who are provided care and services by the  
12 agency or organization involved and deter-  
13 mines—

14 “(1) that the deficiencies involved im-  
15 mediately jeopardize the health and safe-  
16 ty of the individuals to whom the pro-  
17 gram furnishes items and services, the  
18 Secretary shall take immediate action to  
19 remove the jeopardy and correct the defi-  
20 ciencies through the remedy specified in  
21 subsection (b)(2)(A)(iii) or terminate the  
22 certification of the program, and may  
23 provide, in addition, for 1 or more of the  
24 other remedies described in subsection  
25 (b)(2)(A); or

1           **“(2) that the deficiencies involved do**  
2           **not immediately jeopardize the health**  
3           **and safety of the individuals to whom the**  
4           **program furnishes items and services,**  
5           **the Secretary may—**

6                   **“(A) impose intermediate sanc-**  
7                   **tions developed pursuant to sub-**  
8                   **section (b), in lieu of terminating the**  
9                   **certification of the program; and**

10                   **“(B) if, after such a period of in-**  
11                   **termediate sanctions, the program is**  
12                   **still not in compliance with such re-**  
13                   **quirements, the Secretary shall termi-**  
14                   **nate the certification of the program.**

15           **If the Secretary determines that a hos-**  
16           **pice program that is certified for partici-**  
17           **pation under this title is in compliance**  
18           **with such requirements but, as of a pre-**  
19           **vious period, was not in compliance with**  
20           **such requirements, the Secretary may**  
21           **provide for a civil money penalty under**  
22           **subsection (b)(2)(A)(i) for the days in**  
23           **which it finds that the program was not**  
24           **in compliance with such requirements.**

25           **“(b) INTERMEDIATE SANCTIONS.—**

1           **“(1) DEVELOPMENT AND IMPLEMENTA-**  
2           **TION.—The Secretary shall develop and**  
3           **implement, by not later than July 1,**  
4           **2012—**

5                   **“(A) a range of intermediate sanc-**  
6                   **tions to apply to hospice programs**  
7                   **under the conditions described in**  
8                   **subsection (a), and**

9                   **“(B) appropriate procedures for**  
10                   **appealing determinations relating to**  
11                   **the imposition of such sanctions.**

12           **“(2) SPECIFIED SANCTIONS.—**

13                   **“(A) IN GENERAL.—The inter-**  
14                   **mediate sanctions developed under**  
15                   **paragraph (1) may include—**

16                           **“(i) civil money penalties in**  
17                           **an amount not to exceed \$10,000**  
18                           **for each day of noncompliance or,**  
19                           **in the case of a per instance pen-**  
20                           **alty applied by the Secretary, not**  
21                           **to exceed \$25,000,**

22                           **“(ii) denial of all or part of the**  
23                           **payments to which a hospice pro-**  
24                           **gram would otherwise be entitled**  
25                           **under this title with respect to**

1 items and services furnished by a  
2 hospice program on or after the  
3 date on which the Secretary de-  
4 termines that intermediate sanc-  
5 tions should be imposed pursuant  
6 to subsection (a)(2),

7 “(iii) the appointment of tem-  
8 porary management to oversee  
9 the operation of the hospice pro-  
10 gram and to protect and assure  
11 the health and safety of the indi-  
12 viduals under the care of the pro-  
13 gram while improvements are  
14 made,

15 “(iv) corrective action plans,  
16 and

17 “(v) in-service training for  
18 staff.

19 The provisions of section 1128A  
20 (other than subsections (a) and (b))  
21 shall apply to a civil money penalty  
22 under clause (i) in the same manner  
23 as such provisions apply to a penalty  
24 or proceeding under section 1128A(a).  
25 The temporary management under

1           **clause (iii) shall not be terminated**  
2           **until the Secretary has determined**  
3           **that the program has the manage-**  
4           **ment capability to ensure continued**  
5           **compliance with all requirements re-**  
6           **ferred to in that clause.**

7           **“(B) CLARIFICATION.—The sanc-**  
8           **tions specified in subparagraph (A)**  
9           **are in addition to sanctions otherwise**  
10          **available under State or Federal law**  
11          **and shall not be construed as limiting**  
12          **other remedies, including any remedy**  
13          **available to an individual at common**  
14          **law.**

15          **“(C) COMMENCEMENT OF PAY-**  
16          **MENT.—A denial of payment under**  
17          **subparagraph (A)(ii) shall terminate**  
18          **when the Secretary determines that**  
19          **the hospice program no longer dem-**  
20          **onstrates a substandard quality of**  
21          **care and meets such other require-**  
22          **ments as the Secretary may find nec-**  
23          **essary in the interest of the health**  
24          **and safety of the individuals who are**

1           **provided care and services by the**  
2           **agency or organization involved.**

3           **“(3) SECRETARIAL AUTHORITY.—The**  
4           **Secretary shall develop and implement,**  
5           **by not later than July 1, 2011, specific**  
6           **procedures with respect to the conditions**  
7           **under which each of the intermediate**  
8           **sanctions developed under paragraph (1)**  
9           **is to be applied, including the amount of**  
10           **any fines and the severity of each of**  
11           **these sanctions. Such procedures shall be**  
12           **designed so as to minimize the time be-**  
13           **tween identification of deficiencies and**  
14           **imposition of these sanctions and shall**  
15           **provide for the imposition of incremen-**  
16           **tally more severe fines for repeated or**  
17           **uncorrected deficiencies.”.**

18           **(b) APPLICATION TO MEDICAID.—Section**  
19           **1905(o) of the Social Security Act (42 U.S.C.**  
20           **1396d(o)) is amended by adding at the end the**  
21           **following new paragraph:**

22           **“(4) The provisions of section 1819A shall**  
23           **apply to a hospice program providing hospice**  
24           **care under this title in the same manner as**



1 such provisions apply to a hospice program  
2 providing hospice care under title XVIII.”.

3 (c) APPLICATION TO CHIP.—Title XXI of the  
4 Social Security Act is amended by adding at  
5 the end the following new section:

6 “SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

7 “The provisions of section 1819A shall  
8 apply to a hospice program providing hospice  
9 care under this title in the same manner such  
10 provisions apply to a hospice program pro-  
11 viding hospice care under title XVIII.”.

12 SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EX-  
13 CLUDED FROM PROGRAM PARTICIPATION.

14 (a) IN GENERAL.—Section 1128A(a) of the  
15 Social Security Act (42 U.S.C. 1320a-7a(a)), as  
16 amended by the previous sections, is further  
17 amended—

18 (1) by striking “or” at the end of para-  
19 graph (9);

20 (2) by inserting “or” at the end of  
21 paragraph (10);

22 (3) by inserting after paragraph (10)  
23 the following new paragraph:

24 “(11) orders or prescribes an item or  
25 service, including without limitation

1       **home health care, diagnostic and clinical**  
2       **lab tests, prescription drugs, durable**  
3       **medical equipment, ambulance services,**  
4       **physical or occupational therapy, or any**  
5       **other item or service, during a period**  
6       **when the person has been excluded from**  
7       **participation in a Federal health care**  
8       **program, and the person knows or should**  
9       **know that a claim for such item or serv-**  
10       **ice will be presented to such a program;”;**  
11       **and**

12               **(4) in the matter following paragraph**  
13       **(11), as inserted by paragraph (2), by**  
14       **striking “\$15,000 for each day of the fail-**  
15       **ure described in such paragraph” and in-**  
16       **serting “\$15,000 for each day of the fail-**  
17       **ure described in such paragraph, or in**  
18       **cases under paragraph (11), \$50,000 for**  
19       **each order or prescription for an item or**  
20       **service by an excluded individual”.**

21       **(b) EFFECTIVE DATE.—The amendments**  
22       **made by subsection (a) shall apply to viola-**  
23       **tions committed on or 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  
5 the Social Security Act (42 U.S.C. 1395w—  
6 27(g)(2)(A)) is amended by inserting “except  
7 with respect to a determination under sub-  
8 paragraph (E), an assessment of not more  
9 than 3 times the amount claimed by such plan  
10 or plan sponsor based upon the misrepresen-  
11 tation or falsified information involved,” after  
12 “for each such determination,”.

13 (b) EFFECTIVE DATE.—The amendment  
14 made by subsection (a) shall apply to viola-  
15 tions committed on or after January 1, 2010.

16 SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVAN-  
17 TAGE AND PART D MARKETING VIOLATIONS.

18 (a) IN GENERAL.—Section 1857(g)(1) of the  
19 Social Security Act (42 U.S.C. 1395w—  
20 27(g)(1)), as amended by section 1221(b), is  
21 amended—

22 (1) in subparagraph (G), by striking  
23 “or” at the end;

24 (2) by inserting after subparagraph  
25 (H) the following new subparagraphs:

1           **“(I) except as provided under sub-**  
2           **paragraph (C) or (D) of section**  
3           **1860D-1(b)(1), enrolls an individual in**  
4           **any plan under this part without the**  
5           **prior consent of the individual or the**  
6           **designee of the individual;**

7           **“(J) transfers an individual en-**  
8           **rolled under this part from one plan**  
9           **to another without the prior consent**  
10          **of the individual or the designee of**  
11          **the individual or solely for the pur-**  
12          **pose of earning a commission;**

13          **“(K) fails to comply with mar-**  
14          **keting restrictions described in sub-**  
15          **sections (h) and (j) of section 1851 or**  
16          **applicable implementing regulations**  
17          **or guidance; or**

18          **“(L) employs or contracts with**  
19          **any individual or entity who engages**  
20          **in the conduct described in subpara-**  
21          **graphs (A) through (K) of this para-**  
22          **graph;”;** and

23          **(3) by adding at the end the following**  
24          **new sentence: “The Secretary may pro-**  
25          **vide, in addition to any other remedies**

1 authorized by law, for any of the rem-  
2 edies described in paragraph (2), if the  
3 Secretary determines that any employee  
4 or agent of such organization, or any pro-  
5 vider or supplier who contracts with  
6 such organization, has engaged in any  
7 conduct described in subparagraphs (A)  
8 through (L) of this paragraph.”

9 (b) **EFFECTIVE DATE.**—The amendments  
10 made by subsection (a) shall apply to viola-  
11 tions committed on or after January 1, 2010.

12 **SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF**  
13 **PROGRAM AUDITS.**

14 (a) **IN GENERAL.**—Section 1128(b)(2) of the  
15 **Social Security Act (42 U.S.C. 1320a–7(b)(2)) is**  
16 **amended—**

17 (1) **in the heading, by inserting “OR**  
18 **AUDIT” after “INVESTIGATION”; and**

19 (2) **by striking “investigation into”**  
20 **and all that follows through the period**  
21 **and inserting “investigation or audit re-**  
22 **lated to—”**

23 “(i) **any offense described in**  
24 **paragraph (1) or in subsection (a);**  
25 **or**

1           “(ii) the use of funds received,  
2           directly or indirectly, from any  
3           Federal health care program (as  
4           defined in section 1128B(f)).”.

5           **(b) EFFECTIVE DATE.**—The amendments  
6 made by subsection (a) shall apply to viola-  
7 tions committed on or after January 1, 2010.

8 SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND EN-  
9           TITIES FROM PARTICIPATION IN MEDICARE  
10           AND STATE HEALTH CARE PROGRAMS.

11           **(a) IN GENERAL.**—Section 1128(c) of the So-  
12 cial Security Act, as previously amended by  
13 this division, is further amended—

14           (1) in the heading, by striking “AND  
15           PERIOD” and inserting “PERIOD, AND EF-  
16           FECT”; and

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

19           “(4)(A) For purposes of this Act, subject to  
20 subparagraph (C), the effect of exclusion is  
21 that no payment may be made by any Federal  
22 health care program (as defined in section  
23 1128B(f)) with respect to any item or service  
24 furnished—

1           “(i) by an excluded individual or enti-  
2           ty; or

3           “(ii) at the medical direction or on  
4           the prescription of a physician or other  
5           authorized individual when the person  
6           submitting a claim for such item or serv-  
7           ice knew or had reason to know of the ex-  
8           clusion of such individual.

9           “(B) For purposes of this section and sec-  
10          tions 1128A and 1128B, subject to subpara-  
11          graph (C), an item or service has been fur-  
12          nished by an individual or entity if the indi-  
13          vidual or entity directly or indirectly pro-  
14          vided, ordered, manufactured, distributed,  
15          prescribed, or otherwise supplied the item or  
16          service regardless of how the item or service  
17          was paid for by a Federal health care pro-  
18          gram or to whom such payment was made.

19          “(C)(i) Payment may be made under a Fed-  
20          eral health care program for emergency items  
21          or services (not including items or services  
22          furnished in an emergency room of a hospital)  
23          furnished by an excluded individual or entity,  
24          or at the medical direction or on the prescrip-  
25          tion of an excluded physician or other author-

1 ized individual during the period of such indi-  
2 vidual's exclusion.

3       “(ii) In the case that an individual eligible  
4 for benefits under title XVIII or XIX submits  
5 a claim for payment for items or services fur-  
6 nished by an excluded individual or entity,  
7 and such individual eligible for such benefits  
8 did not know or have reason to know that  
9 such excluded individual or entity was so ex-  
10 cluded, then, notwithstanding such exclusion,  
11 payment shall be made for such items or serv-  
12 ices. In such case the Secretary shall notify  
13 such individual eligible for such benefits of  
14 the exclusion of the individual or entity fur-  
15 nishing the items or services. Payment shall  
16 not be made for items or services furnished by  
17 an excluded individual or entity to an indi-  
18 vidual eligible for such benefits after a rea-  
19 sonable time (as determined by the Secretary  
20 in regulations) after the Secretary has noti-  
21 fied the individual eligible for such benefits of  
22 the exclusion of the individual or entity fur-  
23 nishing the items or services.

24       “(iii) In the case that a claim for payment  
25 for items or services furnished by an excluded



1 individual or entity is submitted by an indi-  
2 vidual or entity other than an individual eligi-  
3 ble for benefits under title XVIII or XIX or the  
4 excluded individual or entity, and the Sec-  
5 retary determines that the individual or enti-  
6 ty that submitted the claim took reasonable  
7 steps to learn of the exclusion and reasonably  
8 relied upon inaccurate or misleading informa-  
9 tion from the relevant Federal health care  
10 program or its contractor, the Secretary may  
11 waive repayment of the amount paid in viola-  
12 tion of the exclusion to the individual or enti-  
13 ty that submitted the claim for the items or  
14 services furnished by the excluded individual  
15 or entity. If a Federal health care program  
16 contractor provided inaccurate or misleading  
17 information that resulted in the waiver of an  
18 overpayment under this clause, the Secretary  
19 shall take appropriate action to recover the  
20 improperly paid amount from the con-  
21 tractor.”.

1       **Subtitle C—Enhanced Program**  
2               **and Provider Protections**

3       SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AU-  
4                               THORITY.

5           **(a) IN GENERAL.—Title XI of the Social Se-**  
6       **curity Act (42 U.S.C. 1301 et seq.) is amended**  
7       **by inserting after section 1128F the following**  
8       **new section:**

9       “SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PRO-  
10                           TECTIONS IN THE MEDICARE, MEDICAID, AND  
11                           CHIP PROGRAMS.

12       **“(a) CERTAIN AUTHORIZED SCREENING, EN-**  
13       **HANCED OVERSIGHT PERIODS, AND ENROLLMENT**  
14       **MORATORIA.—**

15           **“(1) IN GENERAL.—For periods begin-**  
16       **ning after January 1, 2011, in the case**  
17       **that the Secretary determines there is a**  
18       **significant risk of fraudulent activity (as**  
19       **determined by the Secretary based on**  
20       **relevant complaints, reports, referrals by**  
21       **law enforcement or other sources, data**  
22       **analysis, trending information, or claims**  
23       **submissions by providers of services and**  
24       **suppliers) with respect to a category of**  
25       **provider of services or supplier of items**

1 or services, including a category within a  
2 geographic area, under title XVIII, XIX,  
3 or XXI, the Secretary may impose any of  
4 the following requirements with respect  
5 to a provider of services or a supplier  
6 (whether such provider or supplier is ini-  
7 tially enrolling in the program or is re-  
8 newing such enrollment):

9 “(A) Screening under paragraph  
10 (2).

11 “(B) Enhanced oversight periods  
12 under paragraph (3).

13 “(C) Enrollment moratoria under  
14 paragraph (4).

15 In applying this subsection for purposes  
16 of title XIX and XXI the Secretary may re-  
17 quire a State to carry out the provisions  
18 of this subsection as a requirement of the  
19 State plan under title XIX or the child  
20 health plan under title XXI. Actions taken  
21 and determinations made under this sub-  
22 section shall not be subject to review by  
23 a judicial tribunal.

24 “(2) SCREENING.—For purposes of  
25 paragraph (1), the Secretary shall estab-

1        **lish procedures under which screening is**  
2        **conducted with respect to providers of**  
3        **services and suppliers described in such**  
4        **paragraph. Such screening may include—**

5                **“(A) licensing board checks;**

6                **“(B) screening against the list of**  
7                **individuals and entities excluded**  
8                **from the program under title XVIII,**  
9                **XIX, or XXI;**

10               **“(C) the excluded provider list**  
11               **system;**

12               **“(D) background checks; and**

13               **“(E) unannounced pre-enrollment**  
14               **or other site visits.**

15               **“(3) ENHANCED OVERSIGHT PERIOD.—**

16        **For purposes of paragraph (1), the Sec-**  
17        **retary shall establish procedures to pro-**  
18        **vide for a period of not less than 30 days**  
19        **and not more than 365 days during which**  
20        **providers of services and suppliers de-**  
21        **scribed in such paragraph, as the Sec-**  
22        **retary determines appropriate, would be**  
23        **subject to enhanced oversight, such as re-**  
24        **quired or unannounced (or required and**  
25        **unannounced) site visits or inspections,**

1       prepayment review, enhanced review of  
2       claims, and such other actions as speci-  
3       fied by the Secretary, under the pro-  
4       grams under titles XVIII, XIX, and XXI.  
5       Under such procedures, the Secretary  
6       may extend such period for more than  
7       365 days if the Secretary determines that  
8       after the initial period such additional  
9       period of oversight is necessary.

10           “(4) MORATORIUM ON ENROLLMENT OF  
11       PROVIDERS AND SUPPLIERS.—For purposes  
12       of paragraph (1), the Secretary, based  
13       upon a finding of a risk of serious ongo-  
14       ing fraud within a program under title  
15       XVIII, XIX, or XXI, may impose a morato-  
16       rium on the enrollment of providers of  
17       services and suppliers within a category  
18       of providers of services and suppliers (in-  
19       cluding a category within a specific geo-  
20       graphic area) under such title. Such a  
21       moratorium may only be imposed if the  
22       Secretary makes a determination that the  
23       moratorium would not adversely impact  
24       access of individuals to care under such  
25       program.

1           **“(5) CLARIFICATION.—Nothing in this**  
2           **subsection shall be interpreted to pre-**  
3           **clude or limit the ability of a State to en-**  
4           **gage in provider screening or enhanced**  
5           **provider oversight activities beyond**  
6           **those required by the Secretary.”.**

7           **(b) CONFORMING AMENDMENTS.—**

8           **(1) MEDICAID.—Section 1902(a) of the**  
9           **Social Security Act (42 U.S.C. 42 U.S.C.**  
10           **1396a(a)) is amended—**

11                   **(A) in paragraph (23), by inserting**  
12                   **before the semicolon at the end the**  
13                   **following: “or by a person to whom or**  
14                   **entity to which a moratorium under**  
15                   **section 1128G(a)(4) is applied during**  
16                   **the period of such moratorium”;**

17                   **(B) in paragraph (72); by striking**  
18                   **at the end “and”;**

19                   **(C) in paragraph (73), by striking**  
20                   **the period at the end and inserting “;**  
21                   **and”;** and

22                   **(D) by adding after paragraph**  
23                   **(73) the following new paragraph:**

24                   **“(74) provide that the State will en-**  
25           **force any determination made by the Sec-**

1       retary under subsection (a) of section  
2       1128G (relating to a significant risk of  
3       fraudulent activity with respect to a cat-  
4       egory of provider or supplier described  
5       in such subsection (a) through use of the  
6       appropriate procedures described in such  
7       subsection (a)), and that the State will  
8       carry out any activities as required by  
9       the Secretary for purposes of such sub-  
10      section (a).”.

11           (2) CHIP.—Section 2102 of such Act  
12      (42 U.S.C. 1397bb) is amended by adding  
13      at the end the following new subsection:

14      “(d) PROGRAM INTEGRITY.—A State child  
15      health plan shall include a description of the  
16      procedures to be used by the State—

17           “(1) to enforce any determination  
18      made by the Secretary under subsection  
19      (a) of section 1128G (relating to a signifi-  
20      cant risk of fraudulent activity with re-  
21      spect to a category of provider or sup-  
22      plier described in such subsection  
23      through use of the appropriate proce-  
24      dures described in such subsection); and

1           **“(2) to carry out any activities as re-**  
2           **quired by the Secretary for purposes of**  
3           **such subsection.”.**

4           **(3) MEDICARE.—Section 1866(j) of such**  
5           **Act (42 U.S.C. 1395cc(j)) is amended by**  
6           **adding at the end the following new**  
7           **paragraph:**

8           **“(3) PROGRAM INTEGRITY.—The provi-**  
9           **sions of section 1128G(a) apply to enroll-**  
10          **ments and renewals of enrollments of**  
11          **providers of services and suppliers under**  
12          **this title.”.**

13   **SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP**  
14                   **PROGRAM DISCLOSURE REQUIREMENTS RE-**  
15                   **LATING TO PREVIOUS AFFILIATIONS.**

16          **(a) IN GENERAL.—Section 1128G of the So-**  
17          **cial Security Act, as inserted by section 1631,**  
18          **is amended by adding at the end the following**  
19          **new subsection:**

20          **“(b) ENHANCED PROGRAM DISCLOSURE RE-**  
21          **QUIREMENTS.—**

22               **“(1) DISCLOSURE.—A provider of serv-**  
23               **ices or supplier who submits on or after**  
24               **July 1, 2011, an application for enroll-**  
25               **ment and renewing enrollment in a pro-**



1 **gram under title XVIII, XIX, or XXI shall**  
2 **disclose (in a form and manner deter-**  
3 **mined by the Secretary) any current af-**  
4 **iliation or affiliation within the previous**  
5 **10-year period with a provider of services**  
6 **or supplier that has uncollected debt or**  
7 **with a person or entity that has been sus-**  
8 **pending or excluded under such program,**  
9 **subject to a payment suspension, or has**  
10 **had its billing privileges revoked.**

11 **“(2) ENHANCED SAFEGUARDS.—If the**  
12 **Secretary determines that such previous**  
13 **affiliation of such provider or supplier**  
14 **poses a risk of fraud, waste, or abuse, the**  
15 **Secretary may apply such enhanced safe-**  
16 **guards as the Secretary determines nec-**  
17 **essary to reduce such risk associated**  
18 **with such provider or supplier enrolling**  
19 **or participating in the program under**  
20 **title XVIII, XIX, or XXI. Such safeguards**  
21 **may include enhanced oversight, such as**  
22 **enhanced screening of claims, required**  
23 **or unannounced (or required and unan-**  
24 **nounced) site visits or inspections, addi-**  
25 **tional information reporting require-**

1        **ments, and conditioning such enrollment**  
2        **on the provision of a surety bond.**

3            **“(3) AUTHORITY TO DENY PARTICIPA-**  
4        **TION.—If the Secretary determines that**  
5        **there has been at least one such affili-**  
6        **ation and that such affiliation or affili-**  
7        **ations, as applicable, of such provider or**  
8        **supplier poses a serious risk of fraud,**  
9        **waste, or abuse, the Secretary may deny**  
10       **the application of such provider or sup-**  
11       **plier.”.**

12       **(b) CONFORMING AMENDMENTS.—**

13            **(1) MEDICAID.—Paragraph (74) of sec-**  
14       **tion 1902(a) of such Act (42 U.S.C.**  
15       **1396a(a)), as added by section 1631(b)(1),**  
16       **is amended—**

17            **(A) by inserting “or subsection (b)**  
18       **of such section (relating to disclosure**  
19       **requirements)” before “, and that the**  
20       **State”; and**

21            **(B) by inserting before the period**  
22       **the following: “and apply any en-**  
23       **hanced safeguards, with respect to a**  
24       **provider or supplier described in**  
25       **such subsection (b), as the Secretary**

1           **determines necessary under such**  
2           **subsection (b)”.**

3           **(2) CHIP.—Subsection (d) of section**  
4           **2102 of such Act (42 U.S.C. 1397bb), as**  
5           **added by section 1631(b)(2), is amended—**

6                   **(A) in paragraph (1), by striking**  
7                   **at the end “and”;**

8                   **(B) in paragraph (2) by striking**  
9                   **the period at the end and inserting “;**  
10                   **and’” and**

11                   **(C) by adding at the end the fol-**  
12                   **lowing new paragraph:**

13                   **“(3) to enforce any determination**  
14                   **made by the Secretary under subsection**  
15                   **(b) of section 1128G (relating to disclo-**  
16                   **sure requirements) and to apply any en-**  
17                   **hanced safeguards, with respect to a pro-**  
18                   **vider or supplier described in such sub-**  
19                   **section, as the Secretary determines nec-**  
20                   **essary under such subsection.”.**

21   **SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER**  
22                   **FOR CERTAIN EVALUATION AND MANAGE-**  
23                   **MENT SERVICES.**

24           **Section 1848 of the Social Security Act (42**  
25   **U.S.C. 1395w-4), as amended by section 4101**

1 of the HITECH Act (Public Law 111-5), is  
2 amended by adding at the end the following  
3 new subsection:

4       “(p) **PAYMENT MODIFIER FOR CERTAIN EVAL-**  
5 **UATION AND MANAGEMENT SERVICES.—The Sec-**  
6 **retary shall establish a payment modifier**  
7 **under the fee schedule under this section for**  
8 **evaluation and management services (as spec-**  
9 **ified in section 1842(b)(16)(B)(ii)) that result**  
10 **in the ordering of additional services (such as**  
11 **lab tests), the prescription of drugs, the fur-**  
12 **nishing or ordering of durable medical equip-**  
13 **ment in order to enable better monitoring of**  
14 **claims for payment for such additional serv-**  
15 **ices under this title, or the ordering, fur-**  
16 **nishing, or prescribing of other items and**  
17 **services determined by the Secretary to pose**  
18 **a high risk of waste, fraud, and abuse. The**  
19 **Secretary may require providers of services**  
20 **or suppliers to report such modifier in claims**  
21 **submitted for payment.”.**

1 SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER  
2 MEDICARE INTEGRITY PROGRAM.

3 (a) **IN GENERAL.**—Section 1893(c) of the So-  
4 cial Security Act (42 U.S.C. 1395ddd(c)) is  
5 amended—

6 (1) in paragraph (3), by striking at the  
7 end “and”;

8 (2) by redesignating paragraph (4) as  
9 paragraph (5); and

10 (3) by inserting after paragraph (3)  
11 the following new paragraph:

12 “(4) for the contract year beginning  
13 in 2011 and each subsequent contract  
14 year, the entity provides assurances to  
15 the satisfaction of the Secretary that the  
16 entity will conduct periodic evaluations  
17 of the effectiveness of the activities car-  
18 ried out by such entity under the Pro-  
19 gram and will submit to the Secretary an  
20 annual report on such activities; and”.

21 (b) **REFERENCE TO MEDICAID INTEGRITY**  
22 **PROGRAM.**—For a similar provision with re-  
23 spect to the Medicaid Integrity Program, see  
24 section 1752.

1 SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO  
2 ADOPT PROGRAMS TO REDUCE WASTE,  
3 FRAUD, AND ABUSE.

4 (a) IN GENERAL.—Section 1874 of the So-  
5 cial Security Act (42 U.S.C. 42 U.S.C. 1395kk)  
6 is amended by adding at the end the following  
7 new subsection:

8 “(e) COMPLIANCE PROGRAMS FOR PROVIDERS  
9 OF SERVICES AND SUPPLIERS.—

10 “(1) IN GENERAL.—The Secretary may  
11 disenroll a provider of services or a sup-  
12 plier (other than a physician or a skilled  
13 nursing facility) under this title (or may  
14 impose any civil monetary penalty or  
15 other intermediate sanction under para-  
16 graph (4)) if such provider of services or  
17 supplier fails to, subject to paragraph (5),  
18 establish a compliance program that con-  
19 tains the core elements established under  
20 paragraph (2).

21 “(2) ESTABLISHMENT OF CORE ELE-  
22 MENTS.—The Secretary, in consultation  
23 with the Inspector General of the Depart-  
24 ment of Health and Human Services,  
25 shall establish core elements for a com-  
26 pliance program under paragraph (1).

1       **Such elements may include written poli-**  
2       **cies, procedures, and standards of con-**  
3       **duct, a designated compliance officer and**  
4       **a compliance committee; effective train-**  
5       **ing and education pertaining to fraud,**  
6       **waste, and abuse for the organization’s**  
7       **employees and contractors; a confidential**  
8       **or anonymous mechanism, such as a hot-**  
9       **line, to receive compliance questions and**  
10      **reports of fraud, waste, or abuse; discipli-**  
11      **nary guidelines for enforcement of stand-**  
12      **ards; internal monitoring and auditing**  
13      **procedures, including monitoring and au-**  
14      **diting of contractors; procedures for en-**  
15      **suring prompt responses to detected of-**  
16      **fenses and development of corrective ac-**  
17      **tion initiatives, including responses to**  
18      **potential offenses; and procedures to re-**  
19      **turn all identified overpayments to the**  
20      **programs under this title, title XIX, and**  
21      **title XXI.**

22           **“(3) TIMELINE FOR IMPLEMENTATION.—**  
23      **The Secretary shall determine a timeline**  
24      **for the establishment of the core ele-**  
25      **ments under paragraph (2) and the date**

1 on which a provider of services and sup-  
2 pliers (other than physicians) shall be re-  
3 quired to have established such a pro-  
4 gram for purposes of this subsection.

5 “(4) CMS ENFORCEMENT AUTHORITY.—  
6 The Administrator for the Centers of  
7 Medicare & Medicaid Services shall have  
8 the authority to determine whether a  
9 provider of services or supplier described  
10 in subparagraph (3) has met the require-  
11 ment of this subsection and to impose a  
12 civil monetary penalty not to exceed  
13 \$50,000 for each violation. The Secretary  
14 may also impose other intermediate sanc-  
15 tions, including corrective action plans  
16 and additional monitoring in the case of  
17 a violation of this subsection.

18 “(5) PILOT PROGRAM.—The Secretary  
19 may conduct a pilot program on the ap-  
20 plication of this subsection with respect  
21 to a category of providers of services or  
22 suppliers (other than physicians) that the  
23 Secretary determines to be a category  
24 which is at high risk for waste, fraud,  
25 and abuse before implementing the re-



1       **quirements of this subsection to all pro-**  
2       **viders of services and suppliers described**  
3       **in paragraph (3).”.**

4       **(b) REFERENCE TO SIMILAR MEDICAID PRO-**  
5       **VISION.—For a similar provision with respect**  
6       **to the Medicaid program under title XIX of**  
7       **the Social Security Act, see section 1753.**

8       **SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-**  
9               **CARE CLAIMS REDUCED TO NOT MORE THAN**  
10              **12 MONTHS.**

11       **(a) PURPOSE.—In general, the 36-month pe-**  
12       **riod currently allowed for claims filing under**  
13       **parts A, B, C, and, D of title XVIII of the Social**  
14       **Security Act presents opportunities for fraud**  
15       **schemes in which processing patterns of the**  
16       **Centers for Medicare & Medicaid Services can**  
17       **be observed and exploited. Narrowing the**  
18       **window for claims processing will not over-**  
19       **burden providers and will reduce fraud and**  
20       **abuse.**

21       **(b) REDUCING MAXIMUM PERIOD FOR SUB-**  
22       **MISSION.—**

23               **(1) PART A.—Section 1814(a) of the So-**  
24       **cial Security Act (42 U.S.C. 1395f(a)) is**  
25       **amended—**

1           (A) in paragraph (1), by striking  
2 “period of 3 calendar years” and all  
3 that follows and inserting “period of 1  
4 calendar year from which such serv-  
5 ices are furnished; and”; and

6           (B) by adding at the end the fol-  
7 lowing new sentence: “In applying  
8 paragraph (1), the Secretary may  
9 specify exceptions to the 1 calendar  
10 year period specified in such para-  
11 graph.”.

12           (2) PART B.—Section 1835(a) of such  
13 Act (42 U.S.C. 1395n(a)) is amended—

14           (A) in paragraph (1), by striking  
15 “period of 3 calendar years” and all  
16 that follows and inserting “period of 1  
17 calendar year from which such serv-  
18 ices are furnished; and”; and

19           (B) by adding at the end the fol-  
20 lowing new sentence: “In applying  
21 paragraph (1), the Secretary may  
22 specify exceptions to the 1 calendar  
23 year period specified in such para-  
24 graph.”.

1           **(3) PARTS C AND D.—Section 1857(d) of**  
2           **such Act is amended by adding at the end**  
3           **the following new paragraph:**

4           **“(7) PERIOD FOR SUBMISSION OF**  
5           **CLAIMS.—The contract shall require an**  
6           **MA organization or PDP sponsor to re-**  
7           **quire any provider of services under con-**  
8           **tract with, in partnership with, or affili-**  
9           **ated with such organization or sponsor to**  
10          **ensure that, with respect to items and**  
11          **services furnished by such provider to an**  
12          **enrollee of such organization, written re-**  
13          **quest, signed by such enrollee, except in**  
14          **cases in which the Secretary finds it im-**  
15          **practicable for the enrollee to do so, is**  
16          **filed for payment for such items and serv-**  
17          **ices in such form, in such manner, and by**  
18          **such person or persons as the Secretary**  
19          **may by regulation prescribe, no later**  
20          **than the close of the 1 calendar year pe-**  
21          **riod after such items and services are**  
22          **furnished. In applying the previous sen-**  
23          **tence, the Secretary may specify excep-**  
24          **tions to the 1 calendar year period speci-**  
25          **fied.”.**

1       **(c) EFFECTIVE DATE.—The amendments**  
2 **made by subsection (b) shall be effective for**  
3 **items and services furnished on or after Janu-**  
4 **ary 1, 2011.**

5 **SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL**  
6 **EQUIPMENT OR HOME HEALTH SERVICES RE-**  
7 **QUIRED TO BE MEDICARE ENROLLED PHYSI-**  
8 **CANS OR ELIGIBLE PROFESSIONALS.**

9       **(a) DME.—Section 1834(a)(11)(B) of the So-**  
10 **cial Security Act (42 U.S.C. 1395m(a)(11)(B)) is**  
11 **amended by striking “physician” and insert-**  
12 **ing “physician enrolled under section 1866(j)**  
13 **or an eligible professional under section**  
14 **1848(k)(3)(B)”.**

15       **(b) HOME HEALTH SERVICES.—**

16           **(1) PART A.—Section 1814(a)(2) of such**  
17 **Act (42 U.S.C. 1395(a)(2)) is amended in**  
18 **the matter preceding subparagraph (A)**  
19 **by inserting “in the case of services de-**  
20 **scribed in subparagraph (C), a physician**  
21 **enrolled under section 1866(j) or an eligi-**  
22 **ble professional under section**  
23 **1848(k)(3)(B),” before “or, in the case of**  
24 **services”.**

1           **(2) PART B.—Section 1835(a)(2) of such**  
2           **Act (42 U.S.C. 1395n(a)(2)) is amended in**  
3           **the matter preceding subparagraph (A)**  
4           **by inserting “, or in the case of services**  
5           **described in subparagraph (A), a physi-**  
6           **cian enrolled under section 1866(j) or an**  
7           **eligible professional under section**  
8           **1848(k)(3)(B),” after “a physician”.**

9           **(c) DISCRETION TO EXPAND APPLICATION.—**  
10          **The Secretary may extend the requirement**  
11          **applied by the amendments made by sub-**  
12          **sections (a) and (b) to durable medical equip-**  
13          **ment and home health services (relating to re-**  
14          **quiring certifications and written orders to be**  
15          **made by enrolled physicians and health pro-**  
16          **fessions) to other categories of items or serv-**  
17          **ices under this title, including covered part D**  
18          **drugs as defined in section 1860D–2(e), if the**  
19          **Secretary determines that such application**  
20          **would help to reduce the risk of waste, fraud,**  
21          **and abuse with respect to such other cat-**  
22          **egories under title XVIII of the Social Secu-**  
23          **rity Act.**

24          **(d) EFFECTIVE DATE.—The amendments**  
25          **made by this section shall apply to written or-**

1 **ders and certifications made on or after July**  
2 **1, 2010.**

3 **SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE**  
4 **DOCUMENTATION ON REFERRALS TO PRO-**  
5 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

6 **(a) PHYSICIANS AND OTHER SUPPLIERS.—**  
7 **Section 1842(h) of the Social Security Act, is**  
8 **amended by adding at the end the following**  
9 **new paragraph**

10 **“(10) The Secretary may disenroll, for a**  
11 **period of not more than one year for each act,**  
12 **a physician or supplier under section 1866(j)**  
13 **if such physician or supplier fails to maintain**  
14 **and, upon request of the Secretary, provide**  
15 **access to documentation relating to written**  
16 **orders or requests for payment for durable**  
17 **medical equipment, certifications for home**  
18 **health services, or referrals for other items or**  
19 **services written or ordered by such physician**  
20 **or supplier under this title, as specified by the**  
21 **Secretary.”.**

22 **(b) PROVIDERS OF SERVICES.—Section**  
23 **1866(a)(1) of such Act (42 U.S.C. 1395cc), is**  
24 **amended—**

1           (1) in subparagraph (U), by striking  
2           at the end “and”;

3           (2) in subparagraph (V), by striking  
4           the period at the end and adding “; and”;  
5           and

6           (3) by adding at the end the following  
7           new subparagraph:

8                   “(W) maintain and, upon request  
9                   of the Secretary, provide access to  
10                   documentation relating to written or-  
11                   ders or requests for payment for du-  
12                   rable medical equipment, certifi-  
13                   cations for home health services, or  
14                   referrals for other items or services  
15                   written or ordered by the provider  
16                   under this title, as specified by the  
17                   Secretary.”.

18           (c) **OIG PERMISSIVE EXCLUSION AUTHOR-**  
19 **ITY.**—Section 1128(b)(11) of the Social Security  
20 **Act (42 U.S.C. 1320a-7(b)(11))** is amended by  
21 **inserting “, ordering, referring for furnishing,**  
22 **or certifying the need for”** after “furnishing”.

23           (d) **EFFECTIVE DATE.**—The amendments  
24 **made by this section shall apply to orders,**

1 **certifications, and referrals made on or after**  
2 **January 1, 2010.**

3 **SEC. 1639. FACE TO FACE ENCOUNTER WITH PATIENT RE-**  
4 **QUIRED BEFORE PHYSICIANS MAY CERTIFY**  
5 **ELIGIBILITY FOR HOME HEALTH SERVICES**  
6 **OR DURABLE MEDICAL EQUIPMENT UNDER**  
7 **MEDICARE.**

8 **(a) CONDITION OF PAYMENT FOR HOME**  
9 **HEALTH SERVICES.—**

10 **(1) PART A.—Section 1814(a)(2)(C) of**  
11 **such Act is amended—**

12 **(A) by striking “and such serv-**  
13 **ices” and inserting “such services”;**  
14 **and**

15 **(B) by inserting after “care of a**  
16 **physician” the following: “, and, in**  
17 **the case of a certification or recertifi-**  
18 **cation made by a physician after Jan-**  
19 **uary 1, 2010, prior to making such**  
20 **certification the physician must docu-**  
21 **ment that the physician has had a**  
22 **face-to-face encounter (including**  
23 **through use of telehealth and other**  
24 **than with respect to encounters that**  
25 **are incident to services involved)**



1 with the individual during the 6-  
2 month period preceding such certifi-  
3 cation, or other reasonable timeframe  
4 as determined by the Secretary”.

5 (2) PART B.—Section 1835(a)(2)(A) of  
6 the Social Security Act is amended—

7 (A) by striking “and” before “(iii)”;  
8 and

9 (B) by inserting after “care of a  
10 physician” the following: “, and (iv) in  
11 the case of a certification or recertifi-  
12 cation after January 1, 2010, prior to  
13 making such certification the physi-  
14 cian must document that the physi-  
15 cian has had a face-to-face encounter  
16 (including through use of telehealth  
17 and other than with respect to en-  
18 counters that are incident to services  
19 involved) with the individual during  
20 the 6-month period preceding such  
21 certification or recertification, or  
22 other reasonable timeframe as deter-  
23 mined by the Secretary”.

24 (b) CONDITION OF PAYMENT FOR DURABLE  
25 MEDICAL EQUIPMENT.—Section 1834(a)(11)(B)

1 of the Social Security Act (42 U.S.C.  
2 1395m(a)(11)(B)) is amended by adding before  
3 the period at the end the following: “and shall  
4 require that such an order be written pursu-  
5 ant to the physician documenting that the  
6 physician has had a face-to-face encounter  
7 (including through use of telehealth and  
8 other than with respect to encounters that  
9 are incident to services involved) with the in-  
10 dividual involved during the 6-month period  
11 preceding such written order, or other rea-  
12 sonable timeframe as determined by the Sec-  
13 retary”.

14 (c) APPLICATION TO OTHER AREAS UNDER  
15 MEDICARE.—The Secretary may apply the  
16 face-to-face encounter requirement described  
17 in the amendments made by subsections (a)  
18 and (b) to other items and services for which  
19 payment is provided under title XVIII of the  
20 Social Security Act based upon a finding that  
21 such an decision would reduce the risk of  
22 waste, fraud, or abuse.

23 (d) APPLICATION TO MEDICAID AND CHIP.—  
24 The requirements pursuant to the amend-  
25 ments made by subsections (a) and (b) shall

1 **apply in the case of physicians making certifi-**  
2 **cations for home health services under title**  
3 **XIX or XXI of the Social Security Act, in the**  
4 **same manner and to the same extent as such**  
5 **requirements apply in the case of physicians**  
6 **making such certifications under title XVIII**  
7 **of such Act.**

8 **SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AU-**  
9 **THORITY TO PROGRAM EXCLUSION INVES-**  
10 **TIGATIONS.**

11 **(a) IN GENERAL.—Section 1128(f) of the So-**  
12 **cial Security Act (42 U.S.C. 1320a-7(f)) is**  
13 **amended by adding at the end the following**  
14 **new paragraph:**

15 **“(4) The provisions of subsections (d) and**  
16 **(e) of section 205 shall apply with respect to**  
17 **this section to the same extent as they are ap-**  
18 **plicable with respect to title II. The Secretary**  
19 **may delegate the authority granted by section**  
20 **205(d) (as made applicable to this section) to**  
21 **the Inspector General of the Department of**  
22 **Health and Human Services or the Adminis-**  
23 **trator of the Centers for Medicare & Medicaid**  
24 **Services for purposes of any investigation**  
25 **under this section.”.**

1       **(b) EFFECTIVE DATE.—**The amendment  
2 made by subsection (a) shall apply to inves-  
3 tigation beginning on or after January 1,  
4 2010.

5 SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND  
6 MEDICAID OVERPAYMENTS.

7       Section 1128G of the Social Security Act,  
8 as inserted by section 1631 and amended by  
9 section 1632, is further amended by adding at  
10 the end the following new subsection:

11       **“(c) REPORTS ON AND REPAYMENT OF OVER-**  
12 **PAYMENTS IDENTIFIED THROUGH INTERNAL AU-**  
13 **DITS AND REVIEWS.—**

14               **“(1) REPORTING AND RETURNING OVER-**  
15 **PAYMENTS.—**If a person knows of an over-  
16 payment, the person must—

17                       **“(A) report and return the over-**  
18 **payment to the Secretary, the State,**  
19 **an intermediary, a carrier, or a con-**  
20 **tractor, as appropriate, at the correct**  
21 **address, and**

22                       **“(B) notify the Secretary, the**  
23 **State, intermediary, carrier, or con-**  
24 **tractor to whom the overpayment**

1           **was returned in writing of the reason**  
2           **for the overpayment.**

3           **“(2) TIMING.—An overpayment must**  
4           **be reported and returned under para-**  
5           **graph (1)(A) by not later than the date**  
6           **that is 60 days after the date the person**  
7           **knows of the overpayment.**

8           **Any known overpayment retained later**  
9           **than the applicable date specified in this**  
10           **paragraph creates an obligation as de-**  
11           **finied in section 3729(b)(3) of title 31 of**  
12           **the United States Code.**

13           **“(3) CLARIFICATION.—Repayment of**  
14           **any overpayments (or refunding by with-**  
15           **holding of future payments) by a pro-**  
16           **vider of services or supplier does not oth-**  
17           **erwise limit the provider or supplier’s po-**  
18           **tential liability for administrative obliga-**  
19           **tions such as applicable interests, fines,**  
20           **and specialties or civil or criminal sanc-**  
21           **tions involving the same claim if it is de-**  
22           **termined later that the reason for the**  
23           **overpayment was related to fraud by the**  
24           **provider or supplier or the employees or**  
25           **agents of such provider or supplier.**

1           **“(4) DEFINITIONS.—In this subsection:**

2                   **“(A) KNOWS.—The term ‘knows’**  
3                   **has the meaning given the terms**  
4                   **‘knowing’ and ‘knowingly’ in section**  
5                   **3729(b) of title 31 of the United States**  
6                   **Code.**

7                   **“(B) OVERPAYMENT.—The term**  
8                   **“overpayment” means any finally de-**  
9                   **termined funds that a person receives**  
10                   **or retains under title XVIII, XIX, or**  
11                   **XXI to which the person, after appli-**  
12                   **cable reconciliation, is not entitled**  
13                   **under such title.**

14                   **“(C) PERSON.—The term ‘person’**  
15                   **means a provider of services, sup-**  
16                   **plier, Medicaid managed care organi-**  
17                   **zation (as defined in section**  
18                   **1903(m)(1)(A)), Medicare Advantage**  
19                   **organization (as defined in section**  
20                   **1859(a)(1)), or PDP sponsor (as de-**  
21                   **defined in section 1860D–41(a)(13)), but**  
22                   **excluding a beneficiary.”.**

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 Secu-  
6 rity Act (42 U.S.C. 1320a-7(c)(3)(B)) is amend-  
7 ed by striking “individuals entitled to benefits  
8 under part A of title XVIII or enrolled under  
9 part B of such title, or both” and inserting  
10 “beneficiaries (as defined in section  
11 1128A(i)(5)) of that program”.

12 SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL  
13 DIALYSIS FACILITIES.

14 Section 1881(b) of the Social Security Act  
15 (42 U.S.C. 1395rr(b)) is amended by adding at  
16 the end the following new paragraph:

17 “(15) For purposes of evaluating or audit-  
18 ing payments made to renal dialysis facilities  
19 for items and services under this section  
20 under paragraph (1), each such renal dialysis  
21 facility, upon the request of the Secretary,  
22 shall provide to the Secretary access to infor-  
23 mation relating to any ownership or com-  
24 pensation arrangement between such facility  
25 and the medical director of such facility or be-  
26 tween such facility and any physician.”.

1 **SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**  
2 **ALTERNATE PAYEES REQUIRED TO REG-**  
3 **ISTER UNDER MEDICARE.**

4 **(a) MEDICARE.—Section 1866(j)(1) of the**  
5 **Social Security Act (42 U.S.C. 1395cc(j)(1)) is**  
6 **amended by adding at the end the following**  
7 **new subparagraph:**

8 **“(D) BILLING AGENTS AND CLEAR-**  
9 **INGHOUSES REQUIRED TO BE REGISTERED**  
10 **UNDER MEDICARE.—Any agent, clear-**  
11 **inghouse, or other alternate payee**  
12 **that submits claims on behalf of a**  
13 **health care provider must be reg-**  
14 **istered with the Secretary in a form**  
15 **and manner specified by the Sec-**  
16 **retary.”.**

17 **(b) MEDICAID.—For a similar provision**  
18 **with respect to the Medicaid program under**  
19 **title XIX of the Social Security Act, see section**  
20 **1759.**

21 **(c) EFFECTIVE DATE.—The amendment**  
22 **made by subsection (a) shall apply to claims**  
23 **submitted on or after January 1, 2012.**



1 SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO  
2 FALSE CLAIMS ACT AMENDMENTS.

3 Section 1128A of the Social Security Act,  
4 as amended by sections 1611, 1612, 1613, and  
5 1615, is further amended—

6 (1) in subsection (a)—

7 (A) in paragraph (1), by striking  
8 “to an officer, employee, or agent of  
9 the United States, or of any depart-  
10 ment or agency thereof, or of any  
11 State agency (as defined in sub-  
12 section (i)(1))”;

13 (B) in paragraph (4)—

14 (i) in the matter preceding  
15 subparagraph (A), by striking  
16 “participating in a program under  
17 title XVIII or a State health care  
18 program” and inserting “partici-  
19 pating in a Federal health care  
20 program (as defined in section  
21 1128B(f))”; and

22 (ii) in subparagraph (A), by  
23 striking “title XVIII or a State  
24 health care program” and insert-  
25 ing “a Federal health care pro-

1           **gram (as defined in section**  
2           **1128B(f))”;**

3           **(C) by striking “or” at the end of**  
4           **paragraph (10);**

5           **(D) by inserting after paragraph**  
6           **(11) the following new paragraphs:**

7           **“(12) conspires to commit a violation**  
8           **of this section; or**

9           **“(13) knowingly makes, uses, or**  
10          **causes to be made or used, a false record**  
11          **or statement material to an obligation to**  
12          **pay or transmit money or property to a**  
13          **Federal health care program, or know-**  
14          **ingly conceals or knowingly and improv-**  
15          **erly avoids or decreases an obligation to**  
16          **pay or transmit money or property to a**  
17          **Federal health care program;”;** and

18          **(E) in the matter following para-**  
19          **graph (13), as inserted by subpara-**  
20          **graph (D)—**

21                 **(i) by striking “or” before “in**  
22                 **cases under paragraph (11)”;** and

23                 **(ii) by inserting “, in cases**  
24                 **under paragraph (12), \$50,000 for**  
25                 **any violation described in this**

1 section committed in furtherance  
2 of the conspiracy involved; or in  
3 cases under paragraph (13),  
4 \$50,000 for each false record or  
5 statement, or concealment, avoid-  
6 ance, or decrease” after “by an ex-  
7 cluded individual”; and

8 (F) in the second sentence, by  
9 striking “such false statement, omis-  
10 sion, or misrepresentation)” and in-  
11 sserting “such false statement or mis-  
12 representation, in cases under para-  
13 graph (12), an assessment of not more  
14 than 3 times the total amount that  
15 would otherwise apply for any viola-  
16 tion described in this section com-  
17 mitted in furtherance of the con-  
18 spiracy involved, or in cases under  
19 paragraph (13), an assessment of not  
20 more than 3 times the total amount of  
21 the obligation to which the false  
22 record or statement was material or  
23 that was avoided or decreased”).

24 (2) in subsection (c)(1), by striking  
25 “six years” and inserting “10 years”; and

1           **(3) in subsection (i)—**

2                   **(A) by amending paragraph (2) to**  
3           **read as follows:**

4           **“(2) The term ‘claim’ means any appli-**  
5           **cation, request, or demand, whether**  
6           **under contract, or otherwise, for money**  
7           **or property for items and services under**  
8           **a Federal health care program (as de-**  
9           **finied in section 1128B(f)), whether or not**  
10           **the United States or a State agency has**  
11           **title to the money or property, that—**

12                   **“(A) is presented or caused to be**  
13                   **presented to an officer, employee, or**  
14                   **agent of the United States, or of any**  
15                   **department or agency thereof, or of**  
16                   **any State agency (as defined in sub-**  
17                   **section (i)(1)); or**

18                   **“(B) is made to a contractor,**  
19                   **grantee, or other recipient if the**  
20                   **money or property is to be spent or**  
21                   **used on the Federal health care pro-**  
22                   **gram’s behalf or to advance a Federal**  
23                   **health care program interest, and if**  
24                   **the Federal health care program—**

1           “(i) provides or has provided  
2           any portion of the money or prop-  
3           erty requested or demanded; or

4           “(ii) will reimburse such con-  
5           tractor, grantee, or other recipi-  
6           ent for any portion of the money  
7           or property which is requested or  
8           demanded.”;

9           (B) by amending paragraph (3) to  
10          read as follows:

11          “(3) The term ‘item or service’ means,  
12          without limitation, any medical, social,  
13          management, administrative, or other  
14          item or service used in connection with  
15          or directly or indirectly related to a Fed-  
16          eral health care program.”;

17          (C) in paragraph (6)—

18                 (i) in subparagraph (C), by  
19                 striking at the end “or”;

20                 (ii) in the first subparagraph  
21                 (D), by striking at the end the pe-  
22                 riod and inserting “; or”; and

23                 (iii) by redesignating the sec-  
24                 ond subparagraph (D) as a sub-  
25                 paragraph (E);

1           **(D) by amending paragraph (7) to**  
2           **read as follows:**

3           **“(7) The terms ‘knowing’, ‘knowingly’,**  
4           **and ‘should know’ mean that a person,**  
5           **with respect to information—**

6           **“(A) has actual knowledge of the**  
7           **information;**

8           **“(B) acts in deliberate ignorance**  
9           **of the truth or falsity of the informa-**  
10          **tion; or**

11          **“(C) acts in reckless disregard of**  
12          **the truth or falsity of the information;**  
13          **and require no proof of specific intent to**  
14          **defraud.”; and**

15          **(E) by adding at the end the fol-**  
16          **lowing new paragraphs:**

17          **“(8) The term ‘obligation’ means an**  
18          **established duty, whether or not fixed,**  
19          **arising from an express or implied con-**  
20          **tractual, grantor-grantee, or licensor-li-**  
21          **censee relationship, from a fee-based or**  
22          **similar relationship, from statute or regu-**  
23          **lation, or from the retention of any over-**  
24          **payment.**

1           **“(9) The term ‘material’ means having**  
2           **a natural tendency to influence, or be ca-**  
3           **pable of influencing, the payment or re-**  
4           **ceipt of money or property.”.**

5           **Subtitle D—Access to Information**  
6           **Needed to Prevent Fraud,**  
7           **Waste, and Abuse**

8           **SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDEN-**  
9           **TIFY FRAUD, WASTE, AND ABUSE.**

10           **Section 1128G of the Social Security Act,**  
11           **as added by section 1631 and amended by sec-**  
12           **tions 1632 and 1641, is further amended by**  
13           **adding at the end the following new sub-**  
14           **section;**

15           **“(d) ACCESS TO INFORMATION NECESSARY TO**  
16           **IDENTIFY FRAUD, WASTE, AND ABUSE.—For pur-**  
17           **poses of law enforcement activity, and to the**  
18           **extent consistent with applicable disclosure,**  
19           **privacy, and security laws, including the**  
20           **Health Insurance Portability and Account-**  
21           **ability Act of 1996 and the Privacy Act of 1974,**  
22           **and subject to any information systems secu-**  
23           **rity requirements enacted by law or other-**  
24           **wise required by the Secretary, the Attorney**  
25           **General shall have access, facilitation by the**

1 **Inspector General of the Department of**  
2 **Health and Human Services, to claims and**  
3 **payment data relating to titles XVIII and XIX,**  
4 **in consultation with the Centers for Medicare**  
5 **& Medicaid Services or the owner of such**  
6 **data.”.**

7 **SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE**  
8 **HEALTHCARE INTEGRITY AND PROTECTION**  
9 **DATA BANK AND THE NATIONAL PRACTI-**  
10 **TIONER DATA BANK.**

11 **(a) IN GENERAL.—To eliminate duplication**  
12 **between the Healthcare Integrity and Protec-**  
13 **tion Data Bank (HIPDB) established under**  
14 **section 1128E of the Social Security Act and**  
15 **the National Practitioner Data Bank (NPBD)**  
16 **established under the Health Care Quality Im-**  
17 **provement Act of 1986, section 1128E of the**  
18 **Social Security Act (42 U.S.C. 1320a-7e) is**  
19 **amended—**

20 **(1) in subsection (a), by striking “Not**  
21 **later than” and inserting “Subject to sub-**  
22 **section (h), not later than”;**

23 **(2) in the first sentence of subsection**  
24 **(d)(2), by striking “(other than with re-**



1 spect to requests by Federal agencies)”;  
2 and

3 (3) by adding at the end the following  
4 new subsection:

5 “(h) SUNSET OF THE HEALTHCARE INTEGRITY  
6 AND PROTECTION DATA BANK; TRANSITION PROC-  
7 ESS.—Effective upon the enactment of this  
8 subsection, the Secretary shall implement a  
9 process to eliminate duplication between the  
10 Healthcare Integrity and Protection Data  
11 Bank (in this subsection referred to as the  
12 ‘HIPDB’ established pursuant to subsection  
13 (a) and the National Practitioner Data Bank  
14 (in this subsection referred to as the ‘NPDB’)  
15 as implemented under the Health Care Qual-  
16 ity Improvement Act of 1986 and section 1921  
17 of this Act, including systems testing nec-  
18 essary to ensure that information formerly  
19 collected in the HIPDB will be accessible  
20 through the NPDB, and other activities nec-  
21 essary to eliminate duplication between the  
22 two data banks. Upon the completion of such  
23 process, notwithstanding any other provision  
24 of law, the Secretary shall cease the operation  
25 of the HIPDB and shall collect information re-

1 **quired to be reported under the preceding**  
2 **provisions of this section in the NPDB. Except**  
3 **as otherwise provided in this subsection, the**  
4 **provisions of subsections (a) through (g) shall**  
5 **continue to apply with respect to the report-**  
6 **ing of (or failure to report), access to, and**  
7 **other treatment of the information specified**  
8 **in this section.”.**

9 **(b) ELIMINATION OF THE RESPONSIBILITY OF**  
10 **THE HHS OFFICE OF THE INSPECTOR GENERAL.—**  
11 **Section 1128C(a)(1) of the Social Security Act**  
12 **(42 U.S.C. 1320a-7c(a)(1)) is amended—**

13 **(1) in subparagraph (C), by adding at**  
14 **the end “and”;**

15 **(2) in subparagraph (D), by striking**  
16 **at the end “, and” and inserting a period;**  
17 **and**

18 **(3) by striking subparagraph (E).**

19 **(c) SPECIAL PROVISION FOR ACCESS TO THE**  
20 **NATIONAL PRACTITIONER DATA BANK BY THE DE-**  
21 **PARTMENT OF VETERANS AFFAIRS.—**

22 **(1) IN GENERAL.—Notwithstanding any**  
23 **other provision of law, during the one**  
24 **year period that begins on the effective**  
25 **date specified in subsection (e)(1), the in-**

1       **formation described in paragraph (2)**  
2       **shall be available from the National Prac-**  
3       **titioner Data Bank (described in section**  
4       **1921 of the Social Security Act) to the**  
5       **Secretary of Veterans Affairs without**  
6       **charge.**

7               **(2) INFORMATION DESCRIBED.—For pur-**  
8       **poses of paragraph (1), the information**  
9       **described in this paragraph is the infor-**  
10       **mation that would, but for the amend-**  
11       **ments made by this section, have been**  
12       **available to the Secretary of Veterans Af-**  
13       **fairs from the Healthcare Integrity and**  
14       **Protection Data Bank.**

15               **(d) FUNDING.—Notwithstanding any provi-**  
16       **sions of this Act, sections 1128E(d)(2) and**  
17       **1817(k)(3) of the Social Security Act, or any**  
18       **other provision of law, there shall be avail-**  
19       **able for carrying out the transition process**  
20       **under section 1128E(h) of the Social Security**  
21       **Act over the period required to complete such**  
22       **process, and for operation of the National**  
23       **Practitioner Data Bank until such process is**  
24       **completed, without fiscal year limitation—**

1           **(1) any fees collected pursuant to sec-**  
2           **tion 1128E(d)(2) of such Act; and**

3           **(2) such additional amounts as nec-**  
4           **essary, from appropriations available to**  
5           **the Secretary and to the Office of the In-**  
6           **pector General of the Department of**  
7           **Health and Human Services under**  
8           **clauses (i) and (ii), respectively, of section**  
9           **1817(k)(3)(A) of such Act, for costs of such**  
10          **activities during the first 12 months fol-**  
11          **lowing the date of the enactment of this**  
12          **Act.**

13          **(e) EFFECTIVE DATE.—The amendments**  
14          **made—**

15               **(1) by subsection (a)(2) shall take ef-**  
16               **fect on the first day after the Secretary of**  
17               **Health and Human Services certifies that**  
18               **the process implemented pursuant to sec-**  
19               **tion 1128E(h) of the Social Security Act**  
20               **(as added by subsection (a)(3)) is com-**  
21               **plete; and**

22               **(2) by subsection (b) shall take effect**  
23               **on the earlier of the date specified in**  
24               **paragraph (1) or the first day of the sec-**

1       **ond succeeding fiscal year after the fiscal**  
2       **year during which this Act is enacted.**

3   **SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECUR-**  
4                           **RITY STANDARDS.**

5       **The provisions of sections 262(a) and 264**  
6       **of the Health Insurance Portability and Ac-**  
7       **countability Act of 1996 (and standards pro-**  
8       **mulgated pursuant to such sections) and the**  
9       **Privacy Act of 1974 shall apply with respect**  
10      **to the provisions of this subtitle and amend-**  
11      **ments made by this subtitle.**

12           **[TITLE VII—MEDICAID AND**  
13                           **CHIP]**

14           **[For title VII of division B, see text of bill**  
15      **as introduced on July 14, 2009.]**

1 **TITLE VIII—REVENUE-RELATED**  
2 **PROVISIONS**

3 **SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION**  
4 **OF INDIVIDUALS LIKELY TO BE INELIGIBLE**  
5 **FOR THE LOW-INCOME ASSISTANCE UNDER**  
6 **THE MEDICARE PRESCRIPTION DRUG PRO-**  
7 **GRAM TO ASSIST SOCIAL SECURITY ADMINIS-**  
8 **TRATION’S OUTREACH TO ELIGIBLE INDIVID-**  
9 **UALS.**

10 **(a) IN GENERAL.—Paragraph (19) of section**  
11 **6103(l) of the Internal Revenue Code of 1986**  
12 **is amended to read as follows:**

13 **“(19) DISCLOSURES TO FACILITATE IDEN-**  
14 **TIFICATION OF INDIVIDUALS LIKELY TO BE IN-**  
15 **ELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER**  
16 **MEDICARE PRESCRIPTION DRUG PROGRAM TO**  
17 **ASSIST SOCIAL SECURITY ADMINISTRATION’S**  
18 **OUTREACH TO ELIGIBLE INDIVIDUALS.—**

19 **“(A) IN GENERAL.—Upon written**  
20 **request from the Commissioner of So-**  
21 **cial Security, the following return in-**  
22 **formation (including such informa-**  
23 **tion disclosed to the Social Security**  
24 **Administration under paragraph (1)**  
25 **or (5)) shall be disclosed to officers**

1           **and employees of the Social Security**  
2           **Administration, with respect to any**  
3           **taxpayer identified by the Commis-**  
4           **sioner of Social Security—**

5                   **“(i) return information for the**  
6                   **applicable year from returns with**  
7                   **respect to wages (as defined in**  
8                   **section 3121(a) or 3401(a)) and**  
9                   **payments of retirement income**  
10                  **(as described in paragraph (1) of**  
11                  **this subsection),**

12                   **“(ii) unearned income infor-**  
13                   **mation and income information of**  
14                   **the taxpayer from partnerships,**  
15                   **trusts, estates, and subchapter S**  
16                   **corporations for the applicable**  
17                   **year,**

18                   **“(iii) if the individual filed an**  
19                   **income tax return for the applica-**  
20                   **ble year, the filing status, number**  
21                   **of dependents, income from farm-**  
22                   **ing, and income from self-employ-**  
23                   **ment, on such return,**

24                   **“(iv) if the individual is a mar-**  
25                   **ried individual filing a separate**

1           **return for the applicable year, the**  
2           **social security number (if reason-**  
3           **ably available) of the spouse on**  
4           **such return,**

5           **“(v) if the individual files a**  
6           **joint return for the applicable**  
7           **year, the social security number,**  
8           **unearned income information,**  
9           **and income information from**  
10          **partnerships, trusts, estates, and**  
11          **subchapter S corporations of the**  
12          **individual’s spouse on such re-**  
13          **turn, and**

14          **“(vi) such other return infor-**  
15          **mation relating to the individual**  
16          **(or the individual’s spouse in the**  
17          **case of a joint return) as is pre-**  
18          **scribed by the Secretary by regu-**  
19          **lation as might indicate that the**  
20          **individual is likely to be ineligible**  
21          **for a low-income prescription**  
22          **drug subsidy under section**  
23          **1860D-14 of the Social Security**  
24          **Act.**



1           **“(B) APPLICABLE YEAR.—For the**  
2 **purposes of this paragraph, the term**  
3 **‘applicable year’ means the most re-**  
4 **cent taxable year for which informa-**  
5 **tion is available in the Internal Rev-**  
6 **enue Service’s taxpayer information**  
7 **records.**

8           **“(C) RESTRICTION ON INDIVIDUALS**  
9 **FOR WHOM DISCLOSURE MAY BE RE-**  
10 **QUESTED.—The Commissioner of So-**  
11 **cial Security shall request informa-**  
12 **tion under this paragraph only with**  
13 **respect to—**

14           **“(i) individuals the Social Se-**  
15 **curity Administration has identi-**  
16 **fied, using all other reasonably**  
17 **available information, as likely to**  
18 **be eligible for a low-income pre-**  
19 **scription drug subsidy under sec-**  
20 **tion 1860D–14 of the Social Secu-**  
21 **urity Act and who have not applied**  
22 **for such subsidy, and**

23           **“(ii) any individual the Social**  
24 **Security Administration has iden-**

1           **tified as a spouse of an individual**  
2           **described in clause (i).**

3           **“(D) RESTRICTION ON USE OF DIS-**  
4           **CLOSED INFORMATION.—Return infor-**  
5           **mation disclosed under this para-**  
6           **graph may be used only by officers**  
7           **and employees of the Social Security**  
8           **Administration solely for purposes of**  
9           **identifying individuals likely to be in-**  
10          **eligible for a low-income prescription**  
11          **drug subsidy under section 1860D-14**  
12          **of the Social Security Act for use in**  
13          **outreach efforts under section 1144 of**  
14          **the Social Security Act.”.**

15          **(b) SAFEGUARDS.—Paragraph (4) of section**  
16          **6103(p) of such Code is amended—**

17                 **(1) by striking “(19),” each place it ap-**  
18                 **pears, and**

19                 **(2) by striking “or (17)” each place it**  
20                 **appears and inserting “(17), or (19)”.**

21          **(c) CONFORMING AMENDMENT.—Paragraph**  
22          **(3) of section 6103(a) of such Code is amended**  
23          **by striking “(19),”.**

24          **(d) EFFECTIVE DATE.—The amendments**  
25          **made by this section shall apply to disclosures**

1 **made after the date which is 12 months after**  
2 **the date of the enactment of this Act.**

3 **SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH**  
4 **TRUST FUND; FINANCING FOR TRUST FUND.**

5 **(a) ESTABLISHMENT OF TRUST FUND.—**

6 **(1) IN GENERAL.—Subchapter A of**  
7 **chapter 98 of the Internal Revenue Code**  
8 **of 1986 (relating to trust fund code) is**  
9 **amended by adding at the end the fol-**  
10 **lowing new section:**

11 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**  
12 **RESEARCH TRUST FUND.**

13 **“(a) CREATION OF TRUST FUND.—There is**  
14 **established in the Treasury of the United**  
15 **States a trust fund to be known as the ‘Health**  
16 **Care Comparative Effectiveness Research**  
17 **Trust Fund’ (hereinafter in this section re-**  
18 **ferred to as the ‘CERTF’), consisting of such**  
19 **amounts as may be appropriated or credited**  
20 **to such Trust Fund as provided in this section**  
21 **and section 9602(b).**

22 **“(b) TRANSFERS TO FUND.—There are here-**  
23 **by appropriated to the Trust Fund the fol-**  
24 **lowing:**

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**  
4 **with fiscal year 2013—**

5                   **“(A) an amount equivalent to the**  
6 **net revenues received in the Treasury**  
7 **from the fees imposed under sub-**  
8 **chapter B of chapter 34 (relating to**  
9 **fees on health insurance and self-in-**  
10 **sured plans) for such fiscal year; and**

11                   **“(B) subject to subsection (c)(2),**  
12 **amounts determined by the Secretary**  
13 **of Health and Human Services to be**  
14 **equivalent to the fair share per cap-**  
15 **ita amount computed under sub-**  
16 **section (c)(1) for the fiscal year multi-**  
17 **plied by the average number of indi-**  
18 **viduals entitled to benefits under**  
19 **part A, or enrolled under part B, of**  
20 **title XVIII of the Social Security Act**  
21 **during such fiscal year.**

22 **The amounts appropriated under paragraphs**  
23 **(1), (2), (3), and (4)(B) shall be transferred**  
24 **from the Federal Hospital Insurance Trust**  
25 **Fund and from the Federal Supplementary**

1 **Medical Insurance Trust Fund** (established  
2 **under section 1841 of such Act**), and from the  
3 **Medicare Prescription Drug Account** within  
4 **such Trust Fund**, in proportion (as estimated  
5 **by the Secretary**) to the total expenditures  
6 **during such fiscal year** that are made under  
7 **title XVIII of such Act** from the respective  
8 **trust fund or account**.

9 **“(c) FAIR SHARE PER CAPITA AMOUNT.—**

10 **“(1) COMPUTATION.—**

11 **“(A) IN GENERAL.—**Subject to sub-  
12 **paragraph (B)**, the fair share per cap-  
13 **ita amount** under this paragraph for  
14 **a fiscal year** (beginning with fiscal  
15 **year 2013**) is an amount computed by  
16 **the Secretary of Health and Human**  
17 **Services** for such fiscal year that,  
18 **when applied under this section** and  
19 **subchapter B of chapter 34 of the In-**  
20 **ternal Revenue Code of 1986**, will re-  
21 **sult in revenues to the CERTF** of  
22 **\$375,000,000** for the fiscal year.

23 **“(B) ALTERNATIVE COMPUTATION.—**

24 **“(i) IN GENERAL.—**If the Sec-  
25 **retary is unable to compute the**

1           **fair share per capita amount**  
2           **under subparagraph (A) for a fis-**  
3           **cal year, the fair share per capita**  
4           **amount under this paragraph for**  
5           **the fiscal year shall be the default**  
6           **amount determined under clause**  
7           **(ii) for the fiscal year.**

8           **“(ii) DEFAULT AMOUNT.—The**  
9           **default amount under this clause**  
10          **for—**

11           **“(I) fiscal year 2013 is**  
12           **equal to \$2; or**

13           **“(II) a subsequent year is**  
14           **equal to the default amount**  
15           **under this clause for the pre-**  
16           **ceding fiscal year increased**  
17           **by the annual percentage in-**  
18           **crease in the medical care**  
19           **component of the consumer**  
20           **price index (United States**  
21           **city average) for the 12-month**  
22           **period ending with April of**  
23           **the preceding fiscal year.**

1           **Any amount determined under**  
2           **subclause (II) shall be rounded to**  
3           **the nearest penny.**

4           **“(2) LIMITATION ON MEDICARE FUND-**  
5           **ING.—In no case shall the amount trans-**  
6           **ferred under subsection (b)(4)(B) for any**  
7           **fiscal year exceed \$90,000,000.**

8           **“(d) EXPENDITURES FROM FUND.—**

9           **“(1) IN GENERAL.—Subject to para-**  
10          **graph (2), amounts in the CERTF are**  
11          **available, without the need for further**  
12          **appropriations and without fiscal year**  
13          **limitation, to the Secretary of Health and**  
14          **Human Services for carrying out section**  
15          **1181 of the Social Security Act.**

16          **“(2) ALLOCATION FOR COMMISSION.—Not**  
17          **less than the following amounts in the**  
18          **CERTF for a fiscal year shall be available**  
19          **to carry out the activities of the Com-**  
20          **parative Effectiveness Research Commis-**  
21          **sion established under section 1181(b) of**  
22          **the Social Security Act for such fiscal**  
23          **year:**

24                  **“(A) For fiscal year 2010,**  
25                  **\$7,000,000.**

1           **“(B) For fiscal year 2011,**  
2           **\$9,000,000.**

3           **“(C) For each fiscal year begin-**  
4           **ning with 2012, \$10,000,000.**

5           **Nothing in this paragraph shall be con-**  
6           **strued as preventing additional amounts**  
7           **in the CERTF from being made available**  
8           **to the Comparative Effectiveness Re-**  
9           **search Commission for such activities.**

10          **“(e) NET REVENUES.—For purposes of this**  
11         **section, the term ‘net revenues’ means the**  
12         **amount estimated by the Secretary based on**  
13         **the excess of—**

14                 **“(1) the fees received in the Treasury**  
15                 **under subchapter B of chapter 34, over**

16                 **“(2) the decrease in the tax imposed**  
17                 **by chapter 1 resulting from the fees im-**  
18                 **posed by such subchapter.”.**

19                 **(2) CLERICAL AMENDMENT.—The table**  
20                 **of sections for such subchapter A is**  
21                 **amended by adding at the end thereof**  
22                 **the following new item:**

**“Sec. 9511. Health Care Comparative Effectiveness Research**  
                  **Trust Fund.”.**

23                 **(b) FINANCING FOR FUND FROM FEES ON IN-**  
24                 **SURED AND SELF-INSURED HEALTH PLANS.—**



1           **(1) GENERAL RULE.—Chapter 34 of the**  
2           **Internal Revenue Code of 1986 is amend-**  
3           **ed by adding at the end the following**  
4           **new subchapter:**

5           **“Subchapter B—Insured and Self-Insured**  
6                                   **Health Plans**

**“Sec. 4375. Health insurance.**

**“Sec. 4376. Self-insured health plans.**

**“Sec. 4377. Definitions and special rules.**

7           **“SEC. 4375. HEALTH INSURANCE.**

8           **“(a) IMPOSITION OF FEE.—There is hereby**  
9           **imposed on each specified health insurance**  
10          **policy for each policy year a fee equal to the**  
11          **fair share per capita amount determined**  
12          **under section 9511(c)(1) multiplied by the av-**  
13          **erage number of lives covered under the pol-**  
14          **icy.**

15          **“(b) LIABILITY FOR FEE.—The fee imposed**  
16          **by subsection (a) shall be paid by the issuer**  
17          **of the policy.**

18          **“(c) SPECIFIED HEALTH INSURANCE POL-**  
19          **ICY.—For purposes of this section:**

20                  **“(1) IN GENERAL.—Except as otherwise**  
21                  **provided in this section, the term ‘speci-**  
22                  **fied health insurance policy’ means any**  
23                  **accident or health insurance policy**

1 issued with respect to individuals resid-  
2 ing in the United States.

3 “(2) EXEMPTION FOR CERTAIN POLI-  
4 CIES.—The term ‘specified health insur-  
5 ance policy’ does not include any insur-  
6 ance if substantially all of its coverage is  
7 of excepted benefits described in section  
8 9832(c).

9 “(3) TREATMENT OF PREPAID HEALTH  
10 COVERAGE ARRANGEMENTS.—

11 “(A) IN GENERAL.—In the case of  
12 any arrangement described in sub-  
13 paragraph (B)—

14 “(i) such arrangement shall be  
15 treated as a specified health in-  
16 surance policy, and

17 “(ii) the person referred to in  
18 such subparagraph shall be treat-  
19 ed as the issuer.

20 “(B) DESCRIPTION OF ARRANGE-  
21 MENTS.—An arrangement is described  
22 in this subparagraph if under such  
23 arrangement fixed payments or pre-  
24 miums are received as consideration  
25 for any person’s agreement to provide

1           **or arrange for the provision of acci-**  
2           **dent or health coverage to residents**  
3           **of the United States, regardless of**  
4           **how such coverage is provided or ar-**  
5           **ranged to be provided.**

6   **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

7           **“(a) IMPOSITION OF FEE.—In the case of any**  
8           **applicable self-insured health plan for each**  
9           **plan year, there is hereby imposed a fee equal**  
10          **to the fair share per capita amount deter-**  
11          **mined under section 9511(c)(1) multiplied by**  
12          **the average number of lives covered under**  
13          **the plan.**

14          **“(b) LIABILITY FOR FEE.—**

15                  **“(1) IN GENERAL.—The fee imposed by**  
16                  **subsection (a) shall be paid by the plan**  
17                  **sponsor.**

18                  **“(2) PLAN SPONSOR.—For purposes of**  
19                  **paragraph (1) the term ‘plan sponsor’**  
20                  **means—**

21                          **“(A) the employer in the case of a**  
22                          **plan established or maintained by a**  
23                          **single employer,**

24                          **“(B) the employee organization in**  
25                          **the case of a plan established or**

1 maintained by an employee organiza-  
2 tion,

3 “(C) in the case of—

4 “(i) a plan established or  
5 maintained by 2 or more employ-  
6 ers or jointly by 1 or more em-  
7 ployers and 1 or more employee  
8 organizations,

9 “(ii) a multiple employer wel-  
10 fare arrangement, or

11 “(iii) a voluntary employees’  
12 beneficiary association described  
13 in section 501(c)(9),

14 the association, committee, joint  
15 board of trustees, or other similar  
16 group of representatives of the par-  
17 ties who establish or maintain the  
18 plan, or

19 “(D) the cooperative or associa-  
20 tion described in subsection (c)(2)(F)  
21 in the case of a plan established or  
22 maintained by such a cooperative or  
23 association.

24 “(c) APPLICABLE SELF-INSURED HEALTH  
25 PLAN.—For purposes of this section, the term

1 **‘applicable self-insured health plan’ means**  
2 **any plan for providing accident or health cov-**  
3 **erage if—**

4 **“(1) any portion of such coverage is**  
5 **provided other than through an insur-**  
6 **ance policy, and**

7 **“(2) such plan is established or main-**  
8 **tained—**

9 **“(A) by one or more employers for**  
10 **the benefit of their employees or**  
11 **former employees,**

12 **“(B) by one or more employee or-**  
13 **ganizations for the benefit of their**  
14 **members or former members,**

15 **“(C) jointly by 1 or more employ-**  
16 **ers and 1 or more employee organiza-**  
17 **tions for the benefit of employees or**  
18 **former employees,**

19 **“(D) by a voluntary employees’**  
20 **beneficiary association described in**  
21 **section 501(c)(9),**

22 **“(E) by any organization de-**  
23 **scribed in section 501(c)(6), or**

24 **“(F) in the case of a plan not de-**  
25 **scribed in the preceding subpara-**

1           **graphs, by a multiple employer wel-**  
2           **fare arrangement (as defined in sec-**  
3           **tion 3(40) of Employee Retirement In-**  
4           **come Security Act of 1974), a rural**  
5           **electric cooperative (as defined in**  
6           **section 3(40)(B)(iv) of such Act), or a**  
7           **rural telephone cooperative associa-**  
8           **tion (as defined in section 3(40)(B)(v)**  
9           **of such Act).**

10 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

11           **“(a) DEFINITIONS.—For purposes of this**  
12 **subchapter—**

13           **“(1) ACCIDENT AND HEALTH COV-**  
14 **ERAGE.—The term ‘accident and health**  
15 **coverage’ means any coverage which, if**  
16 **provided by an insurance policy, would**  
17 **cause such policy to be a specified health**  
18 **insurance policy (as defined in section**  
19 **4375(c)).**

20           **“(2) INSURANCE POLICY.—The term ‘in-**  
21 **surance policy’ means any policy or other**  
22 **instrument whereby a contract of insur-**  
23 **ance is issued, renewed, or extended.**

1           **“(3) UNITED STATES.—**The term ‘United  
2           **States’** includes any possession of the  
3           **United States.**

4           **“(b) TREATMENT OF GOVERNMENTAL ENTI-**  
5           **TIES.—**

6           **“(1) IN GENERAL.—**For purposes of this  
7           **subchapter—**

8                   **“(A) the term ‘person’** includes  
9                   **any governmental entity, and**

10                   **“(B) notwithstanding any other**  
11                   **law or rule of law, governmental enti-**  
12                   **ties shall not be exempt from the fees**  
13                   **imposed by this subchapter except as**  
14                   **provided in paragraph (2).**

15           **“(2) TREATMENT OF EXEMPT GOVERN-**  
16           **MENTAL PROGRAMS.—**In the case of an ex-  
17           **empt governmental program, no fee shall**  
18           **be imposed under section 4375 or section**  
19           **4376 on any covered life under such pro-**  
20           **gram.**

21           **“(3) EXEMPT GOVERNMENTAL PROGRAM**  
22           **DEFINED.—**For purposes of this sub-  
23           **chapter, the term ‘exempt governmental**  
24           **program’ means—**

1           “(A) any insurance program es-  
2           tablished under title XVIII of the So-  
3           cial Security Act,

4           “(B) the medical assistance pro-  
5           gram established by title XIX or XXI  
6           of the Social Security Act,

7           “(C) any program established by  
8           Federal law for providing medical  
9           care (other than through insurance  
10          policies) to individuals (or the  
11          spouses and dependents thereof) by  
12          reason of such individuals being—

13                   “(i) members of the Armed  
14                   Forces of the United States, or

15                   “(ii) veterans, and

16          “(D) any program established by  
17          Federal law for providing medical  
18          care (other than through insurance  
19          policies) to members of Indian tribes  
20          (as defined in section 4(d) of the In-  
21          dian Health Care Improvement Act).

22          “(c) TREATMENT AS TAX.—For purposes of  
23          subtitle F, the fees imposed by this sub-  
24          chapter shall be treated as if they were taxes.



1       “(d) **NO COVER OVER TO POSSESSIONS.—Not-**  
2 **withstanding any other provision of law, no**  
3 **amount collected under this subchapter shall**  
4 **be covered over to any possession of the**  
5 **United States.”.**

6           **(2) CLERICAL AMENDMENTS.—**

7           **(A) Chapter 34 of such Code is**  
8 **amended by striking the chapter**  
9 **heading and inserting the following:**

10       **“CHAPTER 34—TAXES ON CERTAIN**  
11 **INSURANCE POLICIES**

**“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS**

**“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS**

12       **“Subchapter A—Policies Issued By Foreign**  
13 **Insurers”.**

14           **(B) The table of chapters for sub-**  
15 **title D of such Code is amended by**  
16 **striking the item relating to chapter**  
17 **34 and inserting the following new**  
18 **item:**

**“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.**

19           **(3) EFFECTIVE DATE.—The amendments**  
20 **made by this subsection shall apply with**  
21 **respect to policies and plans for portions**  
22 **of policy or plan years beginning on or**  
23 **after October 1, 2012.**

1           **TITLE IX—MISCELLANEOUS**  
2                           **PROVISIONS**

3   **SEC. 1901. REPEAL OF TRIGGER PROVISION.**

4           **Subtitle A of title VIII of the Medicare**  
5 **Prescription Drug, Improvement, and Mod-**  
6 **ernization Act of 2003 (Public Law 108–173) is**  
7 **repealed and the provisions of law amended**  
8 **by such subtitle are restored as if such sub-**  
9 **title had never been enacted.**

10 **SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT**  
11                           **(CCA) PROGRAM.**

12           **Section 1860C–1 of the Social Security Act**  
13 **(42 U.S.C. 1395w–29), as added by section**  
14 **241(a) of the Medicare Prescription Drug, Im-**  
15 **provement, and Modernization Act of 2003**  
16 **(Public Law 108–173), is repealed.**

17 **SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.**

18           **(a) IN GENERAL.—Subsection (d)(3) of sec-**  
19 **tion 5007 of the Deficit Reduction Act of 2005**  
20 **(Public Law 109–171) is amended by inserting**  
21 **“(or September 30, 2011, in the case of a dem-**  
22 **onstration project in operation as of October**  
23 **1, 2008)” after “December 31, 2009”.**

24           **(b) FUNDING.—**

1           **(1) IN GENERAL.—**Subsection (f)(1) of  
2 such section is amended by inserting  
3 “and for fiscal year 2010, \$1,600,000,”  
4 after “\$6,000,000.”

5           **(2) AVAILABILITY.—**Subsection (f)(2) of  
6 such section is amended by striking  
7 “2010” and inserting “2014 or until ex-  
8 pended”.

9           **(c) REPORTS.—**

10           **(1) QUALITY IMPROVEMENT AND SAV-**  
11 **INGS.—**Subsection (e)(3) of such section is  
12 amended by striking “December 1, 2008”  
13 and inserting “March 31, 2011”.

14           **(2) FINAL REPORT.—**Subsection (e)(4)  
15 of such section is amended by striking  
16 “May 1, 2010” and inserting “March 31,  
17 2013”.

18 **SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITA-**  
19 **TION PROGRAMS FOR FAMILIES WITH YOUNG**  
20 **CHILDREN AND FAMILIES EXPECTING CHIL-**  
21 **DREN.**

22           **Part B of title IV of the Social Security Act**  
23 **(42 U.S.C. 621–629i) is amended by adding at**  
24 **the end the following:**

1     **“Subpart 3—Support for Quality Home Visitation**  
2                                   **Programs**

3     **“SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES**  
4                                   **WITH YOUNG CHILDREN AND FAMILIES EX-**  
5                                   **PECTING CHILDREN.**

6             **“(a) PURPOSE.—The purpose of this section**  
7     **is to improve the well-being, health, and de-**  
8     **velopment of children by enabling the estab-**  
9     **lishment and expansion of high quality pro-**  
10    **grams providing voluntary home visitation**  
11    **for families with young children and families**  
12    **expecting children.**

13            **“(b) GRANT APPLICATION.—A State that de-**  
14    **sires to receive a grant under this section**  
15    **shall submit to the Secretary for approval, at**  
16    **such time and in such manner as the Sec-**  
17    **retary may require, an application for the**  
18    **grant that includes the following:**

19                    **“(1) DESCRIPTION OF HOME VISITATION**  
20                    **PROGRAMS.—A description of the high**  
21                    **quality programs of home visitation for**  
22                    **families with young children and families**  
23                    **expecting children that will be supported**  
24                    **by a grant made to the State under this**  
25                    **section, the outcomes the programs are**  
26                    **intended to achieve, and the evidence**

1 supporting the effectiveness of the pro-  
2 grams.

3 **“(2) RESULTS OF NEEDS ASSESSMENT.—**

4 **The results of a statewide needs assess-**  
5 **ment that describes—**

6 **“(A) the number, quality, and ca-**  
7 **capacity of home visitation programs**  
8 **for families with young children and**  
9 **families expecting children in the**  
10 **State;**

11 **“(B) the number and types of fam-**  
12 **ilies who are receiving services under**  
13 **the programs;**

14 **“(C) the sources and amount of**  
15 **funding provided to the programs;**

16 **“(D) the gaps in home visitation**  
17 **in the State, including identification**  
18 **of communities that are in high need**  
19 **of the services; and**

20 **“(E) training and technical assist-**  
21 **ance activities designed to achieve or**  
22 **support the goals of the programs.**

23 **“(3) ASSURANCES.—Assurances from**  
24 **the State that—**

1           **“(A) in supporting home visitation**  
2 **programs using funds provided under**  
3 **this section, the State shall identify**  
4 **and prioritize serving communities**  
5 **that are in high need of such services,**  
6 **especially communities with a high**  
7 **proportion of low-income families or**  
8 **a high incidence of child maltreat-**  
9 **ment;**

10           **“(B) the State will reserve 5 per-**  
11 **cent of the grant funds for training**  
12 **and technical assistance to the home**  
13 **visitation programs using such funds;**

14           **“(C) in supporting home visitation**  
15 **programs using funds provided under**  
16 **this section, the State will promote**  
17 **coordination and collaboration with**  
18 **other home visitation programs (in-**  
19 **cluding programs funded under title**  
20 **XIX) and with other child and family**  
21 **services, health services, income sup-**  
22 **ports, and other related assistance;**

23           **“(D) home visitation programs**  
24 **supported using such funds will,**  
25 **when appropriate, provide referrals**

1           to other programs serving children  
2           and families; and

3           “(E) the State will comply with  
4           subsection (i), and cooperate with  
5           any evaluation conducted under sub-  
6           section (j).

7           “(4) OTHER INFORMATION.—Such other  
8           information as the Secretary may re-  
9           quire.

10          “(c) ALLOTMENTS.—

11           “(1) INDIAN TRIBES.—From the amount  
12           reserved under subsection (1)(2) for a fis-  
13           cal year, the Secretary shall allot to each  
14           Indian tribe that meets the requirement  
15           of subsection (d), if applicable, for the fis-  
16           cal year the amount that bears the same  
17           ratio to the amount so reserved as the  
18           number of children in the Indian tribe  
19           whose families have income that does not  
20           exceed 200 percent of the poverty line  
21           bears to the total number of children in  
22           such Indian tribes whose families have  
23           income that does not exceed 200 percent  
24           of the poverty line.

1           **“(2) STATES AND TERRITORIES.—From**  
2           **the amount appropriated under sub-**  
3           **section (m) for a fiscal year that remains**  
4           **after making the reservations required**  
5           **by subsection (l), the Secretary shall allot**  
6           **to each State that is not an Indian tribe**  
7           **and that meets the requirement of sub-**  
8           **section (d), if applicable, for the fiscal**  
9           **year the amount that bears the same**  
10          **ratio to the remainder of the amount so**  
11          **appropriated as the number of children**  
12          **in the State whose families have income**  
13          **that does not exceed 200 percent of the**  
14          **poverty line bears to the total number of**  
15          **children in such States whose families**  
16          **have income that does not exceed 200**  
17          **percent of the poverty line.**

18          **“(3) REALLOTMENTS.—The amount of**  
19          **any allotment to a State under a para-**  
20          **graph of this subsection for any fiscal**  
21          **year that the State certifies to the Sec-**  
22          **retary will not be expended by the State**  
23          **pursuant to this section shall be available**  
24          **for reallocation using the allotment meth-**  
25          **odology specified in that paragraph. Any**



1        **amount so reallocated to a State is deemed**  
2        **part of the allotment of the State under**  
3        **this subsection.**

4        **“(d) MAINTENANCE OF EFFORT.—Beginning**  
5        **with fiscal year 2011, a State meets the re-**  
6        **quirement of this subsection for a fiscal year**  
7        **if the Secretary finds that the aggregate ex-**  
8        **penditures by the State from State and local**  
9        **sources for programs of home visitation for**  
10       **families with young children and families ex-**  
11       **pecting children for the then preceding fiscal**  
12       **year was not less than 100 percent of such ag-**  
13       **gregate expenditures for the then 2nd pre-**  
14       **ceding fiscal year.**

15       **“(e) PAYMENT OF GRANT.—**

16                **“(1) IN GENERAL.—The Secretary shall**  
17        **make a grant to each State that meets the**  
18        **requirements of subsections (b) and (d), if**  
19        **applicable, for a fiscal year for which**  
20        **funds are appropriated under subsection**  
21        **(m), in an amount equal to the reimburs-**  
22        **able percentage of the eligible expendi-**  
23        **tures of the State for the fiscal year, but**  
24        **not more than the amount allotted to the**

1       **State under subsection (c) for the fiscal**  
2       **year.**

3               **“(2) REIMBURSABLE PERCENTAGE DE-**  
4       **FINED.—In paragraph (1), the term ‘reim-**  
5       **bursable percentage’ means, with respect**  
6       **to a fiscal year—**

7                       **“(A) 85 percent, in the case of fis-**  
8                       **cal year 2010;**

9                       **“(B) 80 percent, in the case of fis-**  
10                      **cal year 2011; or**

11                      **“(C) 75 percent, in the case of fis-**  
12                      **cal year 2012 and any succeeding fis-**  
13                      **cal year.**

14       **“(f) ELIGIBLE EXPENDITURES.—**

15                      **“(1) IN GENERAL.—In this section, the**  
16       **term ‘eligible expenditures’—**

17                      **“(A) means expenditures to pro-**  
18                      **vide voluntary home visitation for as**  
19                      **many families with young children**  
20                      **(under the age of school entry) and**  
21                      **families expecting children as prac-**  
22                      **ticable, through the implementation**  
23                      **or expansion of high quality home**  
24                      **visitation programs that—**

1           “(i) adhere to clear evidence-  
2 based models of home visitation  
3 that have demonstrated positive  
4 effects on important program-de-  
5 termined child and parenting out-  
6 comes, such as reducing abuse  
7 and neglect and improving child  
8 health and development;

9           “(ii) employ well-trained and  
10 competent staff, maintain high  
11 quality supervision, provide for  
12 ongoing training and professional  
13 development, and show strong or-  
14 ganizational capacity to imple-  
15 ment such a program;

16           “(iii) establish appropriate  
17 linkages and referrals to other  
18 community resources and sup-  
19 ports;

20           “(iv) monitor fidelity of pro-  
21 gram implementation to ensure  
22 that services are delivered ac-  
23 cording to the specified model;  
24 and

25           “(v) provide parents with—

1           **“(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);**

2  
3  
4  
5  
6  
7  
8  
9           **“(II) knowledge of realistic expectations of age-appropriate child behaviors;**

10  
11  
12           **“(III) knowledge of health and wellness issues for children and parents;**

13  
14  
15           **“(IV) modeling, consulting, and coaching on parenting practices;**

16  
17  
18           **“(V) skills to interact with their child to enhance age-appropriate development;**

19  
20  
21           **“(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and**

1           **“(VII) activities designed**  
2           **to help parents become full**  
3           **partners in the education of**  
4           **their children;**

5           **“(B) includes expenditures for**  
6           **training, technical assistance, and**  
7           **evaluations related to the programs;**  
8           **and**

9           **“(C) does not include any expend-**  
10          **iture with respect to which a State**  
11          **has submitted a claim for payment**  
12          **under any other provision of Federal**  
13          **law.**

14          **“(2) PRIORITY FUNDING FOR PROGRAMS**  
15          **WITH STRONGEST EVIDENCE.—**

16          **“(A) IN GENERAL.—The expendi-**  
17          **tures, described in paragraph (1), of a**  
18          **State for a fiscal year that are attrib-**  
19          **utable to the cost of programs that do**  
20          **not adhere to a model of home visita-**  
21          **tion with the strongest evidence of ef-**  
22          **fectiveness shall not be considered el-**  
23          **igible expenditures for the fiscal year**  
24          **to the extent that the total of the ex-**  
25          **penditures exceeds the applicable**

1           percentage for the fiscal year of the  
2           allotment of the State under sub-  
3           section (c) for the fiscal year.

4           **“(B) APPLICABLE PERCENTAGE DE-**  
5           **FINED.—**In subparagraph (A), the term  
6           ‘applicable percentage’ means, with  
7           respect to a fiscal year—

8                   “(i) 60 percent for fiscal year  
9                   2010;

10                   “(ii) 55 percent for fiscal year  
11                   2011;

12                   “(iii) 50 percent for fiscal year  
13                   2012;

14                   “(iv) 45 percent for fiscal year  
15                   2013; or

16                   “(v) 40 percent for fiscal year  
17                   2014.

18           **“(g) NO USE OF OTHER FEDERAL FUNDS FOR**  
19           **STATE MATCH.—**A State to which a grant is  
20           made under this section may not expend any  
21           Federal funds to meet the State share of the  
22           cost of an eligible expenditure for which the  
23           State receives a payment under this section.

24           **“(h) WAIVER AUTHORITY.—**

1           **“(1) IN GENERAL.—The Secretary may**  
2           **waive or modify the application of any**  
3           **provision of this section, other than sub-**  
4           **section (b) or (f), to an Indian tribe if the**  
5           **failure to do so would impose an undue**  
6           **burden on the Indian tribe.**

7           **“(2) SPECIAL RULE.—An Indian tribe is**  
8           **deemed to meet the requirement of sub-**  
9           **section (d) for purposes of subsections (c)**  
10          **and (e) if—**

11                  **“(A) the Secretary waives the re-**  
12                  **quirement; or**

13                  **“(B) the Secretary modifies the re-**  
14                  **quirement, and the Indian tribe**  
15                  **meets the modified requirement.**

16          **“(i) STATE REPORTS.—Each State to which**  
17          **a grant is made under this section shall sub-**  
18          **mit to the Secretary an annual report on the**  
19          **progress made by the State in addressing the**  
20          **purposes of this section. Each such report**  
21          **shall include a description of—**

22                  **“(1) the services delivered by the pro-**  
23                  **grams that received funds from the grant;**

24                  **“(2) the characteristics of each such**  
25                  **program, including information on the**

1 service model used by the program and  
2 the performance of the program;

3 “(3) the characteristics of the pro-  
4 viders of services through the program,  
5 including staff qualifications, work expe-  
6 rience, and demographic characteristics;

7 “(4) the characteristics of the recipi-  
8 ents of services provided through the  
9 program, including the number of the re-  
10 cipients, the demographic characteristics  
11 of the recipients, and family retention;

12 “(5) the annual cost of implementing  
13 the program, including the cost per fam-  
14 ily served under the program;

15 “(6) the outcomes experienced by re-  
16 cipients of services through the program;

17 “(7) the training and technical assist-  
18 ance provided to aid implementation of  
19 the program, and how the training and  
20 technical assistance contributed to the  
21 outcomes achieved through the program;

22 “(8) the indicators and methods used  
23 to monitor whether the program is being  
24 implemented as designed; and



1           **“(9) other information as determined**  
2           **necessary by the Secretary.**

3           **“(j) EVALUATION.—**

4           **“(1) IN GENERAL.—The Secretary shall,**  
5           **by grant or contract, provide for the con-**  
6           **duct of an independent evaluation of the**  
7           **effectiveness of home visitation programs**  
8           **receiving funds provided under this sec-**  
9           **tion, which shall examine the following:**

10           **“(A) The effect of home visitation**  
11           **programs on child and parent out-**  
12           **comes, including child maltreatment,**  
13           **child health and development, school**  
14           **readiness, and links to community**  
15           **services.**

16           **“(B) The effectiveness of home**  
17           **visitation programs on different pop-**  
18           **ulations, including the extent to**  
19           **which the ability of programs to im-**  
20           **prove outcomes varies across pro-**  
21           **grams and populations.**

22           **“(2) REPORTS TO THE CONGRESS.—**

23           **“(A) INTERIM REPORT.—Within 3**  
24           **years after the date of the enactment**  
25           **of this section, the Secretary shall**

1           **submit to the Congress an interim re-**  
2           **port on the evaluation conducted**  
3           **pursuant to paragraph (1).**

4           **“(B) FINAL REPORT.—Within 5**  
5           **years after the date of the enactment**  
6           **of this section, the Secretary shall**  
7           **submit to the Congress a final report**  
8           **on the evaluation conducted pursu-**  
9           **ant to paragraph (1).**

10          **“(k) ANNUAL REPORTS TO THE CONGRESS.—**  
11         **The Secretary shall submit annually to the**  
12         **Congress a report on the activities carried out**  
13         **using funds made available under this sec-**  
14         **tion, which shall include a description of the**  
15         **following:**

16                 **“(1) The high need communities tar-**  
17                 **geted by States for programs carried out**  
18                 **under this section.**

19                 **“(2) The service delivery models used**  
20                 **in the programs receiving funds provided**  
21                 **under this section.**

22                 **“(3) The characteristics of the pro-**  
23                 **grams, including—**

1           **“(A) the qualifications and demo-**  
2           **graphic characteristics of program**  
3           **staff; and**

4           **“(B) recipient characteristics in-**  
5           **cluding the number of families**  
6           **served, the demographic characteris-**  
7           **tics of the families served, and family**  
8           **retention and duration of services.**

9           **“(4) The outcomes reported by the**  
10          **programs.**

11          **“(5) The research-based instruction,**  
12          **materials, and activities being used in**  
13          **the activities funded under the grant.**

14          **“(6) The training and technical activi-**  
15          **ties, including on-going professional de-**  
16          **velopment, provided to the programs.**

17          **“(7) The annual costs of implementing**  
18          **the programs, including the cost per fam-**  
19          **ily served under the programs.**

20          **“(8) The indicators and methods used**  
21          **by States to monitor whether the pro-**  
22          **grams are being been implemented as de-**  
23          **signed.**

1       **“(1) RESERVATIONS OF FUNDS.—From the**  
2 **amounts appropriated for a fiscal year under**  
3 **subsection (m), the Secretary shall reserve—**

4               **“(1) an amount equal to 5 percent of**  
5 **the amounts to pay the cost of the evalua-**  
6 **tion provided for in subsection (j), and**  
7 **the provision to States of training and**  
8 **technical assistance, including the dis-**  
9 **semination of best practices in early**  
10 **childhood home visitation; and**

11               **“(2) after making the reservation re-**  
12 **quired by paragraph (1), an amount equal**  
13 **to 3 percent of the amount so appro-**  
14 **priated, to pay for grants to Indian tribes**  
15 **under this section.**

16       **“(m) APPROPRIATIONS.—Out of any money**  
17 **in the Treasury of the United States not other-**  
18 **wise appropriated, there is appropriated to**  
19 **the Secretary to carry out this section—**

20               **“(1) \$50,000,000 for fiscal year 2010;**

21               **“(2) \$100,000,000 for fiscal year 2011;**

22               **“(3) \$150,000,000 for fiscal year 2012;**

23               **“(4) \$200,000,000 for fiscal year 2013;**

24       **and**

25               **“(5) \$250,000,000 for fiscal year 2014.**

1       **“(n) INDIAN TRIBES TREATED AS STATES.—In**  
2 **this section, paragraphs (4), (5), and (6) of sec-**  
3 **tion 431(a) shall apply.”.**

4 **SEC. 1905. IMPROVED COORDINATION AND PROTECTION**  
5 **FOR DUAL ELIGIBLES.**

6       **Title XI of the Social Security Act is**  
7 **amended by inserting after section 1150 the**  
8 **following new section:**

9 **“IMPROVED COORDINATION AND PROTECTION FOR**  
10 **DUAL ELIGIBLES**

11 **“SEC. 1150A. (a) IN GENERAL.—The Sec-**  
12 **retary shall provide, through an identifiable**  
13 **office or program within the Centers for**  
14 **Medicare & Medicaid Services, for a focused**  
15 **effort to provide for improved coordination**  
16 **between Medicare and Medicaid and protec-**  
17 **tion in the case of dual eligibles (as defined**  
18 **in subsection (e)). The office or program**  
19 **shall—**

20       **“(1) review Medicare and Medicaid**  
21 **policies related to enrollment, benefits,**  
22 **service delivery, payment, and grievance**  
23 **and appeals processes under parts A and**  
24 **B of title XVIII, under the Medicare Ad-**  
25 **vantage program under part C of such**  
26 **title, and under title XIX;**

1           “(2) identify areas of such policies  
2 where better coordination and protection  
3 could improve care and costs; and

4           “(3) issue guidance to States regard-  
5 ing improving such coordination and pro-  
6 tection.

7           “(b) ELEMENTS.—The improved coordina-  
8 tion and protection under this section shall  
9 include efforts—

10           “(1) to simplify access of dual eligi-  
11 bles to benefits and services under Medi-  
12 care and Medicaid;

13           “(2) to improve care continuity for  
14 dual eligibles and ensure safe and effec-  
15 tive care transitions;

16           “(3) to harmonize regulatory conflicts  
17 between Medicare and Medicaid rules  
18 with regard to dual eligibles; and

19           “(4) to improve total cost and quality  
20 performance under Medicare and Med-  
21 icaid for dual eligibles.

22           “(c) RESPONSIBILITIES.—In carrying out  
23 this section, the Secretary shall provide for  
24 the following:

1           **“(1) An examination of Medicare and**  
2           **Medicaid payment systems to develop**  
3           **strategies to foster more integrated and**  
4           **higher quality care.**

5           **“(2) Development of methods to facili-**  
6           **tate access to post-acute and community-**  
7           **based services and to identify actions**  
8           **that could lead to better coordination of**  
9           **community-based care.**

10           **“(3) A study of enrollment of dual eli-**  
11           **gibles in the Medicare Savings Program**  
12           **(as defined in section 1144(c)(7)), under**  
13           **Medicaid, and in the low-income subsidy**  
14           **program under section 1860D-14 to iden-**  
15           **tify methods to more efficiently and effec-**  
16           **tively reach and enroll dual eligibles.**

17           **“(4) An assessment of communication**  
18           **strategies for dual eligibles to determine**  
19           **whether additional informational mate-**  
20           **rials or outreach is needed, including an**  
21           **assessment of the Medicare website, 1-**  
22           **800-MEDICARE, and the Medicare hand-**  
23           **book.**

24           **“(5) Research and evaluation of areas**  
25           **where service utilization, quality, and ac-**

1        **cess to cost sharing protection could be**  
2        **improved and an assessment of factors**  
3        **related to enrollee satisfaction with serv-**  
4        **ices and care delivery.**

5            **“(6) Collection (and making available**  
6        **to the public) of data and a database that**  
7        **describe the eligibility, benefit and cost-**  
8        **sharing assistance available to dual eligi-**  
9        **bles by State.**

10           **“(7) Monitoring total combined Medi-**  
11        **care and Medicaid program costs in serv-**  
12        **ing dual eligibles and making rec-**  
13        **ommendations for optimizing total qual-**  
14        **ity and cost performance across both pro-**  
15        **grams.**

16           **“(8) Coordination of activities relat-**  
17        **ing to Medicare Advantage plans under**  
18        **1859(b)(6)(B)(ii) and Medicaid.**

19           **“(d) PERIODIC REPORTS.—Not later than 1**  
20        **year after the date of the enactment of this**  
21        **section and every 3 years thereafter the Sec-**  
22        **retary shall submit to Congress a report on**  
23        **progress in activities conducted under this**  
24        **section.**

25           **“(e) DEFINITIONS.—In this section:**



1           **“(1) DUAL ELIGIBLE.—The term ‘dual**  
2 **eligible’ means an individual who is du-**  
3 **ally eligible for benefits under title XVIII,**  
4 **and medical assistance under title XIX,**  
5 **including such individuals who are eligi-**  
6 **ble for benefits under the Medicare Sav-**  
7 **ings Program (as defined in section**  
8 **1144(c)(7)).**

9           **“(2) MEDICARE; MEDICAID.—The terms**  
10 **‘Medicare’ and ‘Medicaid’ mean the pro-**  
11 **grams under titles XVIII and XIX, respec-**  
12 **tively.”.**

13 **SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE**  
14 **DISEASES AND CONDITIONS.**

15 **(a) INITIAL ASSESSMENT.—**

16           **(1) IN GENERAL.—The Administrator of**  
17 **the Centers for Medicare & Medicaid**  
18 **Services shall conduct an assessment of**  
19 **the diseases and conditions that are the**  
20 **most cost-intensive for the Medicare pro-**  
21 **gram. The assessment shall inform re-**  
22 **search priorities within the Department**  
23 **of Health and Human Services in order**  
24 **improve the prevention, or treatment or**  
25 **cure, of such diseases and conditions.**

1           **(2) REPORT.**—Not later than January  
2           **1, 2011, the Administrator shall submit to**  
3           **the Secretary of Health and Human Serv-**  
4           **ices a report on such assessment and the**  
5           **Secretary shall transmit such report to**  
6           **the Congress.**

7           **(b) UPDATES OF ASSESSMENT.**—Not later  
8           **than January 1, 2013, and biennially there-**  
9           **after, the Administrator of the Centers for**  
10           **Medicare & Medicaid Services shall review**  
11           **and update the assessment described in sub-**  
12           **section (a) and make such recommendations**  
13           **to the Secretary on changes in research prior-**  
14           **ities referred to in such subsection as may be**  
15           **appropriate. The Secretary shall submit to**  
16           **the Congress a report on such recommenda-**  
17           **tions.**

18           **(c) MEDICARE COST-INTENSIVE RESEARCH**  
19           **FUND.**—There is established in the Treasury of  
20           **the United States a Fund to be known as the**  
21           **Medicare Cost-Intensive Research Fund (in**  
22           **this subsection referred to as the “Fund”),**  
23           **consisting of such amounts as may be appro-**  
24           **riated or credited to such Fund for research**

1 priorities identified as a result of the assess-  
 2 ments conducted under this section.

3 **[DIVISION C—PUBLIC HEALTH  
 4 AND WORKFORCE DEVELOP-  
 5 MENT]**

6 **[For division C, see text of bill as intro-  
 7 duced on July 14, 2009.]**

8 *SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES,  
 9 AND SUBTITLES.*

10 *(a) TABLE OF DIVISIONS, TITLES, AND SUB-  
 11 TITLES.—This Act is divided into divisions, ti-  
 12 tles, and 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 Cov-  
 erage*

*Subtitle C—Standards Guaranteeing Access to Essential Bene-  
 fits*

*Subtitle D—Additional Consumer Protections*

*Subtitle E—Governance*

*Subtitle F—Relation to other requirements; Miscellaneous*

*Subtitle G—Early Investments*

*TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED  
 PROVISIONS*

*Subtitle A—Health Insurance Exchange*

*Subtitle B—Public health insurance option*

*Subtitle C—Individual Affordability Credits*

*Subtitle D—State innovation*

*TITLE III—SHARED RESPONSIBILITY*

*Subtitle A—Individual responsibility*

*Subtitle B—Employer Responsibility*

*[FOR DIVISION B—SEE TEXT OF INTRODUCED BILL]*

*DIVISION C—PUBLIC HEALTH AND WORKFORCE  
 DEVELOPMENT*

*[For titles I through IV of division C, see text of introduced bill.]*

*TITLE V—OTHER PROVISIONS*

*[For subtitles A , B, and C of title V, see text of introduced bill.]*

*Subtitle D—Grants for comprehensive programs to provide education to nurses and create a pipeline to nursing*

*[For subtitle E of title V, see text of introduced bill.]*

*Subtitle F—Standards for accessibility to medical equipment for individuals with disabilities.*

*Subtitle G—Other grant programs*

*Subtitle H—Long-term care and family caregiver support*

*Subtitle I—Online resources*

1       ***(b) SHORT TITLE.—This Act may be cited as***  
 2 ***the “America’s Affordable Health Choices Act***  
 3 ***of 2009”.***

4                   ***DIVISION A—AFFORDABLE***  
 5                   ***HEALTH CARE CHOICES***

6 ***SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION;***  
 7                   ***GENERAL DEFINITIONS.***

8       ***(a) PURPOSE.—***

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

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

18                   ***(3) INSURANCE REFORMS.—This divi-***  
 19 ***sion—***

20                   ***(A) enacts strong insurance mar-***  
 21 ***ket reforms;***

1           ***(B) creates a new Health Insur-***  
 2           ***ance Exchange, with a public health***  
 3           ***insurance option alongside private***  
 4           ***plans;***

5           ***(C) includes sliding scale afford-***  
 6           ***ability credits; and***

7           ***(D) initiates shared responsibility***  
 8           ***among workers, employers, and the***  
 9           ***government;***

10          ***so that all Americans have coverage of es-***  
 11          ***sential health benefits.***

12           ***(4) HEALTH DELIVERY REFORM.—This di-***  
 13           ***vision institutes health delivery system re-***  
 14           ***forms both to increase quality and to re-***  
 15           ***duce growth in health spending so that***  
 16           ***health care becomes more affordable for***  
 17           ***businesses, families, and government.***

18           ***(b) TABLE OF CONTENTS OF DIVISION.—The***  
 19          ***table of contents of this division is as follows:***

***Sec. 100. Purpose; table of contents of division; general defini-***  
***tions.***

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

***Subtitle A—General Standards***

***Sec. 101. Requirements reforming health insurance market-***  
***place.***

***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; parity in mental health and substance abuse disorder benefits.*
- Sec. 115. Ensuring adequacy of provider networks.*
- Sec. 116. Ensuring value and lower premiums.*
- Sec. 117. Consistency of costs and coverage under qualified health benefits plans during plan year.*

*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 standards.*
- Sec. 125. Prohibition of discrimination in health care services based on religious or spiritual content.*

*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.*
- Sec. 137. Application of administrative simplification.*
- Sec. 138. Records relative to prescription information.*

*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.*
- Sec. 153. Whistleblower protection.*
- Sec. 154. Construction regarding collective bargaining.*
- Sec. 155. Severability.*
- Sec. 156. Rule of construction regarding Hawaii Prepaid Health Care Act.*
- Sec. 157. Increasing meaningful use of electronic health records.*
- Sec. 158. Private right of contract with health care providers.*

*Subtitle G—Early Investments*

*[For sections 161-163. See text of introduced bill.]*

*Sec. 164. Reinsurance program for retirees.*

*Sec. 165. Prohibition against post-retirement reductions of retiree health benefits by group health plans.*

*Sec. 166. Limitations on preexisting condition exclusions in group health plans in advance of applicability of new prohibition of preexisting condition exclusions.*

*Sec. 167. Extension of COBRA continuation coverage.*

## **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.*

*Sec. 209. Participation of small employer benefit arrangements.*

### **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.*

*Sec. 227. Sense of the House regarding enrollment of Members in the public option.*

### **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.*

### **Subtitle D—State Innovation**

*Sec. 251. Waiver of ERISA limitation; application instead of state single payer system.*

*Sec. 252. Requirements.*

*Sec. 253. Definitions.*

**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. 324. Additional rules relating to health coverage participation requirements.*

*[FOR TITLE IV, SEE TEXT OF INTRODUCED BILL.]*

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

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

5               **(2) BASIC PLAN.—***The term “basic*  
6               **plan”** *has the meaning given such term in*  
7               **section 203(c).**

8               **(3) COMMISSIONER.—***The term “Com-*  
9               **missioner”** *means the Health Choices*  
10              **Commissioner established under section**  
11              **141.**  
12



1           **(4) COST-SHARING.**—*The term “cost-*  
2 *sharing” includes deductibles, coinsur-*  
3 *ance, copayments, and similar charges*  
4 *but does not include premiums or any net-*  
5 *work payment differential for covered*  
6 *services or spending for non-covered serv-*  
7 *ices.*

8           **(5) DEPENDENT.**—*The term “depend-*  
9 *ent” has the meaning given such term by*  
10 *the Commissioner and includes a spouse.*

11           **(6) EMPLOYMENT-BASED HEALTH PLAN.**—  
12 *The term “employment-based health*  
13 *plan”—*

14                   **(A)** *means a group health plan (as*  
15 *defined in section 733(a)(1) of the Em-*  
16 *ployee Retirement Income Security Act*  
17 *of 1974);*

18                   **(B)** *includes such a plan that is*  
19 *the following:*

20                           **(i) FEDERAL, STATE, AND TRIBAL**  
21 **GOVERNMENTAL PLANS.**—*A govern-*  
22 *mental plan (as defined in section*  
23 *3(32) of the Employee Retirement*  
24 *Income Security Act of 1974), in-*  
25 *cluding a health benefits plan of-*

1            *ferred under chapter 89 of title 5,*  
2            *United States Code; or*

3            *(ii) CHURCH PLANS.—A church*  
4            *plan (as defined in section 3(33) of*  
5            *the Employee Retirement Income*  
6            *Security Act of 1974); and*

7            *(C) excludes coverage described in*  
8            *section 202(d)(2)(E) (relating to*  
9            *TRICARE).*

10          *(7) ENHANCED PLAN.—The term “en-*  
11          *hanced plan” has the meaning given such*  
12          *term in section 203(c).*

13          *(8) ESSENTIAL BENEFITS PACKAGE.—The*  
14          *term “essential benefits package” is de-*  
15          *fined in section 122(a).*

16          *(9) FAMILY.—The term “family” means*  
17          *an individual and includes the individ-*  
18          *ual’s dependents.*

19          *(10) FEDERAL POVERTY LEVEL; FPL.—The*  
20          *terms “Federal poverty level” and “FPL”*  
21          *have the meaning given the term “poverty*  
22          *line” in section 673(2) of the Community*  
23          *Services Block Grant Act (42 U.S.C.*  
24          *9902(2)), including any revision required*  
25          *by such section.*

1           **(11) HEALTH BENEFITS PLAN.**—*The*  
2           *terms “health benefits plan” means health*  
3           *insurance coverage and an employment-*  
4           *based health plan and includes the public*  
5           *health insurance option.*

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

12           **(13) HEALTH INSURANCE EXCHANGE.**—  
13           *The term “Health Insurance Exchange”*  
14           *means the Health Insurance Exchange es-*  
15           *tablished under section 201.*

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

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

1           **(16) PLAN SPONSOR.**—*The term “plan*  
2 *sponsor” has the meaning given such term*  
3 *in section 3(16)(B) of the Employee Retire-*  
4 *ment Income Security Act of 1974.*

5           **(17) PLAN YEAR.**—*The term “plan year”*  
6 *means—*

7                   **(A)** *with respect to an employment-*  
8 *based health plan, a plan year as*  
9 *specified under such plan; or*

10                   **(B)** *with respect to a health bene-*  
11 *fits plan other than an employment-*  
12 *based health plan, a 12-month period*  
13 *as specified by the Commissioner.*

14           **(18) PREMIUM PLAN; PREMIUM-PLUS**  
15 **PLAN.**—*The terms “premium plan” and*  
16 *“premium-plus plan” have the meanings*  
17 *given such terms in section 203(c).*

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

21                   **(A)** *a group health plan (as de-*  
22 *defined, subject to subsection (d), in sec-*  
23 *tion 733(a)(1) of the Employee Retire-*  
24 *ment Income Security Act of 1974), the*  
25 *plan sponsor in relation to such group*

1 *health plan, except that, in the case of*  
2 *a plan maintained jointly by 1 or*  
3 *more employers and 1 or more em-*  
4 *ployee organizations and with respect*  
5 *to which an employer is the primary*  
6 *source of financing, such term means*  
7 *such employer;*

8 *(B) health insurance coverage, the*  
9 *health insurance issuer offering the*  
10 *coverage;*

11 *(C) the public health insurance*  
12 *option, the Secretary of Health and*  
13 *Human Services;*

14 *(D) a non-Federal governmental*  
15 *plan (as defined in section 2791(d) of*  
16 *the Public Health Service Act), the*  
17 *State or political subdivision of a*  
18 *State (or agency or instrumentality of*  
19 *such State or subdivision) which es-*  
20 *tablishes or maintains such plan; or*

21 *(E) a Federal governmental plan*  
22 *(as defined in section 2791(d) of the*  
23 *Public Health Service Act), the appro-*  
24 *priate Federal official.*

1           **(20) QUALIFIED HEALTH BENEFITS**  
2           **PLAN.—The term “qualified health benefits**  
3           **plan” means a health benefits plan that**  
4           **meets the requirements for such a plan**  
5           **under title I and includes the public**  
6           **health insurance option.**

7           **(21) PUBLIC HEALTH INSURANCE OP-**  
8           **TION.—The term “public health insurance**  
9           **option” means the public health insur-**  
10          **ance option as provided under subtitle B**  
11          **of title II.**

12          **(22) SERVICE AREA; PREMIUM RATING**  
13          **AREA.—The terms “service area” and “pre-**  
14          **mium rating area” mean with respect to**  
15          **health insurance coverage—**

16                 **(A) offered other than through the**  
17                 **Health Insurance Exchange, such an**  
18                 **area as established by the QHBP offer-**  
19                 **ing entity of such coverage in accord-**  
20                 **ance with applicable State law; and**

21                 **(B) offered through the Health In-**  
22                 **surance Exchange, such an area as es-**  
23                 **tablished by such entity in accordance**  
24                 **with applicable State law and appli-**  
25                 **cable rules of the Commissioner for**

1           *Exchange-participating health bene-*  
2           *fits plans.*

3           (23) *STATE.—The term “State” means*  
4           *the 50 States and the District of Colum-*  
5           *bia.*

6           (24) *STATE MEDICAID AGENCY.—The*  
7           *term “State Medicaid agency” means, with*  
8           *respect to a Medicaid plan, the single*  
9           *State agency responsible for admin-*  
10          *istering such plan under title XIX of the*  
11          *Social Security Act.*

12          (25) *Y1, Y2, ETC.—The terms “Y1” ,*  
13          *“Y2”, “Y3”, “Y4”, “Y5”, and similar subse-*  
14          *quently numbered terms, mean 2013 and*  
15          *subsequent years, respectively.*

16          (26) *EMPLOYEE PREMIUM.—The term*  
17          *“employee premium” does not include a*  
18          *collectively bargained premium in the*  
19          *case of a group health plan (as defined in*  
20          *section 733(a)(1) of the Employee Retire-*  
21          *ment Income Security Act of 1974) that is*  
22          *a multiemployer plan (as defined in sec-*  
23          *tion 3(37) of such Act).*

1 **TITLE I—PROTECTIONS AND**  
2 **STANDARDS FOR QUALIFIED**  
3 **HEALTH BENEFITS PLANS**

4 **Subtitle A—General Standards**

5 **SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE**  
6 **MARKETPLACE.**

7 **(a) PURPOSE.—***The purpose of this title is*  
8 *to establish standards to ensure that new*  
9 *health insurance coverage and employment-*  
10 *based health plans that are offered meet*  
11 *standards guaranteeing access to affordable*  
12 *coverage, essential benefits, and other con-*  
13 *sumer protections.*

14 **(b) REQUIREMENTS FOR QUALIFIED HEALTH**  
15 **BENEFITS PLANS.—***On or after the first day of*  
16 *Y1, a health benefits plan shall not be a quali-*  
17 *fied health benefits plan under this division*  
18 *unless the plan meets the applicable require-*  
19 *ments of the following subtitles for the type of*  
20 *plan and plan year involved:*

21 **(1) Subtitle B (relating to affordable**  
22 **coverage).**

23 **(2) Subtitle C (relating to essential**  
24 **benefits).**



1           **(3) Subtitle D (relating to consumer**  
2 **protection).**

3           **(c) TERMINOLOGY.—In this division:**

4           **(1) ENROLLMENT IN EMPLOYMENT-BASED**  
5 **HEALTH PLANS.—An individual shall be**  
6 **treated as being “enrolled” in an employ-**  
7 **ment-based health plan if the individual**  
8 **is a participant or beneficiary (as such**  
9 **terms are defined in section 3(7) and 3(8),**  
10 **respectively, of the Employee Retirement**  
11 **Income Security Act of 1974) in such plan.**

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

20           **(d) SENSE OF CONGRESS ON HEALTH CARE**  
21 **NEEDS OF UNITED STATES TERRITORIES.—It is**  
22 **the sense of the Congress that the reforms**  
23 **made by H.R. 3200, as introduced, must be**  
24 **strengthened to meaningfully address the**  
25 **health care needs of residents of American**

1 *Samoa, the Commonwealth of the Northern*  
2 *Mariana Islands, Guam, Puerto Rico, and the*  
3 *United States Virgin Islands and Congress is*  
4 *committed to working with the representatives*  
5 *of these territories to ensure that residents of*  
6 *these territories have access to high-quality*  
7 *and affordable health care in such a way that*  
8 *best serves their unique needs.*

9 *SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT*  
10 *COVERAGE.*

11 *(a) GRANDFATHERED HEALTH INSURANCE*  
12 *COVERAGE DEFINED.—Subject to the succeeding*  
13 *provisions of this section, for purposes of es-*  
14 *tablishing acceptable coverage under this di-*  
15 *vision, the term “grandfathered health insur-*  
16 *ance coverage” means individual health in-*  
17 *surance coverage that is offered and in force*  
18 *and effect before the first day of Y1 if the fol-*  
19 *lowing conditions are met:*

20 *(1) LIMITATION ON NEW ENROLLMENT.—*

21 *(A) IN GENERAL.—Except as pro-*  
22 *vided in this paragraph, the indi-*  
23 *vidual health insurance issuer offer-*  
24 *ing such coverage does not enroll any*  
25 *individual in such coverage if the first*

1           *effective date of coverage is on or after*  
2           *the first day of Y1.*

3           **(B) DEPENDENT COVERAGE PER-**  
4           **MITTED.—***Subparagraph (A) shall not*  
5           *affect the subsequent enrollment of a*  
6           *dependent of an individual who is*  
7           *covered as of such first day.*

8           **(2) LIMITATION ON CHANGES IN TERMS**  
9           **OR CONDITIONS.—***Subject to paragraph (3)*  
10          *and except as required by law, the issuer*  
11          *does not change any of its terms or condi-*  
12          *tions, including benefits and cost-sharing,*  
13          *from those in effect as of the day before*  
14          *the first day of Y1.*

15          **(3) RESTRICTIONS ON PREMIUM IN-**  
16          **CREASES.—***The issuer cannot vary the per-*  
17          *centage increase in the premium for a*  
18          *risk group of enrollees in specific grand-*  
19          *fathered health insurance coverage with-*  
20          *out changing the premium for all enroll-*  
21          *ees in the same risk group at the same*  
22          *rate, as specified by the Commissioner.*

23          **(b) GRACE PERIOD FOR CURRENT EMPLOY-**  
24          **MENT-BASED HEALTH PLANS.—**

25                 **(1) GRACE PERIOD.—**

1           **(A) IN GENERAL.—***The Commis-*  
2           *sioner shall establish a grace period*  
3           *whereby, for plan years beginning*  
4           *after the end of the 5-year period be-*  
5           *ginning with Y1, an employment-*  
6           *based health plan in operation as of*  
7           *the day before the first day of Y1 must*  
8           *meet the same requirements as apply*  
9           *to a qualified health benefits plan*  
10           *under section 101, including the essen-*  
11           *tial benefit package requirement*  
12           *under section 121.*

13           **(B) EXCEPTION FOR LIMITED BENE-**  
14           **FITS PLANS.—***Subparagraph (A) shall*  
15           *not apply to an employment-based*  
16           *health plan in which the coverage*  
17           *consists only of one or more of the fol-*  
18           *lowing:*

19                   *(i) Any coverage described in*  
20                   *section 3001(a)(1)(B)(ii)(IV) of di-*  
21                   *vision B of the American Recovery*  
22                   *and Reinvestment Act of 2009 (PL*  
23                   *111-5).*

24                   *(ii) Excepted benefits (as de-*  
25                   *finied in section 733(c) of the Em-*

1            *ployee Retirement Income Security*  
2            *Act of 1974), including coverage*  
3            *under a specified disease or ill-*  
4            *ness policy described in para-*  
5            *graph (3)(A) of such section.*

6            *(iii) Such other limited bene-*  
7            *fits as the Commissioner may*  
8            *specify.*

9            *In no case shall an employment-based*  
10           *health plan in which the coverage*  
11           *consists only of one or more of the cov-*  
12           *erage or benefits described in clauses*  
13           *(i) through (iii) be treated as accept-*  
14           *able coverage under this division*

15           *(2) TRANSITIONAL TREATMENT AS AC-*  
16           *CEPTABLE COVERAGE.—During the grace pe-*  
17           *riod specified in paragraph (1)(A), an em-*  
18           *ployment-based health plan that is de-*  
19           *scribed in such paragraph shall be treat-*  
20           *ed as acceptable coverage under this divi-*  
21           *sion.*

22           *(3) EXCEPTION FOR CONSUMER-DIRECTED*  
23           *HEALTH PLANS AND ARRANGEMENTS.—In the*  
24           *case of a group health plan which con-*  
25           *sists of a consumer-directed health plan*

1 *or arrangement (including a high deduct-*  
2 *ible health plan, within the meaning of*  
3 *section 223(c)(2) of the Internal Revenue*  
4 *Code of 1986), such group health plan*  
5 *shall be treated as acceptable coverage*  
6 *under a current group health plan for*  
7 *purposes of this division.*

8 **(c) LIMITATION ON INDIVIDUAL HEALTH IN-**  
9 **SURANCE COVERAGE.—**

10 **(1) IN GENERAL.—***Individual health in-*  
11 *surance coverage that is not grand-*  
12 *fathered health insurance coverage under*  
13 *subsection (a) may only be offered on or*  
14 *after the first day of Y1 as an Exchange-*  
15 *participating health benefits plan.*

16 **(2) SEPARATE, EXCEPTED COVERAGE PER-**  
17 **MITTED.—***Excepted benefits (as defined in*  
18 *section 2791(c) of the Public Health Serv-*  
19 *ice Act) are not included within the defi-*  
20 *nition of health insurance coverage. Noth-*  
21 *ing in paragraph (1) shall prevent the of-*  
22 *fering, other than through the Health In-*  
23 *surance Exchange, of excepted benefits so*  
24 *long as it is offered and priced separately*  
25 *from health insurance coverage.*

1 ***Subtitle B—Standards Guaranteing Access to Affordable Cov-***  
2 ***erage***  
3

4 ***SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLU-***  
5 ***SIONS.***

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

16 ***SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR INSURED***  
17 ***PLANS.***

18 ***The requirements of sections 2711 (other***  
19 ***than subsections (c) and (e)) and 2712 (other***  
20 ***than paragraphs (3), and (6) of subsection (b)***  
21 ***and subsection (e)) of the Public Health Serv-***  
22 ***ice Act, relating to guaranteed availability***  
23 ***and renewability of health insurance cov-***  
24 ***erage, shall apply to individuals and employ-***  
25 ***ers in all individual and group health insur-***

1 *ance coverage, whether offered to individuals*  
2 *or employers through the Health Insurance*  
3 *Exchange, through any employment-based*  
4 *health plan, or otherwise, in the same manner*  
5 *as such sections apply to employers and health*  
6 *insurance coverage offered in the small group*  
7 *market, except that such section 2712(b)(1)*  
8 *shall apply only if, before nonrenewal or dis-*  
9 *continuation of coverage, the issuer has pro-*  
10 *vided the enrollee with notice of non-payment*  
11 *of premiums and there is a grace period dur-*  
12 *ing which the enrollees has an opportunity to*  
13 *correct such nonpayment. Rescissions of such*  
14 *coverage shall be prohibited except in cases of*  
15 *fraud as defined in sections 2712(b)(2) of such*  
16 *Act.*

17 *SEC. 113. INSURANCE RATING RULES.*

18 *(a) IN GENERAL.—The premium rate*  
19 *charged for an insured qualified health bene-*  
20 *fits plan may not vary except as follows:*

21 *(1) LIMITED AGE VARIATION PER-*  
22 *MITTED.—By age (within such age cat-*  
23 *egories as the Commissioner shall specify)*  
24 *so long as the ratio of the highest such*



1 *premium to the lowest such premium does*  
2 *not exceed the ratio of 2 to 1.*

3 (2) *BY AREA.—By premium rating area*  
4 *(as permitted by State insurance regu-*  
5 *lators or, in the case of Exchange-partici-*  
6 *pating health benefits plans, as specified*  
7 *by the Commissioner in consultation with*  
8 *such regulators).*

9 (3) *BY FAMILY ENROLLMENT.—By family*  
10 *enrollment (such as variations within cat-*  
11 *egories and compositions of families) so*  
12 *long as the ratio of the premium for fam-*  
13 *ily enrollment (or enrollments) to the pre-*  
14 *mium for individual enrollment is uni-*  
15 *form, as specified under State law and*  
16 *consistent with rules of the Commissioner.*

17 (b) *STUDY AND REPORTS.—*

18 (1) *STUDY.—The Commissioner, in co-*  
19 *ordination with the Secretary of Health*  
20 *and Human Services and the Secretary of*  
21 *Labor, shall conduct a study of the large*  
22 *group insured and self-insured employer*  
23 *health care markets. Such study shall ex-*  
24 *amine the following:*

1           (A) *The types of employers by key*  
2 *characteristics, including size, that*  
3 *purchase insured products versus*  
4 *those that self-insure.*

5           (B) *The similarities and dif-*  
6 *ferences between typical insured and*  
7 *self-insured health plans.*

8           (C) *The financial solvency and*  
9 *capital reserve levels of employers*  
10 *that self-insure by employer size.*

11           (D) *The risk of self-insured em-*  
12 *ployers not being able to pay obliga-*  
13 *tions or otherwise becoming finan-*  
14 *cially insolvent.*

15           (E) *The extent to which rating*  
16 *rules are likely to cause adverse selec-*  
17 *tion in the large group market or to*  
18 *encourage small and mid size employ-*  
19 *ers to self-insure*

20           (2) *REPORTS.—Not later than 18*  
21 *months after the date of the enactment of*  
22 *this Act, the Commissioner shall submit to*  
23 *Congress and the applicable agencies a*  
24 *report on the study conducted under para-*  
25 *graph (1). Such report shall include any*

1 *recommendations the Commissioner*  
2 *deems appropriate to ensure that the law*  
3 *does not provide incentives for small and*  
4 *mid-size employers to self-insure or create*  
5 *adverse selection in the risk pools of large*  
6 *group insurers and self-insured employ-*  
7 *ers. Not later than 18 months after the*  
8 *first day of Y1, the Commissioner shall*  
9 *submit to Congress and the applicable*  
10 *agencies an updated report on such study,*  
11 *including updates on such recommenda-*  
12 *tions.*

13 *SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN*  
14 *MENTAL HEALTH AND SUBSTANCE ABUSE*  
15 *DISORDER BENEFITS.*

16 *(a) NONDISCRIMINATION IN BENEFITS.—A*  
17 *qualified health benefits plan shall comply*  
18 *with standards established by the Commis-*  
19 *sioner to prohibit discrimination in health*  
20 *benefits or benefit structures for qualified*  
21 *health benefits plans, building from sections*  
22 *702 of Employee Retirement Income Security*  
23 *Act of 1974, 2702 of the Public Health Service*  
24 *Act, and section 9802 of the Internal Revenue*  
25 *Code of 1986.*

1       **(b) PARITY IN MENTAL HEALTH AND SUB-**  
2 **STANCE ABUSE DISORDER BENEFITS.—To the ex-**  
3 **tent such provisions are not superceded by or**  
4 **inconsistent with subtitle C, the provisions of**  
5 **section 2705 (other than subsections (a)(1),**  
6 **(a)(2), and (c)) of section 2705 of the Public**  
7 **Health Service Act shall apply to a qualified**  
8 **health benefits plan, regardless of whether it**  
9 **is offered in the individual or group market,**  
10 **in the same manner as such provisions apply**  
11 **to health insurance coverage offered in the**  
12 **large group market.**

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

14       **(a) IN GENERAL.—A qualified health bene-**  
15 **fits plan that uses a provider network for**  
16 **items and services shall meet such standards**  
17 **respecting provider networks as the Commis-**  
18 **sioner may establish to assure the adequacy of**  
19 **such networks in ensuring enrollee access to**  
20 **such items and services and transparency in**  
21 **the cost-sharing differentials between in-net-**  
22 **work coverage and out-of-network coverage.**

23       **(b) INTERNET ACCESS TO INFORMATION.—A**  
24 **qualified health benefits plan that uses a pro-**  
25 **vider network shall provide a current listing**

1 *of all providers in its network on its website*  
2 *and such data shall be available on the*  
3 *Health Insurance Exchange website as a ‘click*  
4 *through’ from the basic information on that*  
5 *plan. The Commissioner shall also establish*  
6 *an on-line system whereby an individual may*  
7 *select by name any medical provider (as de-*  
8 *fin ed by the Commissioner) and be informed of*  
9 *the plan or plans with which that provider is*  
10 *contracting.*

11 *(c) PROVIDER NETWORK DEFINED.—In this*  
12 *division, the term “provider network” means*  
13 *the providers with respect to which covered*  
14 *benefits, treatments, and services are avail-*  
15 *able under a health benefits plan.*

16 *SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.*

17 *The QHBP offering entity shall provide*  
18 *that for any plan year in which a qualified*  
19 *health benefits plan that the entity offers has*  
20 *a medical loss ratio (expressed as a percent-*  
21 *age) that is less than a percentage (not less*  
22 *than 85 percent) specified by the Commis-*  
23 *sioner, the QHBP offering entity offering such*  
24 *plan shall provide for rebates to enrollees of*  
25 *payment sufficient to meet such loss ratio. The*

1 *Commissioner shall establish a uniform defi-*  
2 *inition of medical loss ratio and methodology*  
3 *for determining how to calculate the medical*  
4 *loss ratio. Such methodology shall be designed*  
5 *to take into account the special circumstances*  
6 *of smaller and newer plans.*

7 *SEC. 117. CONSISTENCY OF COSTS AND COVERAGE UNDER*  
8 *QUALIFIED HEALTH BENEFITS PLANS DUR-*  
9 *ING PLAN YEAR.*

10 *In the case of health insurance coverage*  
11 *offered under a qualified health benefits plan,*  
12 *the coverage and cost of coverage may not be*  
13 *changed during the course of a plan year ex-*  
14 *cept to increase coverage to the enrollee or to*  
15 *lower costs to the enrollee.*

16 *Subtitle C—Standards Guarant-*  
17 *teeing Access to Essential Bene-*  
18 *fits*

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

20 *(a) IN GENERAL.—A qualified health bene-*  
21 *fits plan shall provide coverage that at least*  
22 *meets the benefit standards adopted under sec-*  
23 *tion 124 for the essential benefits package de-*  
24 *scribed in section 122 for the plan year in-*  
25 *volved.*

1       **(b) CHOICE OF COVERAGE.—**

2               **(1)           NON-EXCHANGE-PARTICIPATING**  
3       **HEALTH BENEFITS PLANS.—***In the case of a*  
4       *qualified health benefits plan that is not*  
5       *an Exchange-participating health bene-*  
6       *fits plan, such plan may offer such cov-*  
7       *erage in addition to the essential benefits*  
8       *package as the QHBP offering entity may*  
9       *specify.*

10              **(2)   EXCHANGE-PARTICIPATING   HEALTH**  
11       **BENEFITS PLANS.—***In the case of an Ex-*  
12       *change-participating   health   benefits*  
13       *plan, such plan is required under section*  
14       *203 to provide specified levels of benefits*  
15       *and, in the case of a plan offering a pre-*  
16       *mium-plus level of benefits, provide addi-*  
17       *tional benefits.*

18              **(3)   CONTINUATION OF OFFERING OF SEP-**  
19       **ARATE   EXCEPTED   BENEFITS   COVERAGE.—**  
20       *Nothing in this division shall be con-*  
21       *strued as affecting the offering of health*  
22       *benefits in the form of excepted benefits*  
23       *(described in section 102(b)(1)(B)(ii)) if*  
24       *such benefits are offered under a separate*

1 *policy, contract, or certificate of insur-*  
2 *ance.*

3 **(c) NO RESTRICTIONS ON COVERAGE UNRE-**  
4 **LATED TO CLINICAL APPROPRIATENESS.—A quali-**  
5 **fied health benefits plan may not impose any**  
6 **restriction (other than cost-sharing) unrelated**  
7 **to clinical appropriateness on the coverage of**  
8 **the health care items and services.**

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

10 **(a) IN GENERAL.—In this division, the term**  
11 **“essential benefits package” means health**  
12 **benefits coverage, consistent with standards**  
13 **adopted under section 124 to ensure the provi-**  
14 **sion of quality health care and financial secu-**  
15 **rity, that—**

16 **(1) provides payment for the items and**  
17 **services described in subsection (b) in ac-**  
18 **cordance with generally accepted stand-**  
19 **ards of medical or other appropriate clin-**  
20 **ical or professional practice;**

21 **(2) limits cost-sharing for such cov-**  
22 **ered health care items and services in ac-**  
23 **cordance with such benefit standards,**  
24 **consistent with subsection (c);**



1           ***(3) does not impose any annual or life-***  
2           ***time limit on the coverage of covered***  
3           ***health care items and services;***

4           ***(4) complies with section 115(a) (relat-***  
5           ***ing to network adequacy); and***

6           ***(5) is equivalent, as certified by Office***  
7           ***of the Actuary of the Centers for Medicare***  
8           ***& Medicaid Services, to the average pre-***  
9           ***vailing employer-sponsored coverage.***

10          ***(b) MINIMUM SERVICES TO BE COVERED.—***  
11         ***The items and services described in this sub-***  
12         ***section are the following:***

13                 ***(1) Hospitalization.***

14                 ***(2) Outpatient hospital and outpatient***  
15                 ***clinic services, including emergency de-***  
16                 ***partment services.***

17                 ***(3) Professional services of physicians***  
18                 ***and other health professionals.***

19                 ***(4) Such services, equipment, and sup-***  
20                 ***plies incident to the services of a physi-***  
21                 ***cian's or a health professional's delivery***  
22                 ***of care in institutional settings, physician***  
23                 ***offices, patients' homes or place of resi-***  
24                 ***dence, or other settings, as appropriate.***

25                 ***(5) Prescription drugs.***

1           ***(6) Rehabilitative and habilitative***  
2           ***services.***

3           ***(7) Mental health and substance use***  
4           ***disorder services.***

5           ***(8) Preventive services, including***  
6           ***those services recommended with a grade***  
7           ***of A or B by the Task Force on Clinical***  
8           ***Preventive Services and including mental***  
9           ***health and substance abuse services rec-***  
10           ***ommended by the Task Force on Clinical***  
11           ***Preventive Services and those mental***  
12           ***health and substance abuse services with***  
13           ***compelling research or evidence, includ-***  
14           ***ing Screening, Brief Intervention and Re-***  
15           ***ferral to Treatment (SBIRT), and those***  
16           ***vaccines recommended for use by the Di-***  
17           ***rector of the Centers for Disease Control***  
18           ***and Prevention.***

19           ***(9) Maternity care.***

20           ***(10) Well baby and well child care and***  
21           ***early and periodic screening, diagnostic,***  
22           ***and treatment services (as defined in sec-***  
23           ***tion 1905(r) of the Social Security Act) at***  
24           ***least for children under 21 years of age.***

1           ***(11) Durable medical equipment, pros-***  
2           ***thetics, orthotics and related supplies.***

3           ***(c) REQUIREMENTS RELATING TO COST-SHAR-***  
4           ***ING AND MINIMUM ACTUARIAL VALUE.—***

5           ***(1) NO COST-SHARING FOR PREVENTIVE***  
6           ***SERVICES.—There shall be no cost-sharing***  
7           ***under the essential benefits package for***  
8           ***preventive items and services (as specified***  
9           ***under the benefit standards), including***  
10           ***well baby and well child care.***

11           ***(2) ANNUAL LIMITATION.—***

12           ***(A) ANNUAL LIMITATION.—The cost-***  
13           ***sharing incurred under the essential***  
14           ***benefits package with respect to an in-***  
15           ***dividual (or family) for a year does***  
16           ***not exceed the applicable level speci-***  
17           ***fied in subparagraph (B).***

18           ***(B) APPLICABLE LEVEL.—The appli-***  
19           ***cable level specified in this subpara-***  
20           ***graph for Y1 is \$5,000 for an indi-***  
21           ***vidual and \$10,000 for a family. Such***  
22           ***levels shall be increased (rounded to***  
23           ***the nearest \$100) for each subsequent***  
24           ***year by the annual percentage in-***  
25           ***crease in the Consumer Price Index***

1           *(United States city average) applica-*  
2           *ble to such year.*

3           **(C) USE OF COPAYMENTS.**—*In estab-*  
4           *lishing cost-sharing levels for basic,*  
5           *enhanced, and premium plans under*  
6           *this subsection, the Secretary shall, to*  
7           *the maximum extent possible, use only*  
8           *copayments and not coinsurance.*

9           **(3) MINIMUM ACTUARIAL VALUE.**—

10           **(A) IN GENERAL.**—*The cost-sharing*  
11           *under the essential benefits package*  
12           *shall be designed to provide a level of*  
13           *coverage that is designed to provide*  
14           *benefits that are actuarially equiva-*  
15           *lent to approximately 70 percent of the*  
16           *full actuarial value of the benefits*  
17           *provided under the reference benefits*  
18           *package described in subparagraph*  
19           *(B).*

20           **(B) REFERENCE BENEFITS PACKAGE**  
21           **DESCRIBED.**—*The reference benefits*  
22           *package described in this subpara-*  
23           *graph is the essential benefits pack-*  
24           *age if there were no cost-sharing im-*  
25           *posed.*

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

2 **(a) ESTABLISHMENT.—**

3 **(1) IN GENERAL.—***There is established*  
4 *a private-public advisory committee*  
5 *which shall be a panel of medical and*  
6 *other experts to be known as the Health*  
7 *Benefits Advisory Committee to rec-*  
8 *ommend covered benefits and essential,*  
9 *enhanced, and premium plans.*

10 **(2) CHAIR.—***The Surgeon General shall*  
11 *be a member and the chair of the Health*  
12 *Benefits Advisory Committee.*

13 **(3) MEMBERSHIP.—***The Health Benefits*  
14 *Advisory Committee shall be composed of*  
15 *the following members, in addition to the*  
16 *Surgeon General:*

17 **(A)** *9 members who are not Fed-*  
18 *eral employees or officers and who are*  
19 *appointed by the President.*

20 **(B)** *9 members who are not Fed-*  
21 *eral employees or officers and who are*  
22 *appointed by the Comptroller General*  
23 *of the United States in a manner simi-*  
24 *lar to the manner in which the Comp-*  
25 *troller General appoints members to*  
26 *the Medicare Payment Advisory Com-*

1           *mission under section 1805(c) of the*  
2           *Social Security Act.*

3           (C) *Such even number of members*  
4           *(not to exceed 8) who are Federal em-*  
5           *ployees and officers, as the President*  
6           *may appoint.*

7           *The membership of the Committee shall*  
8           *include one or more experts in scientific*  
9           *evidence and clinical practice of integra-*  
10          *tive health care services. Such initial ap-*  
11          *pointments shall be made not later than*  
12          *60 days after the date of the enactment of*  
13          *this Act.*

14          (4) *TERMS.—Each member of the*  
15          *Health Benefits Advisory Committee shall*  
16          *serve a 3-year term on the Committee, ex-*  
17          *cept that the terms of the initial members*  
18          *shall be adjusted in order to provide for a*  
19          *staggered term of appointment for all*  
20          *such members.*

21          (5) *PARTICIPATION.—The membership*  
22          *of the Health Benefits Advisory Committee*  
23          *shall at least reflect providers, employers,*  
24          *labor, health insurance issuers, experts in*  
25          *health care financing and delivery, ex-*

1 *perts in racial and ethnic disparities, ex-*  
2 *perts in care for those with disabilities,*  
3 *representatives of relevant governmental*  
4 *agencies. and at least one practicing phy-*  
5 *sician or other health professional and an*  
6 *expert on children’s health and shall rep-*  
7 *resent a balance among various sectors of*  
8 *the health care system so that no single*  
9 *sector unduly influences the recommenda-*  
10 *tions of such Committee. The membership*  
11 *of the Committee shall also include edu-*  
12 *cated patients, consumer advocates, or*  
13 *both, who shall include persons who rep-*  
14 *resent individuals affected by a specific*  
15 *disease or medical condition, are knowl-*  
16 *edgeable about the health care system,*  
17 *and have received training regarding*  
18 *health, medical, and scientific matters.*

19 **(b) DUTIES.—**

20 **(1) RECOMMENDATIONS ON BENEFIT**  
21 **STANDARDS.—***The Health Benefits Advisory*  
22 *Committee shall recommend to the Sec-*  
23 *retary of Health and Human Services (in*  
24 *this subtitle referred to as the “Sec-*  
25 *retary”) benefit standards (as defined in*

1 *paragraph (4)), and periodic updates to*  
2 *such standards. In developing such rec-*  
3 *ommendations, the Committee shall—*

4 *(A) take into account innovation*  
5 *in health care,*

6 *(B) consider how such standards*  
7 *could reduce health disparities,*

8 *(C) take into account integrative*  
9 *health care services, and*

10 *(D) take into account typical mul-*  
11 *tiemployer plan benefit structures and*  
12 *the impact of the essential benefit*  
13 *package on such plans.*

14 *(2) DEADLINE.—The Health Benefits*  
15 *Advisory Committee shall recommend ini-*  
16 *tial benefit standards to the Secretary not*  
17 *later than 1 year after the date of the en-*  
18 *actment of this Act.*

19 *(3) STATE INPUT.—The Health Benefits*  
20 *Advisory Committee shall examine the*  
21 *health coverage laws and benefits of each*  
22 *State in developing recommendations*  
23 *under this subsection and may incor-*  
24 *porate such coverage and benefits as the*  
25 *Committee determines to be appropriate*



1 *and consistent with this Act. The Health*  
2 *Benefits Advisory Committee shall also*  
3 *seek input from the States and consider*  
4 *recommendations on how to ensure that*  
5 *the quality of health coverage does not de-*  
6 *cline in any State.*

7 (4) *PUBLIC INPUT.—The Health Bene-*  
8 *fits Advisory Committee shall allow for*  
9 *public input as a part of developing rec-*  
10 *ommendations under this subsection.*

11 (5) *BENEFIT STANDARDS DEFINED.—In*  
12 *this subtitle, the term “benefit standards”*  
13 *means standards respecting—*

14 (A) *the essential benefits package*  
15 *described in section 122, including*  
16 *categories of covered treatments, items*  
17 *and services within benefit classes,*  
18 *and cost-sharing; and*

19 (B) *the cost-sharing levels for en-*  
20 *hanced plans and premium plans (as*  
21 *provided under section 203(c)) con-*  
22 *sistent with paragraph (5).*

23 (6) *LEVELS OF COST-SHARING FOR EN-*  
24 *HANCED AND PREMIUM PLANS.—*

1           **(A) ENHANCED PLAN.**—*The level of*  
2           *cost-sharing for enhanced plans shall*  
3           *be designed so that such plans have*  
4           *benefits that are actuarially equiva-*  
5           *lent to approximately 85 percent of the*  
6           *actuarial value of the benefits pro-*  
7           *vided under the reference benefits*  
8           *package described in section*  
9           *122(c)(3)(B).*

10           **(B) PREMIUM PLAN.**—*The level of*  
11           *cost-sharing for premium plans shall*  
12           *be designed so that such plans have*  
13           *benefits that are actuarially equiva-*  
14           *lent to approximately 95 percent of the*  
15           *actuarial value of the benefits pro-*  
16           *vided under the reference benefits*  
17           *package described in section*  
18           *122(c)(3)(B).*

19           **(7) RECOMMENDATIONS OF INTEGRATIVE**  
20           **HEALTH CARE SERVICES TASK FORCE.**—

21           **(A) INCLUSION IN COMMITTEE'S REC-**  
22           **COMMENDATIONS.**—*The Health Benefits*  
23           *Advisory Committee shall include in*  
24           *its recommendations under para-*  
25           *graph (1) the recommendations made*

1 *by the Integrative Health Care Serv-*  
2 *ices Task Force established under sub-*  
3 *paragraph (B).*

4 (B) ESTABLISHMENT OF TASK  
5 FORCE.—*The Health Benefits Advisory*  
6 *Committee shall establish an Integra-*  
7 *tive Health Care Services Task Force.*  
8 *Such Task Force shall consist of 5 ex-*  
9 *perts with expertise in research in,*  
10 *and practice of, integrative health*  
11 *care. Such experts shall be appointed*  
12 *by the Committee from among experts*  
13 *nominated by the Secretary, in con-*  
14 *sultation with the National Center for*  
15 *Complementary and Alternative Medi-*  
16 *cine at the National Institutes of*  
17 *Health. The duty of the Task Force*  
18 *shall be to make recommendations to*  
19 *the Committee on evidence-based,*  
20 *clinically effective, and safe integra-*  
21 *tive care services.*

22 (c) OPERATIONS.—

23 (1) PER DIEM PAY.—*Each member of the*  
24 *Health Benefits Advisory Committee shall*  
25 *receive travel expenses, including per*

1 *diem in accordance with applicable provi-*  
2 *sions under subchapter I of chapter 57 of*  
3 *title 5, United States Code, and shall oth-*  
4 *erwise serve without additional pay.*

5 (2) *MEMBERS NOT TREATED AS FEDERAL*  
6 *EMPLOYEES.—Members of the Health Bene-*  
7 *fits Advisory Committee shall not be con-*  
8 *sidered employees of the Federal govern-*  
9 *ment solely by reason of any service on the*  
10 *Committee.*

11 (3) *APPLICATION OF FACA.—The Federal*  
12 *Advisory Committee Act (5 U.S.C. App.),*  
13 *other than section 14, shall apply to the*  
14 *Health Benefits Advisory Committee.*

15 (d) *PUBLICATION.—The Secretary shall pro-*  
16 *vide for publication in the Federal Register*  
17 *and the posting on the Internet website of the*  
18 *Department of Health and Human Services of*  
19 *all recommendations made by the Health Ben-*  
20 *efits Advisory Committee under this section.*

21 *SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDATIONS;*

22 *ADOPTION OF BENEFIT STANDARDS.*

23 (a) *PROCESS FOR ADOPTION OF REC-*  
24 *OMMENDATIONS.—*

1           ***(1) REVIEW OF RECOMMENDED STAND-***  
2           ***ARDS.—Not later than 45 days after the***  
3           ***date of receipt of benefit standards rec-***  
4           ***ommended under section 123 (including***  
5           ***such standards as modified under para-***  
6           ***graph (2)(B)), the Secretary shall review***  
7           ***such standards and shall determine***  
8           ***whether to propose adoption of such***  
9           ***standards as a package.***

10           ***(2) DETERMINATION TO ADOPT STAND-***  
11           ***ARDS.—If the Secretary determines—***

12                   ***(A) to propose adoption of benefit***  
13                   ***standards so recommended as a pack-***  
14                   ***age, the Secretary shall, by regulation***  
15                   ***under section 553 of title 5, United***  
16                   ***States Code, propose adoption such***  
17                   ***standards; or***

18                   ***(B) not to propose adoption of***  
19                   ***such standards as a package, the Sec-***  
20                   ***retary shall notify the Health Benefits***  
21                   ***Advisory Committee in writing of such***  
22                   ***determination and the reasons for not***  
23                   ***proposing the adoption of such rec-***  
24                   ***ommendation and provide the Com-***  
25                   ***mittee with a further opportunity to***

1           *modify its previous recommendations*  
2           *and submit new recommendations to*  
3           *the Secretary on a timely basis.*

4           **(3) CONTINGENCY.**—*If, because of the*  
5           *application of paragraph (2)(B), the Sec-*  
6           *retary would otherwise be unable to pro-*  
7           *pose initial adoption of such rec-*  
8           *ommended standards by the deadline*  
9           *specified in subsection (b)(1), the Sec-*  
10          *retary shall, by regulation under section*  
11          *553 of title 5, United States Code, propose*  
12          *adoption of initial benefit standards by*  
13          *such deadline.*

14          **(4) PUBLICATION.**—*The Secretary shall*  
15          *provide for publication in the Federal*  
16          *Register of all determinations made by*  
17          *the Secretary under this subsection.*

18          **(b) ADOPTION OF STANDARDS.**—

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

1           **(2) PERIODIC UPDATING STANDARDS.—**  
2           *Under subsection (a), the Secretary shall*  
3           *provide for the periodic updating of the*  
4           *benefit standards previously adopted*  
5           *under this section.*

6           **(3) REQUIREMENT.—***The Secretary may*  
7           *not adopt any benefit standards for an es-*  
8           *sential benefits package or for level of*  
9           *cost-sharing that are inconsistent with*  
10          *the requirements for such a package or*  
11          *level under sections 122 and 123(b)(5).*

12 **SEC. 125. PROHIBITION OF DISCRIMINATION IN HEALTH**  
13                   **CARE SERVICES BASED ON RELIGIOUS OR**  
14                   **SPIRITUAL CONTENT.**

15          *Neither the Commissioner nor any health*  
16          *insurance issuer offering health insurance*  
17          *coverage through the Exchange shall discrimi-*  
18          *nate in approving or covering a health care*  
19          *service on the basis of its religious or spiritual*  
20          *content if expenditures for such a health care*  
21          *service are allowable as a deduction under*  
22          *213(d) of the Internal Revenue Code of 1986, as*  
23          *in effect on January 1, 2009.*

1     ***Subtitle D—Additional Consumer***  
2                     ***Protections***

3     ***SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY***  
4                     ***HEALTH INSURERS.***

5             ***The Commissioner shall establish uniform***  
6     ***marketing standards that all insured QHBP***  
7     ***offering entities shall meet.***

8     ***SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS***  
9                     ***MECHANISMS.***

10            ***(a) IN GENERAL.—A QHBP offering entity***  
11     ***shall provide for timely grievance and appeals***  
12     ***mechanisms that the Commissioner shall es-***  
13     ***tablish.***

14            ***(b) INTERNAL CLAIMS AND APPEALS PROC-***  
15     ***ESS.—Under a qualified health benefits plan***  
16     ***the QHBP offering entity shall provide an in-***  
17     ***ternal claims and appeals process that ini-***  
18     ***tially incorporates the claims and appeals***  
19     ***procedures (including urgent claims) set forth***  
20     ***at section 2560.503–1 of title 29, Code of Fed-***  
21     ***eral Regulations, as published on November***  
22     ***21, 2000 (65 Fed. Reg. 70246) and shall update***  
23     ***such process in accordance with any stand-***  
24     ***ards that the Commissioner may establish.***

25            ***(c) EXTERNAL REVIEW PROCESS.—***



1           **(1) IN GENERAL.—***The Commissioner*  
2           *shall establish an external review process*  
3           *(including procedures for expedited re-*  
4           *views of urgent claims) that provides for*  
5           *an impartial, independent, and de novo*  
6           *review of denied claims under this divi-*  
7           *sion.*

8           **(2) REQUIRING FAIR GRIEVANCE AND AP-**  
9           **PEALS MECHANISMS.—***A determination*  
10           *made, with respect to a qualified health*  
11           *benefits plan offered by a QHBP offering*  
12           *entity, under the external review process*  
13           *established under this subsection shall be*  
14           *binding on the plan and the entity.*

15           **(d) CONSTRUCTION.—***Nothing in this sec-*  
16           *tion shall be construed as affecting the avail-*  
17           *ability of judicial review under State law for*  
18           *adverse decisions under subsection (b) or (c),*  
19           *subject to section 151.*

20           **SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND**  
21           **PLAN DISCLOSURE.**

22           **(a) ACCURATE AND TIMELY DISCLOSURE.—**

23           **(1) IN GENERAL.—***A qualified health*  
24           *benefits plan shall comply with standards*  
25           *established by the Commissioner for the*

1 *accurate and timely disclosure of plan*  
2 *documents, plan terms and conditions,*  
3 *claims payment policies and practices,*  
4 *periodic financial disclosure, data on en-*  
5 *rollment, data on disenrollment, data on*  
6 *the number of claims denials, data on rat-*  
7 *ing practices, information on cost-sharing*  
8 *and payments with respect to any out-of-*  
9 *network coverage, and other information*  
10 *as determined appropriate by the Com-*  
11 *missioner. The Commissioner shall re-*  
12 *quire that such disclosure be provided in*  
13 *plain language.*

14 (2) *PLAIN LANGUAGE.—In this sub-*  
15 *section, the term “plain language” means*  
16 *language that the intended audience, in-*  
17 *cluding individuals with limited English*  
18 *proficiency, can readily understand and*  
19 *use because that language is clean, con-*  
20 *cise, well-organized, and follows other*  
21 *best practices of plain language writing.*

22 (3) *GUIDANCE.—The Commissioner*  
23 *shall develop and issue guidance on best*  
24 *practices of plain language writing.*

1       **(b) CONTRACTING REIMBURSEMENT.—A**  
2 *qualified health benefits plan shall comply*  
3 *with standards established by the Commis-*  
4 *sioner to ensure transparency to each health*  
5 *care provider relating to reimbursement ar-*  
6 *rangements between such plan and such pro-*  
7 *vider.*

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

13       **(d) IDENTIFICATION OF PROVIDERS TRAINED**  
14 **AND ACCREDITED IN INTEGRATIVE MEDICINE.—A**  
15 *qualified health benefit plan shall include in*  
16 *the disclosure required under subsection (a)*  
17 *identification to enrollees of any providers of*  
18 *services under the plan that are trained and*  
19 *accredited in integrative health medicine.*

20 **SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS**  
21 **PLANS NOT OFFERED THROUGH THE HEALTH**  
22 **INSURANCE EXCHANGE.**

23       *The requirements of the previous provi-*  
24 *sions of this subtitle shall apply to qualified*  
25 *health benefits plans that are not being of-*

1 *ferred through the Health Insurance Exchange*  
2 *only to the extent specified by the Commis-*  
3 *sioner.*

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

5 *A QHBP offering entity shall comply with*  
6 *the requirements of section 1857(f) of the So-*  
7 *cial Security Act with respect to a qualified*  
8 *health benefits plan it offers in the same man-*  
9 *ner an Medicare Advantage organization is re-*  
10 *quired to comply with such requirements with*  
11 *respect to a Medicare Advantage plan it offers*  
12 *under part C of Medicare.*

13 *SEC. 136. STANDARDIZED RULES FOR COORDINATION AND*  
14 *SUBROGATION OF BENEFITS.*

15 *The Commissioner shall establish stand-*  
16 *ards for the coordination and subrogation of*  
17 *benefits and reimbursement of payments in*  
18 *cases involving individuals and multiple plan*  
19 *coverage.*

20 *SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICA-*  
21 *TION.*

22 *A QHBP offering entity is required to com-*  
23 *ply with standards for electronic financial*  
24 *and administrative transactions under section*

1 *1173A of the Social Security Act, added by sec-*  
2 *tion 163(a).*

3 *SEC. 138. RECORDS RELATIVE TO PRESCRIPTION INFORMA-*  
4 *TION.*

5 *(a) IN GENERAL.—A qualified health bene-*  
6 *fits plan shall ensure that its records relative*  
7 *to prescription information containing patient*  
8 *identifiable and prescriber-identifiable data*  
9 *are maintained in accordance with this sec-*  
10 *tion.”*

11 *(b) REQUIREMENTS.—*

12 *(1) IN GENERAL.—Records described in*  
13 *subsection (a) may not be licensed, trans-*  
14 *ferred, used, or sold by any pharmacy ben-*  
15 *efits manager, insurance company, elec-*  
16 *tronic transmission intermediary, retail,*  
17 *mail order, or Internet pharmacy or other*  
18 *similar entity, for any commercial pur-*  
19 *pose, except for the limited purposes of—*

20 *(A) pharmacy reimbursement;*

21 *(B) formulary compliance;*

22 *(C) care management;*

23 *(D) utilization review by a health*  
24 *care provider, the patient’s insurance*  
25 *provider or the agent of either;*

1           ***(E) health care research; or***

2           ***(F) as otherwise provided by law.***

3           ***(2) COMMERCIAL PURPOSE.—For pur-***  
4           ***poses of paragraph (1), the term “commer-***  
5           ***cial purpose” includes, but is not limited***  
6           ***to, advertising, marketing, promotion, or***  
7           ***any activity that could be used to influ-***  
8           ***ence sales or market share of a pharma-***  
9           ***ceutical product, influence or evaluate***  
10           ***the prescribing behavior of an individual***  
11           ***health care professional, or evaluate the***  
12           ***effectiveness of a professional pharma-***  
13           ***ceutical detailing sales force.***

14           ***(c) CONSTRUCTION.—***

15           ***(1) PERMITTED PRACTICES.—Nothing in***  
16           ***this section shall prohibit—***

17                   ***(A) the dispensing of prescription***  
18                   ***medications to a patient or to the pa-***  
19                   ***tient’s authorized representative;***

20                   ***(B) the transmission of prescrip-***  
21                   ***tion information between an author-***  
22                   ***ized prescriber and a licensed phar-***  
23                   ***macy;***

1           (C) *the transfer of prescription in-*  
2 *formation between licensed phar-*  
3 *macies;*

4           (D) *the transfer of prescription*  
5 *records that may occur in the event a*  
6 *pharmacy ownership is changed or*  
7 *transferred;*

8           (E) *care management educational*  
9 *communications provided to a patient*  
10 *about the patient's health condition,*  
11 *adherence to a prescribed course of*  
12 *therapy, or other information about*  
13 *the drug being dispensed, treatment*  
14 *options, or clinical trials.*

15           (2) *DE-IDENTIFIED DATA.—Nothing in*  
16 *this section shall prohibit the collection,*  
17 *use, transfer, or sale of patient and pre-*  
18 *scriber de-identified data by zip code, geo-*  
19 *graphic region, or medical specialty for*  
20 *commercial purposes.*

## 21           ***Subtitle E—Governance***

22 *SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH*  
23 *CHOICES COMMISSIONER.*

24           (a) *IN GENERAL.—There is hereby estab-*  
25 *lished, as an independent agency in the execu-*

1 *tive branch of the Government, a Health*  
2 *Choices Administration (in this division re-*  
3 *ferred to as the “Administration”).*

4 **(b) COMMISSIONER.—**

5 **(1) IN GENERAL.—***The Administration*  
6 *shall be headed by a Health Choices Com-*  
7 *missioner (in this division referred to as*  
8 *the “Commissioner”) who shall be ap-*  
9 *pointed by the President, by and with the*  
10 *advice and consent of the Senate.*

11 **(2) COMPENSATION; ETC.—***The provi-*  
12 *sions of paragraphs (2), (5) and (7) of sub-*  
13 *section (a) (relating to compensation,*  
14 *terms, general powers, rulemaking, and*  
15 *delegation) of section 702 of the Social Se-*  
16 *curity Act (42 U.S.C. 902) shall apply to*  
17 *the Commissioner and the Administration*  
18 *in the same manner as such provisions*  
19 *apply to the Commissioner of Social Secu-*  
20 *rity and the Social Security Administra-*  
21 *tion.*

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

23 **(a) DUTIES.—***The Commissioner is respon-*  
24 *sible for carrying out the following functions*  
25 *under this division:*



1           **(1) QUALIFIED PLAN STANDARDS.**—*The*  
2           *establishment of qualified health benefits*  
3           *plan standards under this title, including*  
4           *the enforcement of such standards in co-*  
5           *ordination with State insurance regu-*  
6           *lators and the Secretaries of Labor and*  
7           *the Treasury.*

8           **(2) HEALTH INSURANCE EXCHANGE.**—*The*  
9           *establishment and operation of a Health*  
10          *Insurance Exchange under subtitle A of*  
11          *title II.*

12          **(3) INDIVIDUAL AFFORDABILITY CRED-**  
13          **ITS.**—*The administration of individual af-*  
14          *fordability credits under subtitle C of title*  
15          *II, including determination of eligibility*  
16          *for such credits.*

17          **(4) ADDITIONAL FUNCTIONS.**—*Such ad-*  
18          *ditional functions as may be specified in*  
19          *this division.*

20          **(b) PROMOTING ACCOUNTABILITY.**—

21                 **(1) IN GENERAL.**—*The Commissioner*  
22                 *shall undertake activities in accordance*  
23                 *with this subtitle to promote account-*  
24                 *ability of QHBP offering entities in meet-*  
25                 *ing Federal health insurance require-*

1 *ments, regardless of whether such ac-*  
2 *countability is with respect to qualified*  
3 *health benefits plans offered through the*  
4 *Health Insurance Exchange or outside of*  
5 *such Exchange.*

6 **(2) COMPLIANCE EXAMINATION AND AU-**  
7 **DITS.—**

8 **(A) IN GENERAL.—***The commis-*  
9 *sioner shall, in coordination with*  
10 *States, conduct audits of qualified*  
11 *health benefits plan compliance with*  
12 *Federal requirements. Such audits*  
13 *may include random compliance au-*  
14 *ditions and targeted audits in response*  
15 *to complaints or other suspected non-*  
16 *compliance.*

17 **(B) RECOUPMENT OF COSTS IN CON-**  
18 **NECTION WITH EXAMINATION AND AU-**  
19 **DITS.—***The Commissioner is author-*  
20 *ized to recoup from qualified health*  
21 *benefits plans reimbursement for the*  
22 *costs of such examinations and audit*  
23 *of such QHBP offering entities.*

24 **(c) DATA COLLECTION.—***The Commissioner*  
25 *shall collect data for purposes of carrying out*

1 *the Commissioner's duties, including for pur-*  
2 *poses of promoting quality and value, pro-*  
3 *tecting consumers, and addressing disparities*  
4 *in health and health care and may share such*  
5 *data with the Secretary of Health and Human*  
6 *Services.*

7 *(d) SANCTIONS AUTHORITY.—*

8 *(1) IN GENERAL.—In the case that the*  
9 *Commissioner determines that a QHBP of-*  
10 *fering entity violates a requirement of this*  
11 *title, the Commissioner may, in coordina-*  
12 *tion with State insurance regulators and*  
13 *the Secretary of Labor, provide, in addi-*  
14 *tion to any other remedies authorized by*  
15 *law, for any of the remedies described in*  
16 *paragraph (2).*

17 *(2) REMEDIES.—The remedies described*  
18 *in this paragraph, with respect to a quali-*  
19 *fied health benefits plan offered by a*  
20 *QHBP offering entity, are—*

21 *(A) civil money penalties of not*  
22 *more than the amount that would be*  
23 *applicable under similar cir-*  
24 *cumstances for similar violations*

1           *under section 1857(g) of the Social Se-*  
2           *curity Act;*

3           *(B) suspension of enrollment of in-*  
4           *dividuals under such plan after the*  
5           *date the Commissioner notifies the en-*  
6           *tity of a determination under para-*  
7           *graph (1) and until the Commissioner*  
8           *is satisfied that the basis for such de-*  
9           *termination has been corrected and is*  
10          *not likely to recur;*

11          *(C) in the case of an Exchange-*  
12          *participating health benefits plan,*  
13          *suspension of payment to the entity*  
14          *under the Health Insurance Exchange*  
15          *for individuals enrolled in such plan*  
16          *after the date the Commissioner noti-*  
17          *fies the entity of a determination*  
18          *under paragraph (1) and until the*  
19          *Secretary is satisfied that the basis*  
20          *for such determination has been cor-*  
21          *rected and is not likely to recur; or*

22          *(D) working with State insurance*  
23          *regulators to terminate plans for re-*  
24          *peated failure by the offering entity to*  
25          *meet the requirements of this title.*

1       **(e) STANDARD DEFINITIONS OF INSURANCE**  
2 **AND MEDICAL TERMS.—The Commissioner shall**  
3 **provide for the development of standards for**  
4 **the definitions of terms used in health insur-**  
5 **ance coverage, including insurance-related**  
6 **terms.**

7       **(f) EFFICIENCY IN ADMINISTRATION.—The**  
8 **Commissioner shall issue regulations for the**  
9 **effective and efficient administration of the**  
10 **Health Insurance Exchange and affordability**  
11 **credits under subtitle C, including, with re-**  
12 **spect to the determination of eligibility for af-**  
13 **fordability credits, the use of personnel who**  
14 **are employed in accordance with the require-**  
15 **ments of title 5, United States Code, to carry**  
16 **out the duties of the Commissioner or, in the**  
17 **case of sections 208 and 241(b)(2), the use of**  
18 **State personnel who are employed in accord-**  
19 **ance with standards prescribed by the Office**  
20 **of Personnel Management pursuant to section**  
21 **208 of the Intergovernmental Personnel Act of**  
22 **1970 (42 U.S.C. 4728).**

23 **SEC. 143. CONSULTATION AND COORDINATION.**

24       **(a) CONSULTATION.—In carrying out the**  
25 **Commissioner’s duties under this division, the**

1 *Commissioner, as appropriate, shall consult*  
2 *with at least with the following:*

3           (1) *The National Association of Insur-*  
4 *ance Commissioners, State attorneys gen-*  
5 *eral, and State insurance regulators, in-*  
6 *cluding concerning the standards for in-*  
7 *sured qualified health benefits plans*  
8 *under this title and enforcement of such*  
9 *standards.*

10           (2) *Appropriate State agencies, spe-*  
11 *cifically concerning the administration of*  
12 *individual affordability credits under*  
13 *subtitle C of title II and the offering of Ex-*  
14 *change-participating health benefits*  
15 *plans, to Medicaid eligible individuals*  
16 *under subtitle A of such title.*

17           (3) *Other appropriate Federal agen-*  
18 *cies.*

19           (4) *Indian tribes and tribal organiza-*  
20 *tions.*

21           (5) *The National Association of Insur-*  
22 *ance Commissioners for purposes of using*  
23 *model guidelines established by such asso-*  
24 *ciation for purposes of subtitles B and D.*

25           **(b) COORDINATION.—**

1           **(1) IN GENERAL.**—*In carrying out the*  
2           **functions of the Commissioner, including**  
3           **with respect to the enforcement of the pro-**  
4           **visions of this division, the Commissioner**  
5           **shall work in coordination with existing**  
6           **Federal and State entities to the max-**  
7           **imum extent feasible consistent with this**  
8           **division and in a manner that prevents**  
9           **conflicts of interest in duties and ensures**  
10          **effective enforcement.**

11          **(2) UNIFORM STANDARDS.**—*The Com-*  
12          **missioner, in coordination with such enti-**  
13          **ties, shall seek to achieve uniform stand-**  
14          **ards that adequately protect consumers in**  
15          **a manner that does not unreasonably af-**  
16          **fect employers and insurers.**

17 **SEC. 144. HEALTH INSURANCE OMBUDSMAN.**

18          **(a) IN GENERAL.**—*The Commissioner shall*  
19          **appoint within the Health Choices Adminis-**  
20          **tration a Qualified Health Benefits Plan Om-**  
21          **budsman who shall have expertise and experi-**  
22          **ence in the fields of health care and education**  
23          **of (and assistance to) individuals.**

1       ***(b) DUTIES.—The Qualified Health Benefits***  
2 ***Plan Ombudsman shall, in a linguistically ap-***  
3 ***propriate manner—***

4           ***(1) receive complaints, grievances,***  
5 ***and requests for information submitted by***  
6 ***individuals;***

7           ***(2) provide assistance with respect to***  
8 ***complaints, grievances, and requests re-***  
9 ***ferred to in paragraph (1), including—***

10                   ***(A) helping individuals determine***  
11 ***the relevant information needed to***  
12 ***seek an appeal of a decision or deter-***  
13 ***mination;***

14                   ***(B) assistance to such individuals***  
15 ***with any problems arising from***  
16 ***disenrollment from such a plan;***

17                   ***(C) assistance to such individuals***  
18 ***in choosing a qualified health benefits***  
19 ***plan in which to enroll; and***

20                   ***(D) assistance to such individuals***  
21 ***in presenting information under sub-***  
22 ***title C (relating to affordability cred-***  
23 ***its);***



1           ***(3) consult with educated patients and***  
2           ***consumer advocates (described in section***  
3           ***123(a)(5)); and***

4           ***(4) submit annual reports to Congress***  
5           ***and the Commissioner that describe the***  
6           ***activities of the Ombudsman and that in-***  
7           ***clude such recommendations for improve-***  
8           ***ment in the administration of this divi-***  
9           ***sion as the Ombudsman determines ap-***  
10           ***propriate. The Ombudsman shall not***  
11           ***serve as an advocate for any increases in***  
12           ***payments or new coverage of services, but***  
13           ***may identify issues and problems in pay-***  
14           ***ment or coverage policies.***

15           ***Subtitle F—Relation to Other***  
16           ***Requirements; Miscellaneous***

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

18           ***(a) COVERAGE NOT OFFERED THROUGH EX-***  
19           ***CHANGE.—***

20           ***(1) IN GENERAL.—In the case of health***  
21           ***insurance coverage not offered through***  
22           ***the Health Insurance Exchange (whether***  
23           ***or not offered in connection with an em-***  
24           ***ployment-based health plan), and in the***  
25           ***case of employment-based health plans,***

1 *the requirements of this title do not*  
2 *supercede any requirements applicable*  
3 *under titles XXII and XXVII of the Public*  
4 *Health Service Act, parts 6 and 7 of sub-*  
5 *title B of title I of the Employee Retire-*  
6 *ment Income Security Act of 1974, or State*  
7 *law, except insofar as such requirements*  
8 *prevent the application of a requirement*  
9 *of this division, as determined by the Com-*  
10 *missioner.*

11 (2) *CONSTRUCTION.—Nothing in para-*  
12 *graph (1) shall be construed as affecting*  
13 *the application of section 514 of the Em-*  
14 *ployee Retirement Income Security Act of*  
15 *1974.*

16 (b) *COVERAGE OFFERED THROUGH EX-*  
17 *CHANGE.—*

18 (1) *IN GENERAL.—In the case of health*  
19 *insurance coverage offered through the*  
20 *Health Insurance Exchange—*

21 (A) *the requirements of this title*  
22 *do not supercede any requirements*  
23 *(including requirements relating to*  
24 *genetic information nondiscrimina-*  
25 *tion and mental health) applicable*

1           *under title XXVII of the Public Health*  
2           *Service Act or under State law, except*  
3           *insofar as such requirements prevent*  
4           *the application of a requirement of*  
5           *this division, as determined by the*  
6           *Commissioner; and*

7           *(B) individual rights and rem-*  
8           *edies under State laws shall apply.*

9           (2) *CONSTRUCTION.—In the case of cov-*  
10          *erage described in paragraph (1), nothing*  
11          *in such paragraph shall be construed as*  
12          *preventing the application of rights and*  
13          *remedies under State laws with respect to*  
14          *any requirement referred to in paragraph*  
15          *(1)(A).*

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

17          (a) *IN GENERAL.—Except as otherwise ex-*  
18          *PLICITLY permitted by this Act and by subse-*  
19          *quent regulations consistent with this Act, all*  
20          *health care and related services (including in-*  
21          *surance coverage and public health activities)*  
22          *covered by this Act shall be provided without*  
23          *regard to personal characteristics extraneous*  
24          *to the provision of high quality health care or*  
25          *related services.*

1           ***(b) IMPLEMENTATION.—To implement the re-***  
2 ***quirement set forth in subsection (a), the Sec-***  
3 ***retary of Health and Human Services shall,***  
4 ***not later than 18 months after the date of the***  
5 ***enactment of this Act, promulgate such regula-***  
6 ***tions as are necessary or appropriate to insure***  
7 ***that all health care and related services (in-***  
8 ***cluding insurance coverage and public health***  
9 ***activities) covered by this Act are provided***  
10 ***(whether directly or through contractual, li-***  
11 ***censing, or other arrangements) without re-***  
12 ***gard to personal characteristics extraneous to***  
13 ***the provision of high quality health care or re-***  
14 ***lated services.***

15 **SEC. 153. WHISTLEBLOWER PROTECTION.**

16           ***(a) RETALIATION PROHIBITED.—No employer***  
17 ***may discharge any employee or otherwise dis-***  
18 ***criminate against any employee with respect***  
19 ***to his compensation, terms, conditions, or***  
20 ***other privileges of employment because the em-***  
21 ***ployee (or any person acting pursuant to a re-***  
22 ***quest of the employee)—***

23                   ***(1) provided, caused to be provided, or***  
24                   ***is about to provide or cause to be provided***  
25                   ***to the employer, the Federal Government,***

1 *or the attorney general of a State infor-*  
2 *mation relating to any violation of, or any*  
3 *act or omission the employee reasonably*  
4 *believes to be a violation of any provision*  
5 *of this Act or any order, rule, or regula-*  
6 *tion promulgated under this Act;*

7 (2) *testified or is about to testify in a*  
8 *proceeding concerning such violation;*

9 (3) *assisted or participated or is about*  
10 *to assist or participate in such a pro-*  
11 *ceeding; or*

12 (4) *objected to, or refused to partici-*  
13 *pate in, any activity, policy, practice, or*  
14 *assigned task that the employee (or other*  
15 *such person) reasonably believed to be in*  
16 *violation of any provision of this Act or*  
17 *any order, rule, or regulation promul-*  
18 *gated under this Act.*

19 (b) **ENFORCEMENT ACTION.**—*An employee*  
20 *covered by this section who alleges discrimina-*  
21 *tion by an employer in violation of subsection*  
22 *(a) may bring an action governed by the rules,*  
23 *procedures, legal burdens of proof, and rem-*  
24 *edies set forth in section 40(b) of the Consumer*  
25 *Product Safety Act (15 U.S.C. 2087(b)).*

1       **(c) EMPLOYER DEFINED.**—*As used in this*  
2 *section, the term “employer” means any person*  
3 *(including one or more individuals, partner-*  
4 *ships, associations, corporations, trusts, pro-*  
5 *fessional membership organization including*  
6 *a certification, disciplinary, or other profes-*  
7 *sional body, unincorporated organizations,*  
8 *nongovernmental organizations, or trustees)*  
9 *engaged in profit or nonprofit business or in-*  
10 *dustry whose activities are governed by this*  
11 *Act, and any agent, contractor, subcontractor,*  
12 *grantee, or consultant of such person.*

13       **(d) RULE OF CONSTRUCTION.**—*The rule of*  
14 *construction set forth in section 20109(h) of*  
15 *title 49, United States Code, shall also apply*  
16 *to this section.*

17 **SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BAR-**  
18 **GAINING.**

19       *Nothing in this division shall be construed*  
20 *to alter or supercede any statutory or other ob-*  
21 *ligation to engage in collective bargaining*  
22 *over the terms and conditions of employment*  
23 *related to health care.*

1 *SEC. 155. SEVERABILITY.*

2 *If any provision of this Act, or any applica-*  
3 *tion of such provision to any person or cir-*  
4 *cumstance, is held to be unconstitutional, the*  
5 *remainder of the provisions of this Act and the*  
6 *application of the provision to any other per-*  
7 *son or circumstance shall not be affected.*

8 *SEC. 156. RULE OF CONSTRUCTION REGARDING HAWAII*  
9 *PREPAID HEALTH CARE ACT.*

10 *(a) IN GENERAL.—Subject to this section—*

11 *(1) nothing in this division (or an*  
12 *amendment made by this division) shall*  
13 *be construed to modify or limit the appli-*  
14 *cation of the exemption for the Hawaii*  
15 *Prepaid Health Care Act (Haw. Rev. Stat.*  
16 *§§ 393-1 et seq.) as provided for under sec-*  
17 *tion 514(b)(5) of the Employee Retirement*  
18 *Income Security Act of 1974 (29 U.S.C.*  
19 *1144(b)(5)), and such exemption shall also*  
20 *apply with respect to the provisions of this*  
21 *division, and*

22 *(2) for purposes of this division (and*  
23 *the amendments made by this division),*  
24 *coverage provided pursuant to the Hawaii*  
25 *Prepaid Health Care Act shall be treated*  
26 *as a qualified health benefits plan pro-*

1        *viding acceptable coverage so long as the*  
2        *Secretary of Labor determines that such*  
3        *coverage for employees (taking into ac-*  
4        *count the benefits and the cost to employ-*  
5        *ees for such benefits) is substantially*  
6        *equivalent to or greater than the coverage*  
7        *provided for employees pursuant to the es-*  
8        *sential benefits package.*

9        **(b) COORDINATION WITH STATE LAW OF HA-**  
10       *WAII.—The Commissioner shall, based on ongo-*  
11       *ing consultation with the appropriate officials*  
12       *of the State of Hawaii, make adjustments to*  
13       *rules and regulations of the Commissioner*  
14       *under this division as may be necessary, as de-*  
15       *termined by the Commissioner, to most effec-*  
16       *tively coordinate the provisions of this division*  
17       *with the provisions of the Hawaii Prepaid*  
18       *Health Care Act, taking into account any*  
19       *changes made from time to time to the Hawaii*  
20       *Prepaid Health Care Act and related laws of*  
21       *such State.*

22       **SEC. 157. INCREASING MEANINGFUL USE OF ELECTRONIC**  
23       **HEALTH RECORDS.**

24       **(a) STUDY.—The Commissioner shall con-**  
25       **duct a study on methods that QHBP offering**



1 *entities can use to encourage increased mean-*  
2 *ingful use of electronic health records by*  
3 *health care providers, including—*

4       (1) *qualified health benefits plans of-*  
5 *fering higher reimbursement rates for*  
6 *such meaningful use; and*

7       (2) *promoting the use by health care*  
8 *providers of low-cost available electronic*  
9 *health record software packages, such as*  
10 *software made available to health care*  
11 *providers by the Veterans Administration.*

12       **(b) REPORT.**—*Not later than 2 years after*  
13 *the date of the enactment of this Act, the Com-*  
14 *missioner shall submit to the Congress a re-*  
15 *port containing—*

16       (1) *the results of the study under sub-*  
17 *section (a); and*

18       (2) *recommendations concerning*  
19 *whether qualified health benefits plans*  
20 *should increase reimbursement rates to*  
21 *health care providers to increase mean-*  
22 *ingful use of electronic health records by*  
23 *such providers.*

24       **(c) REQUIREMENTS.**—

1           **(1) IN GENERAL.—***Not later than one*  
2           *year after the date the report is submitted*  
3           *to the Congress under subsection (b), if,*  
4           *under subsection (b)(2), the Commissioner*  
5           *recommends increased reimbursement*  
6           *rates, the Commissioner shall require that*  
7           *qualified health benefits plans increase*  
8           *reimbursement rates for health care pro-*  
9           *viders that show meaningful use of elec-*  
10          *tronic health records.*

11          **(2) COST LIMITATION.—***An increase in*  
12          *rates under paragraph (1) shall not result*  
13          *in any increase in affordability premium*  
14          *or cost-sharing credits under subtitle C of*  
15          *title II of this division.*

16 **SEC. 158. PRIVATE RIGHT OF CONTRACT WITH HEALTH**  
17                                   **CARE PROVIDERS.**

18          ***Nothing in this Act shall be construed to***  
19          ***preclude any participant or beneficiary in a***  
20          ***group health plan from entering into any con-***  
21          ***tract or arrangement for health care with any***  
22          ***health care provider.***

1           ***Subtitle G—Early Investments***

2   ***SEC. 161–163. [For sections 161 through 163, see the text of bill,***  
3                               ***as introduced on July 14, 2009.]***

4   ***SEC. 164. REINSURANCE PROGRAM FOR RETIREES.***

5           ***(a) ESTABLISHMENT.—***

6                   ***(1) IN GENERAL.—Not later than 90***  
7                   ***days after the date of the enactment of***  
8                   ***this Act, the Secretary of Health and***  
9                   ***Human Services shall establish a tem-***  
10                   ***porary reinsurance program (in this sec-***  
11                   ***tion referred to as the “reinsurance pro-***  
12                   ***gram”) to provide reimbursement to assist***  
13                   ***participating employment-based plans***  
14                   ***with the cost of providing health benefits***  
15                   ***to retirees and to eligible spouses, sur-***  
16                   ***living spouses and dependents of such re-***  
17                   ***tirees.***

18                   ***(2) DEFINITIONS.—For purposes of this***  
19                   ***section:***

20                               ***(A) The term “eligible employ-***  
21                               ***ment-based plan” means a group***  
22                               ***health benefits plan that—***

23   ***(i) is maintained by one or***  
24   ***more employers, former employers***  
25   ***or employee associations, or a vol-***

1            *untary employees' beneficiary as-*  
2            *sociation, or a committee or board*  
3            *of individuals appointed to ad-*  
4            *minister such plan, and*

5            *(ii) provides health benefits to*  
6            *retirees.*

7            *(B) The term "health benefits"*  
8            *means medical, surgical, hospital,*  
9            *prescription drug, and such other ben-*  
10           *efits as shall be determined by the*  
11           *Secretary, whether self-funded or de-*  
12           *livered through the purchase of insur-*  
13           *ance or otherwise.*

14           *(C) The term "participating em-*  
15           *ployment-based plan" means an eligi-*  
16           *ble employment-based plan that is*  
17           *participating in the reinsurance pro-*  
18           *gram.*

19           *(D) The term "retiree" means, with*  
20           *respect to a participating employ-*  
21           *ment-benefit plan, an individual*  
22           *who—*

23           *(i) is 55 years of age or older;*

1           (ii) *is not eligible for coverage*  
2           *under title XVIII of the Social Se-*  
3           *curity Act; and*

4           (iii) *is not an active employee*  
5           *of an employer maintaining the*  
6           *plan or of any employer that*  
7           *makes or has made substantial*  
8           *contributions to fund such plan.*

9           (E) *The term “Secretary” means*  
10          *Secretary of Health and Human Serv-*  
11          *ices.*

12          (b) *PARTICIPATION.—To be eligible to par-*  
13          *ticipate in the reinsurance program, an eligi-*  
14          *ble employment-based plan shall submit to the*  
15          *Secretary an application for participation in*  
16          *the program, at such time, in such manner,*  
17          *and containing such information as the Sec-*  
18          *retary shall require.*

19          (c) *PAYMENT.—*

20                 (1) *SUBMISSION OF CLAIMS.—*

21                         (A) *IN GENERAL.—Under the rein-*  
22                         *surance program, a participating em-*  
23                         *ployment-based plan shall submit*  
24                         *claims for reimbursement to the Sec-*  
25                         *retary which shall contain docu-*

1        *mentation of the actual costs of the*  
2        *items and services for which each*  
3        *claim is being submitted.*

4            *(B) BASIS FOR CLAIMS.—Each claim*  
5        *submitted under subparagraph (A)*  
6        *shall be based on the actual amount*  
7        *expended by the participating employ-*  
8        *ment-based plan involved within the*  
9        *plan year for the appropriate employ-*  
10       *ment based health benefits provided*  
11       *to a retiree or to the spouse, surviving*  
12       *spouse, or dependent of a retiree. In*  
13       *determining the amount of any claim*  
14       *for purposes of this subsection, the*  
15       *participating employment-based plan*  
16       *shall take into account any negotiated*  
17       *price concessions (such as discounts,*  
18       *direct or indirect subsidies, rebates,*  
19       *and direct or indirect remunerations)*  
20       *obtained by such plan with respect to*  
21       *such health benefits. For purposes of*  
22       *calculating the amount of any claim,*  
23       *the costs paid by the retiree or by the*  
24       *spouse, surviving spouse, or dependent*  
25       *of the retiree in the form of*

1           *deductibles, co-payments, and co-in-*  
2           *surance shall be included along with*  
3           *the amounts paid by the participating*  
4           *employment-based plan.*

5           **(2) PROGRAM PAYMENTS AND LIMIT.**—*If*  
6           *the Secretary determines that a partici-*  
7           *pating employment-based plan has sub-*  
8           *mitted a valid claim under paragraph (1),*  
9           *the Secretary shall reimburse such plan*  
10          *for 80 percent of that portion of the costs*  
11          *attributable to such claim that exceeds*  
12          *\$15,000, but is less than \$90,000. Such*  
13          *amounts shall be adjusted each year*  
14          *based on the percentage increase in the*  
15          *medical care component of the Consumer*  
16          *Price Index (rounded to the nearest mul-*  
17          *tiiple of \$1,000) for the year involved.*

18          **(3) USE OF PAYMENTS.**—*Amounts paid*  
19          *to a participating employment-based plan*  
20          *under this subsection shall be used to*  
21          *lower the costs borne directly by the par-*  
22          *ticipants and beneficiaries for health ben-*  
23          *efits provided under such plan in the form*  
24          *of premiums, co-payments, deductibles, co-*  
25          *insurance, or other out-of-pocket costs.*

1 *Such payments shall not be used to reduce*  
2 *the costs of an employer maintaining the*  
3 *participating employment-based plan. The*  
4 *Secretary shall develop a mechanism to*  
5 *monitor the appropriate use of such pay-*  
6 *ments by such plans.*

7 (4) *APPEALS AND PROGRAM PROTEC-*  
8 *TIONS.—The Secretary shall establish—*

9 (A) *an appeals process to permit*  
10 *participating employment-based plans*  
11 *to appeal a determination of the Sec-*  
12 *retary with respect to claims sub-*  
13 *mitted under this section; and*

14 (B) *procedures to protect against*  
15 *fraud, waste, and abuse under the*  
16 *program.*

17 (5) *AUDITS.—The Secretary shall con-*  
18 *duct annual audits of claims data sub-*  
19 *mitted by participating employment-based*  
20 *plans under this section to ensure that*  
21 *they are in compliance with the require-*  
22 *ments of this section.*

23 (d) *RETIREE RESERVE TRUST FUND.—*

24 (1) *ESTABLISHMENT.—*



1           (A) *IN GENERAL.—There is estab-*  
2 *lished in the Treasury of the United*  
3 *States a trust fund to be known as the*  
4 *“Retiree Reserve Trust Fund” (re-*  
5 *ferred to in this section as the “Trust*  
6 *Fund”), that shall consist of such*  
7 *amounts as may be appropriated or*  
8 *credited to the Trust Fund as pro-*  
9 *vided for in this subsection to enable*  
10 *the Secretary to carry out the reinsur-*  
11 *ance program. Such amounts shall re-*  
12 *main available until expended.*

13           (B) *FUNDING.—There are hereby*  
14 *appropriated to the Trust Fund, out of*  
15 *any moneys in the Treasury not other-*  
16 *wise appropriated, an amount re-*  
17 *quested by the Secretary as necessary*  
18 *to carry out this section, except that*  
19 *the total of all such amounts re-*  
20 *quested shall not exceed*  
21 *\$10,000,000,000.*

22           (C) *APPROPRIATIONS FROM THE*  
23 *TRUST FUND.—*

24           (i) *IN GENERAL.—Amounts in*  
25 *the Trust Fund are appropriated*

1            *to provide funding to carry out the*  
2            *reinsurance program and shall be*  
3            *used to carry out such program.*

4            **(ii) BUDGETARY IMPLICATIONS.—**  
5            *Amounts appropriated under*  
6            *clause (i), and outlays flowing*  
7            *from such appropriations, shall*  
8            *not be taken into account for pur-*  
9            *poses of any budget enforcement*  
10           *procedures including allocations*  
11           *under section 302(a) and (b) of the*  
12           *Balanced Budget and Emergency*  
13           *Deficit Control Act and budget*  
14           *resolutions for fiscal years during*  
15           *which appropriations are made*  
16           *from the Trust Fund.*

17           **(iii) LIMITATION TO AVAILABLE**  
18           **FUNDS.—***The Secretary has the au-*  
19           *thority to stop taking applications*  
20           *for participation in the program*  
21           *or take such other steps in reduc-*  
22           *ing expenditures under the rein-*  
23           *surance program in order to en-*  
24           *sure that expenditures under the*  
25           *reinsurance program do not ex-*

1           *ceed the funds available under*  
2           *this subsection.*

3 **SEC. 165. PROHIBITION AGAINST POST-RETIREMENT RE-**  
4           **DUCTIONS OF RETIREE HEALTH BENEFITS BY**  
5           **GROUP HEALTH PLANS.**

6           **(a) IN GENERAL.—***Part 7 of subtitle B of*  
7 *title I of the Employee Retirement Income Se-*  
8 *curity Act of 1974 is amended by inserting*  
9 *after section 714 the following new section:*

10 **“SEC. 715. PROTECTION AGAINST POST-RETIREMENT RE-**  
11           **DUCTION OF RETIREE HEALTH BENEFITS.**

12           **“(a) IN GENERAL.—***Every group health plan*  
13 *shall contain a provision which expressly bars*  
14 *the plan, or any fiduciary of the plan, from re-*  
15 *ducing the benefits provided under the plan to*  
16 *a retired participant, or beneficiary of such*  
17 *participant, if such reduction affects the bene-*  
18 *fits provided to the participant or beneficiary*  
19 *as of the date the participant retired for pur-*  
20 *poses of the plan and such reduction occurs*  
21 *after the participant’s retirement unless such*  
22 *reduction is also made with respect to active*  
23 *participants.*

24           **“(b) NO REDUCTION.—***Notwithstanding*  
25 *that a group health plan described in sub-*

1 *section (a) may contain a provision reserving*  
2 *the general power to amend or terminate the*  
3 *plan or a provision specifically authorizing*  
4 *the plan to make post-retirement reductions in*  
5 *retiree health benefits, it shall be prohibited*  
6 *for any group health plan, whether through*  
7 *amendment or otherwise, to reduce the bene-*  
8 *fits provided to a retired participant or his or*  
9 *her beneficiary under the terms of the plan if*  
10 *such reduction of benefits occurs after the date*  
11 *the participant retired for purposes of the*  
12 *plan and reduces benefits that were provided*  
13 *to the participant, or his or her beneficiary, as*  
14 *of the date the participant retired unless such*  
15 *reduction is also made with respect to active*  
16 *participants.”.*

17 *(b) CONFORMING AMENDMENT.—The table of*  
18 *contents in section 1 of such Act is amended*  
19 *by inserting after the item relating to section*  
20 *714 the following new item:*

*“Sec. 715. Protection against post-retirement reduction of re-*  
*tiree health benefits.”.*

21 *(c) EFFECTIVE DATE.—The amendments*  
22 *made by this section shall take effect on the*  
23 *date of the enactment of this Act.*

1 *SEC. 166. LIMITATIONS ON PREEXISTING CONDITION EX-*  
2 *CLUSIONS IN GROUP HEALTH PLANS IN AD-*  
3 *VANCE OF APPLICABILITY OF NEW PROHIBI-*  
4 *TION OF PREEXISTING CONDITION EXCLU-*  
5 *SIONS.*

6 *(a) AMENDMENTS TO THE EMPLOYEE RETIRE-*  
7 *MENT INCOME SECURITY ACT OF 1974.—*

8 *(1) REDUCTION IN LOOK-BACK PERIOD.—*  
9 *Section 701(a)(1) of the Employee Retire-*  
10 *ment Income Security Act of 1974 (29*  
11 *U.S.C. 1181(a)(1)) is amended by striking*  
12 *“6-month period” and inserting “30-day*  
13 *period”.*

14 *(2) REDUCTION IN PERMITTED PRE-*  
15 *EXISTING CONDITION LIMITATION PERIOD.—*  
16 *Section 701(a)(2) of such Act (29 U.S.C.*  
17 *1181(a)(2)) is amended by striking “12*  
18 *months” and inserting “3 months”, and by*  
19 *striking “18 months” and inserting “9*  
20 *months”.*

21 *(3) INAPPLICABILITY OF INTERIM LIMITA-*  
22 *TIONS UPON APPLICABILITY OF TOTAL PROHI-*  
23 *BITION OF EXCLUSION.—Section 701 of such*  
24 *Act shall cease to be effective in the case*  
25 *of any group health plan as of the date on*  
26 *which such plan becomes subject to the re-*

1 *quirements of section 111 of this Act (re-*  
2 *lating to prohibiting preexisting condition*  
3 *exclusions).*

4 **(b) EFFECTIVE DATE.—**

5 **(1) IN GENERAL.—***Except as provided in*  
6 *subparagraph (B), the amendments made*  
7 *by paragraphs (1) and (2) of subsection*  
8 *(a) shall apply with respect to group*  
9 *health plans for plan years beginning*  
10 *after the end of the 6th calendar month*  
11 *following the date of the enactment of this*  
12 *Act.*

13 **(2) SPECIAL RULE FOR COLLECTIVE BAR-**  
14 **GAINING AGREEMENTS.—***In the case of a*  
15 *group health plan maintained pursuant*  
16 *to one or more collective bargaining*  
17 *agreements between employee representa-*  
18 *tives and one or more employers ratified*  
19 *before the date of the enactment of this*  
20 *Act, the amendments made by paragraphs*  
21 *(1) and (2) of subsection (a) shall not*  
22 *apply to plan years beginning before the*  
23 *earlier of—*

24 **(A)** *the date on which the last of*  
25 *the collective bargaining agreements*

1 *relating to the plan terminates (deter-*  
2 *mined without regard to any exten-*  
3 *sion thereof agreed to after the date of*  
4 *the enactment of this Act), or*

5 *(B) 3 years after the date of the en-*  
6 *actment of this Act.*

7 *For purposes of subparagraph (A), any*  
8 *plan amendment made pursuant to a col-*  
9 *lective bargaining agreement relating to*  
10 *the plan which amends the plan solely to*  
11 *conform to any requirement added by the*  
12 *amendments made by paragraphs (1) and*  
13 *(2) of subsection (a) shall not be treated*  
14 *as a termination of such collective bar-*  
15 *gaining agreement.*

16 *SEC. 167. EXTENSION OF COBRA CONTINUATION COV-*  
17 *ERAGE.*

18 *(a) EXTENSION OF CURRENT PERIODS OF*  
19 *CONTINUATION COVERAGE.—*

20 *(1) IN GENERAL.—In the case of any in-*  
21 *dividual who is, under a COBRA continu-*  
22 *ation coverage provision, covered under*  
23 *COBRA continuation coverage on or after*  
24 *the date of the enactment of this Act, the*  
25 *required period of any such coverage*

1 *which has not subsequently terminated*  
2 *under the terms of such provision for any*  
3 *reason other than the expiration of a pe-*  
4 *riod of a specified number of months*  
5 *shall, notwithstanding such provision*  
6 *and subject to subsection (b), extend to the*  
7 *earlier of the date on which such indi-*  
8 *vidual becomes eligible for coverage*  
9 *under an employment-based health plan*  
10 *or the date on which such individual be-*  
11 *comes eligible for health insurance cov-*  
12 *erage through the Health Insurance Ex-*  
13 *change (or a State-based Health Insur-*  
14 *ance Exchange operating in a State or*  
15 *group of States).*

16 (2) *NOTICE.—As soon as practicable*  
17 *after the date of the enactment of this Act,*  
18 *the Secretary of Labor, in consultation*  
19 *with the Secretary of the Treasury and the*  
20 *Secretary of Health and Human Services,*  
21 *shall, in consultation with administrators*  
22 *of the group health plans (or other enti-*  
23 *ties) that provide or administer the*  
24 *COBRA continuation coverage involved,*  
25 *provide rules setting forth the form and*



1 *manner in which prompt notice to indi-*  
2 *viduals of the continued availability of*  
3 *COBRA continuation coverage to such in-*  
4 *dividuals under paragraph (1).*

5 **(b) CONTINUED EFFECT OF OTHER TERMI-**  
6 **NATING EVENTS.—***Notwithstanding subsection*  
7 *(a), any required period of COBRA continu-*  
8 *ation coverage which is extended under such*  
9 *subsection shall terminate upon the occur-*  
10 *rence, prior to the date of termination other-*  
11 *wise provided in such subsection, of any termi-*  
12 *nating event specified in the applicable con-*  
13 *tinuation coverage provision other than the*  
14 *expiration of a period of a specified number of*  
15 *months.*

16 **(c) ACCESS TO STATE HEALTH BENEFITS RISK**  
17 **POOLS.—***This section shall supersede any pro-*  
18 *vision of the law of a State or political subdivi-*  
19 *sion thereof to the extent that such provision*  
20 *has the effect of limiting or precluding access*  
21 *by a qualified beneficiary whose COBRA con-*  
22 *tinuation coverage has been extended under*  
23 *this section to a State health benefits risk pool*  
24 *recognized by the Commissioner for purposes*  
25 *of this section solely by reason of the extension*

1 *of such coverage beyond the date on which*  
2 *such coverage otherwise would have expired.*

3 *(d) DEFINITIONS.—For purposes of this sec-*  
4 *tion—*

5 *(1) COBRA CONTINUATION COVERAGE.—*  
6 *The term “COBRA continuation coverage”*  
7 *means continuation coverage provided*  
8 *pursuant to part 6 of subtitle B of title I*  
9 *of the Employee Retirement Income Secu-*  
10 *rity Act of 1974 (other than under section*  
11 *609), title XXII of the Public Health Serv-*  
12 *ice Act, section 4980B of the Internal Rev-*  
13 *enue Code of 1986 (other than subsection*  
14 *(f)(1) of such section insofar as it relates*  
15 *to pediatric vaccines), or section 905a of*  
16 *title 5, United States Code, or under a*  
17 *State program that provides comparable*  
18 *continuation coverage. Such term does*  
19 *not include coverage under a health flexi-*  
20 *ble spending arrangement under a cafe-*  
21 *teria plan within the meaning of section*  
22 *125 of the Internal Revenue Code of 1986.*

23 *(2) COBRA CONTINUATION PROVISION.—*  
24 *The term “COBRA continuation provi-*

1        *sion” means the provisions of law de-*  
2        *scribed in paragraph (1).*

3        **TITLE II—HEALTH INSURANCE**  
4        **EXCHANGE AND RELATED**  
5        **PROVISIONS**

6        **Subtitle A—Health Insurance**  
7        **Exchange**

8        **SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EX-**  
9        **CHANGE; OUTLINE OF DUTIES; DEFINITIONS.**

10        **(a) ESTABLISHMENT.—***There is established*  
11        *within the Health Choices Administration and*  
12        *under the direction of the Commissioner a*  
13        *Health Insurance Exchange in order to facili-*  
14        *tate access of individuals and employers,*  
15        *through a transparent process, to a variety of*  
16        *choices of affordable, quality health insurance*  
17        *coverage, including a public health insurance*  
18        *option.*

19        **(b) OUTLINE OF DUTIES OF COMMISSIONER.—**  
20        *In accordance with this subtitle and in coordi-*  
21        *nation with appropriate Federal and State of-*  
22        *ficials as provided under section 143(b), the*  
23        *Commissioner shall—*

24                *(1) under section 204 establish stand-*  
25                *ards for, accept bids from, and negotiate*

1        *and enter into contracts with, QHBP of-*  
2        *fering entities for the offering of health*  
3        *benefits plans through the Health Insur-*  
4        *ance Exchange, with different levels of*  
5        *benefits required under section 203, and*  
6        *including with respect to oversight and*  
7        *enforcement;*

8            *(2) under section 205 facilitate out-*  
9        *reach and enrollment in such plans of Ex-*  
10       *change-eligible individuals and employers*  
11       *described in section 202; and*

12           *(3) conduct such activities related to*  
13       *the Health Insurance Exchange as re-*  
14       *quired, including establishment of a risk*  
15       *pooling mechanism under section 206 and*  
16       *consumer protections under subtitle D of*  
17       *title I.*

18        *(c) EXCHANGE-PARTICIPATING HEALTH BENE-*  
19       *FITS PLAN DEFINED.—In this division, the term*  
20       *“Exchange-participating health benefits plan”*  
21       *means a qualified health benefits plan that is*  
22       *offered through the Health Insurance Ex-*  
23       *change.*

1 *SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOY-*  
2 *ERS.*

3 *(a) ACCESS TO COVERAGE.—In accordance*  
4 *with this section, all individuals are eligible*  
5 *to obtain coverage through enrollment in an*  
6 *Exchange-participating health benefits plan*  
7 *offered through the Health Insurance Ex-*  
8 *change unless such individuals are enrolled in*  
9 *another qualified health benefits plan or other*  
10 *acceptable coverage.*

11 *(b) DEFINITIONS.—In this division:*

12 *(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—*  
13 *The term “Exchange-eligible individual”*  
14 *means an individual who is eligible under*  
15 *this section to be enrolled through the*  
16 *Health Insurance Exchange in an Ex-*  
17 *change-participating health benefits plan*  
18 *and, with respect to family coverage, in-*  
19 *cludes dependents of such individual.*

20 *(2) EXCHANGE-ELIGIBLE EMPLOYER.—The*  
21 *term “Exchange-eligible employer” means*  
22 *an employer that is eligible under this*  
23 *section to enroll through the Health In-*  
24 *surance Exchange employees of the em-*  
25 *ployer (and their dependents) in Ex-*  
26 *change-eligible health benefits plans.*

1           **(3) EMPLOYMENT-RELATED DEFINI-**  
2           **TIONS.—The terms “employer”, “employee”,**  
3           **“full-time employee”, and “part-time em-**  
4           **ployee” have the meanings given such**  
5           **terms by the Commissioner for purposes of**  
6           **this division.**

7           **(c) TRANSITION.—Individuals and employ-**  
8           **ers shall only be eligible to enroll or partici-**  
9           **pate in the Health Insurance Exchange in ac-**  
10          **cordance with the following transition sched-**  
11          **ule:**

12           **(1) FIRST YEAR.—In Y1 (as defined in**  
13           **section 100(c))—**

14           **(A) individuals described in sub-**  
15           **section (d)(1), including individuals**  
16           **described in paragraphs (3), (4), and**  
17           **(5) of subsection (d); and**

18           **(B) smallest employers described**  
19           **in subsection (e)(1).**

20           **(2) SECOND YEAR.—In Y2—**

21           **(A) individuals and employers de-**  
22           **scribed in paragraph (1); and**

23           **(B) smaller employers described in**  
24           **subsection (e)(2).**

25           **(3) THIRD YEAR.—In Y3—**

1           ***(A) individuals and employers de-***  
2           ***scribed in paragraph (2);***

3           ***(B) larger employers described in***  
4           ***subsection (e)(3); and***

5           ***(C) largest employers as permitted***  
6           ***by the Commissioner under subsection***  
7           ***(e)(4).***

8           ***(4) FOURTH AND SUBSEQUENT YEARS.—***  
9           ***In Y4 and subsequent years—***

10           ***(A) individuals and employers de-***  
11           ***scribed in paragraph (3); and***

12           ***(B) largest employers as permitted***  
13           ***by the Commissioner under subsection***  
14           ***(e)(4).***

15           ***(d) INDIVIDUALS.—***

16           ***(1) INDIVIDUAL DESCRIBED.—Subject to***  
17           ***the succeeding provisions of this sub-***  
18           ***section, an individual described in this***  
19           ***paragraph is an individual who—***

20           ***(A) is not enrolled in coverage de-***  
21           ***scribed in subparagraphs (C) through***  
22           ***(F) of paragraph (2); and***

23           ***(B) is not enrolled in coverage as***  
24           ***a full-time employee (or as a depend-***  
25           ***ent of such an employee) under a***

1           *group health plan if the coverage and*  
2           *an employer contribution under the*  
3           *plan meet the requirements of section*  
4           *312.*

5           *For purposes of subparagraph (B), in the*  
6           *case of an individual who is self-em-*  
7           *ployed, who has at least 1 employee, and*  
8           *who meets the requirements of section 312,*  
9           *such individual shall be deemed a full-*  
10          *time employee described in such subpara-*  
11          *graph.*

12           (2) *ACCEPTABLE COVERAGE.—For pur-*  
13          *poses of this division, the term “accept-*  
14          *able coverage” means any of the fol-*  
15          *lowing:*

16                   (A) *QUALIFIED HEALTH BENEFITS*  
17                   *PLAN COVERAGE.—Coverage under a*  
18                   *qualified health benefits plan.*

19                   (B) *GRANDFATHERED HEALTH INSUR-*  
20                   *ANCE COVERAGE; COVERAGE UNDER CUR-*  
21                   *RENT GROUP HEALTH PLAN.—Coverage*  
22                   *under a grandfathered health insur-*  
23                   *ance coverage (as defined in sub-*  
24                   *section (a) of section 102) or under a*



1           *current group health plan (described*  
2           *in subsection (b) of such section).*

3           **(C) MEDICARE.**—*Coverage under*  
4           *part A of title XVIII of the Social Se-*  
5           *curity Act.*

6           **(D) MEDICAID.**—*Coverage for med-*  
7           *ical assistance under title XIX of the*  
8           *Social Security Act, excluding such*  
9           *coverage that is only available be-*  
10          *cause of the application of subsection*  
11          *(u), (z), or (aa) of section 1902 of such*  
12          *Act*

13          **(E) MEMBERS OF THE ARMED FORCES**  
14          **AND DEPENDENTS (INCLUDING**  
15          **TRICARE).**—*Coverage under chapter 55*  
16          *of title 10, United States Code, includ-*  
17          *ing similar coverage furnished under*  
18          *section 1781 of title 38 of such Code.*

19          **(F) VA.**—*Coverage under the vet-*  
20          *eran's health care program under*  
21          *chapter 17 of title 38, United States*  
22          *Code, but only if the coverage for the*  
23          *individual involved is determined by*  
24          *the Commissioner in coordination*  
25          *with the Secretary of Treasury to be*

1           *not less than a level specified by the*  
2           *Commissioner and Secretary of Vet-*  
3           *eran's Affairs, in coordination with*  
4           *the Secretary of Treasury, based on*  
5           *the individual's priority for services*  
6           *as provided under section 1705(a) of*  
7           *such title.*

8           **(G) OTHER COVERAGE.**—*Such other*  
9           *health benefits coverage, such as a*  
10          *State health benefits risk pool, as the*  
11          *Commissioner, in coordination with*  
12          *the Secretary of the Treasury, recog-*  
13          *nizes for purposes of this paragraph.*

14          *The Commissioner shall make determina-*  
15          *tions under this paragraph in coordina-*  
16          *tion with the Secretary of the Treasury.*

17          **(3) TREATMENT OF CERTAIN NON-TRADI-**  
18          **TIONAL MEDICAID ELIGIBLE INDIVIDUALS.**—  
19          *An individual who is a non-traditional*  
20          *Medicaid eligible individual (as defined*  
21          *in section 205(e)(4)(C)) in a State may be*  
22          *an Exchange-eligible individual if the in-*  
23          *dividual was enrolled in a qualified*  
24          *health benefits plan, grandfathered*  
25          *health insurance coverage, or current*

1 *group health plan during the 6 months*  
2 *before the individual became a non-tradi-*  
3 *tional Medicaid eligible individual. Dur-*  
4 *ing the period in which such an indi-*  
5 *vidual has chosen to enroll in an Ex-*  
6 *change-participating health benefits*  
7 *plan, the individual is not also eligible*  
8 *for medical assistance under Medicaid.*

9 (4) CONTINUING ELIGIBILITY PER-  
10 MITTED.—

11 (A) IN GENERAL.—*Except as pro-*  
12 *vided in subparagraph (B), once an*  
13 *individual qualifies as an Exchange-*  
14 *eligible individual under this sub-*  
15 *section (including as an employee or*  
16 *dependent of an employee of an Ex-*  
17 *change-eligible employer) and enrolls*  
18 *under an Exchange-participating*  
19 *health benefits plan through the*  
20 *Health Insurance Exchange, the indi-*  
21 *vidual shall continue to be treated as*  
22 *an Exchange-eligible individual until*  
23 *the individual is no longer enrolled*  
24 *with an Exchange-participating*  
25 *health benefits plan.*

1           **(B) EXCEPTIONS.—**

2           **(i) IN GENERAL.—Subpara-**  
3 **graph (A) shall not apply to an in-**  
4 **dividual once the individual be-**  
5 **comes eligible for coverage—**

6           **(I) under part A of the**  
7 **Medicare program;**

8           **(II) under the Medicaid**  
9 **program as a Medicaid eligi-**  
10 **ble individual, except as per-**  
11 **mitted under paragraph (3) or**  
12 **clause (i); or**

13           **(III) in such other cir-**  
14 **cumstances as the Commis-**  
15 **sioner may provide.**

16           **(ii) TRANSITION PERIOD.—In the**  
17 **case described in clause (i)(II), the**  
18 **Commissioner shall permit the in-**  
19 **dividual to continue treatment**  
20 **under subparagraph (A) until**  
21 **such limited time as the Commis-**  
22 **sioner determines it is administra-**  
23 **tively feasible, consistent with**  
24 **minimizing disruption in the indi-**  
25 **vidual's access to health care.**

1           **(5) ADVERSELY AFFECTED RETIREE**  
2           **HEALTH BENEFITS GROUP PARTICIPANTS AND**  
3           **BENEFICIARIES.—**

4           **(A) IN GENERAL.—Beginning in Y1,**  
5           **an individual who is a participant or**  
6           **beneficiary in an adversely affected**  
7           **retiree health benefits group who does**  
8           **not have coverage described in para-**  
9           **graph (2)(C) is an Exchange eligible**  
10           **individual, whether or not such an in-**  
11           **dividual has other acceptable cov-**  
12           **erage.**

13           **(B) ADVERSELY AFFECTED RETIREE**  
14           **HEALTH BENEFIT GROUP DEFINED.—In**  
15           **this paragraph, the term “adversely**  
16           **affected retiree health benefits group”**  
17           **means the retired participants and**  
18           **their beneficiaries of a group health**  
19           **plan that cancelled or substantially**  
20           **reduced the amount, type, level, or**  
21           **form of health benefit or option pro-**  
22           **vided prior January 1, 2008.**

23           **(e) EMPLOYERS.—**

24           **(1) SMALLEST EMPLOYERS.—Subject to**  
25           **paragraph (5), smallest employers de-**

1 *scribed in this paragraph are employers*  
2 *with 15 or fewer employees.*

3 (2) *SMALLER EMPLOYERS.—Subject to*  
4 *paragraph (5), smaller employers de-*  
5 *scribed in this paragraph are employers*  
6 *that are not smallest employers described*  
7 *in paragraph (1) and that have 25 or*  
8 *fewer employees.*

9 (3) *LARGER EMPLOYERS.—Subject to*  
10 *paragraph (5), larger employers described*  
11 *in this paragraph are employers that are*  
12 *not smallest employers described in para-*  
13 *graph (1) or smaller employers described*  
14 *in paragraph (2) and that have 50 or*  
15 *fewer employees.*

16 (4) *LARGEST EMPLOYERS.—*

17 (A) *IN GENERAL.—Beginning with*  
18 *Y3, the Commissioner may permit em-*  
19 *ployers not described in paragraphs*  
20 *(1) (2), or (3) to be Exchange-eligible*  
21 *employers.*

22 (B) *PHASE-IN.—In applying sub-*  
23 *paragraph (A), the Commissioner may*  
24 *phase-in the application of such sub-*  
25 *paragraph based on the number of*

1           *full-time employees of an employer*  
2           *and such other considerations as the*  
3           *Commissioner deems appropriate.*

4           **(5) CONTINUING ELIGIBILITY.**—*Once an*  
5           *employer is permitted to be an Exchange-*  
6           *eligible employer under this subsection*  
7           *and enrolls employees through the Health*  
8           *Insurance Exchange, the employer shall*  
9           *continue to be treated as an Exchange-eli-*  
10          *gible employer for each subsequent plan*  
11          *year regardless of the number of employ-*  
12          *ees involved unless and until the employer*  
13          *meets the requirement of section 311(a)*  
14          *through paragraph (1) of such section by*  
15          *offering a group health plan and not*  
16          *through offering Exchange-participating*  
17          *health benefits plan.*

18           **(6) EMPLOYER PARTICIPATION AND CON-**  
19          **TRIBUTIONS.**—

20           **(A) SATISFACTION OF EMPLOYER RE-**  
21          **SPONSIBILITY.**—*For any year in which*  
22          *an employer is an Exchange-eligible*  
23          *employer, such employer may meet the*  
24          *requirements of section 312 with re-*  
25          *spect to employees of such employer by*

1           *offering such employees the option of*  
2           *enrolling with Exchange-partici-*  
3           *pating health benefits plans through*  
4           *the Health Insurance Exchange con-*  
5           *sistent with the provisions of subtitle*  
6           *B of title III.*

7           **(B) EMPLOYEE CHOICE.**—*Any em-*  
8           *ployee offered Exchange-participating*  
9           *health benefits plans by the employer*  
10          *of such employee under subparagraph*  
11          *(A) may choose coverage under any*  
12          *such plan. That choice includes, with*  
13          *respect to family coverage, coverage of*  
14          *the dependents of such employee.*

15          **(7) AFFILIATED GROUPS.**—*Any employer*  
16          *which is part of a group of employers who*  
17          *are treated as a single employer under*  
18          *subsection (b), (c), (m), or (o) of section*  
19          *414 of the Internal Revenue Code of 1986*  
20          *shall be treated, for purposes of this sub-*  
21          *title, as a single employer.*

22          **(8) OTHER COUNTING RULES.**—*The Com-*  
23          *missioner shall establish rules relating to*  
24          *how employees are counted for purposes of*  
25          *carrying out this subsection.*



1           **(9) TREATMENT OF MULTIEMPLOYER**  
2           **PLANS.—***The plan sponsor of a group*  
3           **health plan (as defined in section 733(a)**  
4           **of the Employee Retirement Income Secu-**  
5           **rity Act of 1974) that is multiemployer**  
6           **plan (as defined in section 3(37) of such**  
7           **Act) may obtain health insurance cov-**  
8           **erage with respect to participants in the**  
9           **plan through the Exchange to the same**  
10           **extent as an employer not described in**  
11           **paragraph (1) or (2) is permitted by the**  
12           **Commissioner to obtain health insurance**  
13           **coverage through the Exchange as an Ex-**  
14           **change-eligible employer**

15           **(f) SPECIAL SITUATION AUTHORITY.—***The*  
16           **Commissioner shall have the authority to es-**  
17           **tablish such rules as may be necessary to deal**  
18           **with special situations with regard to unin-**  
19           **sured individuals and employers partici-**  
20           **pating as Exchange-eligible individuals and**  
21           **employers, such as transition periods for indi-**  
22           **viduals and employers who gain, or lose, Ex-**  
23           **change-eligible participation status, and to es-**  
24           **tablish grace periods for premium payment.**

1       **(g) SURVEYS OF INDIVIDUALS AND EMPLOY-**  
2 **ERS.—The Commissioner shall provide for peri-**  
3 **odic surveys of Exchange-eligible individuals**  
4 **and employers concerning satisfaction of such**  
5 **individuals and employers with the Health In-**  
6 **surance Exchange and Exchange-partici-**  
7 **pating health benefits plans.**

8       **(h) EXCHANGE ACCESS STUDY.—**

9           **(1) IN GENERAL.—The Commissioner**  
10 **shall conduct a study of access to the**  
11 **Health Insurance Exchange for individ-**  
12 **uals and for employers, including individ-**  
13 **uals and employers who are not eligible**  
14 **and enrolled in Exchange-participating**  
15 **health benefits plans. The goal of the**  
16 **study is to determine if there are signifi-**  
17 **cant groups and types of individuals and**  
18 **employers who are not Exchange eligible**  
19 **individuals or employers, but who would**  
20 **have improved benefits and affordability**  
21 **if made eligible for coverage in the Ex-**  
22 **change.**

23           **(2) ITEMS INCLUDED IN STUDY.—Such**  
24 **study also shall examine—**

1           (A) *the terms, conditions, and af-*  
2 *fordability of group health coverage*  
3 *offered by employers and QHBP offer-*  
4 *ing entities outside of the Exchange*  
5 *compared to Exchange-participating*  
6 *health benefits plans; and*

7           (B) *the affordability-test standard*  
8 *for access of certain employed individ-*  
9 *uals to coverage in the Health Insur-*  
10 *ance Exchange.*

11           (3) *REPORT.—Not later than January 1*  
12 *of Y3, in Y6, and thereafter, the Commis-*  
13 *sioner shall submit to Congress on the*  
14 *study conducted under this subsection*  
15 *and shall include in such report rec-*  
16 *ommendations regarding changes in*  
17 *standards for Exchange eligibility for for*  
18 *individuals and employers.*

19 *SEC. 203. BENEFITS PACKAGE LEVELS.*

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

1       **(b) LIMITATION ON HEALTH BENEFITS PLANS**  
2 **OFFERED BY OFFERING ENTITIES.—***The Commis-*  
3 *sioner may not enter into a contract with a*  
4 **QHBP offering entity under section 204(c) for**  
5 *the offering of an Exchange-participating*  
6 *health benefits plan in a service area unless*  
7 *the following requirements are met:*

8           **(1) REQUIRED OFFERING OF BASIC**  
9 **PLAN.—***The entity offers only one basic*  
10 *plan for such service area.*

11           **(2) OPTIONAL OFFERING OF ENHANCED**  
12 **PLAN.—***If and only if the entity offers a*  
13 *basic plan for such service area, the entity*  
14 *may offer one enhanced plan for such*  
15 *area.*

16           **(3) OPTIONAL OFFERING OF PREMIUM**  
17 **PLAN.—***If and only if the entity offers an*  
18 *enhanced plan for such service area, the*  
19 *entity may offer one premium plan for*  
20 *such area.*

21           **(4) OPTIONAL OFFERING OF PREMIUM-**  
22 **PLUS PLANS.—***If and only if the entity of-*  
23 *fers a premium plan for such service area,*  
24 *the entity may offer one or more premium-*  
25 *plus plans for such area.*

1 *All such plans may be offered under a single*  
2 *contract with the Commissioner.*

3 (c) *SPECIFICATION OF BENEFIT LEVELS FOR*  
4 *PLANS.—*

5 (1) *IN GENERAL.—The Commissioner*  
6 *shall establish the following standards*  
7 *consistent with this subsection and title I:*

8 (A) *BASIC, ENHANCED, AND PREMIUM*  
9 *PLANS.—Standards for 3 levels of Ex-*  
10 *change-participating health benefits*  
11 *plans: basic, enhanced, and premium*  
12 *(in this division referred to as a*  
13 *“basic plan”, “enhanced plan”, and*  
14 *“premium plan”, respectively).*

15 (B) *PREMIUM-PLUS PLAN BENE-*  
16 *FITS.—Standards for additional bene-*  
17 *fits that may be offered, consistent*  
18 *with this subsection and subtitle C of*  
19 *title I, under a premium plan (such a*  
20 *plan with additional benefits referred*  
21 *to in this division as a “premium-plus*  
22 *plan”)* .

23 (2) *BASIC PLAN.—*

24 (A) *IN GENERAL.—A basic plan*  
25 *shall offer the essential benefits pack-*

1           *age required under title I for a quali-*  
2           *fied health benefits plan.*

3           **(B) TIERED COST-SHARING FOR AF-**  
4           **FORDABLE CREDIT ELIGIBLE INDIVID-**  
5           **UALS.—***In the case of an affordable*  
6           *credit eligible individual (as defined*  
7           *in section 242(a)(1)) enrolled in an Ex-*  
8           *change-participating health benefits*  
9           *plan, the benefits under a basic plan*  
10           *are modified to provide for the re-*  
11           *duced cost-sharing for the income tier*  
12           *applicable to the individual under*  
13           *section 244(c).*

14           **(3) ENHANCED PLAN.—***A enhanced plan*  
15           *shall offer, in addition to the level of ben-*  
16           *efits under the basic plan, a lower level of*  
17           *cost-sharing as provided under title I con-*  
18           *sistent with section 123(b)(5)(A).*

19           **(4) PREMIUM PLAN.—***A premium plan*  
20           *shall offer, in addition to the level of ben-*  
21           *efits under the basic plan, a lower level of*  
22           *cost-sharing as provided under title I con-*  
23           *sistent with section 123(b)(5)(B).*

24           **(5) PREMIUM-PLUS PLAN.—***A premium-*  
25           *plus plan is a premium plan that also*

1 *provides additional benefits, such as*  
2 *adult oral health and vision care, ap-*  
3 *proved by the Commissioner. The portion*  
4 *of the premium that is attributable to*  
5 *such additional benefits shall be sepa-*  
6 *rately specified.*

7 (6) *RANGE OF PERMISSIBLE VARIATION IN*  
8 *COST-SHARING.—The Commissioner shall*  
9 *establish a permissible range of variation*  
10 *of cost-sharing for each basic, enhanced,*  
11 *and premium plan, except with respect to*  
12 *any benefit for which there is no cost-*  
13 *sharing permitted under the essential*  
14 *benefits package. Such variation shall*  
15 *permit a variation of not more than plus*  
16 *(or minus) 10 percent in cost-sharing with*  
17 *respect to each benefit category specified*  
18 *under section 122.*

19 (d) *TREATMENT OF STATE BENEFIT MAN-*  
20 *DATES.—Insofar as a State requires a health*  
21 *insurance issuer offering health insurance*  
22 *coverage to include benefits beyond the essen-*  
23 *tial benefits package, such requirement shall*  
24 *continue to apply to an Exchange-partici-*  
25 *pating health benefits plan, if the State has*

1 *entered into an arrangement satisfactory to*  
2 *the Commissioner to reimburse the Commis-*  
3 *sioner for the amount of any net increase in*  
4 *affordability premium credits under subtitle C*  
5 *as a result of an increase in premium in basic*  
6 *plans as a result of application of such re-*  
7 *quirement.*

8 *SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-*  
9 *PARTICIPATING HEALTH BENEFITS PLANS.*

10 *(a) CONTRACTING DUTIES.—In carrying out*  
11 *section 201(b)(1) and consistent with this sub-*  
12 *title:*

13 *(1) OFFERING ENTITY AND PLAN STAND-*  
14 *ARDS.—The Commissioner shall—*

15 *(A) establish standards necessary*  
16 *to implement the requirements of this*  
17 *title and title I for—*

18 *(i) QHBP offering entities for*  
19 *the offering of an Exchange-par-*  
20 *ticipating health benefits plan;*  
21 *and*

22 *(ii) for Exchange-partici-*  
23 *pating health benefits plans; and*

24 *(B) certify QHBP offering entities*  
25 *and qualified health benefits plans as*



1           *meeting such standards and require-*  
2           *ments of this title and title I for pur-*  
3           *poses of this subtitle.*

4           **(2) SOLICITING AND NEGOTIATING BIDS;**  
5           **CONTRACTS.—***The Commissioner shall—*

6                   **(A)** *solicit bids from QHBP offer-*  
7                   *ing entities for the offering of Ex-*  
8                   *change-participating health benefits*  
9                   *plans;*

10                   **(B)** *based upon a review of such*  
11                   *bids, negotiate with such entities for*  
12                   *the offering of such plans; and*

13                   **(C)** *enter into contracts with such*  
14                   *entities for the offering of such plans*  
15                   *through the Health Insurance Ex-*  
16                   *change under terms (consistent with*  
17                   *this title) negotiated between the Com-*  
18                   *missioner and such entities.*

19           **(3) FAR NOT APPLICABLE.—***The provi-*  
20           *sions of the Federal Acquisition Regula-*  
21           *tion shall not apply to contracts between*  
22           *the Commissioner and QHBP offering en-*  
23           *tities for the offering of Exchange-partici-*  
24           *pating health benefits plans under this*  
25           *title.*

1       **(b) STANDARDS FOR QHBP OFFERING ENTI-**  
2 **TIES TO OFFER EXCHANGE-PARTICIPATING**  
3 **HEALTH BENEFITS PLANS.—***The standards es-*  
4 *tablished under subsection (a)(1)(A) shall re-*  
5 *quire that, in order for a QHBP offering entity*  
6 *to offer an Exchange-participating health ben-*  
7 *efits plan, the entity must meet the following*  
8 *requirements:*

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

13           **(2) DATA REPORTING.—***The entity shall*  
14 *provide for the reporting of such informa-*  
15 *tion as the Commissioner may specify, in-*  
16 *cluding information necessary to admin-*  
17 *ister the risk pooling mechanism de-*  
18 *scribed in section 206(b) and information*  
19 *to address disparities in health and*  
20 *health care.*

21           **(3) IMPLEMENTING AFFORDABILITY CRED-**  
22 **ITS.—***The entity shall provide for imple-*  
23 *mentation of the affordability credits pro-*  
24 *vided for enrollees under subtitle C, in-*

1 *cluding the reduction in cost-sharing*  
2 *under section 244(c).*

3 (4) *ENROLLMENT.—The entity shall ac-*  
4 *cept all enrollments under this subtitle,*  
5 *subject to such exceptions (such as capac-*  
6 *ity limitations) in accordance with the re-*  
7 *quirements under title I for a qualified*  
8 *health benefits plan. The entity shall no-*  
9 *tify the Commissioner if the entity projects*  
10 *or anticipates reaching such a capacity*  
11 *limitation that would result in a limita-*  
12 *tion in enrollment.*

13 (5) *RISK POOLING PARTICIPATION.—The*  
14 *entity shall participate in such risk pool-*  
15 *ing mechanism as the Commissioner es-*  
16 *tablishes under section 206(b).*

17 (6) *ESSENTIAL COMMUNITY PROVIDERS.—*  
18 *With respect to the basic plan offered by*  
19 *the entity, the entity shall contract for*  
20 *outpatient services with covered entities*  
21 *(as defined in section 340B(a)(4) of the*  
22 *Public Health Service Act, as in effect as*  
23 *of July 1, 2009). The Commissioner shall*  
24 *specify the extent to which and manner in*  
25 *which the previous sentence shall apply in*

1 *the case of a basic plan with respect to*  
2 *which the Commissioner determines pro-*  
3 *vides substantially all benefits through a*  
4 *health maintenance organization, as de-*  
5 *fin ed in section 2791(b)(3) of the Public*  
6 *Health Service Act.*

7 (7) *CULTURALLY AND LINGUISTICALLY AP-*  
8 *PROPRIATE SERVICES AND COMMUNICA-*  
9 *TIONS.—The entity shall provide for cul-*  
10 *turally and linguistically appropriate*  
11 *communication and health services.*

12 (8) *ADDITIONAL REQUIREMENTS.—The*  
13 *entity shall comply with other applicable*  
14 *requirements of this title, as specified by*  
15 *the Commissioner, which shall include*  
16 *standards regarding billing and collec-*  
17 *tion practices for premiums and related*  
18 *grace periods and which may include*  
19 *standards to ensure that the entity does*  
20 *not use coercive practices to force pro-*  
21 *viders not to contract with other entities*  
22 *offering coverage through the Health In-*  
23 *surance Exchange.*

24 (c) *CONTRACTS.—*

1           **(1) BID APPLICATION.—To be eligible to**  
2 **enter into a contract under this section, a**  
3 **QHBP offering entity shall submit to the**  
4 **Commissioner a bid at such time, in such**  
5 **manner, and containing such information**  
6 **as the Commissioner may require.**

7           **(2) TERM.—Each contract with a**  
8 **QHBP offering entity under this section**  
9 **shall be for a term of not less than one**  
10 **year, but may be made automatically re-**  
11 **newable from term to term in the absence**  
12 **of notice of termination by either party.**

13           **(3) ENFORCEMENT OF NETWORK ADE-**  
14 **QUACY.—In the case of a health benefits**  
15 **plan of a QHBP offering entity that uses**  
16 **a provider network, the contract under**  
17 **this section with the entity shall provide**  
18 **that if—**

19                   **(A) the Commissioner determines**  
20 **that such provider network does not**  
21 **meet such standards as the Commis-**  
22 **sioner shall establish under section**  
23 **115; and**

24                   **(B) an individual enrolled in such**  
25 **plan receives an item or service from**

1           *a provider that is not within such net-*  
2           *work;*

3           *then any cost-sharing for such item or*  
4           *service shall be equal to the amount of*  
5           *such cost-sharing that would be imposed*  
6           *if such item or service was furnished by a*  
7           *provider within such network.*

8           **(4) OVERSIGHT AND ENFORCEMENT RE-**  
9           **SPONSIBILITIES.—***The Commissioner shall*  
10          *establish processes, in coordination with*  
11          *State insurance regulators, to oversee,*  
12          *monitor, and enforce applicable require-*  
13          *ments of this title with respect to QHBP*  
14          *offering entities offering Exchange-par-*  
15          *ticipating health benefits plans and such*  
16          *plans, including the marketing of such*  
17          *plans. Such processes shall include the*  
18          *following:*

19                 **(A) GRIEVANCE AND COMPLAINT**  
20                 **MECHANISMS.—***The Commissioner shall*  
21                 *establish, in coordination with State*  
22                 *insurance regulators, a process under*  
23                 *which Exchange-eligible individuals*  
24                 *and employers may file complaints*

1           *concerning violations of such stand-*  
2           *ards.*

3           **(B) ENFORCEMENT.**—*In carrying*  
4           *out authorities under this division re-*  
5           *lating to the Health Insurance Ex-*  
6           *change, the Commissioner may impose*  
7           *one or more of the intermediate sanc-*  
8           *tions described in section 142(c).*

9           **(C) TERMINATION.**—

10           **(i) IN GENERAL.**—*The Commis-*  
11           *sioner may terminate a contract*  
12           *with a QHBP offering entity under*  
13           *this section for the offering of an*  
14           *Exchange-participating health*  
15           *benefits plan if such entity fails to*  
16           *comply with the applicable re-*  
17           *quirements of this title. Any deter-*  
18           *mination by the Commissioner to*  
19           *terminate a contract shall be*  
20           *made in accordance with formal*  
21           *investigation and compliance pro-*  
22           *cedures established by the Com-*  
23           *missioner under which—*

24                           **(I)** *the Commissioner pro-*  
25                           *vides the entity with the rea-*

1            *sonable opportunity to develop*  
2            *and implement a corrective*  
3            *action plan to correct the defi-*  
4            *ciencies that were the basis of*  
5            *the Commissioner's determina-*  
6            *tion; and*

7            *(II) the Commissioner pro-*  
8            *vides the entity with reason-*  
9            *able notice and opportunity*  
10           *for hearing (including the*  
11           *right to appeal an initial deci-*  
12           *sion) before terminating the*  
13           *contract.*

14           *(ii) EXCEPTION FOR IMMINENT*  
15           *AND SERIOUS RISK TO HEALTH.—*  
16           *Clause (i) shall not apply if the*  
17           *Commissioner determines that a*  
18           *delay in termination, resulting*  
19           *from compliance with the proce-*  
20           *dures specified in such clause*  
21           *prior to termination, would pose*  
22           *an imminent and serious risk to*  
23           *the health of individuals enrolled*  
24           *under the qualified health bene-*



1           *fits plan of the QHBP offering en-*  
2           *tity.*

3           **(D) CONSTRUCTION.**—*Nothing in*  
4           *this subsection shall be construed as*  
5           *preventing the application of other*  
6           *sanctions under subtitle E of title I*  
7           *with respect to an entity for a viola-*  
8           *tion of such a requirement.*

9 **SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELI-**  
10           **GIBLE INDIVIDUALS AND EMPLOYERS IN EX-**  
11           **CHANGE-PARTICIPATING HEALTH BENEFITS**  
12           **PLAN.**

13           **(a) IN GENERAL.**—

14           **(1) OUTREACH.**—*The Commissioner*  
15           *shall conduct outreach activities con-*  
16           *sistent with subsection (c), including*  
17           *through use of appropriate entities as de-*  
18           *scribed in paragraph (4) of such sub-*  
19           *section, to inform and educate individuals*  
20           *and employers about the Health Insur-*  
21           *ance Exchange and Exchange-partici-*  
22           *pating health benefits plan options. Such*  
23           *outreach shall include outreach specific*  
24           *to vulnerable populations, such as chil-*  
25           *dren, individuals with disabilities, indi-*

1 *viduals with mental illness, and individ-*  
2 *uals with other cognitive impairments.*

3 (2) *ELIGIBILITY.—The Commissioner*  
4 *shall make timely determinations of*  
5 *whether individuals and employers are*  
6 *Exchange-eligible individuals and em-*  
7 *ployers (as defined in section 202).*

8 (3) *ENROLLMENT.—The Commissioner*  
9 *shall establish and carry out an enroll-*  
10 *ment process for Exchange-eligible indi-*  
11 *viduals and employers, including at com-*  
12 *munity locations, in accordance with sub-*  
13 *section (b).*

14 (b) *ENROLLMENT PROCESS.—*

15 (1) *IN GENERAL.—The Commissioner*  
16 *shall establish a process consistent with*  
17 *this title for enrollments in Exchange-par-*  
18 *ticipating health benefits plans. Such*  
19 *process shall provide for enrollment*  
20 *through means such as the mail, by tele-*  
21 *phone, electronically, and in person.*

22 (2) *ENROLLMENT PERIODS.—*

23 (A) *OPEN ENROLLMENT PERIOD.—*

24 *The Commissioner shall establish an*  
25 *annual open enrollment period dur-*

1           *ing which an Exchange-eligible indi-*  
2           *vidual or employer may elect to enroll*  
3           *in an Exchange-participating health*  
4           *benefits plan for the following plan*  
5           *year and an enrollment period for af-*  
6           *fordability credits under subtitle C.*  
7           *Such periods shall be during Sep-*  
8           *tember through November of each*  
9           *year, or such other time that would*  
10          *maximize timeliness of income*  
11          *verification for purposes of such sub-*  
12          *title. The open enrollment period shall*  
13          *not be less than 30 days.*

14           **(B) SPECIAL ENROLLMENT.**—*The*  
15          *Commissioner shall also provide for*  
16          *special enrollment periods to take into*  
17          *account special circumstances of indi-*  
18          *viduals and employers, such as an in-*  
19          *dividual who—*

20                   *(i) loses acceptable coverage;*

21                   *(ii) experiences a change in*  
22                   *marital or other dependent status;*

23                   *(iii) moves outside the service*  
24                   *area of the Exchange-partici-*  
25                   *pating health benefits plan in*

1           *which the individual is enrolled;*  
2           *or*

3           *(iv) experiences a significant*  
4           *change in income.*

5           **(C) ENROLLMENT INFORMATION.—**

6           *The Commissioner shall provide for*  
7           *the broad dissemination of informa-*  
8           *tion to prospective enrollees on the en-*  
9           *rollment process, including before*  
10          *each open enrollment period. In car-*  
11          *rying out the previous sentence, the*  
12          *Commissioner may work with other*  
13          *appropriate entities to facilitate such*  
14          *provision of information.*

15          **(3) AUTOMATIC ENROLLMENT FOR NON-**  
16          **MEDICAID ELIGIBLE INDIVIDUALS.—**

17          **(A) IN GENERAL.—***The Commis-*  
18          *sioner shall provide for a process*  
19          *under which individuals who are Ex-*  
20          *change-eligible individuals described*  
21          *in subparagraph (B) are automati-*  
22          *cally enrolled under an appropriate*  
23          *Exchange-participating health bene-*  
24          *fits plan. Such process may involve a*  
25          *random assignment or some other*

1 *form of assignment that takes into ac-*  
2 *count the health care providers used*  
3 *by the individual involved or such*  
4 *other relevant factors as the Commis-*  
5 *sioner may specify.*

6 **(B) SUBSIDIZED INDIVIDUALS DE-**  
7 **SCRIBED.—***An individual described in*  
8 *this subparagraph is an Exchange-eli-*  
9 *gible individual who is either of the*  
10 *following:*

11 **(i) AFFORDABILITY CREDIT ELIGI-**  
12 **BLE INDIVIDUALS.—***The indi-*  
13 *vidual—*

14 **(I)** *has applied for, and*  
15 *been determined eligible for,*  
16 *affordability credits under*  
17 *subtitle C;*

18 **(II)** *has not opted out from*  
19 *receiving such affordability*  
20 *credit; and*

21 **(III)** *does not otherwise en-*  
22 *roll in another Exchange-par-*  
23 *ticipating health benefits*  
24 *plan.*

1                    *(ii) INDIVIDUALS ENROLLED IN A*  
2                    *TERMINATED PLAN.—The individual*  
3                    *is enrolled in an Exchange-par-*  
4                    *ticipating health benefits plan*  
5                    *that is terminated (during or at*  
6                    *the end of a plan year) and who*  
7                    *does not otherwise enroll in an-*  
8                    *other Exchange-participating*  
9                    *health benefits plan.*

10                  *(4) DIRECT PAYMENT OF PREMIUMS TO*  
11                  *PLANS.—Under the enrollment process, in-*  
12                  *dividuals enrolled in an Exchange-*  
13                  *participating health benefits plan shall*  
14                  *pay such plans directly, and not through*  
15                  *the Commissioner or the Health Insurance*  
16                  *Exchange.*

17                  *(c) COVERAGE INFORMATION AND ASSIST-*  
18                  *ANCE.—*

19                  *(1) COVERAGE INFORMATION.—The Com-*  
20                  *missioner shall provide for the broad dis-*  
21                  *semination of information on Exchange-*  
22                  *participating health benefits plans of-*  
23                  *fered under this title. Such information*  
24                  *shall be provided in a comparative man-*  
25                  *ner, and shall include information on*

1 *benefits, premiums, cost-sharing, quality,*  
2 *provider networks, and consumer satisfac-*  
3 *tion.*

4 (2) *CONSUMER ASSISTANCE WITH*  
5 *CHOICE.—To provide assistance to Ex-*  
6 *change-eligible individuals and employ-*  
7 *ers, the Commissioner shall—*

8 (A) *provide for the operation of a*  
9 *toll-free telephone hotline to respond*  
10 *to requests for assistance and main-*  
11 *tain an Internet website through*  
12 *which individuals may obtain infor-*  
13 *mation on coverage under Exchange-*  
14 *participating health benefits plans*  
15 *and file complaints;*

16 (B) *develop and disseminate infor-*  
17 *mation to Exchange-eligible enrollees*  
18 *on their rights and responsibilities;*

19 (C) *assist Exchange-eligible indi-*  
20 *viduals in selecting Exchange-partici-*  
21 *pating health benefits plans and ob-*  
22 *taining benefits through such plans;*  
23 *and*

24 (D) *ensure that the Internet*  
25 *website described in subparagraph*

1           ***(A) and the information described in***  
2           ***subparagraph (B) is developed using***  
3           ***plain language (as defined in section***  
4           ***133(a)(2)).***

5           ***(3) USE OF OTHER ENTITIES.—In car-***  
6           ***rying out this subsection, the Commis-***  
7           ***sioner may work with other appropriate***  
8           ***entities to facilitate the dissemination of***  
9           ***information under this subsection and to***  
10          ***provide assistance as described in para-***  
11          ***graph (2).***

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

14               ***(1) COVERAGE FOR CERTAIN***  
15               ***NEWBORNS.—***

16                       ***(A) IN GENERAL.—In the case of a***  
17                       ***child born in the United States who at***  
18                       ***the time of birth is not otherwise cov-***  
19                       ***ered under acceptable coverage, for***  
20                       ***the period of time beginning on the***  
21                       ***date of birth and ending on the date***  
22                       ***the child otherwise is covered under***  
23                       ***acceptable coverage (or, if earlier, the***  
24                       ***end of the month in which the 60-day***



1 *period, beginning on the date of birth,*  
2 *ends), the child shall be deemed—*

3 *(i) to be a non-traditional*  
4 *Medicaid eligible individual (as*  
5 *defined in subsection (e)(5)) for*  
6 *purposes of this division and Med-*  
7 *icaid; and*

8 *(ii) to have elected to enroll in*  
9 *Medicaid through the application*  
10 *of paragraph (3).*

11 **(B) EXTENDED TREATMENT AS TRADI-**  
12 **TIONAL MEDICAID ELIGIBLE INDI-**  
13 **VIDUAL.—***In the case of a child de-*  
14 *scribed in subparagraph (A) who at*  
15 *the end of the period referred to in*  
16 *such subparagraph is not otherwise*  
17 *covered under acceptable coverage,*  
18 *the child shall be deemed (until such*  
19 *time as the child obtains such cov-*  
20 *erage or the State otherwise makes a*  
21 *determination of the child's eligibility*  
22 *for medical assistance under its Med-*  
23 *icaid plan pursuant to section*  
24 *1943(c)(1) of the Social Security Act)*  
25 *to be a traditional Medicaid eligible*

1           *individual described in section*  
2           *1902(l)(1)(B) of such Act.*

3           **(2) CHIP TRANSITION.**—*A child who, as*  
4           *of the day before the first day of Y1, is eli-*  
5           *gible for child health assistance under*  
6           *title XXI of the Social Security Act (in-*  
7           *cluding a child receiving coverage under*  
8           *an arrangement described in section*  
9           *2101(a)(2) of such Act) is deemed as of*  
10          *such first day to be an Exchange-eligible*  
11          *individual unless the individual is a tra-*  
12          *ditional Medicaid eligible individual as*  
13          *of such day.*

14          **(3) AUTOMATIC ENROLLMENT OF MED-**  
15          **ICAID ELIGIBLE INDIVIDUALS INTO MED-**  
16          **ICAID.**—*The Commissioner shall provide*  
17          *for a process under which an individual*  
18          *who is described in section 202(d)(3) and*  
19          *has not elected to enroll in an Exchange-*  
20          *participating health benefits plan is auto-*  
21          *matically enrolled under Medicaid.*

22          **(4) NOTIFICATIONS.**—*The Commissioner*  
23          *shall notify each State in Y1 and for pur-*  
24          *poses of section 1902(gg)(1) of the Social*  
25          *Security Act (as added by section 1703(a))*

1 *whether the Health Insurance Exchange*  
2 *can support enrollment of children de-*  
3 *scribed in paragraph (2) in such State in*  
4 *such year.*

5 **(e) MEDICAID COVERAGE FOR MEDICAID ELI-**  
6 **GIBLE INDIVIDUALS.—**

7 **(1) IN GENERAL.—**

8 **(A) CHOICE FOR LIMITED EXCHANGE-**  
9 **ELIGIBLE INDIVIDUALS.—***As part of the*  
10 *enrollment process under subsection*  
11 *(b), the Commissioner shall provide*  
12 *the option, in the case of an Ex-*  
13 *change-eligible individual described*  
14 *in section 202(d)(3), for the individual*  
15 *to elect to enroll under Medicaid in-*  
16 *stead of under an Exchange-partici-*  
17 *pating health benefits plan. Such an*  
18 *individual may change such election*  
19 *during an enrollment period under*  
20 *subsection (b)(2).*

21 **(B) MEDICAID ENROLLMENT OBLIGA-**  
22 **TION.—***An Exchange eligible indi-*  
23 *vidual may apply, in the manner de-*  
24 *scribed in section 241(b)(1), for a de-*  
25 *termination of whether the individual*

1           *is a Medicaid-eligible individual. If*  
2           *the individual is determined to be so*  
3           *eligible, the Commissioner, through*  
4           *the Medicaid memorandum of under-*  
5           *standing, shall provide for the enroll-*  
6           *ment of the individual under the State*  
7           *Medicaid plan in accordance with the*  
8           *Medicaid memorandum of under-*  
9           *standing under paragraph (4). In the*  
10          *case of such an enrollment, the State*  
11          *shall provide for the same periodic re-*  
12          *determination of eligibility under*  
13          *Medicaid as would otherwise apply if*  
14          *the individual had directly applied*  
15          *for medical assistance to the State*  
16          *Medicaid agency.*

17           (2) *NON-TRADITIONAL MEDICAID ELIGI-*  
18          *BLE INDIVIDUALS.—In the case of a non-tra-*  
19          *ditional Medicaid eligible individual de-*  
20          *scribed in section 202(d)(3) who elects to*  
21          *enroll under Medicaid under paragraph*  
22          *(1)(A), the Commissioner shall provide for*  
23          *the enrollment of the individual under the*  
24          *State Medicaid plan in accordance with*

1 *the Medicaid memorandum of under-*  
2 *standing under paragraph (4).*

3 (3) **COORDINATED ENROLLMENT WITH**  
4 **STATE THROUGH MEMORANDUM OF UNDER-**  
5 **STANDING.—The Commissioner, in con-**  
6 **sultation with the Secretary of Health and**  
7 **Human Services, shall enter into a memo-**  
8 **randum of understanding with each State**  
9 **(each in this division referred to as a**  
10 **“Medicaid memorandum of under-**  
11 **standing”)** *with respect to coordinating*  
12 *enrollment of individuals in Exchange-*  
13 *participating health benefits plans and*  
14 *under the State’s Medicaid program con-*  
15 *sistent with this section and to otherwise*  
16 *coordinate the implementation of the pro-*  
17 *visions of this division with respect to the*  
18 *Medicaid program. Such memorandum*  
19 *shall permit the exchange of information*  
20 *consistent with the limitations described*  
21 *in section 1902(a)(7) of the Social Security*  
22 *Act. Nothing in this section shall be con-*  
23 *strued as permitting such memorandum*  
24 *to modify or vitiate any requirement of a*  
25 *State Medicaid plan.*

1           **(4) MEDICAID ELIGIBLE INDIVIDUALS.—**

2           ***For purposes of this division:***

3           **(A) MEDICAID ELIGIBLE INDI-**  
4           **VIDUAL.—***The term “Medicaid eligible*  
5           *individual” means an individual who*  
6           *is eligible for medical assistance*  
7           *under Medicaid.*

8           **(B) TRADITIONAL MEDICAID ELIGIBLE**  
9           **INDIVIDUAL.—***The term “traditional*  
10           *Medicaid eligible individual” means a*  
11           *Medicaid eligible individual other*  
12           *than an individual who is—*

13                   *(i) a Medicaid eligible indi-*  
14                   *vidual by reason of the applica-*  
15                   *tion of subclause (VIII) of section*  
16                   *1902(a)(10)(A)(i) of the Social Se-*  
17                   *curity Act; or*

18                   *(ii) a childless adult not de-*  
19                   *scribed in section 1902(a)(10)(A)*  
20                   *or (C) of such Act (as in effect as*  
21                   *of the day before the date of the*  
22                   *enactment of this Act).*

23           **(C) NON-TRADITIONAL MEDICAID ELI-**  
24           **GIBLE INDIVIDUAL.—***The term “non-tra-*  
25           *ditional Medicaid eligible individual”*

1           *means a Medicaid eligible individual*  
2           *who is not a traditional Medicaid eli-*  
3           *gible individual.*

4           **(f) EFFECTIVE CULTURALLY AND LINGUIS-**  
5           **TICALLY APPROPRIATE COMMUNICATION.**—*In car-*  
6           *rying out this section, the Commissioner shall*  
7           *establish effective methods for communicating*  
8           *in plain language and a culturally and lin-*  
9           *guistically appropriate manner.*

10          **SEC. 206. OTHER FUNCTIONS.**

11           **(a) COORDINATION OF AFFORDABILITY CRED-**  
12           **ITS.**—*The Commissioner shall coordinate the*  
13           *distribution of affordability premium and*  
14           *cost-sharing credits under subtitle C to QHBP*  
15           *offering entities offering Exchange-partici-*  
16           *pating health benefits plans.*

17           **(b) COORDINATION OF RISK POOLING.**—*The*  
18           *Commissioner shall establish a mechanism*  
19           *whereby there is an adjustment made of the*  
20           *premium amounts payable among QHBP offer-*  
21           *ing entities offering Exchange-participating*  
22           *health benefits plans of premiums collected for*  
23           *such plans that takes into account (in a man-*  
24           *ner specified by the Commissioner) the dif-*  
25           *ferences in the risk characteristics of individ-*

1 *uals and employers enrolled under the dif-*  
2 *ferent Exchange-participating health benefits*  
3 *plans offered by such entities so as to minimize*  
4 *the impact of adverse selection of enrollees*  
5 *among the plans offered by such entities.*

6 (c) *SPECIAL INSPECTOR GENERAL FOR THE*  
7 *HEALTH INSURANCE EXCHANGE.—*

8 (1) *ESTABLISHMENT; APPOINTMENT.—*

9 *There is hereby established the Office of*  
10 *the Special Inspector General for the*  
11 *Health Insurance Exchange, to be headed*  
12 *by a Special Inspector General for the*  
13 *Health Insurance Exchange (in this sub-*  
14 *section referred to as the “Special Inspec-*  
15 *tor General”) to be appointed by the Presi-*  
16 *dent, by and with the advice and consent*  
17 *of the Senate. The nomination of an indi-*  
18 *vidual as Special Inspector General shall*  
19 *be made as soon as practicable after the*  
20 *establishment of the program under this*  
21 *subtitle.*

22 (2) *DUTIES.—The Special Inspector*  
23 *General shall—*

24 (A) *conduct, supervise, and coordi-*  
25 *nate audits, evaluations and inves-*



1           *tigations of the Health Insurance Ex-*  
2           *change to protect the integrity of the*  
3           *Health Insurance Exchange, as well*  
4           *as the health and welfare of partici-*  
5           *pants in the Exchange;*

6           *(B) report both to the Commis-*  
7           *sioner and to the Congress regarding*  
8           *program and management problems*  
9           *and recommendations to correct them;*

10           *(C) have other duties (described in*  
11           *paragraphs (2) and (3) of section 121*  
12           *of division A of Public Law 110–343)*  
13           *in relation to the duties described in*  
14           *the previous subparagraphs; and*

15           *(D) have the authorities provided*  
16           *in section 6 of the Inspector General*  
17           *Act of 1978 in carrying out duties*  
18           *under this paragraph.*

19           **(3) APPLICATION OF OTHER SPECIAL IN-**  
20           **SPECTOR GENERAL PROVISIONS.—***The provi-*  
21           *sions of subsections (b) (other than para-*  
22           *graphs (1) and (3)), (d) (other than para-*  
23           *graph (1)), and (e) of section 121 of divi-*  
24           *sion A of the Emergency Economic Sta-*  
25           *bilization Act of 2009 (Public Law 110–*

1       **343) shall apply to the Special Inspector**  
2       **General under this subsection in the same**  
3       **manner as such provisions apply to the**  
4       **Special Inspector General under such sec-**  
5       **tion.**

6           **(4) REPORTS.—Not later than one year**  
7       **after the confirmation of the Special In-**  
8       **pector General, and annually thereafter,**  
9       **the Special Inspector General shall sub-**  
10      **mit to the appropriate committees of Con-**  
11      **gress a report summarizing the activities**  
12      **of the Special Inspector General during**  
13      **the one year period ending on the date**  
14      **such report is submitted.**

15          **(5) TERMINATION.—The Office of the**  
16      **Special Inspector General shall terminate**  
17      **five years after the date of the enactment**  
18      **of this Act.**

19      **(d) ASSISTANCE FOR SMALL EMPLOYERS.—**

20          **(1) IN GENERAL.—The Commissioner, in**  
21      **consultation with the Small Business Ad-**  
22      **ministration, shall establish and carry**  
23      **out a program to provide to small employ-**  
24      **ers counseling and technical assistance**  
25      **with respect to the provision of health in-**

1 *urance to employees of such employers*  
2 *through the Health Insurance Exchange.*

3 (2) *DUTIES.—The program established*  
4 *under paragraph (1) shall include the fol-*  
5 *lowing services:*

6 (A) *Educational activities to in-*  
7 *crease awareness of the Health Insur-*  
8 *ance Exchange and available small*  
9 *employer health plan options.*

10 (B) *Distribution of information to*  
11 *small employers with respect to the*  
12 *enrollment and selection process for*  
13 *health plans available under the*  
14 *Health Insurance Exchange, includ-*  
15 *ing standardized comparative infor-*  
16 *mation on the health plans available*  
17 *under the Health Insurance Ex-*  
18 *change.*

19 (C) *Distribution of information to*  
20 *small employers with respect to avail-*  
21 *able affordability credits or other fi-*  
22 *nancial assistance.*

23 (D) *Referrals to appropriate enti-*  
24 *ties of complaints and questions relat-*  
25 *ing to the Health Insurance Exchange.*

1           ***(E) Enrollment and plan selection***  
2           ***assistance for employers with respect***  
3           ***to the Health Insurance Exchange.***

4           ***(F) Responses to questions relat-***  
5           ***ing to the Health Insurance Exchange***  
6           ***and the program established under***  
7           ***paragraph (1).***

8           ***(3) AUTHORITY TO PROVIDE SERVICES DI-***  
9           ***RECTLY OR BY CONTRACT.—The Commis-***  
10          ***sioner may provide services under para-***  
11          ***graph (2) directly or by contract with non-***  
12          ***profit entities that the Commissioner de-***  
13          ***termines capable of carrying out such***  
14          ***services.***

15          ***(4) SMALL EMPLOYER DEFINED.—In this***  
16          ***subsection, the term “small employer”***  
17          ***means an employer with less than 100 em-***  
18          ***ployees.***

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

20          ***(a) ESTABLISHMENT OF HEALTH INSURANCE***  
21          ***EXCHANGE TRUST FUND.—There is created with-***  
22          ***in the Treasury of the United States a trust***  
23          ***fund to be known as the “Health Insurance Ex-***  
24          ***change Trust Fund” (in this section referred to***  
25          ***as the “Trust Fund”), consisting of such***

1 *amounts as may be appropriated or credited*  
2 *to the Trust Fund under this section or any*  
3 *other provision of law.*

4 **(b) PAYMENTS FROM TRUST FUND.—***The*  
5 *Commissioner shall pay from time to time from*  
6 *the Trust Fund such amounts as the Commis-*  
7 *sioner determines are necessary to make pay-*  
8 *ments to operate the Health Insurance Ex-*  
9 *change, including payments under subtitle C*  
10 *(relating to affordability credits).*

11 **(c) TRANSFERS TO TRUST FUND.—**

12 **(1) DEDICATED PAYMENTS.—***There is*  
13 *hereby appropriated to the Trust Fund*  
14 *amounts equivalent to the following:*

15 **(A) TAXES ON INDIVIDUALS NOT OB-**  
16 **TAINING ACCEPTABLE COVERAGE.—***The*  
17 *amounts received in the Treasury*  
18 *under section 59B of the Internal Rev-*  
19 *enue Code of 1986 (relating to require-*  
20 *ment of health insurance coverage for*  
21 *individuals).*

22 **(B) EMPLOYMENT TAXES ON EMPLOY-**  
23 **ERS NOT PROVIDING ACCEPTABLE COV-**  
24 **ERAGE.—***The amounts received in the*  
25 *Treasury under section 3111(c) of the*

1           ***Internal Revenue Code of 1986 (relat-***  
2           ***ing to employers electing to not pro-***  
3           ***vide health benefits).***

4           ***(C) EXCISE TAX ON FAILURES TO***  
5           ***MEET CERTAIN HEALTH COVERAGE RE-***  
6           ***QUIREMENTS.—The amounts received***  
7           ***in the Treasury under section***  
8           ***4980H(b) (relating to excise tax with***  
9           ***respect to failure to meet health cov-***  
10           ***erage participation requirements).***

11           ***(2) APPROPRIATIONS TO COVER GOVERN-***  
12           ***MENT CONTRIBUTIONS.—There are hereby***  
13           ***appropriated, out of any moneys in the***  
14           ***Treasury not otherwise appropriated, to***  
15           ***the Trust Fund, an amount equivalent to***  
16           ***the amount of payments made from the***  
17           ***Trust Fund under subsection (b) plus such***  
18           ***amounts as are necessary reduced by the***  
19           ***amounts deposited under paragraph (1).***

20           ***(d) APPLICATION OF CERTAIN RULES.—Rules***  
21           ***similar to the rules of subchapter B of chapter***  
22           ***98 of the Internal Revenue Code of 1986 shall***  
23           ***apply with respect to the Trust Fund.***

1 **SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH**  
2 **INSURANCE EXCHANGES.**

3 **(a) IN GENERAL.—If—**

4 **(1) a State (or group of States, subject**  
5 **to the approval of the Commissioner) ap-**  
6 **plies to the Commissioner for approval of**  
7 **a State-based Health Insurance Exchange**  
8 **to operate in the State (or group of**  
9 **States); and**

10 **(2) the Commissioner approves such**  
11 **State-based Health Insurance Exchange,**  
12 **then, subject to subsections (c) and (d), the**  
13 **State-based Health Insurance Exchange shall**  
14 **operate, instead of the Health Insurance Ex-**  
15 **change, with respect to such State (or group of**  
16 **States). The Commissioner shall approve a**  
17 **State-based Health Insurance Exchange if it**  
18 **meets the requirements for approval under**  
19 **subsection (b).**

20 **(b) REQUIREMENTS FOR APPROVAL.—The**  
21 **Commissioner may not approve a State-based**  
22 **Health Insurance Exchange under this section**  
23 **unless the following requirements are met:**

24 **(1) The State-based Health Insurance**  
25 **Exchange must demonstrate the capacity**  
26 **to and provide assurances satisfactory to**

1 *the Commissioner that the State-based*  
2 *Health Insurance Exchange will carry out*  
3 *the functions specified for the Health In-*  
4 *surance Exchange in the State (or States)*  
5 *involved, including—*

6 (A) *negotiating and contracting*  
7 *with QHBP offering entities for the of-*  
8 *fering of Exchange-participating*  
9 *health benefits plan, which satisfy the*  
10 *standards and requirements of this*  
11 *title and title I;*

12 (B) *enrolling Exchange-eligible in-*  
13 *dividuals and employers in such State*  
14 *in such plans;*

15 (C) *the establishment of sufficient*  
16 *local offices to meet the needs of Ex-*  
17 *change-eligible individuals and em-*  
18 *ployers;*

19 (D) *administering affordability*  
20 *credits under subtitle B using the*  
21 *same methodologies (and at least the*  
22 *same income verification methods) as*  
23 *would otherwise apply under such*  
24 *subtitle and at a cost to the Federal*  
25 *Government which does exceed the*



1           *cost to the Federal Government if this*  
2           *section did not apply; and*

3           *(E) enforcement activities con-*  
4           *sistent with federal requirements.*

5           *(2) There is no more than one Health*  
6           *Insurance Exchange operating with re-*  
7           *spect to any one State.*

8           *(3) The State provides assurances sat-*  
9           *isfactory to the Commissioner that ap-*  
10          *proval of such an Exchange will not re-*  
11          *sult in any net increase in expenditures to*  
12          *the Federal Government.*

13          *(4) The State provides for reporting of*  
14          *such information as the Commissioner de-*  
15          *termines and assurances satisfactory to*  
16          *the Commissioner that it will vigorously*  
17          *enforce violations of applicable require-*  
18          *ments.*

19          *(5) Such other requirements as the*  
20          *Commissioner may specify.*

21          **(c) CEASING OPERATION.—**

22          **(1) IN GENERAL.—***A State-based Health*  
23          *Insurance Exchange may, at the option of*  
24          *each State involved, and only after pro-*  
25          *viding timely and reasonable notice to the*

1 *Commissioner, cease operation as such an*  
2 *Exchange, in which case the Health Insur-*  
3 *ance Exchange shall operate, instead of*  
4 *such State-based Health Insurance Ex-*  
5 *change, with respect to such State (or*  
6 *States).*

7 (2) *TERMINATION; HEALTH INSURANCE*  
8 *EXCHANGE RESUMPTION OF FUNCTIONS.—The*  
9 *Commissioner may terminate the ap-*  
10 *proval (for some or all functions) of a*  
11 *State-based Health Insurance Exchange*  
12 *under this section if the Commissioner de-*  
13 *termines that such Exchange no longer*  
14 *meets the requirements of subsection (b)*  
15 *or is no longer capable of carrying out*  
16 *such functions in accordance with the re-*  
17 *quirements of this subtitle. In lieu of ter-*  
18 *minating such approval, the Commis-*  
19 *sioner may temporarily assume some or*  
20 *all functions of the State-based Health In-*  
21 *surance Exchange until such time as the*  
22 *Commissioner determines the State-based*  
23 *Health Insurance Exchange meets such*  
24 *requirements of subsection (b) and is ca-*  
25 *pable of carrying out such functions in*

1 *accordance with the requirements of this*  
2 *subtitle.*

3 (3) *EFFECTIVENESS.—The ceasing or*  
4 *termination of a State-based Health In-*  
5 *urance Exchange under this subsection*  
6 *shall be effective in such time and man-*  
7 *ner as the Commissioner shall specify.*

8 (d) *RETENTION OF AUTHORITY.—*

9 (1) *AUTHORITY RETAINED.—Enforce-*  
10 *ment authorities of the Commissioner*  
11 *shall be retained by the Commissioner.*

12 (2) *DISCRETION TO RETAIN ADDITIONAL*  
13 *AUTHORITY.—The Commissioner may speci-*  
14 *fy functions of the Health Insurance Ex-*  
15 *change that—*

16 (A) *may not be performed by a*  
17 *State-based Health Insurance Ex-*  
18 *change under this section; or*

19 (B) *may be performed by the Com-*  
20 *missioner and by such a State-based*  
21 *Health Insurance Exchange.*

22 (e) *REFERENCES.—In the case of a State-*  
23 *based Health Insurance Exchange, except as*  
24 *the Commissioner may otherwise specify under*  
25 *subsection (d), any references in this subtitle*

1 *to the Health Insurance Exchange or to the*  
2 *Commissioner in the area in which the State-*  
3 *based Health Insurance Exchange operates*  
4 *shall be deemed a reference to the State-based*  
5 *Health Insurance Exchange and the head of*  
6 *such Exchange, respectively.*

7       **(f) FUNDING.**—*In the case of a State-based*  
8 *Health Insurance Exchange, there shall be as-*  
9 *sistance provided for the operation of such Ex-*  
10 *change in the form of a matching grant with*  
11 *a State share of expenditures required.*

12 **SEC. 209. PARTICIPATION OF SMALL EMPLOYER BENEFIT**  
13 **ARRANGEMENTS.**

14       **(a) IN GENERAL.**—*The Commissioner may*  
15 *enter into contracts with small employer ben-*  
16 *efit arrangements to provide consumer infor-*  
17 *mation, outreach, and assistance in the enroll-*  
18 *ment of small employers (and their employees)*  
19 *who are members of such an arrangement*  
20 *under Exchange participating health benefits*  
21 *plans.*

22       **(b) SMALL EMPLOYER BENEFIT ARRANGE-**  
23 **MENT DEFINED.**—*In this section, the term*  
24 *“small employer benefit arrangement” means*

1 *a not-for-profit agricultural or other coopera-*  
2 *tive that—*

3 *(1) consists solely of its members and*  
4 *is operated for the primary purpose of*  
5 *providing affordable employee benefits to*  
6 *its members;*

7 *(2) only has as members small employ-*  
8 *ers in the same industry or line of busi-*  
9 *ness;*

10 *(3) has no member that has more than*  
11 *a 5 percent voting interest in the coopera-*  
12 *tive; and*

13 *(4) is governed by a board of directors*  
14 *elected by its members.*

15 ***Subtitle B—Public Health***  
16 ***Insurance Option***

17 ***SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A***  
18 ***PUBLIC HEALTH INSURANCE OPTION AS AN***  
19 ***EXCHANGE-QUALIFIED HEALTH BENEFITS***  
20 ***PLAN.***

21 ***(a) ESTABLISHMENT.—For years beginning***  
22 ***with Y1, the Secretary of Health and Human***  
23 ***Services (in this subtitle referred to as the***  
24 ***“Secretary”) shall provide for the offering of***  
25 ***an Exchange-participating health benefits***

1 *plan (in this division referred to as the “public*  
2 *health insurance option”)* that ensures choice,  
3 *competition, and stability of affordable, high*  
4 *quality coverage throughout the United States*  
5 *in accordance with this subtitle. In designing*  
6 *the option, the Secretary’s primary responsi-*  
7 *bility is to create a low-cost plan without*  
8 *comprimising quality or access to care.*

9       **(b) OFFERING AS AN EXCHANGE-PARTICI-**  
10 **PATING HEALTH BENEFITS PLAN.—**

11           **(1) EXCLUSIVE TO THE EXCHANGE.—***The*  
12 *public health insurance option shall only*  
13 *be made available through the Health In-*  
14 *surance Exchange.*

15           **(2) ENSURING A LEVEL PLAYING FIELD.—**  
16 *Consistent with this subtitle, the public*  
17 *health insurance option shall comply with*  
18 *requirements that are applicable under*  
19 *this title to an Exchange-participating*  
20 *health benefits plan, including require-*  
21 *ments related to benefits, benefit levels,*  
22 *provider networks, notices, consumer pro-*  
23 *tections, and cost sharing.*

24           **(3) PROVISION OF BENEFIT LEVELS.—***The*  
25 *public health insurance option—*

1           (A) shall offer basic, enhanced,  
2           and premium plans; and

3           (B) may offer premium-plus plans.

4       (c) ADMINISTRATIVE CONTRACTING.—The  
5 Secretary may enter into contracts for the pur-  
6 pose of performing administrative functions  
7 (including functions described in subsection  
8 (a)(4) of section 1874A of the Social Security  
9 Act) with respect to the public health insur-  
10 ance option in the same manner as the Sec-  
11 retary may enter into contracts under sub-  
12 section (a)(1) of such section. The Secretary  
13 has the same authority with respect to the pub-  
14 lic health insurance option as the Secretary  
15 has under subsections (a)(1) and (b) of section  
16 1874A of the Social Security Act with respect  
17 to title XVIII of such Act. Contracts under this  
18 subsection shall not involve the transfer of in-  
19 surance risk to such entity.

20       (d) OMBUDSMAN.—The Secretary shall es-  
21 tablish an office of the ombudsman for the  
22 public health insurance option which shall  
23 have duties with respect to the public health  
24 insurance option similar to the duties of the

1 *Medicare Beneficiary Ombudsman under sec-*  
2 *tion 1808(c)(2) of the Social Security Act.*

3       **(e) DATA COLLECTION.**—*The Secretary shall*  
4 *collect such data as may be required to estab-*  
5 *lish premiums and payment rates for the pub-*  
6 *lic health insurance option and for other pur-*  
7 *poses under this subtitle, including to improve*  
8 *quality and to reduce disparities in health*  
9 *and health care based on race, ethnicity, pri-*  
10 *mary language, sex, sexual orientation, gender*  
11 *identity, disability, socioeconomic status,*  
12 *rural, urban, or other geographic setting, and*  
13 *any other population or subpopulation as de-*  
14 *termined appropriate by the Secretary, but*  
15 *only if the data collection is conducted on a*  
16 *voluntary basis and consistent with the stand-*  
17 *ards, including privacy protections, estab-*  
18 *lished pursuant to section 1709 of the Public*  
19 *Health Service Act.*

20       **(f) TREATMENT OF PUBLIC HEALTH INSUR-**  
21 **ANCE OPTION.**—*With respect to the public*  
22 *health insurance option, the Secretary shall be*  
23 *treated as a QHBP offering entity offering an*  
24 *Exchange-participating health benefits plan.*



1       **(g) ACCESS TO FEDERAL COURTS.—***The pro-*  
2 *visions of Medicare (and related provisions of*  
3 *title II of the Social Security Act) relating to*  
4 *access of Medicare beneficiaries to Federal*  
5 *courts for the enforcement of rights under*  
6 *Medicare, including with respect to amounts*  
7 *in controversy, shall apply to the public health*  
8 *insurance option and individuals enrolled*  
9 *under such option under this title in the same*  
10 *manner as such provisions apply to Medicare*  
11 *and Medicare beneficiaries.*

12 **SEC. 222. PREMIUMS AND FINANCING.**

13       **(a) ESTABLISHMENT OF PREMIUMS.—**

14           **(1) IN GENERAL.—***The Secretary shall*  
15 *establish geographically-adjusted pre-*  
16 *mium rates for the public health insur-*  
17 *ance option in a manner—*

18                   **(A)** *that complies with the pre-*  
19 *mium rules established by the Com-*  
20 *missioner under section 113 for Ex-*  
21 *change-participating health benefit*  
22 *plans; and*

23                   **(B)** *at a level sufficient to fully fi-*  
24 *nance the costs of—*

1           *(i) health benefits provided by*  
2           *the public health insurance op-*  
3           *tion; and*

4           *(ii) administrative costs re-*  
5           *lated to operating the public*  
6           *health insurance option.*

7           **(2) CONTINGENCY MARGIN.**—*In estab-*  
8           *lishing premium rates under paragraph*  
9           *(1), the Secretary shall include an appro-*  
10          *priate amount for a contingency margin.*

11          **(b) ACCOUNT.**—

12           **(1) ESTABLISHMENT.**—*There is estab-*  
13          *lished in the Treasury of the United States*  
14          *an Account for the receipts and disburse-*  
15          *ments attributable to the operation of the*  
16          *public health insurance option, including*  
17          *the start-up funding under paragraph (2).*  
18          *Section 1854(g) of the Social Security Act*  
19          *shall apply to receipts described in the*  
20          *previous sentence in the same manner as*  
21          *such section applies to payments or pre-*  
22          *miums described in such section.*

23           **(2) START-UP FUNDING.**—

24           **(A) IN GENERAL.**—*In order to pro-*  
25          *vide for the establishment of the pub-*

1        *lic health insurance option there is*  
2        *hereby appropriated to the Secretary,*  
3        *out of any funds in the Treasury not*  
4        *otherwise                                appropriated,*  
5        *\$2,000,000,000. In order to provide for*  
6        *initial claims reserves before the col-*  
7        *lection of premiums, there is hereby*  
8        *appropriated to the Secretary, out of*  
9        *any funds in the Treasury not other-*  
10       *wise appropriated, such sums as nec-*  
11       *essary to cover 90 days worth of*  
12       *claims reserves based on projected en-*  
13       *rollment.*

14                *(B) AMORTIZATION OF START-UP*  
15        *FUNDING.—The Secretary shall provide*  
16        *for the repayment of the startup fund-*  
17        *ing provided under subparagraph (A)*  
18        *to the Treasury in an amortized man-*  
19        *ner over the 10-year period beginning*  
20        *with Y1.*

21                *(C) LIMITATION ON FUNDING.—Noth-*  
22        *ing in this section shall be construed*  
23        *as authorizing any additional appro-*  
24        *priations to the Account, other than*  
25        *such amounts as are otherwise pro-*

1            *vided with respect to other Exchange-*  
2            *participating health benefits plans.*

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

4            **(a) RATES ESTABLISHED BY SECRETARY.—**

5            **(1) IN GENERAL.—***The Secretary shall*  
6            *establish payment rates for the public*  
7            *health insurance option for services and*  
8            *health care providers consistent with this*  
9            *section and may change such payment*  
10           *rates in accordance with section 224.*

11           **(2) INITIAL PAYMENT RULES.—**

12           **(A) IN GENERAL.—***Except as pro-*  
13           *vided in subparagraph (B) and sub-*  
14           *section (b)(1), during Y1, Y2, and Y3,*  
15           *the Secretary shall base the payment*  
16           *rates under this section for services*  
17           *and providers described in paragraph*  
18           *(1) on the payment rates for similar*  
19           *services and providers under parts A*  
20           *and B of Medicare.*

21           **(B) EXCEPTIONS.—**

22           **(i) PRACTITIONERS' SERVICES.—**  
23           *Payment rates for practitioners'*  
24           *services otherwise established*  
25           *under the fee schedule under sec-*

1            *tion 1848 of the Social Security*  
2            *Act shall be applied without re-*  
3            *gard to the provisions under sub-*  
4            *section (f) of such section and the*  
5            *update under subsection (d)(4)*  
6            *under such section for a year as*  
7            *applied under this paragraph*  
8            *shall be not less than 1 percent.*

9            *(ii) ADJUSTMENTS.—The Sec-*  
10           *retary may determine the extent to*  
11           *which Medicare adjustments ap-*  
12           *plicable to base payment rates*  
13           *under parts A and B of Medicare*  
14           *shall apply under this subtitle.*

15           *(3) FOR NEW SERVICES.—The Secretary*  
16           *shall modify payment rates described in*  
17           *paragraph (2) in order to accommodate*  
18           *payments for services, such as well-child*  
19           *visits, that are not otherwise covered*  
20           *under Medicare.*

21           *(4) PRESCRIPTION DRUGS.—Payment*  
22           *rates under this section for prescription*  
23           *drugs that are not paid for under part A*  
24           *or part B of Medicare shall be at rates ne-*  
25           *gotiated by the Secretary.*

1       **(b) INCENTIVES FOR PARTICIPATING PRO-**  
2 **VIDERS.—**

3           **(1) INITIAL INCENTIVE PERIOD.—**

4               **(A) IN GENERAL.—***The Secretary*  
5 *shall provide, in the case of services*  
6 *described in subparagraph (B) fur-*  
7 *nished during Y1, Y2, and Y3, for pay-*  
8 *ment rates that are 5 percent greater*  
9 *than the rates established under sub-*  
10 *section (a).*

11               **(B) SERVICES DESCRIBED.—***The*  
12 *services described in this subpara-*  
13 *graph are items and professional serv-*  
14 *ices, under the public health insur-*  
15 *ance option by a physician or other*  
16 *health care practitioner who partici-*  
17 *pates in both Medicare and the public*  
18 *health insurance option.*

19               **(C) SPECIAL RULES.—***A pediatri-*  
20 *cian and any other health care practi-*  
21 *tioner who is a type of practitioner*  
22 *that does not typically participate in*  
23 *Medicare (as determined by the Sec-*  
24 *retary) shall also be eligible for the*

1           *increased payment rates under sub-*  
2           *paragraph (A).*

3           **(2) SUBSEQUENT PERIODS.**—*Beginning*  
4           *with Y4 and for subsequent years, the Sec-*  
5           *retary shall continue to use an adminis-*  
6           *trative process to set such rates in order*  
7           *to promote payment accuracy, to ensure*  
8           *adequate beneficiary access to providers,*  
9           *and to promote affordability and the effi-*  
10           *cient delivery of medical care consistent*  
11           *with section 221(a). Such rates shall not*  
12           *be set at levels expected to increase over-*  
13           *all medical costs under the option beyond*  
14           *what would be expected if the process*  
15           *under subsection (a)(2) and paragraph (1)*  
16           *of this subsection were continued.*

17           **(3) ESTABLISHMENT OF A PROVIDER NET-**  
18           **WORK.**—*Health care providers partici-*  
19           *pating under Medicare are participating*  
20           *providers in the public health insurance*  
21           *option unless they opt out in a process es-*  
22           *tablished by the Secretary.*

23           **(c) ADMINISTRATIVE PROCESS FOR SETTING**  
24           **RATES.**—*Chapter 5 of title 5, United States*  
25           *Code shall apply to the process for the initial*

1 *establishment of payment rates under this sec-*  
2 *tion but not to the specific methodology for es-*  
3 *tablishing such rates or the calculation of*  
4 *such rates.*

5       **(d) CONSTRUCTION.**—*Nothing in this sub-*  
6 *title shall be construed as limiting the Sec-*  
7 *retary’s authority to correct for payments that*  
8 *are excessive or deficient, taking into account*  
9 *the provisions of section 221(a) and the*  
10 *amounts paid for similar health care pro-*  
11 *viders and services under other Exchange-par-*  
12 *ticipating health benefits plans.*

13       **(e) CONSTRUCTION.**—*Nothing in this sub-*  
14 *title shall be construed as affecting the au-*  
15 *thority of the Secretary to establish payment*  
16 *rates, including payments to provide for the*  
17 *more efficient delivery of services, such as the*  
18 *initiatives provided for under section 224.*

19       **(f) LIMITATIONS ON REVIEW.**—*There shall be*  
20 *no administrative or judicial review of a pay-*  
21 *ment rate or methodology established under*  
22 *this section or under section 224.*



1 *SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIV-*  
2 *ERY SYSTEM REFORM.*

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

16 *(b) REQUIREMENTS FOR INNOVATIVE PAY-*  
17 *MENTS.—The Secretary shall design and imple-*  
18 *ment the payment mechanisms and policies*  
19 *under this section in a manner that—*

20 *(1) seeks to—*

21 *(A) improve health outcomes;*

22 *(B) reduce health disparities (in-*  
23 *cluding racial, ethnic, and other dis-*  
24 *parities);*

25 *(C) provide efficient and afford-*  
26 *able care;*

1           ***(D) address geographic variation***  
2           ***in the provision of health services; or***

3           ***(E) prevent or manage chronic ill-***  
4           ***ness; and***

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

7           ***(c) ENCOURAGING THE USE OF HIGH VALUE***  
8           ***SERVICES.—To the extent allowed by the benefit***  
9           ***standards applied to all Exchange-partici-***  
10           ***pating health benefits plans, the public health***  
11           ***insurance option may modify cost sharing and***  
12           ***payment rates to encourage the use of services***  
13           ***that promote health and value.***

14           ***(d) NON-UNIFORMITY PERMITTED.—Nothing***  
15           ***in this subtitle shall prevent the Secretary***  
16           ***from varying payments based on different pay-***  
17           ***ment structure models (such as accountable***  
18           ***care organizations and medical homes) under***  
19           ***the public health insurance option for dif-***  
20           ***ferent geographic areas.***

21           ***SEC. 225. PROVIDER PARTICIPATION.***

22           ***(a) IN GENERAL.—The Secretary shall es-***  
23           ***tablish conditions of participation for health***  
24           ***care providers under the public health insur-***  
25           ***ance option.***

1       **(b) LICENSURE OR CERTIFICATION.—***The Sec-*  
2 *retary shall not allow a health care provider*  
3 *to participate in the public health insurance*  
4 *option unless such provider is appropriately*  
5 *licensed, certified, or otherwise permitted to*  
6 *practice under State law.*

7       **(c) PAYMENT TERMS FOR PROVIDERS.—**

8           **(1) PHYSICIANS.—***The Secretary shall*  
9 *provide for the annual participation of*  
10 *physicians under the public health insur-*  
11 *ance option, for which payment may be*  
12 *made for services furnished during the*  
13 *year, in one of 2 classes:*

14           **(A) PREFERRED PHYSICIANS.—***Those*  
15 *physicians who agree to accept the*  
16 *payment rate established under sec-*  
17 *tion 223 (without regard to cost-shar-*  
18 *ing) as the payment in full.*

19           **(B) PARTICIPATING, NON-PREFERRED**  
20 **PHYSICIANS.—***Those physicians who*  
21 *agree not to impose charges (in rela-*  
22 *tion to the payment rate described in*  
23 *section 223 for such physicians) that*  
24 *exceed the ratio permitted under sec-*

1            *tion 1848(g)(2)(C) of the Social Secu-*  
2            *rity Act.*

3            **(2) OTHER PROVIDERS.—***The Secretary*  
4            *shall provide for the participation (on an*  
5            *annual or other basis specified by the Sec-*  
6            *retary) of health care providers (other*  
7            *than physicians) under the public health*  
8            *insurance option under which payment*  
9            *shall only be available if the provider*  
10           *agrees to accept the payment rate estab-*  
11           *lished under section 223 (without regard*  
12           *to cost-sharing) as the payment in full.*

13           **(d) EXCLUSION OF CERTAIN PROVIDERS.—**  
14           *The Secretary shall exclude from participa-*  
15           *tion under the public health insurance option*  
16           *a health care provider that is excluded from*  
17           *participation in a Federal health care pro-*  
18           *gram (as defined in section 1128B(f) of the So-*  
19           *cial Security Act).*

20           **SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.**

21           *Provisions of law (other than criminal law*  
22           *provisions) identified by the Secretary by regu-*  
23           *lation, in consultation with the Inspector Gen-*  
24           *eral of the Department of Health and Human*  
25           *Services, that impose sanctions with respect to*

1 *waste, fraud, and abuse under Medicare, such*  
2 *as the False Claims Act (31 U.S.C. 3729 et seq.),*  
3 *shall also apply to the public health insurance*  
4 *option.*

5 *SEC. 227. SENSE OF THE HOUSE REGARDING ENROLLMENT*  
6 *OF MEMBERS IN THE PUBLIC OPTION.*

7 *It is the sense of the House of Representa-*  
8 *tives that Members who vote in favor of the es-*  
9 *tablishment of a public, Federal Government*  
10 *run health insurance option, and senior mem-*  
11 *bers of the President's administration, are*  
12 *urged to forgo their right to participate in the*  
13 *Federal Employees Health Benefits Program*  
14 *(FEHBP) and agree to enroll under that public*  
15 *option.*

16 *Subtitle C—Individual*  
17 *Affordability Credits*

18 *SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EX-*  
19 *CHANGE.*

20 *(a) IN GENERAL.—Subject to the succeeding*  
21 *provisions of this subtitle, in the case of an af-*  
22 *fordable credit eligible individual enrolled in*  
23 *an Exchange-participating health benefits*  
24 *plan—*

1           ***(1) the individual shall be eligible for,***  
2           ***in accordance with this subtitle, afford-***  
3           ***ability credits consisting of—***

4                   ***(A) an affordability premium***  
5                   ***credit under section 243 to be applied***  
6                   ***against the premium for the Ex-***  
7                   ***change-participating health benefits***  
8                   ***plan in which the individual is en-***  
9                   ***rolled; and***

10                   ***(B) an affordability cost-sharing***  
11                   ***credit under section 244 to be applied***  
12                   ***as a reduction of the cost-sharing oth-***  
13                   ***erwise applicable to such plan; and***

14           ***(2) the Commissioner shall pay the***  
15           ***QHBP offering entity that offers such plan***  
16           ***from the Health Insurance Exchange***  
17           ***Trust Fund the aggregate amount of af-***  
18           ***fordability credits for all affordable cred-***  
19           ***it eligible individuals enrolled in such***  
20           ***plan.***

21           ***(b) APPLICATION.—***

22                   ***(1) IN GENERAL.—An Exchange eligible***  
23                   ***individual may apply to the Commissioner***  
24                   ***through the Health Insurance Exchange***  
25                   ***or through another entity under an ar-***

1 *rangement made with the Commissioner,*  
2 *in a form and manner specified by the*  
3 *Commissioner. The Commissioner through*  
4 *the Health Insurance Exchange or*  
5 *through another public entity under an*  
6 *arrangement made with the Commis-*  
7 *sioner shall make a determination as to*  
8 *eligibility of an individual for afford-*  
9 *ability credits under this subtitle. The*  
10 *Commissioner shall establish a process*  
11 *whereby, on the basis of information oth-*  
12 *erwise available, individuals may be*  
13 *deemed to be affordable credit eligible in-*  
14 *dividuals. In carrying this subtitle, the*  
15 *Commissioner shall establish effective*  
16 *methods that ensure that individuals with*  
17 *limited English proficiency are able to*  
18 *apply for affordability credits.*

19 *(2) USE OF STATE MEDICAID AGENCIES.—*  
20 *If the Commissioner determines that a*  
21 *State Medicaid agency has the capacity to*  
22 *make a determination of eligibility for af-*  
23 *fordability credits under this subtitle and*  
24 *under the same standards as used by the*  
25 *Commissioner, under the Medicaid memo-*

1 *randum of understanding (as defined in*  
2 *section 205(c)(4))—*

3 *(A) the State Medicaid agency is*  
4 *authorized to conduct such deter-*  
5 *minations for any Exchange-eligible*  
6 *individual who requests such a deter-*  
7 *mination; and*

8 *(B) the Commissioner shall reim-*  
9 *burse the State Medicaid agency for*  
10 *the costs of conducting such deter-*  
11 *minations.*

12 *(3) MEDICAID SCREEN AND ENROLL OBLI-*  
13 *GATION.—In the case of an application*  
14 *made under paragraph (1), there shall be*  
15 *a determination of whether the individual*  
16 *is a Medicaid-eligible individual. If the*  
17 *individual is determined to be so eligible,*  
18 *the Commissioner, through the Medicaid*  
19 *memorandum of understanding, shall*  
20 *provide for the enrollment of the indi-*  
21 *vidual under the State Medicaid plan in*  
22 *accordance with the Medicaid memo-*  
23 *randum of understanding. In the case of*  
24 *such an enrollment, the State shall pro-*  
25 *vide for the same periodic redetermina-*



1 *tion of eligibility under Medicaid as*  
2 *would otherwise apply if the individual*  
3 *had directly applied for medical assist-*  
4 *ance to the State Medicaid agency.*

5 **(c) USE OF AFFORDABILITY CREDITS.—**

6 **(1) IN GENERAL.—***In Y1 and Y2 an af-*  
7 *fordable credit eligible individual may*  
8 *use an affordability credit only with re-*  
9 *spect to a basic plan.*

10 **(2) FLEXIBILITY IN PLAN ENROLLMENT**  
11 **AUTHORIZED.—***Beginning with Y3, the*  
12 *Commissioner shall establish a process to*  
13 *allow an affordability credit to be used*  
14 *for enrollees in enhanced or premium*  
15 *plans. In the case of an affordable credit*  
16 *eligible individual who enrolls in an en-*  
17 *hanced or premium plan, the individual*  
18 *shall be responsible for any difference be-*  
19 *tween the premium for such plan and the*  
20 *affordable credit amount otherwise appli-*  
21 *cable if the individual had enrolled in a*  
22 *basic plan.*

23 **(d) ACCESS TO DATA.—***In carrying out this*  
24 *subtitle, the Commissioner shall request from*  
25 *the Secretary of the Treasury consistent with*

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

4 *(e) NO CASH REBATES.—In no case shall an*  
5 *affordable credit eligible individual receive*  
6 *any cash payment as a result of the applica-*  
7 *tion of this subtitle.*

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

9 *(a) DEFINITION.—*

10 *(1) IN GENERAL.—For purposes of this*  
11 *division, the term “affordable credit eligi-*  
12 *ble individual” means, subject to sub-*  
13 *section (b), an individual who is lawfully*  
14 *present in a State in the United States*  
15 *(other than as a nonimmigrant described*  
16 *in a subparagraph (excluding subpara-*  
17 *graphs (K), (T), (U), and (V)) of section*  
18 *101(a)(15) of the Immigration and Nation-*  
19 *ality Act)—*

20 *(A) who is enrolled under an Ex-*  
21 *change-participating health benefits*  
22 *plan and is not enrolled under such*  
23 *plan as an employee (or dependent of*  
24 *an employee) through an employer*

1           *qualified health benefits plan that*  
2           *meets the requirements of section 312;*

3           *(B) with family income below 400*  
4           *percent of the Federal poverty level for*  
5           *a family of the size involved; and*

6           *(C) who is not a Medicaid eligible*  
7           *individual, other than an individual*  
8           *described in section 202(d)(3) or an in-*  
9           *dividual during a transition period*  
10           *under section 202(d)(4)(B)(ii).*

11           **(2) TREATMENT OF FAMILY.—***Except as*  
12           *the Commissioner may otherwise provide,*  
13           *members of the same family who are af-*  
14           *fordable credit eligible individuals shall*  
15           *be treated as a single affordable credit in-*  
16           *dividual eligible for the applicable credit*  
17           *for such a family under this subtitle.*

18           **(b) LIMITATIONS ON EMPLOYEE AND DEPEND-**  
19           **ENT DISQUALIFICATION.—**

20           **(1) IN GENERAL.—***Subject to paragraph*  
21           *(2), the term “affordable credit eligible in-*  
22           *dividual” does not include a full-time em-*  
23           *ployee of an employer if the employer of-*  
24           *fers the employee coverage (for the em-*  
25           *ployee and dependents) as a full-time em-*

1     *ployee under a group health plan if the*  
2     *coverage and employer contribution*  
3     *under the plan meet the requirements of*  
4     *section 312.*

5           (2) *EXCEPTIONS.—*

6           (A) *FOR CERTAIN FAMILY CIR-*  
7     *CUMSTANCES.—The Commissioner shall*  
8     *establish such exceptions and special*  
9     *rules in the case described in para-*  
10    *graph (1) as may be appropriate in*  
11    *the case of a divorced or separated in-*  
12    *dividual or such a dependent of an*  
13    *employee who would otherwise be an*  
14    *affordable credit eligible individual.*

15          (B) *FOR UNAFFORDABLE EMPLOYER*  
16    *COVERAGE.—For years beginning with*  
17    *Y2, in the case of full-time employees*  
18    *for which the cost of the employee pre-*  
19    *mium (plus, to the extent specified by*  
20    *the Commissioner, out-of-pocket cost-*  
21    *sharing for such year or the preceding*  
22    *year) for coverage under a group*  
23    *health plan would exceed 11 percent*  
24    *of current family income (determined*  
25    *by the Commissioner on the basis of*

1           *verifiable documentation and without*  
2           *regard to section 245), paragraph (1)*  
3           *shall not apply.*

4           **(c) INCOME DEFINED.—**

5           **(1) IN GENERAL.—***In this title, the term*  
6           *“income” means modified adjusted gross*  
7           *income (as defined in section 59B of the*  
8           *Internal Revenue Code of 1986).*

9           **(2) STUDY OF INCOME DISREGARDS.—***The*  
10          *Commissioner shall conduct a study that*  
11          *examines the application of income dis-*  
12          *regards for purposes of this subtitle. Not*  
13          *later than the first day of Y2, the Commis-*  
14          *sioner shall submit to Congress a report*  
15          *on such study and shall include such rec-*  
16          *ommendations as the Commissioner deter-*  
17          *mines appropriate.*

18          **(d) CLARIFICATION OF TREATMENT OF AF-**  
19          **FORDABILITY CREDITS.—***Affordabilty credits*  
20          *under this subtitle shall not be treated, for*  
21          *purposes of title IV of the Personal Responsi-*  
22          *bility and Work Opportunity Reconciliation*  
23          *Act of 1996, to be a benefit provided under sec-*  
24          *tion 403 of such title.*

1 **SEC. 243. AFFORDABLE PREMIUM CREDIT.**

2       **(a) IN GENERAL.—***The affordability pre-*  
3 *mium credit under this section for an afford-*  
4 *able credit eligible individual enrolled in an*  
5 *Exchange-participating health benefits plan*  
6 *is in an amount equal to the amount (if any)*  
7 *by which the premium for the plan (or, if less,*  
8 *the reference premium amount specified in*  
9 *subsection (c)), exceeds the affordable pre-*  
10 *mium amount specified in subsection (b) for*  
11 *the individual.*

12       **(b) AFFORDABLE PREMIUM AMOUNT.—**

13           **(1) IN GENERAL.—***The affordable pre-*  
14 *mium amount specified in this subsection*  
15 *for an individual for monthly premium in*  
16 *a plan year shall be equal to  $\frac{1}{12}$  of the*  
17 *product of—*

18                   **(A)** *the premium percentage limit*  
19 *specified in paragraph (2) for the in-*  
20 *dividual based upon the individual's*  
21 *family income for the plan year; and*

22                   **(B)** *the individual's family income*  
23 *for such plan year.*

24           **(2) PREMIUM PERCENTAGE LIMITS BASED**  
25 **ON TABLE.—***The Commissioner shall estab-*  
26 *lish premium percentage limits so that for*

1 *individuals whose family income is within*  
2 *an income tier specified in the table in*  
3 *subsection (d) such percentage limits*  
4 *shall increase, on a sliding scale in a lin-*  
5 *ear manner, from the initial premium*  
6 *percentage to the final premium percent-*  
7 *age specified in such table for such in-*  
8 *come tier.*

9 **(c) REFERENCE PREMIUM AMOUNT.**—*The ref-*  
10 *erence premium amount specified in this sub-*  
11 *section for a plan year for an individual in a*  
12 *premium rating area is equal to the average*  
13 *premium for the 3 basic plans in the area for*  
14 *the plan year with the lowest premium levels.*  
15 *In computing such amount the Commissioner*  
16 *may exclude plans with extremely limited en-*  
17 *rollments.*

18 **(d) TABLE OF PREMIUM PERCENTAGE LIMITS**  
19 **AND ACTUARIAL VALUE PERCENTAGES BASED ON**  
20 **INCOME TIER.**—

21 **(1) IN GENERAL.**—*For purposes of this*  
22 *subtitle, the table specified in this sub-*  
23 *section is as follows:*

*In the case of family income (expressed as a percent of FPL) within the following income tier:*

<i>The initial premium percentage is—</i>	<i>The final premium percentage is—</i>	<i>The actuarial value percentage is—</i>
<i>133% through 150%</i>	<i>1.5%</i>	<i>3%</i>
<i>150% through 200%</i>	<i>3%</i>	<i>5%</i>
<i>200% through 250%</i>	<i>5%</i>	<i>7%</i>
<i>250% through 300%</i>	<i>7%</i>	<i>9%</i>
<i>300% through 350%</i>	<i>9%</i>	<i>10%</i>
<i>350% through 400%</i>	<i>10%</i>	<i>11%</i>

1           **(2) SPECIAL RULES.—For purposes of**  
 2           **applying the table under paragraph (1)—**

3                   **(A) FOR LOWEST LEVEL OF INCOME.—**

4                   ***In the case of an individual with in-***  
 5                   ***come that does not exceed 133 percent***  
 6                   ***of FPL, the individual shall be consid-***  
 7                   ***ered to have income that is 133% of***  
 8                   ***FPL.***

9                   **(B) APPLICATION OF HIGHER ACTU-**  
 10                   **ARIAL VALUE PERCENTAGE AT TIER TRAN-**  
 11                   **SITION POINTS.—If two actuarial value**  
 12                   **percentages may be determined with**  
 13                   **respect to an individual, the actuarial**  
 14                   **value percentage shall be the higher**  
 15                   **of such percentages.**

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

17           **(a) IN GENERAL.—The affordability cost-**  
 18           **sharing credit under this section for an afford-**  
 19           **able credit eligible individual enrolled in an**



1 *Exchange-participating health benefits plan*  
2 *is in the form of the cost-sharing reduction de-*  
3 *scribed in subsection (b) provided under this*  
4 *section for the income tier in which the indi-*  
5 *vidual is classified based on the individual's*  
6 *family income.*

7       **(b) COST-SHARING REDUCTIONS.—***The Com-*  
8 *missioner shall specify a reduction in cost-*  
9 *sharing amounts and the annual limitation*  
10 *on cost-sharing specified in section*  
11 *122(c)(2)(B) under a basic plan for each in-*  
12 *come tier specified in the table under section*  
13 *243(d), with respect to a year, in a manner so*  
14 *that, as estimated by the Commissioner, the ac-*  
15 *tuarial value of the coverage with such re-*  
16 *duced cost-sharing amounts (and the reduced*  
17 *annual cost-sharing limit) is equal to the actu-*  
18 *arial value percentage (specified in the table*  
19 *under section 243(d) for the income tier in-*  
20 *volved) of the full actuarial value if there were*  
21 *no cost-sharing imposed under the plan.*

22       **(c) DETERMINATION AND PAYMENT OF COST-**  
23 **SHARING AFFORDABILITY CREDIT.—***In the case of*  
24 *an affordable credit eligible individual in a*  
25 *tier enrolled in an Exchange-participating*

1 *health benefits plan offered by a QHBP offer-*  
2 *ing entity, the Commissioner shall provide for*  
3 *payment to the offering entity of an amount*  
4 *equivalent to the increased actuarial value of*  
5 *the benefits under the plan provided under*  
6 *section 203(c)(2)(B) resulting from the reduc-*  
7 *tion in cost-sharing described in subsection*  
8 *(b).*

9 *SEC. 245. INCOME DETERMINATIONS.*

10 *(a) IN GENERAL.—In applying this subtitle*  
11 *for an affordability credit for an individual*  
12 *for a plan year, the individual’s income shall*  
13 *be the income (as defined in section 242(c)) for*  
14 *the individual for the most recent taxable year*  
15 *(as determined in accordance with rules of the*  
16 *Commissioner). The Federal poverty level ap-*  
17 *plied shall be such level in effect as of the date*  
18 *of the application.*

19 *(b) PROGRAM INTEGRITY; INCOME*  
20 *VERIFICATION PROCEDURES.—*

21 *(1) PROGRAM INTEGRITY.—The Commis-*  
22 *sioner shall take such steps as may be ap-*  
23 *propriate to ensure the accuracy of deter-*  
24 *minations and redeterminations under*  
25 *this subtitle.*

1           **(2) INCOME VERIFICATION.—**

2           **(A) IN GENERAL.—***Upon an initial*  
3 *application of an individual for an af-*  
4 *fordability credit under this subtitle*  
5 *(or in applying section 242(b)) or upon*  
6 *an application for a change in the af-*  
7 *fordability credit based upon a sig-*  
8 *nificant change in family income de-*  
9 *scribed in subparagraph (A)—*

10           **(i)** *the Commissioner shall re-*  
11 *quest from the Secretary of the*  
12 *Treasury the disclosure to the*  
13 *Commissioner of such information*  
14 *as may be permitted to verify the*  
15 *information contained in such ap-*  
16 *plication; and*

17           **(ii)** *the Commissioner shall*  
18 *use the information so disclosed to*  
19 *verify such information.*

20           **(B) ALTERNATIVE PROCEDURES.—**  
21 *The Commissioner shall establish pro-*  
22 *cedures for the verification of income*  
23 *for purposes of this subtitle if no in-*  
24 *come tax return is available for the*  
25 *most recent completed tax year.*

1       **(c) SPECIAL RULES.—**

2           **(1) CHANGES IN INCOME AS A PERCENT**  
3       **OF FPL.—***In the case that an individual's*  
4       *income (expressed as a percentage of the*  
5       *Federal poverty level for a family of the*  
6       *size involved) for a plan year is expected*  
7       *(in a manner specified by the Commis-*  
8       *sioner) to be significantly different from*  
9       *the income (as so expressed) used under*  
10       *subsection (a), the Commissioner shall es-*  
11       *tablish rules requiring an individual to*  
12       *report, consistent with the mechanism es-*  
13       *tablished under paragraph (2), signifi-*  
14       *cant changes in such income (including a*  
15       *significant change in family composition)*  
16       *to the Commissioner and requiring the*  
17       *substitution of such income for the income*  
18       *otherwise applicable.*

19           **(2) REPORTING OF SIGNIFICANT CHANGES**  
20       **IN INCOME.—***The Commissioner shall es-*  
21       *tablish rules under which an individual*  
22       *determined to be an affordable credit eli-*  
23       *gible individual would be required to in-*  
24       *form the Commissioner when there is a*  
25       *significant change in the family income of*

1 *the individual (expressed as a percentage*  
2 *of the FPL for a family of the size in-*  
3 *volved) and of the information regarding*  
4 *such change. Such mechanism shall pro-*  
5 *vide for guidelines that specify the cir-*  
6 *cumstances that qualify as a significant*  
7 *change, the verifiable information re-*  
8 *quired to document such a change, and*  
9 *the process for submission of such infor-*  
10 *mation. If the Commissioner receives new*  
11 *information from an individual regarding*  
12 *the family income of the individual, the*  
13 *Commissioner shall provide for a redeter-*  
14 *mination of the individual's eligibility to*  
15 *be an affordable credit eligible indi-*  
16 *vidual.*

17 (3) *TRANSITION FOR CHIP.—In the case*  
18 *of a child described in section 202(d)(2),*  
19 *the Commissioner shall establish rules*  
20 *under which the family income of the*  
21 *child is deemed to be no greater than the*  
22 *family income of the child as most re-*  
23 *cently determined before Y1 by the State*  
24 *under title XXI of the Social Security Act.*

1           **(4) STUDY OF GEOGRAPHIC VARIATION IN**  
2           **APPLICATION OF FPL.—The Commissioner**  
3           **shall examine the feasibility and implica-**  
4           **tion of adjusting the application of the**  
5           **Federal poverty level under this subtitle**  
6           **for different geographic areas so as to re-**  
7           **fect the variations in cost-of-living**  
8           **among different areas within the United**  
9           **States. If the Commissioner determines**  
10           **that an adjustment is feasible, the study**  
11           **should include a methodology to make**  
12           **such an adjustment. Not later than the**  
13           **first day of Y2, the Commissioner shall**  
14           **submit to Congress a report on such study**  
15           **and shall include such recommendations**  
16           **as the Commissioner determines appro-**  
17           **priate.**

18           **(d) PENALTIES FOR MISREPRESENTATION.—**  
19           **In the case of an individual intentionally mis-**  
20           **represents family income or the individual**  
21           **fails (without regard to intent) to disclose to**  
22           **the Commissioner a significant change in fam-**  
23           **ily income under subsection (c) in a manner**  
24           **that results in the individual becoming an af-**  
25           **fordable credit eligible individual when the**

1 *individual is not or in the amount of the af-*  
2 *fordability credit exceeding the correct*  
3 *amount—*

4 *(1) the individual is liable for repay-*  
5 *ment of the amount of the improper af-*  
6 *fordability credit; ;and*

7 *(2) in the case of such an intentional*  
8 *misrepresentation or other egregious cir-*  
9 *cumstances specified by the Commis-*  
10 *sioner, the Commissioner may impose an*  
11 *additional penalty.*

12 *SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED*  
13 *ALIENS.*

14 *Nothing in this subtitle shall allow Fed-*  
15 *eral payments for affordability credits on be-*  
16 *half of individuals who are not lawfully*  
17 *present in the United States.*

18 *Subtitle D—State Innovation*

19 *SEC. 251. WAIVER OF ERISA LIMITATION; APPLICATION IN-*  
20 *STEAD OF STATE SINGLE PAYER SYSTEM.*

21 *(a) IN GENERAL.—A State may request from*  
22 *the Secretary, and the Secretary must grant*  
23 *except under extraordinary circumstances, a*  
24 *waiver of application of section 514 of the Em-*  
25 *ployee Retirement Income Security Act of 1974*

1 *with respect to a state single payer system en-*  
2 *acted into law by such State that would be*  
3 *structured and operate in a manner consistent*  
4 *with this subtitle. The Secretary shall provide*  
5 *for the revocation of any waiver granted under*  
6 *this section upon a determination made by the*  
7 *Secretary that the requirements of the pre-*  
8 *ceding sentence are no longer being met.*

9       **(b) EFFECT OF WAIVER.**—*During any period*  
10 *for which a waiver under subsection (a) is in*  
11 *effect—*

12               **(1)** *the provisions of section 514 of the*  
13 *Employee Retirement Income Security Act*  
14 *of 1974 shall not apply with respect to the*  
15 *State single payer system; and*

16               **(2)** *the State single payer system shall*  
17 *operate in the State instead of the public*  
18 *health insurance option or the National*  
19 *Health Exchange.*

20       **(c) CONSTRUCTION.**—*Nothing in this sub-*  
21 *title shall be construed to limit or otherwise*  
22 *affect the transfer and allocation under this*  
23 *Act of funds to States with single payer sys-*  
24 *tems.*



1 **SEC. 252. REQUIREMENTS.**

2 ***A State single payer system shall—***

3 ***(1) ) provide benefits that meet or ex-***  
4 ***ceed the standards of coverage and qual-***  
5 ***ity of care set forth in this Act; and***

6 ***(2) ensure that the cost to the Federal***  
7 ***Government resulting from the waiver***  
8 ***granted under section 261 is neither sub-***  
9 ***stantially greater nor substantially less***  
10 ***than would have been the case in the ab-***  
11 ***sence of such waiver, except that:***

12 ***(A) the State may seek and benefit***  
13 ***from planning and start-up funds***  
14 ***with respect to the system; and***

15 ***(B) nothing in this paragraph***  
16 ***shall be construed to preclude allow-***  
17 ***ance for normal variations in popu-***  
18 ***lation demographics, health status,***  
19 ***and other factors exogenous to the***  
20 ***health care system that may affect dif-***  
21 ***ferences in costs.***

22 **SEC. 253. DEFINITIONS.**

23 ***(a) STATE SINGLE PAYER SYSTEM.—The term***  
24 ***“State single payer system” means, in connec-***  
25 ***tion with a State, a non-profit program of the***  
26 ***State for providing health care—***

1           (1) *in which a single agency of the*  
2           *State is responsible for financing health*  
3           *care benefits for all residents of the State*  
4           *and for the administration or supervision*  
5           *of the administration of the program;*

6           (2) *under which private insurance du-*  
7           *plicating the benefits provided in the sin-*  
8           *gle payer program is prohibited;*

9           (3) *which provides comprehensive*  
10          *health benefits to all residents of the*  
11          *State, and provides measures to assure*  
12          *free choice of providers for covered serv-*  
13          *ices, to promote quality, and to help re-*  
14          *solve complaints and disputes between*  
15          *consumers and providers; and*

16          (4) *under which participation by*  
17          *health maintenance organizations is lim-*  
18          *ited to non-profit health maintenance or-*  
19          *ganizations that own their own delivery*  
20          *facilities and employ physicians on sal-*  
21          *ary, and funding is limited to services*  
22          *that the health maintenance organiza-*  
23          *tions actually deliver; and*

1           ***(5) which may be maintained by such***  
 2           ***State together one or more other States in***  
 3           ***a geographic region.***

4           ***(b) SECRETARY.—The term “Secretary”***  
 5           ***means the Secretary of Labor, acting in con-***  
 6           ***sultation with the Secretary of Health and***  
 7           ***Human Services.***

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

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

13           ***For an individual’s responsibility to ob-***  
 14           ***tain acceptable coverage, see section 59B of the***  
 15           ***Internal Revenue Code of 1986 (as added by***  
 16           ***section 401 of this Act).***

17       **Subtitle B—Employer Responsibility**

18           **PART 1—HEALTH COVERAGE PARTICIPATION**

19                           **REQUIREMENTS**

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

22           ***(a) IN GENERAL.—An employer meets the re-***  
 23           ***quirements of this section if such employer***  
 24           ***does all of the following:***

1           **(1) OFFER OF COVERAGE.**—*The employer*  
2           *offers each employee individual and fam-*  
3           *ily coverage under a qualified health ben-*  
4           *efits plan (or under a current employ-*  
5           *ment-based health plan (within the mean-*  
6           *ing of section 102(b))) in accordance with*  
7           *section 312.*

8           **(2) CONTRIBUTION TOWARDS COV-**  
9           **ERAGE.**—*If an employee accepts such offer*  
10          *of coverage, the employer makes timely*  
11          *contributions towards such coverage in*  
12          *accordance with section 312.*

13          **(3) CONTRIBUTION IN LIEU OF COV-**  
14          **ERAGE.**—*Beginning with Y2, if an employee*  
15          *declines such offer but otherwise obtains*  
16          *coverage in an Exchange-participating*  
17          *health benefits plan (other than by reason*  
18          *of being covered by family coverage as a*  
19          *spouse or dependent of the primary in-*  
20          *sured), the employer shall make a timely*  
21          *contribution to the Health Insurance Ex-*  
22          *change with respect to each such em-*  
23          *ployee in accordance with section 313.*

24          **(b) HARDSHIP EXEMPTION.**—*Notwith-*  
25          *standing any other provision of this part, an*

1 *employer may, in a form and manner which*  
2 *shall be prescribed by the Secretary, apply to*  
3 *the Secretary for a waiver from the health cov-*  
4 *erage participation requirements of this part*  
5 *for any 2-year period. The Secretary shall*  
6 *grant the waiver within 30 days after submis-*  
7 *sion of the application if the application rea-*  
8 *sonably demonstrates to the Secretary that*  
9 *meeting the requirements of this part would*  
10 *result in job losses that would negatively im-*  
11 *pect the employer or the community in which*  
12 *the employer is located.*

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

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

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

1           **(2) EMPLOYER REQUIRED CONTRIBU-**  
2           **TION.—***The employer timely pays to the*  
3           *issuer of such coverage an amount not*  
4           *less than the employer required contribu-*  
5           *tion specified in subsection (b) for such*  
6           *coverage.*

7           **(3) PROVISION OF INFORMATION.—***The*  
8           *employer provides the Health Choices*  
9           *Commissioner, the Secretary of Labor, the*  
10          *Secretary of Health and Human Services,*  
11          *and the Secretary of the Treasury, as ap-*  
12          *plicable, with such information as the*  
13          *Commissioner may require to ascertain*  
14          *compliance with the requirements of this*  
15          *section.*

16          **(4) AUTOENROLLMENT OF EMPLOYEES.—**  
17          *The employer provides for autoenrollment*  
18          *of the employee in accordance with sub-*  
19          *section (c).*

20          **(b) REDUCTION OF EMPLOYEE PREMIUMS**  
21          **THROUGH MINIMUM EMPLOYER CONTRIBUTION.—**

22                 **(1) FULL-TIME EMPLOYEES.—***The min-*  
23                 *imum employer contribution described in*  
24                 *this subsection for coverage of a full-time*  
25                 *employee (and, if any, the employee's*

1 *spouse and qualifying children (as de-*  
2 *defined in section 152(c) of the Internal Rev-*  
3 *enue Code of 1986) under a qualified*  
4 *health benefits plan (or current employ-*  
5 *ment-based health plan) is equal to—*

6 *(A) in case of individual coverage,*  
7 *not less than 72.5 percent of the appli-*  
8 *cable premium (as defined in section*  
9 *4980B(f)(4) of such Code, subject to*  
10 *paragraph (2)) of the lowest cost plan*  
11 *offered by the employer that is a*  
12 *qualified health benefits plan (or is*  
13 *such current employment-based*  
14 *health plan); and*

15 *(B) in the case of family coverage*  
16 *which includes coverage of such*  
17 *spouse and children, not less 65 per-*  
18 *cent of such applicable premium of*  
19 *such lowest cost plan.*

20 *(2) APPLICABLE PREMIUM FOR EXCHANGE*  
21 *COVERAGE.—In this subtitle, the amount of*  
22 *the applicable premium of the lowest cost*  
23 *plan with respect to coverage of an em-*  
24 *ployee under an Exchange-participating*  
25 *health benefits plan is the reference pre-*

1 *mium amount under section 243(c) for in-*  
2 *dividual coverage (or, if elected, family*  
3 *coverage) for the premium rating area in*  
4 *which the individual or family resides.*

5 **(3) MINIMUM EMPLOYER CONTRIBUTION**  
6 **FOR EMPLOYEES OTHER THAN FULL-TIME EM-**  
7 **PLOYEES.—In the case of coverage for an**  
8 **employee who is not a full-time employee,**  
9 **the amount of the minimum employer con-**  
10 **tribution under this subsection shall be a**  
11 **proportion (as determined in accordance**  
12 **with rules of the Health Choices Commis-**  
13 **sioner, the Secretary of Labor, the Sec-**  
14 **retary of Health and Human Services,**  
15 **and the Secretary of the Treasury, as ap-**  
16 **licable) of the minimum employer con-**  
17 **tribution under this subsection with re-**  
18 **spect to a full-time employee that reflects**  
19 **the proportion of—**

20 **(A) the average weekly hours of**  
21 **employment of the employee by the em-**  
22 **ployer, to**

23 **(B) the minimum weekly hours**  
24 **specified by the Commissioner for an**  
25 **employee to be a full-time employee.**



1           **(4) SALARY REDUCTIONS NOT TREATED AS**  
2           **EMPLOYER CONTRIBUTIONS.—For purposes**  
3           **of this section, any contribution on behalf**  
4           **of an employee with respect to which there**  
5           **is a corresponding reduction in the com-**  
6           **ensation of the employee shall not be**  
7           **treated as an amount paid by the em-**  
8           **ployer.**

9           **(c) AUTOMATIC ENROLLMENT FOR EMPLOYER**  
10          **SPONSORED HEALTH BENEFITS.—**

11           **(1) IN GENERAL.—The requirement of**  
12           **this subsection with respect to an em-**  
13           **ployer and an employee is that the em-**  
14           **ployer automatically enroll suchs em-**  
15           **ployee into the employment-based health**  
16           **benefits plan for individual coverage**  
17           **under the plan option with the lowest ap-**  
18           **plicable employee premium.**

19           **(2) OPT-OUT.—In no case may an em-**  
20           **ployer automatically enroll an employee**  
21           **in a plan under paragraph (1) if such em-**  
22           **ployee makes an affirmative election to**  
23           **opt out of such plan or to elect coverage**  
24           **under an employment-based health bene-**  
25           **fits plan offered by such employer. An em-**

1        *ployer shall provide an employee with a*  
2        *30-day period to make such an affirmative*  
3        *election before the employer may auto-*  
4        *matically enroll the employee in such a*  
5        *plan.*

6            **(3) NOTICE REQUIREMENTS.—**

7            **(A) IN GENERAL.—***Each employer*  
8        *described in paragraph (1) who auto-*  
9        *matically enrolls an employee into a*  
10       *plan as described in such paragraph*  
11       *shall provide the employees, within a*  
12       *reasonable period before the begin-*  
13       *ning of each plan year (or, in the case*  
14       *of new employees, within a reasonable*  
15       *period before the end of the enroll-*  
16       *ment period for such a new employee),*  
17       *written notice of the employees' rights*  
18       *and obligations relating to the auto-*  
19       *matic enrollment requirement under*  
20       *such paragraph. Such notice must be*  
21       *comprehensive and understood by the*  
22       *average employee to whom the auto-*  
23       *matic enrollment requirement applies.*

24            **(B) INCLUSION OF SPECIFIC INFOR-**  
25       **MATION.—***The written notice under*



1           ***(1) shall be paid to the Health Choices***  
 2           ***Commissioner for deposit into the Health***  
 3           ***Insurance Exchange Trust Fund, and***

4           ***(2) shall not be applied against the***  
 5           ***premium of the employee under the Ex-***  
 6           ***change-participating health benefits plan***  
 7           ***in which the employee is enrolled.***

8           ***(b) SPECIAL RULES FOR SMALL EMPLOYERS.—***

9           ***(1) IN GENERAL.—In the case of any em-***  
 10          ***ployer who is a small employer for any***  
 11          ***calendar year, subsection (a) shall be ap-***  
 12          ***plied by substituting the applicable per-***  
 13          ***centage determined in accordance with***  
 14          ***the following table for “8 percent”:***

<i>If the annual payroll of such employer for the preceding calendar year:</i>	<i>The applicable percentage is:</i>
<i>Does not exceed \$250,000 .....</i>	<i>0 percent</i>
<i>Exceeds \$250,000, but does not exceed \$300,000.</i>	<i>2 percent</i>
<i>Exceeds \$300,000, but does not exceed \$350,000.</i>	<i>4 percent</i>
<i>Exceeds \$350,000, but does not exceed \$400,000.</i>	<i>6 percent</i>

15          ***(2) SMALL EMPLOYER.—For purposes of***  
 16          ***this subsection, the term “small employer”***  
 17          ***means any employer for any calendar year***  
 18          ***if the annual payroll of such employer for***  
 19          ***the preceding calendar year does not ex-***  
 20          ***ceed \$400,000.***

1           **(3) ANNUAL PAYROLL.**—*For purposes of*  
2           *this paragraph, the term “annual pay-*  
3           *roll” means, with respect to any employer*  
4           *for any calendar year, the aggregate*  
5           *wages paid by the employer during such*  
6           *calendar year.*

7           **(4) AGGREGATION RULES.**—*Related em-*  
8           *ployers and predecessors shall be treated*  
9           *as a single employer for purposes of this*  
10          *subsection.*

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

12          *The Health Choices Commissioner (in co-*  
13          *ordination with the Secretary of Labor, the*  
14          *Secretary of Health and Human Services, and*  
15          *the Secretary of the Treasury) shall have au-*  
16          *thority to set standards for determining*  
17          *whether employers or insurers are under-*  
18          *taking any actions to affect the risk pool with-*  
19          *in the Health Insurance Exchange by inducing*  
20          *individuals to decline coverage under a quali-*  
21          *fied health benefits plan (or current employ-*  
22          *ment-based health plan (within the meaning*  
23          *of section 102(b)) offered by the employer and*  
24          *instead to enroll in an Exchange-participating*  
25          *health benefits plan. An employer violating*

1 *such standards shall be treated as not meeting*  
 2 *the requirements of this section.*

3 **PART 2—SATISFACTION OF HEALTH COVERAGE**  
 4 **PARTICIPATION REQUIREMENTS**

5 **SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICI-**  
 6 **PATION REQUIREMENTS UNDER THE EM-**  
 7 **PLOYEE RETIREMENT INCOME SECURITY ACT**  
 8 **OF 1974.**

9 **(a) IN GENERAL.—***Subtitle B of title I of the*  
 10 *Employee Retirement Income Security Act of*  
 11 *1974 is amended by adding at the end the fol-*  
 12 *lowing new part:*

13 **“PART 8—NATIONAL HEALTH COVERAGE**  
 14 **PARTICIPATION REQUIREMENTS**  
 15 **“SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NA-**  
 16 **TIONAL HEALTH COVERAGE PARTICIPATION**  
 17 **REQUIREMENTS.**

18 **“(a) IN GENERAL.—***An employer may make*  
 19 *an election with the Secretary to be subject to*  
 20 *the health coverage participation require-*  
 21 *ments.*

22 **“(b) TIME AND MANNER.—***An election under*  
 23 *subsection (a) may be made at such time and*  
 24 *in such form and manner as the Secretary may*  
 25 *prescribe.*

1 **“SEC. 802. TREATMENT OF COVERAGE RESULTING FROM**  
2 **ELECTION.**

3 **“(a) IN GENERAL.—If an employer makes an**  
4 **election to the Secretary under section 801—**

5 **“(1) such election shall be treated as**  
6 **the establishment and maintenance of a**  
7 **group health plan (as defined in section**  
8 **733(a)) for purposes of this title, subject to**  
9 **section 151 of the America’s Affordable**  
10 **Health Choices Act of 2009, and**

11 **“(2) the health coverage participation**  
12 **requirements shall be deemed to be in-**  
13 **cluded as terms and conditions of such**  
14 **plan.**

15 **“(b) PERIODIC INVESTIGATIONS TO DISCOVER**  
16 **NONCOMPLIANCE.—The Secretary shall regu-**  
17 **larly audit a representative sampling of em-**  
18 **ployers and group health plans and conduct**  
19 **investigations and other activities under sec-**  
20 **tion 504 with respect to such sampling of plans**  
21 **so as to discover noncompliance with the**  
22 **health coverage participation requirements in**  
23 **connection with such plans. The Secretary**  
24 **shall communicate findings of noncompliance**  
25 **made by the Secretary under this subsection to**  
26 **the Secretary of the Treasury and the Health**





1 *under subsection (b), (c), (m), or (o) of section*  
2 *414 of the Internal Revenue Code of 1986, the*  
3 *election under section 801 shall be made by*  
4 *such employer as the Secretary may provide.*  
5 *Any such election, once made, shall apply to*  
6 *all members of such group.*

7 *“(b) SEPARATE ELECTIONS.—Under regula-*  
8 *tions prescribed by the Secretary, separate*  
9 *elections may be made under section 801 with*  
10 *respect to—*

11 *“(1) separate lines of business, and*  
12 *“(2) full-time employees and employees*  
13 *who are not full-time employees.*

14 *“SEC. 805. TERMINATION OF ELECTION IN CASES OF SUB-*  
15 *STANTIAL NONCOMPLIANCE.*

16 *“The Secretary may terminate the election*  
17 *of any employer under section 801 if the Sec-*  
18 *retary (in coordination with the Health*  
19 *Choices Commissioner) determines that such*  
20 *employer is in substantial noncompliance with*  
21 *the health coverage participation require-*  
22 *ments and shall refer any such determination*  
23 *to the Secretary of the Treasury as appro-*  
24 *priate.*

1 **“SEC. 806. REGULATIONS.**

2 **“The Secretary may promulgate such regu-**  
3 **lations as may be necessary or appropriate to**  
4 **carry out the provisions of this part, in accord-**  
5 **ance with section 324(a) of the America’s Af-**  
6 **ordable Health Choices Act of 2009. The Sec-**  
7 **retary may promulgate any interim final rules**  
8 **as the Secretary determines are appropriate to**  
9 **carry out this part.”.**

10 **(b) ENFORCEMENT OF HEALTH COVERAGE**  
11 **PARTICIPATION REQUIREMENTS.—Section 502 of**  
12 **such Act (29 U.S.C. 1132) is amended—**

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

18 **(2) in subsection (c), by redesignating**  
19 **the second paragraph (10) as paragraph**  
20 **(12) and by inserting after the first para-**  
21 **graph (10) the following new paragraph:**

22 **“(11) HEALTH COVERAGE PARTICIPATION**  
23 **REQUIREMENTS.—**

24 **“(A) CIVIL PENALTIES.—In the case**  
25 **of any employer who fails (during any**  
26 **period with respect to which an elec-**

1            *tion under section 801(a) is in effect)*  
2            *to satisfy the health coverage partici-*  
3            *ipation requirements with respect to*  
4            *any employee, the Secretary may as-*  
5            *sess a civil penalty against the em-*  
6            *ployer of \$100 for each day in the pe-*  
7            *riod beginning on the date such fail-*  
8            *ure first occurs and ending on the*  
9            *date such failure is corrected.*

10            *“(B) HEALTH COVERAGE PARTICIPA-*  
11            *TION REQUIREMENTS.—For purposes of*  
12            *this paragraph, the term ‘health cov-*  
13            *erage participation requirements’ has*  
14            *the meaning provided in section 803.*

15            *“(C) LIMITATIONS ON AMOUNT OF*  
16            *PENALTY.—*

17            *“(i) PENALTY NOT TO APPLY*  
18            *WHERE FAILURE NOT DISCOVERED EX-*  
19            *ERCISING REASONABLE DILIGENCE.—*  
20            *No penalty shall be assessed*  
21            *under subparagraph (A) with re-*  
22            *spect to any failure during any pe-*  
23            *riod for which it is established to*  
24            *the satisfaction of the Secretary*  
25            *that the employer did not know, or*

1           *exercising reasonable diligence*  
2           *would not have known, that such*  
3           *failure existed.*

4           “(ii) *PENALTY NOT TO APPLY TO*  
5           *FAILURES CORRECTED WITHIN 30*  
6           *DAYS.—No penalty shall be as-*  
7           *essed under subparagraph (A)*  
8           *with respect to any failure if—*

9                   “(I) *such failure was due*  
10                   *to reasonable cause and not to*  
11                   *willful neglect, and*

12                   “(II) *such failure is cor-*  
13                   *rected during the 30-day pe-*  
14                   *riod beginning on the 1st date*  
15                   *that the employer knew, or ex-*  
16                   *ercising reasonable diligence*  
17                   *would have known, that such*  
18                   *failure existed.*

19           “(iii) *OVERALL LIMITATION FOR*  
20           *UNINTENTIONAL FAILURES.—In the*  
21           *case of failures which are due to*  
22           *reasonable cause and not to will-*  
23           *ful neglect, the penalty assessed*  
24           *under subparagraph (A) for fail-*  
25           *ures during any 1-year period*

1           *shall not exceed the amount equal*  
2           *to the lesser of—*

3                   “(I) 10 percent of the ag-  
4                   gregate amount paid or in-  
5                   curred by the employer (or  
6                   predecessor employer) during  
7                   the preceding 1-year period for  
8                   group health plans, or

9                   “(II) \$500,000.

10                   “(D) ADVANCE NOTIFICATION OF  
11                   FAILURE PRIOR TO ASSESSMENT.—*Before*  
12                   *a reasonable time prior to the assess-*  
13                   *ment of any penalty under this para-*  
14                   *graph with respect to any failure by*  
15                   *an employer, the Secretary shall in-*  
16                   *form the employer in writing of such*  
17                   *failure and shall provide the employer*  
18                   *information regarding efforts and*  
19                   *procedures which may be undertaken*  
20                   *by the employer to correct such fail-*  
21                   *ure.*

22                   “(E) COORDINATION WITH EXCISE  
23                   TAX.—*Under regulations prescribed in*  
24                   *accordance with section 324 of the*  
25                   *America’s Affordable Health Choices*

1           *Act of 2009, the Secretary and the Sec-*  
 2           *retary of the Treasury shall coordi-*  
 3           *nate the assessment of penalties under*  
 4           *this section in connection with fail-*  
 5           *ures to satisfy health coverage partici-*  
 6           *pation requirements with the imposi-*  
 7           *tion of excise taxes on such failures*  
 8           *under section 4980H(b) of the Internal*  
 9           *Revenue Code of 1986 so as to avoid*  
 10          *duplication of penalties with respect*  
 11          *to such failures.*

12           “(F) *DEPOSIT OF PENALTY COL-*  
 13          *LECTED.—Any amount of penalty col-*  
 14          *lected under this paragraph shall be*  
 15          *deposited as miscellaneous receipts in*  
 16          *the Treasury of the United States.”.*

17          (c) *CLERICAL AMENDMENTS.—The table of*  
 18          *contents in section 1 of such Act is amended*  
 19          *by inserting after the item relating to section*  
 20          *734 the following new items:*

“PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION  
 REQUIREMENTS

“Sec. 801. *Election of employer to be subject to national health coverage participation requirements.*

“Sec. 802. *Treatment of coverage resulting from election.*

“Sec. 803. *Health coverage participation requirements.*

“Sec. 804. *Rules for applying requirements.*

“Sec. 805. *Termination of election in cases of substantial non-compliance.*

“Sec. 806. *Regulations.”.*

1       ***(d) EFFECTIVE DATE.—The amendments***  
2 ***made by this section shall apply to periods be-***  
3 ***ginning after December 31, 2012.***

4       ***[For sections 322 and 323, see text of bill***  
5 ***as introduced on July 14, 2009.]***

6 **SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COV-**  
7 **ERAGE PARTICIPATION REQUIREMENTS.**

8       ***(a) ASSURING COORDINATION.—The officers***  
9 ***consisting of the Secretary of Labor, the Sec-***  
10 ***retary of the Treasury, the Secretary of Health***  
11 ***and Human Services, and the Health Choices***  
12 ***Commissioner shall ensure, through the execu-***  
13 ***tion of an interagency memorandum of under-***  
14 ***standing among such officers, that—***

15           ***(1) regulations, rulings, and interpre-***  
16 ***tations issued by such officers relating to***  
17 ***the same matter over which two or more***  
18 ***of such officers have responsibility under***  
19 ***subpart B of part 6 of subtitle B of title I***  
20 ***of the Employee Retirement Income Secu-***  
21 ***rity Act of 1974, section 4980H of the Inter-***  
22 ***nal Revenue Code of 1986, and section***  
23 ***2793 of the Public Health Service Act are***  
24 ***administered so as to have the same effect***  
25 ***at all times; and***

1           (2) *coordination of policies relating to*  
2           *enforcing the same requirements through*  
3           *such officers in order to have a coordi-*  
4           *nated enforcement strategy that avoids*  
5           *duplication of enforcement efforts and as-*  
6           *signs priorities in enforcement.*

7           **(b) MULTIEMPLOYER PLANS.**—*In the case of*  
8           *a group health plan that is a multiemployer*  
9           *plan (as defined in section 3(37) of the Em-*  
10           *ployee Retirement Income Security Act of*  
11           *1974), the regulations prescribed in accord-*  
12           *ance with subsection (a) by the officers re-*  
13           *ferred to in subsection (a) shall provide for the*  
14           *application of the health coverage participa-*  
15           *tion requirements to the plan sponsor and con-*  
16           *tributing sponsors of such plan.*

17           **DIVISION B—MEDICARE AND**  
18           **MEDICAID IMPROVEMENTS**

19           **[For division B, see text of bill as intro-**  
20           **duced on July 14, 2009.]**



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 con-***  
 6 ***tents of this division is as follows:***

*Sec. 2001. Table of contents; references.*  
*[For section 2002, see text of introduced bill.]*

***[FOR TEXT OF TITLES I THROUGH IV, SEE TEXT OF  
 INTRODUCED BILL.]***

***TITLE V—OTHER PROVISIONS***

*[For Subtitles A, B, and C, See Text of Introduced Bill.]*

***Subtitle D—Grants for Comprehensive Programs to Provide  
 Education to Nurses and Create a Pipeline to Nursing***

*[For Subtitle E, See Text of Introduced Bill.]*

***Sec. 2531. Establishment of grant program.***

***Subtitle F—Standards for Accessibility to Medical Equipment  
 for Individuals With Disabilities.***

***Sec. 2541. Access for individuals with disabilities.***

***Subtitle G—Other Grant Programs***

***Sec. 2551. Reducing student-to-school nurse ratios.***

***Sec. 2552. Wellness program grants.***

***Sec. 2553. Health professions training for diversity programs.***

***Subtitle H—Long-term Care and Family Caregiver Support***

***Sec. 2561. Long-term care and family caregiver support.***

***Subtitle I—Online Resources***

***Sec. 2571. Web site on health care labor market and related edu-  
 cational and training opportunities.***

***Sec. 2572. Online health workforce training programs.***

7 ***(b) REFERENCES.—Except as otherwise***  
 8 ***specified, whenever in this division an amend-***  
 9 ***ment is expressed in terms of an amendment***

1 *to a section or other provision, the reference*  
2 *shall be considered to be made to a section or*  
3 *other provision of the Public Health Service*  
4 *Act (42 U.S.C. 201 et seq.)*

5 *[For section 2002 and titles I through IV*  
6 *of division C, see text of bill as introduced on*  
7 *July 14, 2009.]*

## 8 **TITLE V—OTHER PROVISIONS**

9 *[For subtitles A through C of title V of di-*  
10 *vision C, see text of bill as introduced on July*  
11 *14, 2009.]*

### 12 **Subtitle D—Grants for Comprehen-** 13 **sive Programs to Provide Edu-** 14 **cation to Nurses and Create a** 15 **Pipeline to Nursing**

16 **SEC. 2531. ESTABLISHMENT OF GRANT PROGRAM.**

17 **(a) PURPOSES.—***It is the purpose of this sec-*  
18 *tion to authorize grants to—*

19 *(1) address the projected shortage of*  
20 *nurses by funding comprehensive pro-*  
21 *grams to create a career ladder to nurs-*  
22 *ing (including Certified Nurse Assistants,*  
23 *Licensed Practical Nurses, Licensed Voca-*  
24 *tional Nurses, and Registered Nurses) for*  
25 *incumbent ancillary health care workers;*

1           ***(2) increase the capacity for educating***  
2           ***nurses by increasing both nurse faculty***  
3           ***and clinical opportunities through col-***  
4           ***laborative programs between staff nurse***  
5           ***organizations, health care providers, and***  
6           ***accredited schools of nursing; and***

7           ***(3) provide training programs***  
8           ***through education and training organiza-***  
9           ***tions jointly administered by health care***  
10          ***providers and health care labor organiza-***  
11          ***tions or other organizations representing***  
12          ***staff nurses and frontline health care***  
13          ***workers, working in collaboration with***  
14          ***accredited schools of nursing and aca-***  
15          ***demie institutions.***

16          ***(b) GRANTS.—Not later than 6 months after***  
17          ***the date of the enactment of this Act, the Sec-***  
18          ***retary of Labor (referred to in this section as***  
19          ***the “Secretary”) shall establish a partnership***  
20          ***grant program to award grants to eligible en-***  
21          ***tities to carry out comprehensive programs to***  
22          ***provide education to nurses and create a pipe-***  
23          ***line to nursing for incumbent ancillary health***  
24          ***care workers who wish to advance their ca-***

1 *reers, and to otherwise carry out the purposes*  
2 *of this section.*

3 *(c) ELIGIBILITY.—To be eligible for a grant*  
4 *under this section, an entity shall be—*

5 *(1) a health care entity that is jointly*  
6 *administered by a health care employer*  
7 *and a labor union representing the health*  
8 *care employees of the employer and that*  
9 *carries out activities using labor manage-*  
10 *ment training funds as provided for*  
11 *under section 302(c)(6) of the Labor Man-*  
12 *agement Relations Act, 1947 (29 U.S.C.*  
13 *186(c)(6));*

14 *(2) an entity that operates a training*  
15 *program that is jointly administered by—*

16 *(A) one or more health care pro-*  
17 *viders or facilities, or a trade associa-*  
18 *tion of health care providers; and*

19 *(B) one or more organizations*  
20 *which represent the interests of direct*  
21 *care health care workers or staff*  
22 *nurses and in which the direct care*  
23 *health care workers or staff nurses*  
24 *have direct input as to the leadership*  
25 *of the organization;*

1           ***(3) a State training partnership pro-***  
2           ***gram that consists of nonprofit organiza-***  
3           ***tions that include equal participation***  
4           ***from industry, including public or private***  
5           ***employers, and labor organizations in-***  
6           ***cluding joint labor-management training***  
7           ***programs, and which may include rep-***  
8           ***resentatives from local governments,***  
9           ***worker investment agency one-stop career***  
10           ***centers, community-based organizations,***  
11           ***community colleges, and accredited***  
12           ***schools of nursing; or***

13           ***(4) a school of nursing (as defined in***  
14           ***section 801 of the Public Health Service***  
15           ***Act (42 U.S.C. 296)).***

16           ***(d) ADDITIONAL REQUIREMENTS FOR HEALTH***  
17           ***CARE EMPLOYER DESCRIBED IN SUBSECTION***  
18           ***(c).—To be eligible for a grant under this sec-***  
19           ***tion, a health care employer described in sub-***  
20           ***section (c) shall demonstrate that it—***

21           ***(1) has an established program within***  
22           ***their facility to encourage the retention of***  
23           ***existing nurses;***

24           ***(2) provides wages and benefits to its***  
25           ***nurses that are competitive for its market***

1 *or that have been collectively bargained*  
2 *with a labor organization; and*

3 *(3) supports programs funded under*  
4 *this section through 1 or more of the fol-*  
5 *lowing:*

6 *(A) The provision of paid leave*  
7 *time and continued health coverage to*  
8 *incumbent health care workers to*  
9 *allow their participation in nursing*  
10 *career ladder programs, including*  
11 *certified nurse assistants, licensed*  
12 *practical nurses, licensed vocational*  
13 *nurses, and registered nurses.*

14 *(B) Contributions to a joint labor-*  
15 *management training fund which ad-*  
16 *ministers the program involved.*

17 *(C) The provision of paid release*  
18 *time, incentive compensation, or con-*  
19 *tinued health coverage to staff nurses*  
20 *who desire to work full- or part-time*  
21 *in a faculty position.*

22 *(D) The provision of paid release*  
23 *time for staff nurses to enable them to*  
24 *obtain a bachelor of science in nurs-*  
25 *ing degree, other advanced nursing*

1           *degrees, specialty training, or certifi-*  
2           *cation program.*

3           *(E) The payment of tuition assist-*  
4           *ance which is managed by a joint*  
5           *labor-management training fund or*  
6           *other jointly administered program.*

7           **(e) OTHER REQUIREMENTS.—**

8           **(1) MATCHING REQUIREMENT.—**

9           **(A) IN GENERAL.—***The Secretary*  
10           *may not make a grant under this sec-*  
11           *tion unless the applicant involved*  
12           *agrees, with respect to the costs to be*  
13           *incurred by the applicant in carrying*  
14           *out the program under the grant, to*  
15           *make available non-Federal contribu-*  
16           *tions (in cash or in kind under sub-*  
17           *paragraph (B)) toward such costs in*  
18           *an amount equal to not less than \$1*  
19           *for each \$1 of Federal funds provided*  
20           *in the grant. Such contributions may*  
21           *be made directly or through donations*  
22           *from public or private entities, or may*  
23           *be provided through the cash equiva-*  
24           *lent of paid release time provided to*  
25           *incumbent worker students.*

1           **(B) DETERMINATION OF AMOUNT OF**  
2           **NON-FEDERAL CONTRIBUTION.—***Non-Fed-*  
3           *eral contributions required in sub-*  
4           *paragraph (A) may be in cash or in*  
5           *kind (including paid release time),*  
6           *fairly evaluated, including equipment*  
7           *or services (and excluding indirect or*  
8           *overhead costs). Amounts provided by*  
9           *the Federal Government, or services*  
10           *assisted or subsidized to any signifi-*  
11           *cant extent by the Federal Govern-*  
12           *ment, may not be included in deter-*  
13           *mining the amount of such non-Fed-*  
14           *eral contributions.*

15           **(2) REQUIRED COLLABORATION.—***Enti-*  
16           *ties carrying out or overseeing programs*  
17           *carried out with assistance provided*  
18           *under this section shall demonstrate col-*  
19           *laboration with accredited schools of*  
20           *nursing which may include community*  
21           *colleges and other academic institutions*  
22           *providing associate, bachelor's, or ad-*  
23           *vanced nursing degree programs or spe-*  
24           *cialty training or certification programs.*



1       ***(f) USE OF FUNDS.—Amounts awarded to an***  
2 ***entity under a grant under this section shall***  
3 ***be used for the following:***

4           ***(1) To carry out programs that pro-***  
5 ***vide education and training to establish***  
6 ***nursing career ladders to educate incum-***  
7 ***bent health care workers to become nurses***  
8 ***(including certified nurse assistants, li-***  
9 ***censed practical nurses, licensed voca-***  
10 ***tional nurses, and registered nurses).***  
11 ***Such programs shall include one or more***  
12 ***of the following:***

13           ***(A) Preparing incumbent workers***  
14 ***to return to the classroom through***  
15 ***English -as-a-second language edu-***  
16 ***cation, GED education, pre-college***  
17 ***counseling, college preparation class-***  
18 ***es, and support with entry level col-***  
19 ***lege classes that are a prerequisite to***  
20 ***nursing.***

21           ***(B) Providing tuition assistance***  
22 ***with preference for dedicated cohort***  
23 ***classes in community colleges, univer-***  
24 ***sities, accredited schools of nursing***

1           *with supportive services including tu-*  
2           *toring and counseling.*

3           *(C) Providing assistance in pre-*  
4           *paring for and meeting all nursing li-*  
5           *cence tests and requirements.*

6           *(D) Carrying out orientation and*  
7           *mentorship programs that assist*  
8           *newly graduated nurses in adjusting*  
9           *to working at the bedside to ensure*  
10          *their retention postgraduation, and*  
11          *ongoing programs to support nurse re-*  
12          *tention.*

13          *(E) Providing stipends for release*  
14          *time and continued health care cov-*  
15          *erage to enable incumbent health care*  
16          *workers to participate in these pro-*  
17          *grams.*

18          *(2) To carry out programs that assist*  
19          *nurses in obtaining advanced degrees and*  
20          *completing specialty training or certifi-*  
21          *cation programs and to establish incen-*  
22          *tives for nurses to assume nurse faculty*  
23          *positions on a part-time or full-time basis.*  
24          *Such programs shall include one or more*  
25          *of the following:*

1           ***(A) Increasing the pool of nurses***  
2           ***with advanced degrees who are inter-***  
3           ***ested in teaching by funding pro-***  
4           ***grams that enable incumbent nurses***  
5           ***to return to school.***

6           ***(B) Establishing incentives for ad-***  
7           ***vanced degree bedside nurses who***  
8           ***wish to teach in nursing programs so***  
9           ***they can obtain a leave from their***  
10          ***bedside position to assume a full- or***  
11          ***part-time position as adjunct or full-***  
12          ***time faculty without the loss of salary***  
13          ***or benefits.***

14          ***(C) Collaboration with accredited***  
15          ***schools of nursing which may include***  
16          ***community colleges and other aca-***  
17          ***ademic institutions providing asso-***  
18          ***ciate, bachelor's, or advanced nursing***  
19          ***degree programs, or specialty training***  
20          ***or certification programs, for nurses***  
21          ***to carry out innovative nursing pro-***  
22          ***grams which meet the needs of bed-***  
23          ***side nursing and health care pro-***  
24          ***viders.***

1       **(g) PREFERENCE.—***In awarding grants*  
2 *under this section the Secretary shall give*  
3 *preference to programs that—*

4           **(1) provide for improving nurse reten-**  
5 **tion;**

6           **(2) provide for improving the diversity**  
7 **of the new nurse graduates to reflect**  
8 **changes in the demographics of the pa-**  
9 **tient population;**

10          **(3) provide for improving the quality**  
11 **of nursing education to improve patient**  
12 **care and safety;**

13          **(4) have demonstrated success in up-**  
14 **grading incumbent health care workers to**  
15 **become nurses or which have established**  
16 **effective programs or pilots to increase**  
17 **nurse faculty; or**

18          **(5) are modeled after or affiliated**  
19 **with such programs described in para-**  
20 **graph (4).**

21       **(h) EVALUATION.—**

22           **(1) PROGRAM EVALUATIONS.—***An entity*  
23 *that receives a grant under this section*  
24 *shall annually evaluate, and submit to*  
25 *the Secretary a report on, the activities*

1 *carried out under the grant and the out-*  
2 *comes of such activities. Such outcomes*  
3 *may include—*

4 *(A) an increased number of in-*  
5 *cumbent workers entering an accred-*  
6 *ited school of nursing and in the pipe-*  
7 *line for nursing programs;*

8 *(B) an increasing number of grad-*  
9 *uating nurses and improved nurse*  
10 *graduation and licensure rates;*

11 *(C) improved nurse retention;*

12 *(D) an increase in the number of*  
13 *staff nurses at the health care facility*  
14 *involved;*

15 *(E) an increase in the number of*  
16 *nurses with advanced degrees in nurs-*  
17 *ing;*

18 *(F) an increase in the number of*  
19 *nurse faculty;*

20 *(G) improved measures of patient*  
21 *quality (which may include staffing*  
22 *ratios of nurses, patient satisfaction*  
23 *rates, patient safety measures); and*

1           ***(H) an increase in the diversity of***  
2           ***new nurse graduates relative to the***  
3           ***patient population.***

4           ***(2) GENERAL REPORT.—Not later than 2***  
5           ***years after the date of the enactment of***  
6           ***this Act, and annually thereafter, the Sec-***  
7           ***retary of Labor shall, using data and in-***  
8           ***formation from the reports received under***  
9           ***paragraph (1), submit to the Congress a***  
10           ***report concerning the overall effectiveness***  
11           ***of the grant program carried out under***  
12           ***this section.***

13           ***(i) AUTHORIZATION OF APPROPRIATIONS.—***  
14           ***There are authorized to be appropriated to***  
15           ***carry out this section such sums as may be nec-***  
16           ***essary.***

17           ***[For subtitle E of title V of division C, see***  
18           ***text of bill as introduced on July 14, 2009.]***

19           ***Subtitle F—Standards for Accessi-***  
20           ***bility to Medical Equipment for***  
21           ***Individuals With Disabilities.***

22           ***SEC. 2541. ACCESS FOR INDIVIDUALS WITH DISABILITIES.***

23           ***Title V of the Rehabilitation Act of 1973***  
24           ***(29 U.S.C. 791 et seq.) is amended by adding at***  
25           ***the end of the following:***

1 *“SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DI-*  
2 *AGNOSTIC EQUIPMENT.*

3 *“(a) STANDARDS.—Not later than 9 months*  
4 *after the date of enactment of the America’s Af-*  
5 *fordable Health Choices Act of 2009, the Archi-*  
6 *tectural and Transportation Barriers Compli-*  
7 *ance Board shall issue guidelines setting forth*  
8 *the minimum technical criteria for medical di-*  
9 *agnostic equipment used in (or in conjunction*  
10 *with) physician’s offices, clinics, emergency*  
11 *rooms, hospitals, and other medical settings.*  
12 *The guidelines shall ensure that such equip-*  
13 *ment is accessible to, and usable by, individ-*  
14 *uals with disabilities, including provisions to*  
15 *ensure independent entry to, use of, and exit*  
16 *from the equipment by such individuals to the*  
17 *maximum extent possible.*

18 *“(b) MEDICAL DIAGNOSTIC EQUIPMENT COV-*  
19 *ERED.—The guidelines issued under subsection*  
20 *(a) for medical diagnostic equipment shall*  
21 *apply to equipment that includes examination*  
22 *tables, examination chairs (including chairs*  
23 *used for eye examinations or procedures, and*  
24 *dental examinations or procedures), weight*  
25 *scales, mammography equipment, x-ray ma-*  
26 *chines, and other equipment commonly used*

1 *for diagnostic or examination purposes by*  
2 *health professionals.*

3       “(c) *INTERIM STANDARDS.—Until the date*  
4 *on which final regulations are issued under*  
5 *subsection (d), purchases of examination ta-*  
6 *bles, weight scales, and mammography equip-*  
7 *ment and used in (or in conjunction with)*  
8 *medical settings described in subsection (a),*  
9 *shall adhere to the following interim accessi-*  
10 *bility requirements:*

11               “(1) *Examination tables shall be*  
12 *height-adjustable between a range of at*  
13 *least 18 inches to 37 inches.*

14               “(2) *Weight scales shall be capable of*  
15 *weighing individuals who remain seated*  
16 *in a wheelchair or other personal mobility*  
17 *aid.*

18               “(3) *Mammography machines and*  
19 *equipment shall be capable of being used*  
20 *by individuals in a standing, seated, or*  
21 *recumbent position, including individuals*  
22 *who remain seated in a wheelchair or*  
23 *other personal mobility aid.*

24       “(d) *REGULATIONS.—Not later than 6*  
25 *months after the date of the issuance of the*



1 *guidelines under subsection (a), each appro-*  
2 *priate Federal agency authorized to promul-*  
3 *gate regulations under this Act or under the*  
4 *Americans with Disabilities Act shall—*

5       “(1) *prescribe regulations in an acces-*  
6 *sible format as necessary to carry out the*  
7 *provisions of such Act and section 504 of*  
8 *this Act that include accessibility stand-*  
9 *ards that are consistent with the guide-*  
10 *lines issued under subsection (a); and*

11       “(2) *ensure that health care providers*  
12 *and health care plans covered by the*  
13 *America’s Affordable Health Choices Act*  
14 *of 2009 meet the requirements of the*  
15 *Americans with Disabilities Act and sec-*  
16 *tion 504, including provisions ensuring*  
17 *that individuals with disabilities receive*  
18 *equal access to all aspects of the health*  
19 *care delivery system.*

20       “(e) *REVIEW AND AMEND.—The Architec-*  
21 *tural and Transportation Barriers Compli-*  
22 *ance Board shall periodically review and, as*  
23 *appropriate, amend the guidelines as pre-*  
24 *scribed under subsection (a). Not later than 6*  
25 *months after the date of the issuance of such*

1 *revised guidelines, revised regulations con-*  
2 *sistent with such guidelines shall be promul-*  
3 *gated in an accessible format by the appro-*  
4 *priate Federal agencies described in sub-*  
5 *section (d).”.*

6 ***Subtitle G—Other Grant Programs***

7 ***SEC. 2551. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.***

8 ***(a) DEMONSTRATION GRANTS.—***

9 ***(1) IN GENERAL.—The Secretary of Edu-***  
10 ***cation, in consultation with the Secretary***  
11 ***of Health and Human Services and the***  
12 ***Director of the Centers for Disease Con-***  
13 ***trol and Prevention, may make dem-***  
14 ***onstration grants to eligible local edu-***  
15 ***cation agencies for the purpose of reduc-***  
16 ***ing the student-to-school nurse ratio in***  
17 ***public elementary and secondary schools.***

18 ***(2) SPECIAL CONSIDERATION.—In***  
19 ***awarding grants under this section, the***  
20 ***Secretary of Education shall give special***  
21 ***consideration to applications submitted***  
22 ***by high-need local educational agencies***  
23 ***that demonstrate the greatest need for***  
24 ***new or additional nursing services among***  
25 ***children in the public elementary and sec-***

1        *ondary schools served by the agency, in*  
2        *part by providing information on current*  
3        *ratios of students to school nurses.*

4            (3) *MATCHING FUNDS.—The Secretary*  
5        *of Education may require recipients of*  
6        *grants under this subsection to provide*  
7        *matching funds from non-Federal sources,*  
8        *and shall permit the recipients to match*  
9        *funds in whole or in part with in-kind*  
10       *contributions.*

11          (b) *REPORT.—Not later than 24 months*  
12       *after the date on which assistance is first*  
13       *made available to local educational agencies*  
14       *under this section, the Secretary of Education*  
15       *shall submit to the Congress a report on the*  
16       *results of the demonstration grant program*  
17       *carried out under this section, including an*  
18       *evaluation of the effectiveness of the program*  
19       *in improving the student-to-school nurse ra-*  
20       *tios described in subsection (a) and an evalua-*  
21       *tion of the impact of any resulting enhanced*  
22       *health of students on learning.*

23          (c) *DEFINITIONS.—For purposes of this sec-*  
24       *tion:*

1           (1) *The terms “elementary school”,*  
2           *“local educational agency”, and “sec-*  
3           *ondary school” have the meanings given*  
4           *to those terms in section 9101 of the Ele-*  
5           *mentary and Secondary Education Act of*  
6           *1965 (20 U.S.C. 7801).*

7           (2) *The term “eligible local edu-*  
8           *cational agency” means a local edu-*  
9           *cational agency in which the student-to-*  
10          *school nurse ratio in the public elemen-*  
11          *tary and secondary schools served by the*  
12          *agency is 750 or more students to every*  
13          *school nurse.*

14          (3) *The term “high-need local edu-*  
15          *cational agency” means a local edu-*  
16          *cational agency—*

17                 (A) *that serves not fewer than*  
18                 *10,000 children from families with in-*  
19                 *comes below the poverty line; or*

20                 (B) *for which not less than 20 per-*  
21                 *cent of the children served by the*  
22                 *agency are from families with incomes*  
23                 *below the poverty line.*

24          (4) *The term “nurse” means a licensed*  
25          *nurse, as defined under State law.*

1       ***(d) AUTHORIZATION OF APPROPRIATIONS.—***

2       ***To carry out this section, there are authorized***  
3       ***to be appropriated such sums as may be nec-***  
4       ***essary for each of the fiscal years 2010 through***  
5       ***2014.***

6       ***SEC. 2552. WELLNESS PROGRAM GRANTS.***

7       ***(a) ALLOWANCE OF GRANT.—***

8               ***(1) IN GENERAL.—For purposes of this***  
9       ***section, the Secretary of Labor shall***  
10       ***award wellness grants as determined***  
11       ***under this section. Wellness program***  
12       ***grants shall be awarded to qualified em-***  
13       ***ployers for any plan year in an amount***  
14       ***equal to 50 percent of the costs paid or in-***  
15       ***curring by the employer in connection with***  
16       ***a qualified wellness program during the***  
17       ***plan year. For purposes of the preceding***  
18       ***sentence, in the case of any qualified***  
19       ***wellness program offered as part of an***  
20       ***employment-based health plan, only costs***  
21       ***attributable to the qualified wellness pro-***  
22       ***gram and not to the health plan, or***  
23       ***health insurance coverage offered in con-***  
24       ***nection with such a plan, may be taken***  
25       ***into account.***

1           **(2) LIMITATION.—***The amount of the*  
2           *grant allowed under paragraph (1) for*  
3           *any plan year shall not exceed the sum*  
4           *of—*

5                   **(A)** *the product of \$200 and the*  
6                   *number of employees of the employer*  
7                   *not in excess of 200 employees; plus*

8                   **(B)** *the product of \$100 and the*  
9                   *number of employees of the employer*  
10                  *in excess of 200 employees.*

11           *The wellness grants awarded to an em-*  
12           *ployer under this section shall be for up to*  
13           *3 years and shall not exceed \$50,000.*

14           **(b) QUALIFIED WELLNESS PROGRAM.—***For*  
15           *purposes of this section:*

16                   **(1) QUALIFIED WELLNESS PROGRAM.—**  
17           *The term “qualified wellness program”*  
18           *means a program that —*

19                   **(A)** *includes any 3 wellness compo-*  
20                   *nents described in subsection (c); and*

21                   **(B)** *is be certified by the Secretary*  
22                   *of Labor, in coordination with the*  
23                   *Health Choices Commissioner and the*  
24                   *Director of the Center for Disease Con-*

1           *trol and Prevention, as a qualified*  
2           *wellness program under this section.*

3           **(2) PROGRAMS MUST BE CONSISTENT**  
4           **WITH RESEARCH AND BEST PRACTICES.—**

5           **(A) IN GENERAL.—***The Secretary of*  
6           *Labor shall not certify a program as a*  
7           *qualified wellness program unless the*  
8           *program—*

9                   *(i) is newly established or in*  
10                   *existence on the date of enactment*  
11                   *of this Act but not yet meeting the*  
12                   *requirements of this section;*

13                   *(ii) is consistent with evi-*  
14                   *denced-based researched and best*  
15                   *practices, as identified by persons*  
16                   *with expertise in employer health*  
17                   *promotion and wellness programs;*

18                   *(iii) includes multiple, evi-*  
19                   *denced-based strategies which are*  
20                   *based on the existing and emerg-*  
21                   *ing research and careful scientific*  
22                   *reviews, including the Guide to*  
23                   *Community Preventative Services,*  
24                   *the Guide to Clinical Preventative*

1            *Services, and the National Reg-*  
2            *istry for Effective Programs, and*

3            *(iv) includes strategies which*  
4            *focus on prevention and support*  
5            *for employee populations at risk of*  
6            *poor health outcomes.*

7            *(B) PERIODIC UPDATING AND RE-*  
8            *VIEW.—The Secretary of Labor, in con-*  
9            *sultation with other appropriate*  
10           *agencies shall establish procedures*  
11           *for periodic review, evaluation, and*  
12           *update of the programs under this*  
13           *subsection.*

14           *(3) HEALTH LITERACY/ACCESSIBILITY.—*  
15           *The Secretary of Labor shall, as part of*  
16           *the certification process: —*

17           *(A) ensure that employers make*  
18           *the programs culturally competent.*  
19           *physically and programmatically ac-*  
20           *cessible (including for individuals*  
21           *with disabilities), and appropriate to*  
22           *the health literacy needs of the em-*  
23           *ployees covered by the programs;*

24           *(B) require a health literacy com-*  
25           *ponent to provide special assistance*



1           *and materials to employees with low*  
2           *literacy skills, limited English and*  
3           *from under-served populations; and*

4           (C) *require the Secretary of Labor,*  
5           *in consultation with Secretary of*  
6           *Health and Human Services, to com-*  
7           *pile and disseminate to employer*  
8           *health plans info on model health lit-*  
9           *eracy curricula, instructional pro-*  
10           *grams, and effective intervention*  
11           *strategies.*

12           (c) **WELLNESS PROGRAM COMPONENTS.**—*For*  
13           *purposes of this section, the wellness program*  
14           *components described in this subsection are*  
15           *the following:*

16           (1) **HEALTH AWARENESS COMPONENT.**—*A*  
17           *health awareness component which pro-*  
18           *vides for the following:*

19           (A) **HEALTH EDUCATION.**—*The dis-*  
20           *semination of health information*  
21           *which addresses the specific needs*  
22           *and health risks of employees.*

23           (B) **HEALTH SCREENINGS.**—*The op-*  
24           *portunity for periodic screenings for*

1           *health problems and referrals for ap-*  
2           *propriate follow up measures.*

3           **(2) EMPLOYEE ENGAGEMENT COMPO-**  
4           **NENT.—***An employee engagement compo-*  
5           *nent which provides for the active engage-*  
6           *ment of employees in worksite wellness*  
7           *programs through worksite assessments*  
8           *and program planning, onsite delivery,*  
9           *evaluation, and improvement efforts.*

10           **(3) BEHAVIORAL CHANGE COMPONENT.—**  
11           *A behavioral change component which*  
12           *provides for altering employee lifestyles to*  
13           *encourage healthy living through coun-*  
14           *seling, seminars, on-line programs, or*  
15           *self-help materials which provide tech-*  
16           *nical assistance and problem solving*  
17           *skills. such component may include pro-*  
18           *grams relating to—*

- 19                   **(A) tobacco use;**  
20                   **(B) obesity;**  
21                   **(C) stress management;**  
22                   **(D) physical fitness;**  
23                   **(E) nutrition;**  
24                   **(F) substance abuse;**  
25                   **(G) depression; and**

1            *(H) mental health promotion (in-*  
2            *cluding anxiety).*

3            *(4) SUPPORTIVE ENVIRONMENT COMPO-*  
4            *NENT.—A supportive environment compo-*  
5            *nent which includes the following:*

6            *(A) ON-SITE POLICIES.—Policies*  
7            *and services at the worksite which*  
8            *promote a healthy lifestyle, including*  
9            *policies relating to—*

10            *(i) tobacco use at the worksite;*

11            *(ii) the nutrition of food avail-*  
12            *able at the worksite through cafe-*  
13            *terias and vending options;*

14            *(iii) minimizing stress and*  
15            *promoting positive mental health*  
16            *in the workplace; and*

17            *(iv) the encouragement of*  
18            *physical activity before, during,*  
19            *and after work hours.*

20            *(d) PARTICIPATION REQUIREMENT.—No*  
21            *grant shall be allowed under subsection (a)*  
22            *unless the Secretary of Labor in consultation*  
23            *with other appropriate agencies, certifies, as a*  
24            *part of any certification described in sub-*

1 *section (b), that each wellness program compo-*  
2 *nent of the qualified wellness program—*

3 *(1) shall be available to all employees*  
4 *of the employer;*

5 *(2) shall not mandate participation by*  
6 *employees; and*

7 *(3) shall not require participation by*  
8 *individual employees as a condition to ob-*  
9 *tain a premium discount, rebate, deduct-*  
10 *ible reduction, or other financial reward.*

11 *(e) PRIVACY PROTECTIONS.—Any employee*  
12 *health information collected through partici-*  
13 *pation in an employer wellness program shall*  
14 *be confidential and available only to appro-*  
15 *priately trained health professions as defined*  
16 *by the Secretary of Labor. Employers or em-*  
17 *ployees of the employer sponsoring a wellness*  
18 *program shall have no access to employee*  
19 *health data. All entities offering employer-*  
20 *sponsored wellness programs shall be consid-*  
21 *ered “business associates” pursuant to the*  
22 *American Reinvestment and Recovery Act and*  
23 *must comply with privacy protections restrict-*  
24 *ing the release of personal medical informa-*  
25 *tion.*

1       **(f) DEFINITIONS AND SPECIAL RULES.—For**  
2 ***purposes of this section:***

3           **(1) QUALIFIED EMPLOYER.—The term**  
4 ***“qualified employer” means an employer***  
5 ***that offers a qualified health benefits***  
6 ***plan to every employee (including each***  
7 ***employee required to be offered coverage***  
8 ***under a qualified health benefits plan***  
9 ***under subtitle B of title III of division A),***  
10 ***and meets the health coverage participa-***  
11 ***tion requirements as defined in section***  
12 ***312.***

13           **(2) CERTAIN COSTS NOT INCLUDED.—**  
14 ***Costs paid or incurred by an employer for***  
15 ***food or health insurance shall not be***  
16 ***taken into account under subsection (a).***

17       **(g) OUTREACH.—**

18           **(1) IN GENERAL.—The Secretary of the**  
19 ***Labor, in conjunction with other appro-***  
20 ***priate agencies and members of the busi-***  
21 ***ness community, shall institute an out-***  
22 ***reach program to inform businesses about***  
23 ***the availability of the wellness program***  
24 ***grant as well as to educate businesses on***  
25 ***how to develop programs according to rec-***

1        *ognized and promising practices and on*  
2        *how to measure the success of imple-*  
3        *mented programs.*

4        *(h) EFFECTIVE DATE.—This section shall*  
5        *take effect on January 1, 2013.*

6        *(i) AUTHORIZATION OF APPROPRIATIONS.—*  
7        *There are authorized to be appropriated such*  
8        *sums as are necessary to carry out this section.*

9        *SEC. 2553. HEALTH PROFESSIONS TRAINING FOR DIVER-*  
10        *SITY PROGRAMS.*

11        *Section 171 of the Workforce Investment*  
12        *Act of 1998 (29 U.S.C. 2916) is amended by add-*  
13        *ing at the end the following:*

14        *“(f) HEALTH PROFESSIONS TRAINING FOR DI-*  
15        *VERSITY PROGRAM.—*

16                *“(1) IN GENERAL.—The Secretary shall*  
17                *make available 20 grants of no more than*  
18                *\$1,000,000 annually to nonprofit organiza-*  
19                *tions for the purposes of providing work-*  
20                *force development training program for*  
21                *those who are currently employed in the*  
22                *health care workforce.*

23                *“(2) ELIGIBILITY.—For the purposes of*  
24                *providing assistance and services under*  
25                *the program established in this sub-*

1 *section, grants are to be awarded to Area*  
2 *Health Education Centers or similar non-*  
3 *profit organizations involved in the devel-*  
4 *opment and implementation of health*  
5 *care workforce development programs*  
6 *and that—*

7 *“(A) have a formal affiliation with*  
8 *a hospital or community health cen-*  
9 *ter, and institution of higher edu-*  
10 *cation as defined by section 101 of the*  
11 *Higher Education Act of 1965;*

12 *“(B) have a history of providing*  
13 *program services to minority popu-*  
14 *lations; and*

15 *“(C) provide workforce develop-*  
16 *ment programs to low-income persons,*  
17 *veterans, or urban and rural under-*  
18 *served communities.”.*

19 ***Subtitle H—Long-term Care and***  
20 ***Family Caregiver Support***

21 ***SEC. 2561. LONG-TERM CARE AND FAMILY CAREGIVER SUP-***  
22 ***PORT.***

23 ***(a) AMENDMENTS TO THE OLDER AMERICANS***  
24 ***ACT OF 1965.—***

1           **(1) PROMOTION OF DIRECT CARE WORK-**  
2           **FORCE.—Section 202(b)(1) of the Older**  
3           **Americans Act of 1965 (42 U.S.C.**  
4           **3012(b)(1)) is amended by inserting before**  
5           **the semicolon the following: “, and, in car-**  
6           **rying out the purposes of this paragraph,**  
7           **shall make recommendations to other**  
8           **Federal entities regarding appropriate**  
9           **and effective means of identifying, pro-**  
10           **moting, and implementing investments in**  
11           **the direct care workforce necessary to**  
12           **meet the growing demand for long-term**  
13           **health services and supports and assist-**  
14           **ing States in developing a comprehensive**  
15           **state workforce development plans with**  
16           **respect to such workforce including ef-**  
17           **forts to systematically assess, track, and**  
18           **report on workforce adequacy and capac-**  
19           **ity”.**

20           **(2) PERSONAL CARE ATTENDANT WORK-**  
21           **FORCE ADVISORY PANEL.—Section 202 of**  
22           **such Act (42 U.S.C. 3012) is amended by**  
23           **adding at the end the following new sub-**  
24           **section:**



1       ***“(g)(1) The Assistant Secretary shall estab-***  
2 ***lish a Personal Care Attendant Workforce Ad-***  
3 ***visory Panel and pilot program to improve***  
4 ***working conditions and training for long term***  
5 ***care workers, including home health aides,***  
6 ***certified nurse aides, and personal care at-***  
7 ***tendants.***

8       ***“(2) The Panel shall include representa-***  
9 ***tives from—***

10           ***“(A) relevant health care agencies***  
11 ***and facilities (including personal or home***  
12 ***care agencies, home health care agencies,***  
13 ***nursing homes and residential care facili-***  
14 ***ties);***

15           ***“(B) the disability community;***

16           ***“(C) the nursing community;***

17           ***“(D) direct care workers (which may***  
18 ***include unions and national organiza-***  
19 ***tions);***

20           ***“(E) older individuals and family***  
21 ***caregivers;***

22           ***“(F) State and federal health care en-***  
23 ***tities; and***

24           ***“(G) experts in workforce development***  
25 ***and adult learning.***

1       “(3) *Within one year after the establish-*  
2 *ment of the Panel, the Panel shall submit a re-*  
3 *port to the Assistant Secretary articulating*  
4 *core competencies for eligible personal or*  
5 *home care aides necessary to successfully pro-*  
6 *vide long-term services and supports to eligi-*  
7 *ble consumers, as well as recommended train-*  
8 *ing curricula and resources.*

9       “(4) *Within 180 days after receipt by the As-*  
10 *stant Secretary of the report under para-*  
11 *graph (3), the Assistant Secretary shall estab-*  
12 *lish a 3-year demonstration program in 4*  
13 *states to pilot and evaluate the effectiveness of*  
14 *the competencies articulated by the Panel and*  
15 *the training curricula and training methods*  
16 *recommended by the Panel.*

17       “(5) *Not later than 1 year after the comple-*  
18 *tion of the demonstration program under*  
19 *paragraph (4), the Assistant Secretary shall*  
20 *submit to each House of the Congress a report*  
21 *containing the results of the evaluations by the*  
22 *Assistant Secretary pursuant to paragraph*  
23 *(4), together with such recommendations for*  
24 *legislation or administrative action as the As-*  
25 *stant Secretary determines appropriate.”.*

1       **(b) AUTHORIZATION OF ADDITIONAL APPRO-**  
2 **PRIATIONS FOR THE FAMILY CAREGIVER SUPPORT**  
3 **PROGRAM UNDER THE OLDER AMERICANS ACT OF**  
4 **1965.—Section 303(e)(2) of the Older Ameri-**  
5 **cans Act of 1965 (42 U.S.C. 3023(e)(2)) is**  
6 **amended by striking “\$173,000,000” and all**  
7 **that follows through “2011”, and inserting**  
8 **“and \$250,000,000 for each of the fiscal years**  
9 **2010, 2011, and 2012”.**

10       **(c) AUTHORIZATION OF ADDITIONAL APPRO-**  
11 **PRIATIONS FOR THE NATIONAL CLEARINGHOUSE**  
12 **FOR LONG-TERM CARE INFORMATION.—There is**  
13 **authorized to be appropriated \$10,000,000 for**  
14 **each of the fiscal years 2010, 2011, and 2012 for**  
15 **the operation of the National Clearinghouse**  
16 **for Long-Term Care Information established**  
17 **by the Secretary of Health and Human Serv-**  
18 **ices under section 6021(d) of Public Law 109-**  
19 **171.**

## 20       **Subtitle I—Online Resources**

21 **SEC. 2571. WEB SITE ON HEALTH CARE LABOR MARKET AND**  
22 **RELATED EDUCATIONAL AND TRAINING OP-**  
23 **PORTUNITIES.**

24       **(a) IN GENERAL.—The Secretary of Labor,**  
25 **in consultation with the National Center for**

1 *Health Workforce Analysis, shall establish*  
2 *and maintain a Web site to serve as a com-*  
3 *prehensive source of information, searchable*  
4 *by workforce region, on the health care labor*  
5 *market and related educational and training*  
6 *opportunities.*

7 (b) *CONTENTS.—The Web site maintained*  
8 *under this section shall include the following:*

9 (1) *Information on the types of jobs*  
10 *that are currently or are projected to be*  
11 *in high demand in the health care field,*  
12 *including—*

13 (A) *salary information; and*

14 (B) *training requirements, such as*  
15 *requirements for educational creden-*  
16 *tials, licensure, or certification.*

17 (2) *Information on training and edu-*  
18 *cational opportunities within each region*  
19 *for the type jobs described in paragraph*  
20 *(1), including by—*

21 (A) *type of provider or program*  
22 *(such as public, private nonprofit, or*  
23 *private for-profit);*

24 (B) *duration;*

1           (C) *cost (such as tuition, fees,*  
2           *books, laboratory expenses, and other*  
3           *mandatory costs);*

4           (D) *performance outcomes (such*  
5           *as graduation rates, job placement,*  
6           *average salary, job retention, and*  
7           *wage progression);*

8           (E) *Federal financial aid partici-*  
9           *pation;*

10          (F) *average graduate loan debt;*

11          (G) *student loan default rates;*

12          (H) *average institutional grant*  
13          *aid provided;*

14          (I) *Federal and State accredita-*  
15          *tion information; and*

16          (J) *other information determined*  
17          *by the Secretary.*

18          (3) *A mechanism for searching and*  
19          *comparing training and educational op-*  
20          *tions for specific health care occupations*  
21          *to facilitate informed career and edu-*  
22          *cation choices.*

23          (4) *Financial aid information, includ-*  
24          *ing with respect to loan forgiveness, loan*  
25          *cancellation, loan repayment, stipends,*

1        *scholarships, and grants or other assist-*  
2        *ance authorized by this Act or other Fed-*  
3        *eral or State programs.*

4        **(c) PUBLIC ACCESSIBILITY.**—*The Web site*  
5        *maintained under this section shall—*

6                *(1) be publicly accessible;*

7                *(2) be user friendly and convey infor-*  
8        *mation in a manner that is easily under-*  
9        *standable; and*

10               *(3) be in English and the second most*  
11        *prevalent language spoken based on the*  
12        *latest Census information.*

13        **SEC. 2572. ONLINE HEALTH WORKFORCE TRAINING PRO-**  
14                **GRAMS.**

15        *Section 171 of the Workforce Investment*  
16        *Act of 1998 (29 U.S.C. 2916) (as amended by*  
17        *section 2553) is further amended by adding at*  
18        *the end the following:*

19               **“(g) ONLINE HEALTH WORKFORCE TRAINING**  
20        **PROGRAM.—**

21                **“(1) GRANT PROGRAM.—**

22                        **“(A) IN GENERAL.—The Secretary**  
23        *shall award National Health Work-*  
24        *force Online Training Grants on a*  
25        *competitive basis to eligible entities to*

1           *enable such entities to carry out train-*  
2           *ing for individuals to attain or ad-*  
3           *vance in health care occupations. An*  
4           *entity may leverage such grant with*  
5           *other Federal, State, local, and pri-*  
6           *ivate resources, in order to expand the*  
7           *participation of businesses, employees,*  
8           *and individuals in such training pro-*  
9           *grams.*

10           “(B) *ELIGIBILITY.—In order to re-*  
11           *ceive a grant under the program es-*  
12           *tablished under this paragraph—*

13                   “(i) *an entity shall be an edu-*  
14                   *cational institution, community-*  
15                   *based organization, non-profit or-*  
16                   *ganization, workforce investment*  
17                   *board, or local or county govern-*  
18                   *ment; and*

19                   “(ii) *an entity shall provide*  
20                   *online workforce training for indi-*  
21                   *viduals seeking to attain or ad-*  
22                   *vance in health care occupations,*  
23                   *including nursing, nursing assist-*  
24                   *ants, dentistry, pharmacy, health*  
25                   *care management and adminis-*

1            *tration, public health, health in-*  
2            *formation systems analysis, med-*  
3            *ical assistants, and other health*  
4            *care practitioner and support oc-*  
5            *cupations.*

6            **“(C) PRIORITY.—Priority in award-**  
7            **ing grants under this paragraph shall**  
8            **be given to entities that—**

9                    **“(i) have demonstrated experi-**  
10                   **ence in implementing and oper-**  
11                   **ating online worker skills train-**  
12                   **ing and education programs;**

13                   **“(ii) have demonstrated expe-**  
14                   **rience coordinating activities,**  
15                   **where appropriate, with the work-**  
16                   **force investment system; and**

17                   **“(iii) conduct training for oc-**  
18                   **cupations with national or local**  
19                   **shortages.**

20            **“(D) DATA COLLECTION.—Grantees**  
21            **under this paragraph shall collect**  
22            **and report information on—**

23                   **“(i) the number of partici-**  
24                   **pants;**



1           “(ii) *the services received by*  
2           *the participants;*

3           “(iii) *program completion*  
4           *rates;*

5           “(iv) *factors determined as sig-*  
6           *nificantly interfering with pro-*  
7           *gram participation or completion;*

8           “(v) *the rate of job placement;*  
9           *and*

10          “(vi) *other information as de-*  
11          *termined as needed by the Sec-*  
12          *retary.*

13          “(E) *OUTREACH.—Grantees under*  
14          *this paragraph shall conduct out-*  
15          *reach activities to disseminate infor-*  
16          *mation about their program and re-*  
17          *sults to workforce investment boards,*  
18          *local governments, educational insti-*  
19          *tutions, and other workforce training*  
20          *organizations.*

21          “(F) *PERFORMANCE LEVELS.—The*  
22          *Secretary shall establish indicators of*  
23          *performance that will be used to*  
24          *evaluate the performance of grantees*  
25          *under this paragraph in carrying out*

1        *the activities described in this para-*  
2        *graph. The Secretary shall negotiate*  
3        *and reach agreement with each grant-*  
4        *ee regarding the levels of performance*  
5        *expected to be achieved by the grantee*  
6        *on the indicators of performance.*

7            **“(G) AUTHORIZATION OF APPROPRIA-**  
8        **TIONS.—***There are authorized to be ap-*  
9        *propriated to the Secretary to carry*  
10       *out this subsection \$50,000,000 for fis-*  
11       *cal years 2011 through 2020.*

12           **“(2) ONLINE HEALTH PROFESSIONS**  
13       **TRAINING PROGRAM CLEARINGHOUSE.—**

14           **“(A) DESCRIPTION OF GRANT.—***The*  
15       *Secretary shall award one grant to an*  
16       *eligible postsecondary educational in-*  
17       *stitution to provide the services de-*  
18       *scribed in this paragraph.*

19           **“(B) ELIGIBILITY.—***To be eligible to*  
20       *receive a grant under this paragraph,*  
21       *a postsecondary educational institu-*  
22       *tion shall—*

23                    **“(i) have demonstrated the**  
24                    **ability to disseminate research on**  
25                    **best practices for implementing**

1 *workforce investment programs;*  
2 *and*

3 *“(ii) be a national leader in*  
4 *producing cutting-edge research*  
5 *on technology related to workforce*  
6 *investment systems under subtitle*  
7 *B.*

8 *“(C) SERVICES.—The postsecondary*  
9 *educational institution that receives a*  
10 *grant under this paragraph shall use*  
11 *such grant—*

12 *“(i) to provide technical assist-*  
13 *ance to entities that receive grants*  
14 *under paragraph (1);*

15 *“(ii) to collect and nationally*  
16 *disseminate the data gathered by*  
17 *entities that receive grants under*  
18 *paragraph (1); and*

19 *“(iii) to disseminate the best*  
20 *practices identified by the Na-*  
21 *tional Health Workforce Online*  
22 *Training Grant Program to other*  
23 *workforce training organizations.*

24 *“(D) AUTHORIZATION OF APPROPRIA-*  
25 *TIONS.—There are authorized to be ap-*

1           *propriated to the Secretary to carry*  
2           *out this subsection \$1,000,000 for fis-*  
3           *cal years 2011 through 2020.”.*



Union Calendar No. 168

111<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

**H. R. 3200**

[Report No. 111-299, Parts I, II, and III]

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**A BILL**

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

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OCTOBER 14, 2009

Reported from the Committee on Energy and Commerce with an amendment; reported from the Committee on Ways and Means with an amendment; reported from the Committee on Education and Labor with an amendment

OCTOBER 14, 2009

Committees on Oversight and Government Reform and the Budget discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed