

Calendar No. _____

111TH CONGRESS
1ST SESSION

S. _____

[Report No. 111-_____]]

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

IN THE SENATE OF THE UNITED STATES

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

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 CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “America’s Healthy Future Act of 2009”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE COVERAGE

Subtitle A—Insurance Market Reforms

Sec. 1001. Insurance market reforms in the individual and small group markets.

“TITLE XXII—HEALTH INSURANCE COVERAGE

“Sec. 2200. Ensuring essential and affordable health benefits coverage for all Americans.

“PART A—INSURANCE REFORMS

“SUBPART 1—REQUIREMENTS IN INDIVIDUAL AND SMALL GROUP MARKETS

- “Sec. 2201. General requirements and definitions.
- “Sec. 2202. Prohibition on preexisting condition exclusions.
- “Sec. 2203. Guaranteed issue and renewal for insured plans.
- “Sec. 2204. Premium rating rules.
- “Sec. 2205. Use of uniform outline of coverage documents.

“SUBPART 2—REFORMS RELATING TO ALLOCATION OF RISKS

- “Sec. 2211. Rating areas; pooling of risks; phase in of rating rules in small group markets.
- “Sec. 2212. Risk adjustment.
- “Sec. 2213. Establishment of transitional reinsurance program for individual markets in each State.
- “Sec. 2214. Establishment of risk corridors for plans in individual and small group markets.
- “Sec. 2215. Temporary high risk pools for individuals with preexisting conditions.
- “Sec. 2216. Reinsurance for retirees covered by employer-based plans.

“SUBPART 3—PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE

- “Sec. 2221. Grandfathered health benefits plans.

“SUBPART 4—CONTINUED ROLE OF STATES

- “Sec. 2225. Continued State enforcement of insurance regulations.
- “Sec. 2226. Waiver of health insurance reform requirements.
- “Sec. 2227. Provisions relating to offering of plans in more than one State.
- “Sec. 2228. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.

“SUBPART 5—OTHER DEFINITIONS AND RULES

- “Sec. 2230. Other definitions and rules.

Subtitle B—Exchanges and Consumer Assistance

Sec. 1101. Establishment of qualified health benefits plan exchanges.

“PART B—EXCHANGE AND CONSUMER ASSISTANCE

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“SUBPART 1—INDIVIDUALS AND SMALL EMPLOYERS OFFERED AFFORDABLE CHOICES

“Sec. 2231. Rights and responsibilities regarding choice of coverage through exchange.

“Sec. 2232. Qualified individuals and small employers; access limited to citizens and lawful residents.

“SUBPART 2—ESTABLISHMENT OF EXCHANGES

“Sec. 2235. Establishment of exchanges by States.

“Sec. 2236. Functions performed by Secretary, States, and exchanges.

“Sec. 2237. Duties of the Secretary to facilitate exchanges.

“Sec. 2238. Procedures for determining eligibility for exchange participation, premium credits and cost-sharing subsidies, and individual responsibility exemptions.

“Sec. 2239. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

Sec. 1102. Encouraging meaningful use of electronic health records.

Subtitle C—Making Coverage Affordable

PART I—ESSENTIAL BENEFITS COVERAGE

Sec. 1201. Provisions to ensure coverage of essential benefits.

“PART C—MAKING COVERAGE AFFORDABLE

“SUBPART 1—ESSENTIAL BENEFITS COVERAGE

“Sec. 2241. Requirements for qualified health benefits plan.

“Sec. 2242. Essential benefits package defined.

“Sec. 2243. Levels of coverage.

“Sec. 2244. Application of certain rules to plans in group markets.

“Sec. 2245. Special rules relating to coverage of abortion services.

Sec. 1202. Application of State and Federal laws regarding abortion.

Sec. 1203. Application of emergency services laws.

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

SUBPART A—PREMIUM CREDITS AND COST-SHARING SUBSIDIES

Sec. 1205. Refundable credit providing premium assistance for coverage under a qualified health benefits plan.

“Sec. 36B. Refundable credit for coverage under a qualified health benefits plan.

Sec. 1206. Cost-sharing subsidies and advance payments of premium credits and cost-sharing subsidies.

“SUBPART 2—PREMIUM CREDITS AND COST-SHARING SUBSIDIES

“Sec. 2246. Premium credits.

“Sec. 2247. Cost-sharing subsidies for individuals enrolling in qualified health benefit plans.

“Sec. 2248. Advance determination and payment of premium credits and cost-sharing subsidies.

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- Sec. 1207. Disclosures to carry out eligibility requirements for certain programs.
- Sec. 1208. Premium credit and subsidy refunds and payments disregarded for Federal and Federally-assisted programs.
- Sec. 1209. Fail-safe mechanism to prevent increase in Federal budget deficit.

SUBPART B—CREDIT FOR SMALL EMPLOYERS

- Sec. 1221. Credit for employee health insurance expenses of small businesses.
 “Sec. 45R. Employee health insurance expenses of small employers.

Subtitle D—Shared Responsibility

PART I—INDIVIDUAL RESPONSIBILITY

- Sec. 1301. Excise tax on individuals without essential health benefits coverage.
- “CHAPTER 48—MAINTENANCE OF ESSENTIAL HEALTH BENEFITS COVERAGE
- “Sec. 5000A. Failure to maintain essential health benefits coverage.
- Sec. 1302. Reporting of health insurance coverage.

“SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE

- “Sec. 6055. Reporting of health insurance coverage.

PART II—EMPLOYER RESPONSIBILITY

- Sec. 1306. Employer shared responsibility requirement.
 “Sec. 4980H. Employer responsibility to provide health coverage.
- Sec. 1307. Reporting of employer health insurance coverage.
 “Sec. 6056. Large employers required to report on health insurance coverage.

Subtitle E—Federal Program for Health Care Cooperatives

- Sec. 1401. Establishment of Federal program for health care cooperatives.
- “PART D—FEDERAL PROGRAM FOR HEALTH CARE COOPERATIVES
- “Sec. 2251. Federal program to assist establishment and operation of non-profit, member-run health insurance issuers.

Subtitle F—Transparency and Accountability

- Sec. 1501. Provisions ensuring transparency and accountability.
 “Sec. 2229. Requirements relating to transparency and accountability.
- Sec. 1502. Reporting on utilization of premium dollars and standard hospital charges.
- Sec. 1503. Development and utilization of uniform outline of coverage documents.
- Sec. 1504. Development of standard definitions, personal scenarios, and annual personalized statements.

Subtitle G—Role of Public Programs

PART I—MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS

- Sec. 1601. Medicaid coverage for the lowest income populations.

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- Sec. 1602. Income eligibility for nonelderly determined using modified gross income.
- Sec. 1603. Requirement to offer premium assistance for employer-sponsored insurance.
- Sec. 1604. Payments to territories.
- Sec. 1605. Medicaid Improvement Fund rescission.

PART II—CHILDREN’S HEALTH INSURANCE PROGRAM

- Sec. 1611. Additional federal financial participation for CHIP.
- Sec. 1612. Technical corrections.

PART III—ENROLLMENT SIMPLIFICATION

- Sec. 1621. Enrollment Simplification and coordination with State health insurance exchanges.
- Sec. 1622. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.
- Sec. 1623. Promoting transparency in the development, implementation, and evaluation of Medicaid and CHIP waivers and section 1937 State plan amendments.
- Sec. 1624. Standards and best practices to improve enrollment of vulnerable and underserved populations.

PART IV—MEDICAID SERVICES

- Sec. 1631. Coverage for freestanding birth center services.
- Sec. 1632. Concurrent care for children.
- Sec. 1633. Funding to expand State Aging and Disability Resource Centers.
- Sec. 1634. Community First Choice Option.
- Sec. 1635. Protection for recipients of home and community-based services against spousal impoverishment.
- Sec. 1636. Incentives for States to offer home and community-based services as a long-term care alternative to nursing homes.
- Sec. 1636A. Removal of barriers to providing home and community-based services.
- Sec. 1637. Money Follows the Person Rebalancing Demonstration.
- Sec. 1638. Clarification of definition of medical assistance.
- Sec. 1639. State eligibility option for family planning services.
- Sec. 1640. Grants for school-based health centers.
- Sec. 1641. Therapeutic foster care.
- Sec. 1642. Sense of the Senate regarding long-term care.

PART V—MEDICAID PRESCRIPTION DRUG COVERAGE

- Sec. 1651. Prescription drug rebates.
- Sec. 1652. Elimination of exclusion of coverage of certain drugs.
- Sec. 1653. Providing adequate pharmacy reimbursement.
- Sec. 1654. Study of barriers to appropriate utilization of generic medicine in federal health care programs.

PART VI—MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

- Sec. 1655. Disproportionate share hospital payments.

PART VII—DUAL ELIGIBLES

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- Sec. 1661. 5-year period for demonstration projects.
- Sec. 1662. Providing Federal coverage and payment coordination for low-income Medicare beneficiaries.

PART VIII—MEDICAID QUALITY

- Sec. 1671. Adult health quality measures.
- Sec. 1672. Payment Adjustment for Health Care-Acquired Conditions.
- Sec. 1673. Demonstration project to evaluate integrated care around a hospitalization.
- Sec. 1674. Medicaid Global Payment System Demonstration Project.
- Sec. 1675. Pediatric Accountable Care Organization Demonstration Project.
- Sec. 1676. Medicaid emergency psychiatric demonstration project.

PART IX—IMPROVEMENTS TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC)

- Sec. 1681. MACPAC assessment of policies affecting all Medicaid beneficiaries.

PART X—AMERICAN INDIANS AND ALASKA NATIVES

- Sec. 1691. Special rules relating to Indians.
- Sec. 1692. Elimination of sunset for reimbursement for all medicare part B services furnished by certain indian hospitals and clinics.

Subtitle H—Addressing Health Disparities

- Sec. 1701. Standardized collection of data.
- Sec. 1702. Required collection of data.
- Sec. 1703. Data sharing and protection.
- Sec. 1704. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.

Subtitle I—Maternal and Child Health Services

- Sec. 1801. Maternal, infant, and early childhood home visiting programs.
- Sec. 1802. Support, education, and research for postpartum depression.
- Sec. 1803. Personal responsibility education for adulthood training.
- Sec. 1804. Restoration of funding for abstinence education.

Subtitle J—Programs of Health Promotion and Disease Prevention

- Sec. 1901. Programs of health promotion and disease prevention.

Subtitle K—Elder Justice Act

- Sec. 1911. Short title of subtitle.
- Sec. 1912. Definitions.
- Sec. 1913. Elder Justice.

Subtitle L—Provisions of General Application

- Sec. 1921. Protecting Americans and ensuring taxpayer funds in government health care plans do not support or fund physician-assisted suicide; prohibition against discrimination on assisted suicide.
- Sec. 1922. Protection of access to quality health care through the Department of Veterans Affairs and the Department of Defense.
- Sec. 1923. Continued application of antitrust laws.

TITLE II—PROMOTING DISEASE PREVENTION AND WELLNESS

Subtitle A—Medicare

- Sec. 2001. Coverage of annual wellness visit providing a personalized prevention plan.
- Sec. 2002. Removal of barriers to preventive services.
- Sec. 2003. Evidence-based coverage of preventive services.
- Sec. 2004. GAO study and report on medicare beneficiary access to vaccines.
- Sec. 2005. Incentives for healthy lifestyles.

Subtitle B—Medicaid

- Sec. 2101. Improving access to preventive services for eligible adults.
- Sec. 2102. Coverage of comprehensive tobacco cessation services for pregnant women.
- Sec. 2103. Incentives for healthy lifestyles.
- Sec. 2104. State option to provide health homes for enrollees with chronic conditions.
- Sec. 2105. Funding for Childhood Obesity Demonstration Project.
- Sec. 2106. Public awareness of preventive and obesity-related services.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

- Sec. 3001. Hospital Value-Based purchasing program.
- Sec. 3002. Improvements to the physician quality reporting system.
- Sec. 3003. Improvements to the physician feedback program.
- Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
- Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
- Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies.
- Sec. 3007. Value-based payment modifier under the physician fee schedule.
- Sec. 3008. Payment adjustment for conditions acquired in hospitals.

PART II—STRENGTHENING THE QUALITY INFRASTRUCTURE

- Sec. 3011. National strategy.
- Sec. 3012. Interagency Working Group on Health Care Quality.
- Sec. 3013. Quality measure development.
- Sec. 3014. Quality measure endorsement.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

- Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.
- Sec. 3022. Medicare shared savings program.
- Sec. 3023. National pilot program on payment bundling.
- Sec. 3024. Independence at home pilot program.
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PART IV—STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE
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- Sec. 3031. Expanding access to primary care services and general surgery services.
- Sec. 3031A. Medicare Federally qualified health center improvements.
- Sec. 3032. Distribution of additional residency positions.
- Sec. 3033. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.
- Sec. 3034. Rules for counting resident time for didactic and scholarly activities and other activities.
- Sec. 3035. Preservation of resident cap positions from closed and acquired hospitals.
- Sec. 3036. Workforce Advisory Committee.
- Sec. 3037. Demonstration projects To address health professions workforce needs; extension of family-to-family health information centers.
- Sec. 3038. Increasing teaching capacity.
- Sec. 3039. Graduate nurse education demonstration program.

PART V—HEALTH INFORMATION TECHNOLOGY

- Sec. 3041. Free clinics and certified EHR technology.

Subtitle B—Improving Medicare for Patients and Providers

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- Sec. 3101. Increase in the physician payment update.
- Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.
- Sec. 3103. Extension of exceptions process for Medicare therapy caps.
- Sec. 3104. Extension of payment for technical component of certain physician pathology services.
- Sec. 3105. Extension of ambulance add-ons.
- Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.
- Sec. 3107. Extension of physician fee schedule mental health add-on.
- Sec. 3108. Permitting physician assistants to order post-Hospital extended care services and to provide for recognition of attending physician assistants as attending physicians to serve hospice patients.
- Sec. 3109. Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services.
- Sec. 3110. Exemption of certain pharmacies from accreditation requirements.
- Sec. 3111. Part B special enrollment period for disabled TRICARE beneficiaries.
- Sec. 3112. Payment for bone density tests.
- Sec. 3113. Revision to the Medicare Improvement Fund.
- Sec. 3114. Treatment of certain complex diagnostic laboratory tests.
- Sec. 3115. Improved access for certified-midwife services.
- Sec. 3116. Working Group on Access to Emergency Medical Care.

PART II—RURAL PROTECTIONS

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- Sec. 3121. Extension of outpatient hold harmless provision.
- Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
- Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.
- Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.
- Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.
- Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.
- Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.
- Sec. 3128. Technical correction related to critical access hospital services.
- Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.

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- Sec. 3131. Payment adjustments for home health care.
- Sec. 3132. Hospice reform.
- Sec. 3133. Improvement to medicare disproportionate share hospital (DSH) payments.
- Sec. 3134. Misvalued codes under the physician fee schedule.
- Sec. 3135. Modification of equipment utilization factor for advanced imaging services.
- Sec. 3136. Revision of payment for power-driven wheelchairs.
- Sec. 3137. Hospital wage index improvement.
- Sec. 3138. Treatment of certain cancer hospitals.
- Sec. 3139. Payment for biosimilar biological products.
- Sec. 3140. Public meeting and report on payment systems for new clinical laboratory diagnostic tests.
- Sec. 3141. Medicare hospice concurrent care demonstration program.
- Sec. 3142. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state.
- Sec. 3143. HHS study on urban Medicare-dependent hospitals.

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- Sec. 3201. Medicare Advantage payment.
- Sec. 3202. Benefit protection and simplification.
- Sec. 3203. Application of coding intensity adjustment during MA payment transition.
- Sec. 3204. Simplification of annual beneficiary election periods.
- Sec. 3205. Extension for specialized MA plans for special needs individuals.
- Sec. 3206. Extension of reasonable cost contracts.
- Sec. 3207. Technical correction to MA private fee-for-service plans.
- Sec. 3208. Making senior housing facility demonstration permanent.
- Sec. 3209. Development of new standards for certain Medigap plans.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

- Sec. 3301. Medicare prescription drug discount program for brand-Name drugs.

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- Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.
- Sec. 3303. Voluntary de minimus policy for subsidy eligible individuals under prescription drug plans and MA–PD plans.
- Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.
- Sec. 3305. Improved information for subsidy eligible individuals reassigned to prescription drug plans and MA–PD plans.
- Sec. 3306. Funding outreach and assistance for low-income programs.
- Sec. 3307. Improving formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.
- Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries.
- Sec. 3309. Simplification of plan information.
- Sec. 3310. Limitation on removal or change of coverage of covered part D drugs under a formulary under a prescription drug plan or an MA–PD plan.
- Sec. 3311. Elimination of cost sharing for certain dual eligible individuals.
- Sec. 3312. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans and MA–PD plans.
- Sec. 3313. Improved Medicare prescription drug plan and MA–PD plan complaint system.
- Sec. 3314. Uniform exceptions and appeals process for prescription drug plans and MA–PD plans.
- Sec. 3315. Office of the Inspector General studies and reports.
- Sec. 3316. HHS study and annual reports on coverage for dual eligibles.
- Sec. 3317. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.

Subtitle E—Ensuring Medicare Sustainability

- Sec. 3401. Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.
- Sec. 3402. Temporary adjustment to the calculation of part B premiums.
- Sec. 3403. Medicare Commission.
- Sec. 3404. Ensuring medicare savings are kept in the medicare program.

Subtitle F—Comparative Effectiveness Research

- Sec. 3501. Comparative effectiveness research.
- Sec. 3502. Coordination with Federal coordinating council for comparative effectiveness research.
- Sec. 3503. GAO report on national coverage determinations process.

Subtitle G—Administrative Simplification

- Sec. 3601. Administrative Simplification.

Subtitle H—Sense of the Senate Regarding Medical Malpractice

- Sec. 3701. Sense of the Senate regarding medical malpractice.

TITLE IV—TRANSPARENCY AND PROGRAM INTEGRITY

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Subtitle A—Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals

Sec. 4001. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.

Subtitle B—Physician Ownership and Other Transparency

Sec. 4101. Transparency reports and reporting of physician ownership or investment interests.

Sec. 4102. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.

Sec. 4103. Prescription drug sample transparency.

Subtitle C—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

Sec. 4201. Required disclosure of ownership and additional disclosable parties information.

Sec. 4202. Accountability requirements for skilled nursing facilities and nursing facilities.

Sec. 4203. Nursing home compare Medicare website.

Sec. 4204. Reporting of expenditures.

Sec. 4205. Standardized complaint form.

Sec. 4206. Ensuring staffing accountability.

Sec. 4207. GAO study and report on Five-Star Quality Rating System.

PART II—TARGETING ENFORCEMENT

Sec. 4211. Civil money penalties.

Sec. 4212. National independent monitor pilot program.

Sec. 4213. Notification of facility closure.

Sec. 4214. National demonstration projects on culture change and use of information technology in nursing homes.

PART III—IMPROVING STAFF TRAINING

Sec. 4221. Dementia and abuse prevention training.

Subtitle D—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

Sec. 4301. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Subtitle E—Pharmacy Benefit Managers

Sec. 4401. Pharmacy benefit managers transparency requirements.

TITLE V—FRAUD, WASTE, AND ABUSE

Subtitle A—Medicare and Medicaid

Sec. 5001. Provider screening and other enrollment requirements under Medicare and Medicaid.

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- Sec. 5002. Enhanced Medicare and Medicaid program integrity provisions.
- Sec. 5003. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.
- Sec. 5004. Maximum period for submission of Medicare claims reduced to not more than 12 months.
- Sec. 5005. Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.
- Sec. 5006. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
- Sec. 5007. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.
- Sec. 5008. Enhanced penalties.
- Sec. 5009. Medicare self-referral disclosure protocol.
- Sec. 5010. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program.
- Sec. 5011. Expansion of the Recovery Audit Contractor (RAC) program.

Subtitle B—Additional Medicaid Provisions

- Sec. 5101. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.
- Sec. 5102. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.
- Sec. 5103. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.
- Sec. 5104. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.
- Sec. 5105. Prohibition on payments to institutions or entities located outside of the United States.
- Sec. 5106. Overpayments.
- Sec. 5107. Enhanced funding for program integrity activities.
- Sec. 5108. Mandatory State use of national correct coding initiative.
- Sec. 5109. General effective date.

TITLE VI—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

- Sec. 6001. Excise tax on high cost employer-sponsored health coverage.
- Sec. 6002. Inclusion of cost of employer-sponsored health coverage on W-2.
- Sec. 6003. Distributions for medicine qualified only if for prescribed drug or insulin.
- Sec. 6004. Increase in additional tax on distributions from HSAs not used for qualified medical expenses.
- Sec. 6005. Limitation on health flexible spending arrangements under cafeteria plans.
- Sec. 6006. Expansion of information reporting requirements.
- Sec. 6007. Additional requirements for charitable hospitals.
- Sec. 6008. Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers.
- Sec. 6009. Imposition of annual fee on medical device manufacturers and importers.
- Sec. 6010. Imposition of annual fee on health insurance providers.
- Sec. 6011. Study and report of effect on veterans health care.

- Sec. 6012. Elimination of deduction for expenses allocable to Medicare Part D subsidy.
- Sec. 6013. Modification of itemized deduction for medical expenses.
- Sec. 6014. Limitation on excessive remuneration paid by certain health insurance providers.

Subtitle B—Other Provisions

- Sec. 6021. Exclusion of health benefits provided by Indian tribal governments.
- Sec. 6022. Establishment of simple cafeteria plans for small businesses.
- Sec. 6023. Qualifying therapeutic discovery project credit.

1 **TITLE I—HEALTH CARE**
 2 **COVERAGE**
 3 **Subtitle A—Insurance Market**
 4 **Reforms**

5 **SEC. 1001. INSURANCE MARKET REFORMS IN THE INDI-**
 6 **VIDUAL AND SMALL GROUP MARKETS.**

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

9 **“TITLE XXII—HEALTH**
 10 **INSURANCE COVERAGE**

11 **“SEC. 2200. ENSURING ESSENTIAL AND AFFORDABLE**
 12 **HEALTH BENEFITS COVERAGE FOR ALL**
 13 **AMERICANS.**

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

17 “(1) by requiring that all new health benefits
 18 plans offered to individuals and employees in the in-
 19 dividual and small group markets be qualified health
 20 benefits plans that meet the insurance rating re-

1 forms and essential health benefits coverage require-
2 ments established under parts A and C;

3 “(2) by establishing State exchanges under part
4 B that provide individuals and employees in the indi-
5 vidual and small group markets greater access to
6 qualified health benefits plans and to information
7 concerning these health plans;

8 “(3) by making health benefits coverage more
9 affordable by establishing premium credits and cost-
10 sharing subsidies under part C for individuals enroll-
11 ing in a health benefits plan through an exchange;
12 and

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

16 **“PART A—INSURANCE REFORMS**

17 **“Subpart 1—Requirements in Individual and Small**
18 **Group Markets**

19 **“SEC. 2201. GENERAL REQUIREMENTS AND DEFINITIONS.**

20 “(a) NEW PLANS MUST BE QUALIFIED HEALTH
21 BENEFITS PLANS.—Except as provided in subpart 3 (re-
22 lating to preservation of existing coverage), each State
23 shall provide that each health benefits plan which is of-
24 fered in the individual or small group market within the
25 State shall be a qualified health benefits plan.

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

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

9 “(A) this part (relating to requirements for
10 insurance market reforms); and

11 “(B) part C (relating to requirements to
12 make health insurance affordable); and

13 “(2) the offeror of the plan—

14 “(A) is licensed by the State (and in good
15 standing with the State) to offer a health bene-
16 fits plan in the State; and

17 “(B) complies with such other require-
18 ments as the Secretary or the State may estab-
19 lish pursuant to this title for qualified health
20 benefits plans.

21 “(c) TERMS RELATING TO HEALTH BENEFITS
22 PLANS.—In this title:

23 “(1) HEALTH BENEFITS PLAN.—

1 “(A) IN GENERAL.—The term ‘health ben-
2 efits plan’ means health insurance coverage and
3 a group health plan.

4 “(B) EXCEPTION FOR SELF-INSURED
5 PLANS AND MEWAS.—Except to the extent spe-
6 cifically provided by this title, the term ‘health
7 benefits plan’ shall not include a group health
8 plan or multiple employer welfare arrangement
9 to the extent the plan is not subject to State in-
10 surance regulation under section 514 of the
11 Employee Retirement Income Security Act of
12 1974.

13 “(2) HEALTH INSURANCE COVERAGE AND
14 ISSUER.—The terms ‘health insurance coverage’ and
15 ‘health insurance issuer’ have the meanings given
16 such terms by section 9832(b) of the Internal Rev-
17 enue Code of 1986.

18 “(3) GROUP HEALTH PLAN.—The term ‘group
19 health plan’ has the meaning given such term by
20 section 5000(b) of such Code.

21 “(4) HEALTH BENEFITS PLAN OFFEROR.—The
22 terms ‘health benefits plan offeror’ and ‘offeror’
23 mean in the case of—

24 “(A) health insurance coverage, the health
25 insurance issuer offering the coverage; and

1 “(B) a group health plan—
2 “(i) the plan sponsor; or
3 “(ii) in the case of a plan maintained
4 jointly by 1 or more employers and 1 or
5 more employee organizations and with re-
6 spect to which an employer is the primary
7 source of financing, such employer.

8 “(d) DEFINITIONS RELATING TO MARKETS.—In this
9 title:

10 “(1) GROUP MARKET.—The term ‘group mar-
11 ket’ means the health insurance market under which
12 individuals obtain health insurance coverage (directly
13 or through any arrangement) on behalf of them-
14 selves (and their dependents) through a group health
15 plan maintained by an employer.

16 “(2) INDIVIDUAL MARKET.—The term ‘indi-
17 vidual market’ means the market for health insur-
18 ance coverage offered to individuals other than in
19 connection with a group health plan.

20 “(3) LARGE AND SMALL GROUP MARKETS.—
21 The terms ‘large group market’ and ‘small group
22 market’ mean the health insurance market under
23 which individuals obtain health insurance coverage
24 (directly or through any arrangement) on behalf of
25 themselves (and their dependents) through a group

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

4 **“SEC. 2202. PROHIBITION ON PREEXISTING CONDITION EX-**
5 **CLUSIONS.**

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

9 “(1) impose any preexisting condition exclusion
10 with respect to the plan; or

11 “(2) otherwise impose any limit or condition on
12 the coverage under the plan with respect to an indi-
13 vidual or dependent of an individual based on any
14 health status-related factors in relation to the indi-
15 vidual or dependent.

16 “(b) PREEXISTING CONDITION EXCLUSION.—For
17 purposes of this section, the term ‘preexisting condition
18 exclusion’ means, with respect to coverage, a limitation or
19 exclusion of benefits relating to a condition based on the
20 fact that the condition was present before the date of en-
21 rollment for such coverage, whether or not any medical
22 advice, diagnosis, care, or treatment was recommended or
23 received before such date.

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

1 factors' means health status, medical condition (including
2 both physical and mental illnesses), claims experience, re-
3 ceipt of health care, medical history, genetic information,
4 evidence of insurability (including conditions arising out
5 of acts of domestic violence), and disability.

6 **“SEC. 2203. GUARANTEED ISSUE AND RENEWAL FOR IN-**
7 **SURED PLANS.**

8 “(a) IN GENERAL.—Except as provided in this sec-
9 tion, a health benefits plan shall be treated as a qualified
10 health benefits plan only if the offeror of the plan—

11 “(1) in the case of a plan offered—

12 “(A) in the individual market in a State,
13 must accept every individual that applies for en-
14 rollment in the plan;

15 “(B) in the small group market in a State,
16 must accept—

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

20 “(ii) every individual who is eligible to
21 enroll in the plan by reason of a relation-
22 ship to the employer as is determined—

23 “(I) in accordance with the terms
24 of such plan;

1 “(II) as provided by the offeror
2 under rules of the offeror that are
3 uniformly applicable to small employ-
4 ers in the small group market within
5 a State; and

6 “(III) in accordance with all ap-
7 plicable State laws governing the of-
8 feror and the small group market; and

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

12 An offeror of a plan shall not be treated as meeting the
13 requirements of this subsection unless the plan also ac-
14 cepts, renews, or continues in force coverage of an indi-
15 vidual who is eligible for enrollment in the plan by reason
16 of their relationship to the named insured under the plan.

17 “(b) SPECIAL RULES FOR GUARANTEED ISSUE.—

18 “(1) ENROLLMENT.—Each offeror of a health
19 benefits plan shall establish annual and special en-
20 rollment periods meeting the requirements of section
21 2236(d)(2) and may restrict enrollment described in
22 subsection (a)(1) to such enrollment periods.

23 “(2) CAPACITY LIMITS.—For purposes of apply-
24 ing subsection (a)(1), if, as determined under regu-
25 lations prescribed by the Secretary, a plan has a ca-

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

7 “(c) **GUARANTEED RENEWABILITY.**—For purposes
8 of applying subsection (a)(2)—

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

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

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

17 **“SEC. 2204. PREMIUM RATING RULES.**

18 “(a) **IN GENERAL.**—A health benefits plan shall be
19 treated as a qualified health benefits plan only if the pre-
20 mium rate charged for any benefit level of the plan may
21 not vary except as provided in this section.

22 “(b) **LIMITS BASED ON SPECIFIC RATIOS.**—

23 “(1) **IN GENERAL.**—In the case of a health ben-
24 efits plan offered in a rating area, the premium rate

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

3 “(2) BY FAMILY ENROLLMENT.—The premium
4 rate may vary by family enrollment (such as vari-
5 ations within categories and compositions of fami-
6 lies) so long as the ratio of the premium for the fol-
7 lowing types of enrollment to the premium for indi-
8 vidual enrollment does not exceed the following ra-
9 tios:

10 “(A) Individual, 1 to 1.

11 “(B) Adult with child, 1.8 to 1.

12 “(C) Two adults, 2 to 1.

13 “(D) Family, 3 to 1.

14 “(3) AGE AND TOBACCO USE.—Within any fam-
15 ily enrollment category, the portion of the premium
16 attributable to each individual covered by the health
17 benefits plan in that category may vary as follows:

18 “(A) LIMITED AGE VARIATION PER-
19 MITTED.—By age (within the standard age
20 bands established under subsection (c)) so long
21 as the ratio of the highest such premium to the
22 lowest such premium does not exceed the ratio
23 of 4 to 1.

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

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

3 “(c) STANDARD AGE CATEGORIES.—The Secretary
4 shall establish standard age bands between which pre-
5 mium rates may vary as provided in subsection (b)(3)(A).

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

11 **“SEC. 2205. USE OF UNIFORM OUTLINE OF COVERAGE DOC-
12 UMENTS.**

13 “A health benefits plan shall provide an outline of
14 the plan’s health insurance coverage meeting the stand-
15 ards of uniformity adopted by the Secretary under section
16 1503 of the America’s Healthy Future Act of 2009 to—

17 “(1) an applicant at the time of application;

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

19 “(3) a policyholder or certificate holder of the
20 plan at the time the policy is issued or the certificate
21 is delivered.

1 **“Subpart 2—Reforms Relating to Allocation of Risks**

2 **“SEC. 2211. RATING AREAS; POOLING OF RISKS; PHASE IN**

3 **OF RATING RULES IN SMALL GROUP MAR-**

4 **KETS.**

5 “(a) RATING AREAS.—

6 “(1) IN GENERAL.—Each State shall establish
7 1 or more rating areas within that State for pur-
8 poses of applying the requirements of this title.

9 “(2) SECRETARIAL REVIEW.—The Secretary
10 shall review the rating areas established by each
11 State under subsection (a) to ensure the adequacy of
12 such areas for purposes of carrying out the require-
13 ments of this title. If the Secretary determines a
14 State’s rating areas are not so adequate, the Sec-
15 retary may establish rating areas for that State.

16 “(b) SINGLE RISK POOL.—

17 “(1) IN GENERAL.—For purposes of applying
18 the insurance reform requirements under subpart
19 1—

20 “(A) INDIVIDUAL MARKET.—The offeror of
21 an insured qualified health benefits plan offered
22 in the individual market in an area covered by
23 an exchange shall consider all enrollees in the
24 plan, including individuals who do not purchase
25 such a plan through an exchange, to be mem-
26 bers of a single risk pool.

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

8 “(2) STATE ELECTION.—A State may elect to
9 combine the individual and small group markets
10 within the State for purposes of applying this sub-
11 section.

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

18 **“SEC. 2212. RISK ADJUSTMENT.**

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

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

3 “(b) RISK ADJUSTMENT MODELS.—

4 “(1) IN GENERAL.—The Secretary shall estab-
5 lish 1 or more risk adjustment models for proper ad-
6 justments of premium amounts payable among
7 offerors of qualified health benefits plans that take
8 into account (in a manner specified by the Sec-
9 retary) the differences in the risk characteristics of
10 individuals and employers enrolled under the dif-
11 ferent plans so as to minimize the impact of adverse
12 selection of enrollees among the plans.

13 “(2) STATE OPTION.—A State may—

14 “(A) adopt a risk adjustment model estab-
15 lished under paragraph (1); or

16 “(B) establish its own risk adjustment
17 model for purposes of subsection (a), but only
18 if the State establishes to the satisfaction of the
19 Secretary that such model will produce results
20 substantially similar to the results of risk ad-
21 justment models established under paragraph
22 (1) and will not increase costs to the Federal
23 government.

24 “(3) OPERATION OF RISK ADJUSTMENT SYS-
25 TEM.—A State may select an entity certified under

1 subsection (c) to implement and operate its risk ad-
2 justment model under this section.

3 “(c) CERTIFICATION OF ENTITIES CONDUCTING
4 RISK ADJUSTMENT.—The Secretary shall certify entities
5 which the Secretary determines have the required exper-
6 tise to implement the risk adjustment models adopted or
7 established under subsection (b). The Secretary may not
8 certify any entity which is a health benefits plan offeror
9 or any entity owned or operated by such an offeror.

10 **“SEC. 2213. ESTABLISHMENT OF TRANSITIONAL REINSUR-**
11 **ANCE PROGRAM FOR INDIVIDUAL MARKETS**
12 **IN EACH STATE.**

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

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

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

22 “(b) MODEL REGULATION.—

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

1 ciation of Insurance Commissioners (the ‘NAIC’) to
2 include provisions that enable States to establish
3 and maintain a program under which—

4 “(A) the offerors of health benefits plans
5 that are offered in the individual market are re-
6 quired to make payments to an applicable rein-
7 surance entity for any plan year beginning in
8 the 36-month period beginning July 1, 2013;
9 and

10 “(B) the applicable reinsurance entity col-
11 lects payments under subparagraph (A) and
12 uses amounts so collected to make reinsurance
13 payments to offerors of health benefits plans
14 described in subparagraph (A) that cover high
15 risk individuals for any plan year beginning in
16 such 36-month period.

17 If the NAIC does not include such provisions as part
18 of the Model Regulation , the Secretary shall include
19 such provisions in a Federal standard under section
20 2225(a)(1)(B).

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

24 “(A) DETERMINATION OF HIGH-RISK INDI-
25 VIDUALS.—The method by which individuals

1 will be identified as high risk individuals for
2 purposes of the reinsurance program estab-
3 lished under this section. Such method shall
4 provide for identification of individuals as high-
5 risk individuals on the basis of—

6 “(i) a list of at least 50 but not more
7 than 100 medical conditions that are iden-
8 tified as high-risk conditions and that may
9 be based on the identification of diagnostic
10 and procedure codes that are indicative of
11 individuals with pre-existing, high-risk con-
12 ditions; or

13 “(ii) any other comparable objective
14 method of identification recommended by
15 the American Academy of Actuaries.

16 “(B) PAYMENT AMOUNT.—

17 “(i) IN GENERAL.—The formula for
18 determining the amount of payments that
19 will be paid to the offerors of health bene-
20 fits plans that insure high-risk individuals.
21 Such formula shall provide for the equi-
22 table allocation of available funds through
23 reconciliation and may be designed—

24 “(I) to provide a schedule of pay-
25 ments that specifies the amount that

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

3 “(II) to use any other com-
4 parable method for determining pay-
5 ment amounts that is recommended
6 by the American Academy of Actua-
7 ries and that encourages the use of
8 care coordination and care manage-
9 ment programs for high risk condi-
10 tions.

11 “(ii) COORDINATION WITH COST-
12 SHARING AND RISK ADJUSTMENT PAY-
13 MENTS.—Such provisions shall provide
14 methods to coordinate the payment system
15 under this section with any cost-sharing
16 requirements of a plan and the risk-adjust-
17 ment program under section 2212.

18 “(3) DETERMINATION OF REQUIRED CONTRIBU-
19 TIONS.—

20 “(A) IN GENERAL.—The provisions under
21 paragraph (1) shall include the method for de-
22 termining the amount each offeror of a health
23 benefits plan participating in the reinsurance
24 program under this section is required to con-
25 tribute under paragraph (1)(A) for each plan

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

8 “(B) SPECIFIC REQUIREMENTS.—The
9 method under this paragraph shall be designed
10 so that—

11 “(i) the contribution amount for each
12 offeror proportionally reflects each
13 offeror’s fully insured commercial book of
14 business for all major medical products
15 and third party administration fees;

16 “(ii) the contribution amount can in-
17 clude an additional amount to fund the ad-
18 ministrative expenses of the applicable re-
19 insurance entity;

20 “(iii) subject to clause (iv), the aggre-
21 gate contribution amounts for all States
22 shall, based on the best estimates of the
23 NAIC or the Secretary, whichever is appli-
24 cable, and without regard to amounts de-
25 scribed in clause (ii), equal

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

4 “(ii) amounts remaining unexpended
5 as of June 30, 2016, may be used to make
6 payments under any reinsurance program
7 of a State in the individual market in ef-
8 fect in the 24-month period beginning on
9 July 1, 2016.

10 “(B) TRANSFERS TO SECRETARY FOR RE-
11 TIREE REINSURANCE.—The provisions under
12 paragraph (1) shall provide that each applicable
13 reinsurance entity shall transfer to the Sec-
14 retary amounts collected that are allocable to
15 amounts required to be collected under para-
16 graph (3)(B)(iv).

17 “(c) APPLICABLE REINSURANCE ENTITY.—For pur-
18 poses of this section—

19 “(1) IN GENERAL.—The term ‘applicable rein-
20 surance entity’ means a not-for-profit organization—

21 “(A) the purpose of which is to help sta-
22 bilize premiums for coverage in the individual
23 market in a State during the first 3 years of
24 operation of an exchange for that market within
25 the State when the risk of adverse selection re-

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

3 “(B) the duties of which shall be to carry
4 out the reinsurance program under this section
5 by coordinating the funding and operation of
6 the risk-spreading mechanisms designed to im-
7 plement the reinsurance program.

8 “(2) STATE DISCRETION.—A State may have
9 more than 1 applicable reinsurance entity to carry
10 out the reinsurance program under this section with-
11 in the State and 2 or more States may enter into
12 agreements to provide for an applicable reinsurance
13 entity to carry out such program in all such States.

14 “(3) ENTITIES ARE TAX-EXEMPT.—An applica-
15 ble reinsurance entity established under this section
16 shall be treated as an organization exempt from tax-
17 ation under section 501(a) of the Internal Revenue
18 Code of 1986. The preceding sentence shall not
19 apply to the tax imposed by section 511 such Code
20 (relating to tax on unrelated business taxable income
21 of an exempt organization).

22 “(d) COORDINATION WITH STATE HIGH-RISK
23 POOLS.—The State shall eliminate or modify any State
24 high-risk pool to the extent necessary to carry out the re-
25 insurance program established under this section. The

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

4 **“SEC. 2214. ESTABLISHMENT OF RISK CORRIDORS FOR**
5 **PLANS IN INDIVIDUAL AND SMALL GROUP**
6 **MARKETS.**

7 “(a) IN GENERAL.—The Secretary shall establish
8 and administer a program of risk corridors for plan years
9 beginning during the 36-month period beginning on July
10 1, 2013, under which a qualified health benefits plan of-
11 fered in the individual or small group market may elect
12 (before the beginning of such 36-month period) to partici-
13 pate in a payment adjustment system based on the ratio
14 of the allowable costs of the plan to the plan’s aggregate
15 premiums. Such program shall be based on the program
16 for regional participating provider organizations under
17 part D of title XVIII.

18 “(b) PAYMENT METHODOLOGY.—

19 “(1) PAYMENTS OUT.—The Secretary shall pro-
20 vide under the program established under subsection
21 (a) that if—

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

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

4 “(B) a participating plan’s allowable costs
5 for any plan year are more than 108 percent of
6 the target amount, the Secretary shall pay to
7 the plan an amount equal to the sum of 2.5
8 percent of the target amount plus 80 percent of
9 allowable costs in excess of 108 percent of the
10 target amount.

11 “(2) PAYMENTS IN.—The Secretary shall pro-
12 vide under the program established under subsection
13 (a) that if—

14 “(A) a participating plan’s allowable costs
15 for any plan year are less than 97 percent but
16 not less than 92 percent of the target amount,
17 the plan shall pay to the Secretary an amount
18 equal to 50 percent of the excess of 97 percent
19 of the target amount over the allowable costs;
20 and

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

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

3 “(c) DEFINITIONS.—In this section:

4 “(1) ALLOWABLE COSTS.—

5 “(A) IN GENERAL.—The amount of allow-
6 able costs of a plan for any year is an amount
7 equal to the total costs (other than administra-
8 tive costs) of the plan in providing benefits cov-
9 ered by the plan.

10 “(B) REDUCTION FOR RISK ADJUSTMENT
11 AND REINSURANCE PAYMENTS.—Allowable
12 costs shall be reduced by any risk adjustment
13 and reinsurance payments received under sec-
14 tion 2212 and 2213.

15 “(2) TARGET AMOUNT.—The target amount of
16 a plan for any year is an amount equal to the total
17 premiums (including any premium credits or sub-
18 sidies under any governmental program) reduced by
19 the administrative costs of the plan.

20 **“SEC. 2215. TEMPORARY HIGH RISK POOLS FOR INDIVID-**
21 **UALS WITH PREEXISTING CONDITIONS.**

22 “(a) ESTABLISHMENT OF HIGH RISK POOLS.—

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

1 “(A) provide to all eligible individuals
2 health insurance coverage (or comparable cov-
3 erage) that does not impose any preexisting
4 condition exclusion with respect to such cov-
5 erage for all eligible individuals; and

6 “(B) provide for health benefits coverage
7 and premium rates described under subsection
8 (b).

9 “(2) ADMINISTRATION.—The Secretary may
10 carry out this section—

11 “(A) directly; or

12 “(B) through agreements, grants, or con-
13 tracts with States or other persons the Sec-
14 retary determines appropriate.

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

17 “(1) COVERAGE.—The Secretary shall provide
18 that the health benefits coverage provided to an eli-
19 gible individual through a high risk pool under this
20 section shall—

21 “(A) consist of the essential benefits pack-
22 age described in section 2242; and

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

25 “(2) PREMIUM RATES.—

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

8 “(B) VARIATION OF PREMIUMS.—The Sec-
9 retary may vary the premium under subpara-
10 graph (A) to the same extent, and in the same
11 manner, as the offeror of a qualified health ben-
12 efits plan may vary the premium for the plan
13 under section 2204.

14 “(c) FUNDING; TERMINATION OF AUTHORITY.—

15 “(1) IN GENERAL.—There is appropriated to
16 the Secretary, out of any moneys in the Treasury
17 not otherwise appropriated, \$5,000,000,000 to pay
18 claims against (and administrative costs of) the high
19 risk pool in excess of the premiums collected from el-
20 igible individuals enrolled in the high risk pool. Such
21 funds shall be available without fiscal year limita-
22 tion.

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

1 high risk pool will be less than the amount of the
2 expenses, the Secretary shall make such adjustments
3 as are necessary to eliminate such deficit, including
4 reducing benefits, increasing premiums, or estab-
5 lishing waiting lists.

6 “(3) TERMINATION OF AUTHORITY.—

7 “(A) IN GENERAL.—Except as provided in
8 subparagraph (B), coverage of eligible individ-
9 uals under a high risk pool shall terminate as
10 of the end of June 30, 2013.

11 “(B) TRANSITION TO EXCHANGE.—The
12 Secretary shall develop procedures to provide
13 for the transition of eligible individuals enrolled
14 in health insurance coverage offered through a
15 high risk pool established under this section
16 into qualified health benefits plans offered
17 through an exchange. Such procedures shall en-
18 sure that there is no lapse in coverage with re-
19 spect to the individual and may extend coverage
20 after June 30, 2013, if the Secretary deter-
21 mines necessary to avoid such a lapse.

22 “(d) ELIGIBLE INDIVIDUAL.—In this section, the
23 term ‘eligible individual’ means an individual who dem-
24 onstrates to the satisfaction of the Secretary that the indi-
25 vidual—

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

4 “(2) has been uninsured for a continuous pe-
5 riod of at least 6 months before the date of applica-
6 tion for enrollment in a high risk pool;

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

9 “(4) is an individual who is, and who is reason-
10 ably expected to be for the entire period of coverage,
11 a citizen or national of the United States, an alien
12 lawfully admitted to the United States for perma-
13 nent residence, or an alien lawfully present in the
14 United States.

15 **“SEC. 2216. REINSURANCE FOR RETIREES COVERED BY EM-**
16 **PLOYER-BASED PLANS.**

17 “(a) ADMINISTRATION.—

18 “(1) IN GENERAL.—Not later than 90 days
19 after the date of enactment of this section, the Sec-
20 retary shall establish a temporary reinsurance pro-
21 gram to provide reimbursement to participating em-
22 ployment-based plans for a portion of the cost of
23 providing health benefits to retirees during the pe-
24 riod beginning on the date on which such program
25 is established and ending on the date on which the

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

5 “(2) REFERENCE.—In this section:

6 “(A) HEALTH BENEFITS.—The term
7 ‘health benefits’ means medical, surgical, hos-
8 pital, prescription drug, and such other benefits
9 as shall be determined by the Secretary, wheth-
10 er self-funded, or delivered through the pur-
11 chase of insurance or otherwise.

12 “(B) EMPLOYMENT-BASED PLAN.—The
13 term ‘employment-based plan’ means a group
14 health benefits plan that—

15 “(i) is—

16 “(I) maintained by one or more
17 current or former employers (includ-
18 ing without limitation any State or
19 local government or political subdivi-
20 sion thereof), an employee organiza-
21 tion, a voluntary employees’ bene-
22 ficiary association, or a committee or
23 board of individuals appointed to ad-
24 minister such plan; or

1 “(II) a multiemployer plan (as
2 defined in section 3(37) of the Em-
3 ployee Retirement Income Security
4 Act of 1974); and

5 “(ii) provides health benefits to retir-
6 ees.

7 “(C) RETIREES.—The term ‘retirees’
8 means individuals who are age 55 and older but
9 are not eligible for coverage under title XVIII
10 of the Social Security Act, and who are not ac-
11 tive employees of an employer maintaining, or
12 currently contributing to, the employment-based
13 plan or of any employer that has made substan-
14 tial contributions to fund such plan.

15 “(b) PARTICIPATION.—

16 “(1) EMPLOYMENT-BASED PLAN ELIGI-
17 BILITY.—A participating employment-based plan is
18 an employment-based plan that—

19 “(A) meets the requirements of paragraph
20 (2) with respect to benefits provided under the
21 plan; and

22 “(B) submits to the Secretary an applica-
23 tion for participation in the program, at such
24 time, in such manner, and containing such in-
25 formation as the Secretary shall require.

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

4 “(A) provides benefits appropriate for indi-
5 viduals between the ages described in subsection
6 (a)(2)(C) and that are certified as so appro-
7 priate by the Secretary;

8 “(B) implements programs and procedures
9 to generate cost-savings with respect to partici-
10 pants with chronic and high-cost conditions;
11 and

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

15 “(c) PAYMENTS.—

16 “(1) SUBMISSION OF CLAIMS.—

17 “(A) IN GENERAL.—A participating em-
18 ployment-based plan shall submit claims for re-
19 imbursement to the Secretary which shall con-
20 tain documentation of the actual costs of the
21 items and services for which each claim is being
22 submitted.

23 “(B) BASIS FOR CLAIMS.—Claims sub-
24 mitted under paragraph (1) shall be based on
25 the actual amount expended by the partici-

1 participating employment-based plan involved within
2 the plan year for the appropriate employment-
3 based health benefits provided to a retiree or
4 the spouse, surviving spouse, or dependent of
5 such retiree. In determining the amount of a
6 claim for purposes of this subsection, the par-
7 ticipating employment-based plan shall take
8 into account any negotiated price concessions
9 (such as discounts, direct or indirect subsidies,
10 rebates, and direct or indirect remunerations)
11 obtained by such plan with respect to such
12 health benefit. For purposes of determining the
13 amount of any such claim, the costs paid by the
14 retiree or the retiree's spouse, surviving spouse,
15 or dependent in the form of deductibles, co-pay-
16 ments, or co-insurance shall be included in the
17 amounts paid by the participating employment-
18 based plan.

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

1 “(3) LIMIT.—To be eligible for reimbursement
2 under the program, a claim submitted by a partici-
3 pating employment-based plan under paragraph (1)
4 with respect to any individual shall not be less than
5 \$15,000 nor greater than \$90,000. Such amounts
6 shall be adjusted each fiscal year based on the per-
7 centage increase in the Medical Care Component of
8 the Consumer Price Index for all urban consumers
9 (rounded to the nearest multiple of \$1,000) for the
10 year involved.

11 “(4) USE OF PAYMENTS.—Amounts paid to a
12 participating employment-based plan under this sub-
13 section shall be used to lower costs for the plan.
14 Such payments may be used to reduce premium
15 costs for an entity described in subsection
16 (a)(2)(B)(i) or to reduce premium contributions, co-
17 payments, deductibles, co-insurance, or other out-of-
18 pocket costs for plan participants. Such payments
19 shall not be used as general revenues for an entity
20 described in subsection (a)(2)(B)(i). The Secretary
21 shall develop a mechanism to monitor the appro-
22 priate use of such payments by such entities.

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

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

4 “(6) APPEALS.—The Secretary shall estab-
5 lish—

6 “(A) an appeals process to permit partici-
7 pating 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 “(d) AUDITS.—The Secretary shall conduct annual
13 audits of claims data submitted by participating employ-
14 ment-based plans under this section to ensure that such
15 plans are in compliance with the requirements of this sec-
16 tion.

17 “(e) AVAILABLE FUNDS.—

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

23 “(2) APPROPRIATIONS.—Amounts in the ac-
24 count are hereby appropriated for use by the Sec-

1 retary in carrying out the program under this sec-
2 tion.

3 “(3) LIMITATIONS.—The Secretary has the au-
4 thority to stop taking applications for participation
5 in the program if applications will exceed amounts
6 in the account.

7 **“Subpart 3—Preservation of Right to Maintain**
8 **Existing Coverage**

9 **“SEC. 2221. GRANDFATHERED HEALTH BENEFITS PLANS.**

10 “(a) IN GENERAL.—In the case of a grandfathered
11 health benefits plan—

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

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

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

21 “(b) APPLICATION OF RATING RULES IN SMALL
22 GROUP MARKET.—Each State shall phase in the applica-
23 tion of the insurance reform requirements under subpart
24 1 to grandfathered health benefits plans offered in the
25 small group market within the State over a consecutive

1 period of years (not greater than 5) beginning July 1,
2 2013.

3 “(c) GRANDFATHERED HEALTH BENEFITS PLAN.—

4 In this title:

5 “(1) IN GENERAL.—The term ‘grandfathered
6 health benefits plan’ means any of the following that
7 was offered and was in force and effect on the effec-
8 tive date of this title:

9 “(A) Health insurance coverage in the in-
10 dividual market.

11 “(B) A group health plan.

12 “(2) LIMITED NEW ENROLLMENT.—

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

19 “(B) ALLOWANCE FOR FAMILY MEMBERS
20 TO JOIN CURRENT COVERAGE.—Family mem-
21 bers of an individual enrolled in a health bene-
22 fits plan as of the day before the date described
23 in paragraph (1) may enroll in the plan on or
24 after such date.

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

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

14 **“Subpart 4—Continued Role of States**

15 **“SEC. 2225. CONTINUED STATE ENFORCEMENT OF INSUR-**
16 **ANCE REGULATIONS.**

17 “(a) IN GENERAL.—

18 “(1) MODEL REGULATION.—

19 “(A) IN GENERAL.—The Secretary shall
20 request the National Association of Insurance
21 Commissioners (in this section referred to as
22 the ‘NAIC’) to, not later than 12 months after
23 the date of enactment of this title, develop and
24 promulgate a Model Regulation that imple-
25 ments the requirements set forth in this title

1 for health benefit plans offered within a State.
2 In developing and promulgating the Model Reg-
3 ulation, the NAIC shall consult with its mem-
4 bers, health insurance issuers, consumer organi-
5 zations, and such other individuals as the NAIC
6 selects in a manner designed to ensure balanced
7 representation among interested parties.

8 “(B) SECRETARIAL ACTION.—The Sec-
9 retary shall include the Model Regulation estab-
10 lished under paragraph (1) in the regulations
11 prescribed by the Secretary to implement the
12 requirements described in subparagraph (A). If
13 the NAIC does not promulgate the Model Regu-
14 lation within the 12-month period under sub-
15 subparagraph (A), the Secretary shall establish a
16 Federal standard implementing such require-
17 ments.

18 “(2) STATE ACTION.—Each State that elects to
19 apply the requirements set forth in this title to
20 health benefit plans offered within the State shall,
21 not later than July 1, 2013, adopt and have in ef-
22 fect—

23 “(A) the Model Regulation or Federal
24 standard established under paragraph (1),
25 whichever is applicable; or

1 “(B) a State law or regulation that the
2 Secretary determines implements the require-
3 ments for health benefit plans offered within
4 the State.

5 “(3) FAILURE TO IMPLEMENT PROVISIONS.—

6 “(A) IN GENERAL.—If—

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

11 “(ii) the Secretary determines that an
12 electing State has failed to adopt or sub-
13 stantially enforce the Model Regulation,
14 Federal standard, or State law or regula-
15 tions described in paragraph (2), whichever
16 is applicable, with respect to health bene-
17 fits plan offerors in the State,

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

24 “(B) ENFORCEMENT AUTHORITY.—The
25 provisions of section 2722(b) of the Public

1 Health Services Act shall apply to the enforce-
2 ment under subparagraph (A) of the provisions
3 of this part (without regard to any limitation on
4 the application of those provisions to group
5 health plans).

6 “(4) RATINGS REFORMS MUST APPLY UNI-
7 FORMLY TO ALL OFFERORS.—The Model Regula-
8 tion, Federal standard, or State law and regulation
9 implemented by a State under this subsection shall
10 require that any standard or requirement adopted
11 pursuant to this title (including any standard or re-
12 quirement described in subsection (c) that offers
13 more protection to consumers than the protection of-
14 fered by any standard or requirement set forth in
15 this title) shall be applied uniformly to all offerors
16 of all health benefits plans in the individual or small
17 group market, whichever is applicable.

18 “(b) STATE EXCHANGES.—

19 “(1) EXCHANGES FOR QUALIFIED PLANS.—

20 “(A) IN GENERAL.—Subject to paragraph
21 (2), not later than July 1, 2013, an electing
22 State under subsection (a)(2) shall establish
23 and have in operation 1 or more exchanges (in-
24 cluding SHOP exchanges) meeting the require-
25 ments of part B with respect to the offering of

1 qualified health benefits plans through the ex-
2 change.

3 “(B) FAILURE TO ESTABLISH.—If—

4 “(i) a State is not an electing State
5 under subsection (a)(2); or

6 “(ii) an electing State does not estab-
7 lish the exchanges described in subpara-
8 graph (A) within 24 months after the date
9 of enactment of this title (or the Secretary
10 determines at the end of the 24-month pe-
11 riod that the exchanges will not be oper-
12 ational by July 1, 2013),

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

16 “(2) INTERIM EXCHANGES.—Each electing
17 State under subsection (a)(2) shall as soon as prac-
18 ticable establish the exchanges described in section
19 2235(e) for use by residents of the State during the
20 period beginning January 1, 2010, and ending June
21 30, 2013. In the case of a State that is not an elect-
22 ing State under subsection (a)(2), or if the Secretary
23 determines that the exchanges in an electing State
24 will not be operational within a reasonable period of
25 time after the date of enactment of this title, the

1 Secretary shall enter into a contract with a non-
2 governmental entity to establish and operate the ex-
3 changes within the State during such period.

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

6 “(1) IN GENERAL.—Subject to paragraphs (2)
7 and (3), this title shall not be construed to super-
8 sede any provision of State law which establishes,
9 implements, or continues in effect any standard or
10 requirement relating to health benefits plan offerors
11 in connection with a health benefits plan that offers
12 more protection to consumers than the protection of-
13 fered by any standard or requirement set forth in
14 this title. The standards or requirements referred to
15 in the preceding sentence shall include standards or
16 requirements relating to—

17 “(A) consumer protections, including
18 claims grievance procedures, external review of
19 claims determinations, oversight of insurance
20 agent practices and training, and insurance
21 market conduct;

22 “(B) premium rating reviews;

23 “(C) solvency and reserve requirements re-
24 lating to the licensure of health insurance
25 issuers operating in the State; and

1 “(D) the assessment of State-based pre-
2 mium taxes on health insurance issuers.

3 “(2) SPECIAL RULE FOR RATING REQUIRE-
4 MENTS.—For purposes of paragraph (1), in the case
5 of the ratings requirements under section 2204, a
6 State law shall not be treated as offering more pro-
7 tection to consumers than the protection offered by
8 such requirements if the State law imposes ratios
9 that are greater than the ratios specified in section
10 2204(b).

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

17 “(d) AUTOMATIC ENROLLMENT.—A State may insti-
18 tute a program to provide that offerors of qualified health
19 benefit plans, small employers, and exchanges offering
20 qualified health benefits plans in the individual and small
21 group market within the State may automatically enroll
22 individuals and employees in, or continue enrollment of in-
23 dividuals in, qualified health benefit plans where appro-
24 priate to ensure coverage of the individuals. Any auto-
25 matic enrollment program shall include adequate notice

1 and the opportunity for an individual or employee to opt
2 out of any coverage the individual or employee were auto-
3 matically enrolled in.

4 “(e) CLAIMS REVIEW PROCESS.—Each State shall—

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

7 “(A) to provide an internal claims appeal
8 process;

9 “(B) to provide notice in clear language
10 and in the enrollee’s primary language of avail-
11 able internal and external appeals processes and
12 the availability of the ombudsman established
13 under section 2229(a) to assist them with the
14 appeals processes; and

15 “(C) to allow an enrollee to review their
16 file, to present evidence and testimony as part
17 of the appeals process, and to receive continued
18 coverage pending the outcome of the appeals
19 process;

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

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

3 “(f) APPLICABLE STATE AUTHORITY.—In this title,
4 the term ‘applicable State authority’ means the State in-
5 surance commissioner or official or officials designated by
6 the State to enforce the requirements of this title for the
7 State involved.

8 **“SEC. 2226. WAIVER OF HEALTH INSURANCE REFORM RE-**
9 **QUIREMENTS.**

10 “(a) APPLICATION.—A State may apply to the Sec-
11 retary for the waiver of all or any requirements under this
12 title and section 5000A of the Internal Revenue Code of
13 1986 with respect to health insurance coverage within that
14 State for plan years beginning on or after July 1, 2015.
15 Such application shall—

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

18 “(2) contain such information as the Secretary
19 may require, including—

20 “(A) a comprehensive description of the
21 State legislation or program for implementing a
22 plan meeting the requirements for a waiver
23 under this section; and

1 “(B) a 10-year budget plan for such plan
2 that is budget neutral for the Federal govern-
3 ment.

4 “(b) GRANTING OF WAIVERS.—The Secretary may
5 grant a request for a waiver under this section if the Sec-
6 retary determines that—

7 “(1) the State plan to provide health care cov-
8 erage to its residents provides coverage that is at
9 least as comprehensive as the coverage required
10 under a qualified health benefits plan offered
11 through exchanges established under this title; and

12 “(2) the State plan to provide health care cov-
13 erage to its residents will lower the growth in health
14 care spending, will improve delivery system perform-
15 ance, will provide affordable choices for its citizens,
16 will expand protection against excessive out-of-pock-
17 et spending, will provide coverage to the same num-
18 ber of uninsured as the provisions of this title will
19 provide, and will not increase the Federal deficit.

20 “(c) SCOPE OF WAIVER.—

21 “(1) IN GENERAL.—The Secretary shall deter-
22 mine the scope of a waiver granted to a State under
23 this section, including which Federal laws and re-
24 quirements will not apply to the State under the
25 waiver.

1 “(2) LIMITATION.—The Secretary may not
2 waive under this section any Federal law or require-
3 ment that is not within the authority of the Sec-
4 retary.

5 “(d) DETERMINATIONS BY SECRETARY.—

6 “(1) TIME FOR DETERMINATION.—The Sec-
7 retary shall make a determination under this section
8 not later than 180 days after the receipt of an appli-
9 cation from a State under subsection (a).

10 “(2) EFFECT OF DETERMINATION.—

11 “(A) GRANTING OF WAIVERS.—If the Sec-
12 retary determines to grant a waiver under this
13 section, the Secretary shall notify the State in-
14 volved of such determination and the terms and
15 effectiveness of such waiver.

16 “(B) DENIAL OF WAIVER.—If the Sec-
17 retary determines a waiver should not be grant-
18 ed under this section, the Secretary shall notify
19 the State involved, and the appropriate commit-
20 tees of Congress of such determination and the
21 reasons therefor.

22 **“SEC. 2227. PROVISIONS RELATING TO OFFERING OF PLANS**
23 **IN MORE THAN ONE STATE.**

24 “(a) HEALTH CARE CHOICE COMPACTS.—

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

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

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

15 “(i) would continue to be subject to
16 market conduct, unfair trade practices,
17 network adequacy, and consumer protec-
18 tion standards, including addressing dis-
19 putes as to the performance of the con-
20 tract, of the State in which the purchaser
21 resides;

22 “(ii) would be required to be licensed
23 in each State in which it offers the plan
24 under the compact or to submit to the ju-
25 risdiction of each such State with regard to

1 the standards described in clause (i) (in-
2 cluding allowing access to records as if the
3 insurer were licensed in the State); and

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

8 If the NAIC does not promulgate the model rules by
9 July 1, 2012, the Secretary shall, not later than
10 July 1, 2013, establish a Federal standard imple-
11 menting such rules.

12 “(2) STATE AUTHORITY.—A State may not
13 enter into an agreement under this subsection unless
14 the State enacts a law after the date of the enact-
15 ment of this title that specifically authorizes the
16 State to enter into such agreements.

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

20 “(b) AUTHORITY FOR NATIONWIDE PLANS.—

21 “(1) IN GENERAL.—Notwithstanding section
22 2225(e)(1), and except as provided in paragraph (2),
23 if an offeror of a qualified health benefits plan in the
24 individual or small group market meets the require-
25 ments of this subsection—

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

4 “(B) any State law mandating benefit cov-
5 erage by a health benefits plan shall not apply
6 to the qualified health benefits plan.

7 “(2) STATE OPT-OUT.—A State may, by spe-
8 cific reference in a law enacted after the date of en-
9 actment of this title, provide that this subsection
10 shall not apply to that State. Such opt-out shall be
11 effective until such time as the State by law revokes
12 it.

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

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

20 “(B) the offeror is licensed in each State
21 in which it offers the plan and is subject in
22 such State to the standards and requirements
23 described in the last sentence of section
24 2225(c)(1);

1 “(C) the offeror meets all requirements of
2 this title with respect to a qualified health bene-
3 fits plan, including the requirement to offer the
4 silver and gold levels of the plan in each ex-
5 change in the State for the market in which the
6 plan is offered; and

7 “(D) the offeror determines the premiums
8 for the plan in any State on the basis of the
9 ratings rules in effect in that State for the rat-
10 ings areas in which it is offered.

11 “(4) APPLICABLE REGULATIONS.—

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

18 “(i) the implementation of benefit cat-
19 egories, taking into account how each ben-
20 efit is offered in a majority of States; and

21 “(ii) harmonization between applicable
22 State authorities of State insurance regula-
23 tions relating to filing of forms and the fil-
24 ing of premium rates.

1 If the NAIC does not promulgate the model
2 rules by December 31, 2012, the Secretary
3 shall, not later than December 31, 2013, estab-
4 lish a Federal standard implementing such
5 rules.

6 “(B) STATE ACTION.—Each State (other
7 than a State described in paragraph (2)) shall
8 include the provisions described in subpara-
9 graph (A) in the Model Regulation, Federal
10 standard, or State law or regulation the State
11 adopts and has in effect under section
12 2225(a)(2).

13 **“SEC. 2228. STATE FLEXIBILITY TO ESTABLISH BASIC**
14 **HEALTH PROGRAMS FOR LOW-INCOME INDI-**
15 **VIDUALS NOT ELIGIBLE FOR MEDICAID.**

16 “(a) ESTABLISHMENT OF PROGRAM.—

17 “(1) IN GENERAL.—The Secretary shall estab-
18 lish a basic health program meeting the require-
19 ments of this section under which a State may enter
20 into contracts to offer 1 or more standard health
21 plans providing at least an essential benefits package
22 described in section 2242 to eligible individuals in
23 lieu of offering such individuals coverage through an
24 exchange established under part B.

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

7 “(II) the cost-sharing required
8 under a gold plan in the case of an el-
9 igible individual; and

10 “(B) the benefits provided under the
11 standard health plans offered through the pro-
12 gram cover at least benefits required under an
13 essential benefits package described in section
14 2242.

15 For purposes of subparagraph (A)(i), the amount of
16 the monthly premium an individual is required to
17 pay under either the standard health plan or the ap-
18 plicable second lowest cost silver plan shall be deter-
19 mined after reduction for any premium credits and
20 premium subsidies allowable with respect to either
21 plan.

22 “(b) STANDARD HEALTH PLAN.—In this section, the
23 term ‘standard health plan’ means a health benefits plan
24 that the State contracts with under this section—

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

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

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

9 “(c) CONTRACTING PROCESS.—

10 “(1) IN GENERAL.—A State basic health pro-
11 gram shall establish a competitive process for enter-
12 ing into contracts with standard health plans under
13 subsection (a), including negotiation of premiums
14 and cost-sharing and negotiation of benefits in addi-
15 tion to those required by an essential benefits pack-
16 age described in section 2242.

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

20 “(A) INNOVATION.—Negotiation with
21 offerors of a standard health plan for the inclu-
22 sion of innovative features in the plan, includ-
23 ing—

1 “(i) care coordination and care man-
2 agement for enrollees, especially for those
3 with chronic health conditions;

4 “(ii) incentives for use of preventive
5 services; and

6 “(iii) the establishment of relation-
7 ships between providers and patients that
8 maximize patient involvement in health
9 care decision-making, including providing
10 incentives for appropriate utilization under
11 the plan.

12 “(B) HEALTH AND RESOURCE DIF-
13 FERENCES.—Consideration of, and the making
14 of suitable allowances for, differences in health
15 care needs of enrollees and differences in local
16 availability of, and access to, health care pro-
17 viders. Nothing in this subparagraph shall be
18 construed as allowing discrimination on the
19 basis of pre-existing condition or other health
20 status-related factors.

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

1 “(D) PERFORMANCE MEASURES.—Estab-
2 lishing specific performance measures and
3 standards for offerors of standard health plans
4 that focus on quality of care and improved
5 health outcomes, requiring such plan to report
6 to the State with respect to the measures and
7 standards, and making the performance and
8 quality information available to enrollees in a
9 useful form.

10 “(3) ENHANCED AVAILABILITY.—

11 “(A) MULTIPLE PLANS.—A State shall, to
12 the maximum extent feasible, seek to make
13 multiple standard health plans available to eligi-
14 ble individuals within a State to ensure individ-
15 uals have a choice of such plans.

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

21 “(4) COORDINATION WITH OTHER STATE PRO-
22 GRAMS.—A State shall, to the maximum extent fea-
23 sible, seek to coordinate the administration of, and
24 provision of benefits under, its program under this
25 section with the State medicaid program under title

1 XIX, the State child health plan under title XXI,
2 and other State-administered health programs to
3 maximize the efficiency of such programs and to im-
4 prove the continuity of care.

5 “(d) TRANSFER OF FUNDS TO STATES.—

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

13 “(2) USE OF FUNDS.—A State shall establish a
14 trust for the deposit of the amounts received under
15 paragraph (1) and amounts in the trust fund shall
16 only be used to reduce the premiums and cost-shar-
17 ing of, or to provide additional benefits for, eligible
18 individuals enrolled in standard health plans within
19 the State. Amounts in the trust fund, and expendi-
20 tures of such amounts, shall not be included in de-
21 termining the amount of any non-Federal funds for
22 purposes of meeting any matching or expenditure re-
23 quirement of any federally-funded program.

24 “(3) AMOUNT OF PAYMENT.—

25 “(A) SECRETARIAL DETERMINATION.—

1 “(4) APPLICATION OF ABORTION COVERAGE RE-
2 QUIREMENTS.—The rules of section 2245 shall apply
3 to a State basic health program, and to standard
4 health plans offered through such program, in the
5 same manner as such rules apply to qualified basic
6 health benefits plans.

7 “(e) ELIGIBLE INDIVIDUAL.—

8 “(1) IN GENERAL.—In this section, the term
9 ‘eligible individual’ means, with respect to any State,
10 an individual—

11 “(A) who a resident of the State who is
12 not eligible to enroll in the State’s medicaid
13 program under title XIX for benefits that at a
14 minimum consist of the essential benefits pack-
15 age described in section 2242;

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

19 “(C) who is not eligible for essential health
20 benefits coverage (as defined in section
21 5000A(f)) or is eligible for an employer-spon-
22 sored plan that is not affordable coverage (as
23 determined under section 5000A(e)(2)); and

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

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

5 “(2) ELIGIBLE INDIVIDUALS MAY NOT USE EX-
6 CHANGE.—An eligible individual shall not be treated
7 as a qualified individual under section 2223 eligible
8 for enrollment in a qualified health benefits plan of-
9 fered through an exchange established under part B.

10 “(f) SECRETARIAL OVERSIGHT.—The Secretary shall
11 each year conduct a review of each State program to en-
12 sure compliance with the requirements of this section, in-
13 cluding ensuring that the State program meets—

14 “(1) eligibility verification requirements for par-
15 ticipation in the program;

16 “(2) the requirements for use of Federal funds
17 received by the program; and

18 “(3) the quality and performance standards
19 under this section.

20 “(g) STANDARD HEALTH PLAN OFFERORS.—A
21 State may provide that persons eligible to offer standard
22 health plans under a basic health program established
23 under this section may include a licensed health mainte-
24 nance organization, a licensed health insurance insurer, or

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

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

7 **“Subpart 5—Other Definitions and Rules**

8 **“SEC. 2230. OTHER DEFINITIONS AND RULES.**

9 “(a) EMPLOYERS.—In this title:

10 “(1) LARGE EMPLOYER.—The term ‘large em-
11 ployer’ means, in connection with a group health
12 plan with respect to a calendar year and a plan year,
13 an employer who employed an average of at least
14 101 employees on business days during the pre-
15 ceding calendar year and who employs at least 1 em-
16 ployee on the first day of the plan year.

17 “(2) SMALL EMPLOYER.—The term ‘small em-
18 ployer’ means, in connection with a group health
19 plan with respect to a calendar year and a plan year,
20 an employer who employed an average of at least 1
21 but not more than 100 employees on business days
22 during the preceding calendar year and who employs
23 at least 1 employee on the first day of the plan year.

24 Unless an employer elects otherwise, if an employer
25 is treated as a small employer for any plan year to

1 which this title applies, then such employer shall
2 continue to be treated as a small employer for any
3 subsequent plan year even if the number of employ-
4 ees exceeds the number in effect under this subpara-
5 graph.

6 “(3) STATE OPTION TO TREAT 50 EMPLOYEES
7 AS SMALL.—In the case of plan years beginning be-
8 fore January 1, 2015, a State may elect to apply
9 this subsection by substituting ‘51 employees’ for
10 ‘101 employees’ in paragraph (1) and by sub-
11 stituting ‘50 employees’ for ‘100 employees’ in para-
12 graph (2).

13 “(4) RULES FOR DETERMINING EMPLOYER
14 SIZE.—For purposes of this subsection—

15 “(A) APPLICATION OF AGGREGATION RULE
16 FOR EMPLOYERS.—All persons treated as a sin-
17 gle employer under subsection (b), (c), (m), or
18 (o) of section 414 of the Internal Revenue Code
19 of 1986 shall be treated as 1 employer.

20 “(B) EMPLOYERS NOT IN EXISTENCE IN
21 PRECEDING YEAR.—In the case of an employer
22 which was not in existence throughout the pre-
23 ceding calendar year, the determination of
24 whether such employer is a small or large em-
25 ployer shall be based on the average number of

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

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

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

8 “(1) 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 “(2) PLAN YEAR.—The term ‘plan year’
13 means—

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

16 “(B) with respect to another health bene-
17 fits plan, the calendar year, the 12-month pe-
18 riod beginning on July 1 of each year, or such
19 other 12-month period as may be specified by
20 the Secretary.”.

1 **Subtitle B—Exchanges and**
2 **Consumer Assistance**

3 **SEC. 1101. ESTABLISHMENT OF QUALIFIED HEALTH BENE-**
4 **FITS PLAN EXCHANGES.**

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

8 **“PART B—EXCHANGE AND CONSUMER**
9 **ASSISTANCE**

10 **“Subpart 1—Individuals and Small Employers**
11 **Offered Affordable Choices**

12 **“SEC. 2231. RIGHTS AND RESPONSIBILITIES REGARDING**
13 **CHOICE OF COVERAGE THROUGH EXCHANGE.**

14 “(a) RIGHT TO ENROLL THROUGH AN EXCHANGE.—

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

22 “(2) QUALIFIED SMALL EMPLOYERS.—

23 “(A) IN GENERAL.—In the case of a quali-
24 fied small employer—

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

8 “(ii) each employee of such employer
9 shall have the choice to enroll or to not en-
10 roll in a qualified health benefits plan of-
11 fered through such exchange.

12 If a qualified small employer elects to limit the
13 qualified health benefits plans or levels of cov-
14 erage under part C that employees may enroll
15 in through such exchange, employees may only
16 choose to enroll in those plans or plans in those
17 levels.

18 “(B) SELF-INSURED PLANS.—If a quali-
19 fied small employer offers its employees cov-
20 erage under a self-insured health benefits plan,
21 the employer may not offer its employees quali-
22 fied health benefits plans through an exchange.

23 “(3) MEMBERS OF CONGRESS AND CONGRES-
24 SIONAL STAFF REQUIRED TO PARTICIPATE IN EX-
25 CHANGE.—

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

4 “(i) each Member of Congress and
5 Congressional employee shall be treated as
6 a qualified individual entitled to the right
7 under this paragraph to enroll in a quali-
8 fied health benefits plan in the individual
9 market offered through an exchange in the
10 State in which the Member or employee re-
11 sides; and

12 “(ii) any employer contribution under
13 such chapter on behalf of the Member or
14 employee may be paid only to the offeror
15 of a qualified health benefits plan in which
16 the Member or employee enrolled in
17 through such exchange and not to the of-
18 feror of a plan offered through the Federal
19 employees health benefit program under
20 such chapter.

21 “(B) PAYMENTS BY FEDERAL GOVERN-
22 MENT.—The Secretary, in consultation with the
23 Director of the Office of Personnel Manage-
24 ment, shall establish procedures under which—

1 “(i) the employer contributions on be-
2 half of a Member or Congressional em-
3 ployee are actuarially adjusted for age; and

4 “(ii) the employer contributions may
5 be made directly to an exchange for pay-
6 ment to an offeror.

7 “(C) CONGRESSIONAL EMPLOYEE.—In this
8 paragraph, the term ‘Congressional employe’
9 means an employee whose pay is disbursed by
10 the Secretary of the Senate or the Clerk of the
11 House of Representatives.

12 “(b) RESPONSIBILITY OF OFFERORS OF QUALIFIED
13 HEALTH BENEFITS PLANS.—

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

17 “(A) shall offer the plan through the ex-
18 change established by the State for the market
19 in which the plan is being offered; and

20 “(B) may offer such plan outside of an ex-
21 change.

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

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

5 “(B) may offer 1 or more qualified health
6 benefits plan in the bronze and platinum cov-
7 erage levels, a catastrophic plan described in
8 section 2243(c), or a child-only plan described
9 in section 2243(d).

10 “(c) RESPONSIBILITY OF EXCHANGES.—

11 “(1) IN GENERAL.—Each exchange offering
12 plans in the individual or small group market within
13 a State shall offer all qualified health benefits plans
14 in the State that are licensed by the State to be of-
15 fered in that market.

16 “(2) OFFERING OF STAND-ALONE DENTAL
17 BENEFITS.—

18 “(A) IN GENERAL.—Each exchange within
19 a State shall allow an offeror of a health bene-
20 fits plan that only provides limited scope dental
21 benefits meeting the requirements of section
22 9832(c)(2)(A) of the Internal Revenue Code of
23 1986 to offer the plan through the exchange
24 (either separately or in conjunction with a
25 qualified health benefits plan) if the plan pro-

1 vides pediatric dental benefits meeting the re-
2 quirements of 2242(b)(11) for individuals who
3 have not attained the age of 21.

4 “(B) ELIGIBILITY FOR CREDIT AND SUB-
5 SIDY.—If an individual enrolls in both a quali-
6 fied health benefits plan and a plan described
7 in subparagraph (A) for any plan year, the por-
8 tion of the premium for the plan described in
9 subparagraph (A) that (under regulations pre-
10 scribed by the Secretary) is properly allocable
11 to individuals covered by the plan who have not
12 attained the age of 21 before the beginning of
13 the plan year shall be treated as a premium
14 payable for a qualified health benefits plan for
15 purposes of determining the amount of the pre-
16 mium credit under section 36B of such Code
17 and cost-sharing subsidies under section 2237
18 with respect to the plan year.

19 “(d) ENROLLMENT THROUGH AGENTS OR BRO-
20 KERS.—The Secretary shall establish procedures under
21 which a State is required to allow agents or brokers—

22 “(1) to enroll individuals in any qualified health
23 benefits plans in the individual or small group mar-
24 ket as soon as the plan is offered through an ex-
25 change in the State; and

1 “(2) to assist individuals in applying for pre-
2 mium credits and cost-sharing subsidies for plans
3 sold through an exchange.

4 **“SEC. 2232. QUALIFIED INDIVIDUALS AND SMALL EMPLOY-**
5 **ERS; ACCESS LIMITED TO CITIZENS AND LAW-**
6 **FUL RESIDENTS.**

7 “(a) QUALIFIED INDIVIDUALS.—In this title:

8 “(1) IN GENERAL.—The term ‘qualified indi-
9 vidual’ means, with respect to an exchange, an indi-
10 vidual who—

11 “(A) is seeking to enroll in a qualified
12 health benefits plan in the individual market of-
13 fered through the exchange; and

14 “(B) resides in the State that established
15 the exchange.

16 “(2) INCARCERATED INDIVIDUALS EX-
17 CLUDED.—An individual shall not be treated as a
18 qualified individual if, at the time of enrollment, the
19 individual is incarcerated, other than incarceration
20 pending the disposition of charges.

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

1 lished under this subtitle that offers qualified health bene-
2 fits plans in the small group market.

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

9 “(1) the individual shall not be treated as a
10 qualified individual and may not be covered under a
11 qualified health benefits plan in the individual mar-
12 ket that is offered through an exchange; and

13 “(2) if the individual is an employee of a quali-
14 fied small employer offering employees the oppor-
15 tunity to enroll in a qualified health benefits plan in
16 the small group market through an exchange (or an
17 individual bearing a relationship to such an em-
18 ployee that entitles such individual to coverage
19 under such plan), the individual may not be covered
20 under such plan.

21 **“Subpart 2—Establishment of Exchanges**

22 **“SEC. 2235. ESTABLISHMENT OF EXCHANGES BY STATES.**

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

1 “(1) an exchange for the State that is designed
2 to facilitate the enrollment of qualified individuals in
3 qualified health benefits plans offered in the indi-
4 vidual market in the State; and

5 “(2) a Small Business Health Options Program
6 (in this title referred to as a ‘SHOP exchange’) that
7 is designed to assist qualified small employers in fa-
8 cilitating the enrollment of their employees in quali-
9 fied health benefits plans offered in either the indi-
10 vidual or the small group market in the State.

11 “(b) STATE FLEXIBILITY.—

12 “(1) MERGER OF INDIVIDUAL AND SHOP EX-
13 CHANGES.—A State may elect to provide only one
14 exchange in the State for providing both exchange
15 and SHOP exchange services to both qualified indi-
16 viduals and qualified small employers, but only if the
17 exchange has separate resources to assist individuals
18 and employers.

19 “(2) REGIONAL EXCHANGES.—An exchange or
20 SHOP exchange may operate in more than 1 State
21 if—

22 “(A) each of the States agrees to the oper-
23 ation of the exchange in that State; and

24 “(B) the Secretary approves of the oper-
25 ation of the exchange in all such States.

1 “(3) AUTHORITY TO CONTRACT FOR EXCHANGE
2 SERVICES.—

3 “(A) CONTRACT WITH SUB-EXCHANGE.—
4 Subject to such conditions and restrictions as
5 the Secretary, in consultation with the Sec-
6 retary of the Treasury, may prescribe under
7 sections 2238 and 2248—

8 “(i) IN GENERAL.—A State may elect
9 to authorize an exchange established by
10 the State under this title to contract with
11 an eligible entity to carry out 1 or more re-
12 sponsibilities of the exchange, including
13 marketing and sale of qualified health ben-
14 efits plans offered by the exchange, enroll-
15 ment activities, broker relations, customer
16 service, customer education, premium bill-
17 ing and collection, member advocacy with
18 qualified health benefits plans, maintaining
19 call center support, and performing the du-
20 ties of the exchange under section 2238 in
21 determining eligibility to participate in the
22 exchange and to receive any credit or sub-
23 sidy. An eligible entity may charge an ad-
24 ditional fee to be used to pay the adminis-

1 trative and operational expenses of the en-
2 tity.

3 “(ii) ELIGIBLE ENTITY.—In this sub-
4 paragraph, the term ‘eligible entity’ means
5 a person—

6 “(I) incorporated under, and sub-
7 ject to the laws of, 1 or more States;

8 “(II) that has demonstrated ex-
9 perience on a State or regional basis
10 in the individual and small group
11 health insurance and benefits cov-
12 erage; and

13 “(III) that is not a health insur-
14 ance issuer or that is treated under
15 subsection (a) or (b) of section 52 as
16 a member of the same controlled
17 group of corporations (or under com-
18 mon control with) a health insurance
19 issuer.

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

1 section in establishing the eligibility of individ-
2 uals to participate in the exchange and to re-
3 ceive the premium credit under section 36B of
4 the Internal Revenue Code of 1986 and the
5 cost-sharing subsidy under section 2247. An ex-
6 change may enter into an agreement under this
7 subparagraph only if the agreement meets re-
8 quirements promulgated by the Secretary (after
9 consultation with the Secretary of the Treas-
10 ury) ensuring that the agreement lowers overall
11 administrative costs and reduces the likelihood
12 of eligibility errors and disruptions in coverage.

13 “(c) ESTABLISHMENT OF BROKER RATE SCHED-
14 ULES.—Each State shall provide for the establishment of
15 rate schedules for broker commissions paid by health ben-
16 efits plans offered through an exchange.

17 “(d) OFFERING OF PLANS IN LARGE GROUP MAR-
18 KET.—Beginning in 2017, each State may allow offerors
19 of health benefits plans in the large group market in the
20 State to offer the plans through an exchange. Nothing in
21 this subsection shall be construed as requiring an offeror
22 to offer such plans through an exchange.

23 “(e) INTERIM EXCHANGES BEFORE QUALIFIED
24 PLANS.—

1 “(1) IN GENERAL.—Each State shall, as soon
2 as practicable after the date of enactment of this
3 Act, establish an exchange through which enrollment
4 in eligible health insurance coverage is offered for
5 coverage during the period beginning January 1,
6 2010, and ending June 30, 2013. Each State may
7 use the database established under paragraph
8 (2)(C)(ii) in the operation of the exchange.

9 “(2) ELIGIBLE HEALTH INSURANCE COV-
10 ERAGE.—In this subsection:

11 “(A) IN GENERAL.—The term ‘eligible
12 health insurance coverage’ means, with respect
13 to any State, any health insurance coverage
14 meeting the requirements of section 2244 which
15 is offered—

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

18 “(ii) in the individual or small group
19 markets within the State.

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

1 “(C) ADMINISTRATION.—

2 “(i) IN GENERAL.—The Secretary
3 shall provide technical assistance to each
4 State in establishing exchanges under this
5 subsection.

6 “(ii) DATABASE OF PLAN OFFER-
7 INGS.—The Secretary, either directly or by
8 grant or contract with a private entity,
9 shall establish and maintain a database of
10 health insurance coverage in the individual
11 and small group markets. The Secretary
12 shall ensure that individuals and small em-
13 ployers are able to access the information
14 in the database that is specific to the State
15 in which the individuals and employees re-
16 side.

17 **“SEC. 2236. FUNCTIONS PERFORMED BY SECRETARY,**
18 **STATES, AND EXCHANGES.**

19 “(a) AGREEMENTS TO PERFORM FUNCTIONS.—The
20 Secretary shall enter into an agreement with each State
21 (in this section referred to as the ‘agreement’) setting
22 forth which of the functions described in this section with
23 respect to an exchange shall be performed by the Sec-
24 retary, the State, or the exchange.

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

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

9 “(1) OUTREACH.—

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

17 “(B) CALL CENTERS.—The establishment
18 and maintenance of call centers to provide in-
19 formation to, and answer questions from, indi-
20 viduals seeking to enroll in qualified health ben-
21 efit plans through an exchange, including pro-
22 viding multilingual assistance and mailing of
23 relevant information to individuals based on
24 their inquiry and zip code.

1 “(C) INTERNET PORTALS.—The develop-
2 ment of a model template for an Internet portal
3 to be used to direct qualified individuals and
4 qualified small employers to qualified health
5 benefits plans, to assist individuals and employ-
6 ers in determining whether they are eligible to
7 participate in an exchange or eligible for a pre-
8 mium credit or cost-sharing subsidy, and to
9 present standardized information regarding
10 qualified health benefits plans offered through
11 an exchange to enable easier consumer choice.
12 Such template shall include with respect to each
13 qualified health benefits plan offered through
14 the exchange in each rating area access to the
15 uniform outline of coverage the plan is required
16 to provide under section 2205 and to a copy of
17 the plan’s policy.

18 “(D) RATING SYSTEM.—The establishment
19 of a rating system that would rate qualified
20 health benefits plans offered through an ex-
21 change on the basis of the relative quality and
22 price of plans in the same benefit level. The ex-
23 change shall include the quality rating in the
24 information provided to individuals and employ-

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

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

5 “(A) individuals or employers are qualified
6 individuals or qualified small employers eligible
7 to participate in the exchange; and

8 “(B) an individual is disqualified from par-
9 ticipation in the exchange or from receiving any
10 premium credit or cost-sharing subsidy because
11 the individual is not, or is not reasonably ex-
12 pected to be for the entire plan year for which
13 enrollment is sought, a citizen or national of the
14 United States, an alien lawfully admitted to the
15 United States for permanent residence, or an
16 alien lawfully present in the United States.

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

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

22 “(A) through enrollment in local hospitals
23 and schools, State motor vehicle offices, local
24 Social Security offices, locations operated by In-
25 dian tribes and tribal organizations, and any

1 other accessible locations specified by the ex-
2 change; and

3 “(B) through use of the call center and
4 Web portal established under subsection (c)(1);
5 “(2) provides for—

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

8 “(B) annual open enrollment periods from
9 March 1 through May 31 of subsequent cal-
10 endar years;

11 “(C) special enrollment periods specified in
12 section 9801 of the Internal Revenue Code of
13 1986 and other special enrollment periods
14 under circumstances similar to such periods
15 under part D of title XVIII; and

16 “(D) special monthly enrollment periods
17 for Indians (as defined in section 4 of the In-
18 dian Health Care Improvement Act).

19 “(3) subject to section 2239—

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

1 Association of Insurance Commissioners devel-
2 ops and submits to the Secretary; and

3 “(B) informs individuals of eligibility re-
4 quirements for the medicaid program under
5 title XIX, the CHIP program under title XXI,
6 or any applicable State or local public program
7 and refers individuals to such programs if a de-
8 termination is made that the individuals are so
9 eligible;

10 “(4) establishes standardized marketing re-
11 quirements that are based on the standards used for
12 Medicare Advantage plans and ensures that mar-
13 keting practices with respect to qualified health ben-
14 efits plans offered through the exchange meet the re-
15 quirements; and

16 “(5) provides for a standardized format for pre-
17 senting health benefits plan options in the exchange,
18 including use of the uniform outline of coverage es-
19 tablished under section 1503 of the America’s
20 Healthy Future Act of 2009.

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

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

3 “(f) CERTIFICATION OF EXEMPTION FROM INDI-
4 VIDUAL RESPONSIBILITY EXCISE TAX.—Subject to sec-
5 tion 2238, the agreement shall establish procedures for—

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

12 “(A) there is no affordable qualified health
13 benefits plan available through the exchange, or
14 the individual’s employer, covering the indi-
15 vidual; or

16 “(B) the individual meets the requirements
17 for any other such exemption from the indi-
18 vidual responsibility requirement or tax; and

19 “(2) transferring to the Secretary of the Treas-
20 ury or the Secretary’s delegate a list of the individ-
21 uals who are so exempt.

22 The Secretary shall establish the period for which any cer-
23 tification under this subsection is in effect.

1 **“SEC. 2237. DUTIES OF THE SECRETARY TO FACILITATE EX-**
2 **CHANGES.**

3 “(a) CREDIT AND SUBSIDY DETERMINATIONS.—The
4 Secretary and the Secretary of the Treasury shall carry
5 out the responsibilities under section 2248 (relating to ad-
6 vance determination and payment of premium credit and
7 cost-sharing subsidies) that are delegated specifically to
8 the Secretary and the Secretary of the Treasury.

9 “(b) SHOP EXCHANGE ASSISTANCE.—The Sec-
10 retary shall designate an office within the Department of
11 Health and Human Services to provide technical assist-
12 ance to States to facilitate the participation of qualified
13 small businesses in SHOP exchanges.

14 “(c) FUNDING OF START-UP COSTS.—

15 “(1) IN GENERAL.—The Secretary shall pay to
16 each State the amount the Secretary reasonably esti-
17 mates to be the unreimbursed start-up costs for any
18 exchange or SHOP exchange established within a
19 State. The Secretary shall make separate payments
20 for the start-up costs of the interim and permanent
21 exchanges.

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

1 fied health benefits plan offered through the ex-
2 change its proportional share of such costs.

3 **“SEC. 2238. PROCEDURES FOR DETERMINING ELIGIBILITY**
4 **FOR EXCHANGE PARTICIPATION, PREMIUM**
5 **CREDITS AND COST-SHARING SUBSIDIES,**
6 **AND INDIVIDUAL RESPONSIBILITY EXEMP-**
7 **TIONS.**

8 “(a) IN GENERAL.—The Secretary shall establish a
9 program meeting the requirements of this section for de-
10 termining—

11 “(1) whether an individual who is to be covered
12 by a qualified health benefits plan offered through
13 an exchange, or who is claiming a premium credit or
14 cost-sharing subsidy, meets the requirements of sec-
15 tions 2236(c)(2)(B) and 2247(e) of this title and
16 section 36B(e) of the Internal Revenue Code of
17 1986 that the individual be a citizen or national of
18 the United States, an alien lawfully admitted to the
19 United States for permanent residence, or an alien
20 lawfully present in the United States;

21 “(2) in the case of an individual claiming a pre-
22 mium credit or cost-sharing subsidy under section
23 36B of such Code or section 2247—

1 “(A) whether the individual meets the in-
2 come and coverage requirements of such sec-
3 tions; and

4 “(B) the amount of the credit or subsidy;

5 “(3) whether an individual’s coverage under an
6 employer-sponsored health benefits plan is treated as
7 unaffordable under sections 36B(c)(2)(C),
8 4980H(c)(2), and 5000A(e)(2); and

9 “(4) whether to grant a certification under sec-
10 tion 2237(f) attesting that, for purposes of the indi-
11 vidual responsibility excise tax under section 5000A
12 of the Internal Revenue Code of 1986, an individual
13 is entitled to an exemption from either the individual
14 responsibility requirement or the tax imposed by
15 such section.

16 “(b) INFORMATION REQUIRED TO BE PROVIDED BY
17 APPLICANTS.—

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

21 “(A) the name, address, and date of birth
22 of each individual who is to be covered by the
23 plan (in this subsection referred to as an ‘en-
24 rollee’); and

1 “(B) the information required by any of
2 the following paragraphs that is applicable to
3 an enrollee.

4 “(2) CITIZENSHIP OR IMMIGRATION STATUS.—
5 The following information shall be provided with re-
6 spect to every enrollee:

7 “(A) In the case of an enrollee whose eligi-
8 bility is based on an attestation of citizenship of
9 the enrollee, the enrollee’s social security num-
10 ber.

11 “(B) In the case of an individual whose eli-
12 gibility is based on an attestation of the enroll-
13 ee’s immigration status, the enrollee’s social se-
14 curity number (if applicable) and such identi-
15 fying information with respect to the enrollee’s
16 immigration status as the Secretary, after con-
17 sultation with the Secretary of Homeland Secu-
18 rity, determines appropriate.

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

24 “(A) INFORMATION REGARDING INCOME
25 AND FAMILY SIZE.—The information described

1 in section 6103(l)(21) for the taxable year end-
2 ing with or within the second calendar year pre-
3 ceding the calendar year in which the plan year
4 begins.

5 “(B) CHANGES IN CIRCUMSTANCES.—The
6 information described in section 2248(b)(2), in-
7 cluding information with respect to individuals
8 who were not required to file an income tax re-
9 turn for the taxable year described in subpara-
10 graph (A) or individuals who experienced
11 changes in marital status or family size or sig-
12 nificant reductions in income.

13 “(4) EMPLOYER-SPONSORED COVERAGE.—In
14 the case of an enrollee with respect to whom eligi-
15 bility for a premium credit under section 36B of
16 such Code or cost-sharing subsidy under section
17 2247, is being established on the basis that the en-
18 rollee’s (or related individual’s) employer is not
19 treated under section 36B(e)(2)(C) of such Code as
20 providing essential benefits coverage or affordable
21 essential benefits coverage, the following informa-
22 tion:

23 “(A) The name, address, and employer
24 identification number (if available) of the em-
25 ployer.

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

4 “(C) If the employer provides such essen-
5 tial benefits coverage, the lowest cost option for
6 the enrollee’s or individual’s enrollment status
7 and the enrollee’s or individual’s required con-
8 tribution (as defined in section 5000A(e)(2) of
9 such Code) under the employer-sponsored plan.

10 “(D) If an enrollee claims an employer’s
11 essential benefits coverage is unaffordable, the
12 information described in paragraph (3).

13 “(5) EXEMPTIONS FROM INDIVIDUAL RESPON-
14 SIBILITY REQUIREMENTS.—In the case of an indi-
15 vidual who is seeking an exemption certificate under
16 section 2237(f) from any requirement or tax im-
17 posed by section 5000A, the following information:

18 “(A) In the case of an individual seeking
19 exemption based on the individual’s status as a
20 member of an exempt religious sect or division,
21 as a member of a health care sharing ministry,
22 as an Indian, or as an individual eligible for a
23 hardship exemption, such information as the
24 Secretary shall prescribe.

1 “(B) In the case of an individual seeking
2 exemption based on the lack of affordable cov-
3 erage or the individual’s status as a taxpayer
4 with household income less than 100 percent of
5 the poverty line, the information described in
6 paragraphs (3) and (4), as applicable.

7 “(c) VERIFICATION OF INFORMATION CONTAINED IN
8 RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

9 “(1) INFORMATION TRANSFERRED TO SEC-
10 RETARY.—An exchange shall submit the information
11 provided by an applicant under subsection (b) to the
12 Secretary for verification in accordance with the re-
13 quirements of this subsection and subsection (d).

14 “(2) CITIZENSHIP OR IMMIGRATION STATUS.—

15 “(A) COMMISSIONER OF SOCIAL SECUR-
16 ITY.—The Secretary shall submit to the Com-
17 missioner of Social Security the following infor-
18 mation for a determination as to whether the
19 information provided is consistent with the in-
20 formation in the records of the Commissioner:

21 “(i) The name, date of birth, and so-
22 cial security number of each individual for
23 whom such information was provided
24 under subsection (b)(2).

1 “(ii) The attestation of an individual
2 that the individual is a citizen.

3 “(B) SECRETARY OF HOMELAND SECU-
4 RITY.—

5 “(i) IN GENERAL.—In the case of an
6 individual—

7 “(I) who attests that the indi-
8 vidual is an alien lawfully admitted to
9 the United States for permanent resi-
10 dence or an alien lawfully present in
11 the United States; or

12 “(II) who attests that the indi-
13 vidual is a citizen but with respect to
14 whom the Commissioner of Social Se-
15 curity has notified the Secretary
16 under subsection (e)(3) that the attes-
17 tation is inconsistent with information
18 in the records maintained by the
19 Commissioner;

20 the Secretary shall submit to the Secretary
21 of Homeland Security the information de-
22 scribed in clause (ii) for a determination as
23 to whether the information provided is con-
24 sistent with the information in the records
25 of the Secretary of Homeland Security.

1 “(ii) INFORMATION.—The information
2 described in clause (ii) is the following:

3 “(I) The name, date of birth, and
4 any identifying information with re-
5 spect to the individual’s immigration
6 status provided under subsection
7 (b)(2).

8 “(II) The attestation that the in-
9 dividual is an alien lawfully admitted
10 to the United States for permanent
11 residence or an alien lawfully present
12 in the United States or in the case of
13 an individual described in clause
14 (i)(II), the attestation that the indi-
15 vidual is a citizen.

16 “(3) ELIGIBILITY FOR CREDIT AND SUBSIDY.—
17 The Secretary shall submit the information de-
18 scribed in subsection (b)(3)(A) provided under para-
19 graph (3), (4), or (5) of subsection (b) to the Sec-
20 retary of the Treasury for verification of household
21 income and family size for purposes of eligibility.

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

1 Security, shall provide that verifications and deter-
2 minations under this subsection shall be done—

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

7 “(B) by determining the consistency of the
8 information submitted with the information
9 maintained in the records of the Secretary of
10 the Treasury, the Secretary of Homeland Secu-
11 rity, or the Commissioner of Social Security
12 through such other method as is approved by
13 the Secretary.

14 “(d) VERIFICATION BY SECRETARY.—In the case of
15 information provided under subsection (b) that is not sub-
16 ject to verification under subsection (c), the Secretary
17 shall verify the accuracy of such information in such man-
18 ner as the Secretary determines appropriate, including
19 delegating responsibility for verification to the exchange.

20 “(e) ACTIONS RELATING TO VERIFICATION.—

21 “(1) IN GENERAL.—Each person to whom the
22 Secretary provided information under subsection (c)
23 shall report to the Secretary under the method es-
24 tablished under subsection (c)(4) the results of its
25 verification and the Secretary shall notify the ex-

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

5 “(2) VERIFICATION.—

6 “(A) ELIGIBILITY FOR ENROLLMENT AND
7 SUBSIDIES.—If information provided by an ap-
8 plicant under paragraphs (1), (2), (3), and (4)
9 of subsection (b) is verified under subsections
10 (c) and (d)—

11 “(i) the individual’s eligibility to enroll
12 through the exchange and to apply for pre-
13 mium credits and cost-sharing subsidies
14 shall be satisfied; and

15 “(ii) the Secretary shall, if applicable,
16 notify the Secretary of the Treasury under
17 section 2248(e) of the amount of any ad-
18 vance payment to be made.

19 “(B) EXEMPTION FROM INDIVIDUAL RE-
20 SPONSIBILITY.—If information provided by an
21 applicant under subsection (b)(5) is verified
22 under subsections (c) and (d), the Secretary
23 shall issue the certification of exemption de-
24 scribed in section 2236(f).

1 “(3) INCONSISTENCIES.—If the information
2 provided by an applicant is inconsistent with infor-
3 mation in the records maintained by persons under
4 subsection (c) or is not verified under subsection (d),
5 the Secretary shall notify the exchange and the ex-
6 change shall take the following actions:

7 “(A) REASONABLE EFFORT.—The ex-
8 change shall make a reasonable effort to iden-
9 tify and address the causes of such inconsist-
10 ency, including through typographical or other
11 clerical errors, by contacting the applicant to
12 confirm the accuracy of the information, and by
13 taking such additional actions as the Secretary,
14 through regulation or other guidance, may iden-
15 tify.

16 “(B) NOTICE AND OPPORTUNITY TO COR-
17 RECT.—In the case the inconsistency or inabil-
18 ity to verify is not resolved under subparagraph
19 (A), the exchange shall—

20 “(i) notify the applicant of such fact;

21 “(ii) provide the applicant with a rea-
22 sonable period from the date on which the
23 notice required under clause (i) is received
24 by the applicant to either present satisfac-
25 tory documentary evidence or resolve the

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

3 “(4) SPECIFIC ACTIONS.—

4 “(A) CITIZENSHIP OR IMMIGRATION STA-
5 TUS.—If an inconsistency involving citizenship
6 or immigration status with respect to any en-
7 rollee is unresolved under this subsection, the
8 exchange shall notify the applicant that the en-
9 rollee is not eligible to participate in the ex-
10 change.

11 “(B) ELIGIBILITY OR AMOUNT OF CREDIT
12 OR SUBSIDY.—If an inconsistency involving the
13 eligibility for, or amount of, any credit or sub-
14 sidy is unresolved under this subsection, the ex-
15 change shall notify the applicant of the amount
16 (if any) of the credit or subsidy.

17 “(C) EMPLOYER AFFORDABILITY.—If the
18 Secretary notifies an exchange that an enrollee
19 is eligible for a premium credit under section
20 36B of such Code or cost-sharing subsidy under
21 section 2247 because the enrollee’s (or related
22 individual’s) employer does not provide essential
23 benefits coverage through an employer-spon-
24 sored plan or that the employer does provide
25 that coverage but it is not affordable coverage,

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

5 “(D) EXEMPTION.—In any case where the
6 inconsistency involving, or inability to verify, in-
7 formation provided under subsection (b)(5) is
8 not resolved, the exchange shall notify an appli-
9 cant that no certification of exemption from any
10 requirement or tax under section 5000A will be
11 issued.

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

16 “(f) APPEALS AND REDETERMINATIONS.—

17 “(1) IN GENERAL.—The Secretary, in consulta-
18 tion with the Secretary of the Treasury, the Sec-
19 retary of Homeland Security, and the Commissioner
20 of Social Security, shall establish procedures by
21 which the Secretary or one of such other Federal of-
22 ficers—

23 “(A) hears and makes decisions with re-
24 spect to appeals of any determination under
25 subsection (c); and

1 “(B) redetermines eligibility on a periodic
2 basis in appropriate circumstances.

3 “(2) EMPLOYER LIABILITY.—The Secretary
4 shall establish a separate appeals process for em-
5 ployers who are notified under subsection (e)(4)(C)
6 that the employer may be liable for the tax imposed
7 by section 4980H with respect to an employee be-
8 cause of a determination that the employer does not
9 provide essential benefits coverage through an em-
10 ployer-sponsored plan or that the employer does pro-
11 vide that coverage but it is not affordable coverage
12 with respect to an employee. Such process shall pro-
13 vide an employer the opportunity to—

14 “(A) present information to the exchange
15 for review of the determination either by the ex-
16 change or the person making the determination,
17 including evidence of the employer-sponsored
18 plan and employer contributions to the plan;
19 and

20 “(B) have access to the data used to make
21 the determination to the extent allowable by
22 law.

23 Such process shall be in addition to any rights of ap-
24 peal the employer may have under subtitle F of the
25 Internal Revenue Code of 1986.

1 “(g) CONFIDENTIALITY OF APPLICANT INFORMA-
2 TION.—Any person who receives information provided by
3 an applicant under subsection (b), or receives information
4 from a Federal agency under subsection (c), (d), or (e)
5 shall—

6 “(1) use the information only for the purposes
7 of, and to the extent necessary in, ensuring the effi-
8 cient operation of the exchange, including verifying
9 the eligibility of an individual to enroll through an
10 exchange or to claim a premium credit or cost-shar-
11 ing subsidy or the amount of the credit or subsidy;
12 and

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

15 “(h) PENALTIES.—

16 “(1) FALSE OR FRAUDULENT INFORMATION.—

17 “(A) CIVIL PENALTY.—If—

18 “(i) any person fails to provides cor-
19 rect information under subsection (b); and

20 “(ii) such failure is attributable to
21 negligence or disregard of any rules or reg-
22 ulations of the Secretary,

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

1 respect to any failures involving an application
2 for a plan year. For purposes of this subpara-
3 graph, the terms ‘negligence’ and ‘disregard’
4 shall have the same meanings as when used in
5 section 6662 of the Internal Revenue Code of
6 1986.

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

13 “(2) IMPROPER USE OR DISCLOSURE OF INFOR-
14 MATION.—Any person who knowingly and willfully
15 uses or discloses information in violation of sub-
16 section (g) shall be guilty of a felony, and upon con-
17 viction thereof, shall be fined not more than
18 \$25,000, imprisoned for not more than 5 years, or
19 both.

20 **“SEC. 2239. STREAMLINING OF PROCEDURES FOR ENROLL-**
21 **MENT THROUGH AN EXCHANGE AND STATE**
22 **MEDICAID, CHIP, AND HEALTH SUBSIDY PRO-**
23 **GRAMS.**

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

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

5 “(b) REQUIREMENTS RELATING TO FORMS AND NO-
6 TICE.—

7 “(1) REQUIREMENTS RELATING TO FORMS.—

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

11 “(i) may be used to apply for all ap-
12 plicable State health subsidy programs
13 within the State;

14 “(ii) may be filed online, in person, by
15 mail, or by telephone;

16 “(iii) may be filed with an exchange
17 or with State officials operating one of the
18 other applicable State health subsidy pro-
19 grams; and

20 “(iv) is structured to maximize an ap-
21 plicant’s ability to complete the form satis-
22 factorily, taking into account the charac-
23 teristics of individuals who qualify for ap-
24 plicable State health subsidy programs.

1 “(B) STATE AUTHORITY TO ESTABLISH
2 FORM.—A State may develop and use its own
3 single, streamlined form as an alternative to the
4 form developed under subparagraph (A) if the
5 alternative form is consistent with standards
6 promulgated by the Secretary under this sec-
7 tion.

8 “(C) SUPPLEMENTAL ELIGIBILITY
9 FORMS.—The Secretary may allow a State to
10 use a supplemental or alternative form in the
11 case of individuals who apply for eligibility that
12 is not determined on the basis of the household
13 income (as defined in section 36B of the Inter-
14 nal Revenue Code of 1986).

15 “(2) NOTICE.—The Secretary shall provide that
16 an applicant filing a form under paragraph (1) shall
17 receive notice of eligibility for an applicable State
18 health subsidy program without any need to provide
19 additional information or paperwork unless such in-
20 formation or paperwork is specifically required by
21 law when information provided on the form is incon-
22 sistent with data used for the electronic verification
23 under paragraph (3) or is otherwise insufficient to
24 determine eligibility.

1 “(c) REQUIREMENTS RELATING TO ELIGIBILITY
2 BASED ON DATA EXCHANGES.—

3 “(1) DEVELOPMENT OF SECURE INTER-
4 FACES.—Each State shall develop for all applicable
5 State health subsidy programs a secure, electronic
6 interface allowing an exchange of data (including in-
7 formation contained in the application forms de-
8 scribed in subsection (b)) that allows a determina-
9 tion of eligibility for all such programs based on a
10 single application. Such interface shall be compatible
11 with the exchange method established for data
12 verification under section 2238(c)(4).

13 “(2) DATA MATCHING PROGRAM.—Each appli-
14 cable State health subsidy program shall participate
15 in a data matching arrangement for determining eli-
16 gibility for participation in the program under para-
17 graph (3) that—

18 “(A) provides access to data described in
19 paragraph (3);

20 “(B) applies only to individuals who—

21 “(i) receive assistance from an appli-
22 cable State health subsidy program; or

23 “(ii) apply for such assistance—

24 “(I) by filing a form described in
25 subsection (b); or

1 “(II) by requesting a determina-
2 tion of eligibility and authorizing dis-
3 closure of the information described in
4 paragraph (3) to applicable State
5 health coverage subsidy programs for
6 purposes of determining and estab-
7 lishing eligibility; and

8 “(C) consistent with standards promul-
9 gated by the Secretary, including the privacy
10 and data security safeguards described in sec-
11 tion 1946 or that are otherwise applicable to
12 such programs.

13 “(3) DETERMINATION OF ELIGIBILITY.—

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

17 “(i) establish, verify, and update eligi-
18 bility for participation in the program
19 using the data matching arrangement
20 under paragraph (2); and

21 “(ii) determine such eligibility on the
22 basis of reliable, third party data, includ-
23 ing information described in sections 1137,
24 453(i), and 1942(a), obtained through
25 such arrangement.

1 “(B) EXCEPTION.—This paragraph shall
2 not apply in circumstances with respect to
3 which the Secretary determines that the admin-
4 istrative and other costs of use of the data
5 matching arrangement under paragraph (2)
6 outweigh its expected gains in accuracy, effi-
7 ciency, and program participation.

8 “(4) SECRETARIAL STANDARDS.—The Sec-
9 retary shall, after consultation with persons in pos-
10 session of the data to be matched and representa-
11 tives of applicable State health subsidy programs,
12 promulgate standards governing the timing, con-
13 tents, and procedures for data matching described in
14 this subsection. Such standards shall take into ac-
15 count administrative and other costs and the value
16 of data matching to the establishment, verification,
17 and updating of eligibility for applicable State health
18 subsidy programs.

19 “(d) ADMINISTRATIVE AUTHORITY.—

20 “(1) AGREEMENTS.—Subject to section 2238
21 and section 6103(l)(21) of the Internal Revenue
22 Code of 1986 and any other requirement providing
23 safeguards of privacy and data integrity, the Sec-
24 retary may establish model agreements, and enter

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

3 “(2) AUTHORITY OF EXCHANGE TO CONTRACT
4 OUT.—Nothing in this section shall be construed
5 to—

6 “(A) prohibit contractual arrangements
7 through which a State medicaid agency deter-
8 mines eligibility for all applicable State health
9 subsidy programs, but only if such agency com-
10 plies with the Secretary’s requirements ensuring
11 reduced administrative costs, eligibility errors,
12 and disruptions in coverage; or

13 “(B) change any requirement under title
14 XIX that eligibility for participation in a
15 State’s medicaid program must be determined
16 by a public agency.

17 “(e) APPLICABLE STATE HEALTH SUBSIDY PRO-
18 GRAM.—In this section, the term ‘applicable State health
19 subsidy program’ means—

20 “(1) the program under this title for the enroll-
21 ment in qualified health benefits plans offered
22 through an exchange, including the premium credits
23 under section 36B of the Internal Revenue Code of
24 1986 and cost-sharing subsidies under section 2237;

25 “(2) a State medicaid program under title XIX;

1 “(3) a State children’s health insurance pro-
2 gram (CHIP) under title XXI; and

3 “(4) a State program under section 2228 estab-
4 lishing qualified basic health plans.”.

5 (b) STUDY OF ADMINISTRATION OF EMPLOYER RE-
6 SPONSIBILITY.—

7 (1) IN GENERAL.—The Secretary of Health and
8 Human Services shall, in consultation with the Sec-
9 retary of the Treasury, conduct a study of the proce-
10 dures that are necessary to ensure that in the ad-
11 ministration of part B of subtitle A of title XXII of
12 the Social Security Act (as added by this section)
13 and section 4980H of the Internal Revenue Code of
14 1986 (as added by section 1306) that the following
15 rights are protected:

16 (A) The rights of employees to preserve
17 their right to confidentiality of their taxpayer
18 return information and their right to enroll in
19 a qualified basic health benefits plan through
20 an exchange if an employer does not provide af-
21 fordable coverage.

22 (B) The rights of employers to adequate
23 due process and access to information necessary
24 to accurately determine any tax imposed on em-
25 ployers.

1 (2) REPORT.—Not later than July 1, 2012, the
2 Secretary of Health and Human Services shall re-
3 port the results of the study conducted under para-
4 graph (1), including any recommendations for legis-
5 lative changes, to the Committees on Finance and
6 Health, Education, Labor and Pensions of the Sen-
7 ate and the Committees of Education and Labor and
8 Ways and Means of the House of Representatives.

9 **SEC. 1102. ENCOURAGING MEANINGFUL USE OF ELEC-**
10 **TRONIC HEALTH RECORDS.**

11 (a) STUDY.—The Secretary of Health and Human
12 Services shall conduct a study of methods that can be em-
13 ployed by qualified health benefits plans offered through
14 an exchange to encourage increased meaningful use of
15 electronic health records by health care providers, includ-
16 ing—

17 (1) payment systems established by qualified
18 health benefit plans that provide higher rates of re-
19 imbursement for health care providers that engage
20 in meaningful use of electronic health records; and

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

1 (b) REPORT.—

2 (1) IN GENERAL.—Not later than 24 months
3 after the date of enactment of this Act, the Sec-
4 retary shall submit to Congress a report containing
5 the results of the study conducted under subsection
6 (a), together with recommendations for such legisla-
7 tion and administrative action as the Secretary de-
8 termines appropriate, including recommendations re-
9 garding the feasibility and effectiveness of payment
10 systems established by qualified health benefit plans
11 offered through an exchange to provide for higher
12 rates of reimbursement for health care providers
13 that engage in meaningful use of electronic health
14 records.

15 (2) DISSEMINATION TO EXCHANGES.—Not later
16 than 12 month after submitting the report under
17 paragraph (1), the Secretary shall provide such re-
18 port to any regional exchange or exchange estab-
19 lished within a State.

1 **Subtitle C—Making Coverage**
2 **Affordable**

3 **PART I—ESSENTIAL BENEFITS COVERAGE**

4 **SEC. 1201. PROVISIONS TO ENSURE COVERAGE OF ESSEN-**
5 **TIAL BENEFITS.**

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

9 **“PART C—MAKING COVERAGE AFFORDABLE**

10 **“Subpart 1—Essential Benefits Coverage**

11 **“SEC. 2241. REQUIREMENTS FOR QUALIFIED HEALTH BEN-**
12 **EFITS PLAN.**

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

15 “(1) the plan provides an essential benefits
16 package described in section 2242;

17 “(2) subject to section 2243(c), the plan pro-
18 vides either the bronze, silver, gold, or platinum level
19 of coverage described in section 2243; and

20 “(3) the offeror of the plan charges the same
21 premium rate for the plan without regard to whether
22 the plan is purchased through an exchange or
23 whether the plan is purchased directly from the of-
24 feror or through an agent.

1 **“SEC. 2242. ESSENTIAL BENEFITS PACKAGE DEFINED.**

2 “(a) IN GENERAL.—In this division, the term ‘essen-
3 tial benefits package’ means, with respect to any health
4 benefits plan, coverage that—

5 “(1) provides payment for the items and serv-
6 ices described in subsection (b) in accordance with
7 generally accepted standards of medical or other ap-
8 propriate clinical or professional practice;

9 “(2) limits cost-sharing for such covered health
10 care items and services in accordance with sub-
11 section (c);

12 “(3) meets the requirements with respect to
13 specific items and services described in subsection
14 (d); and

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

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

21 “(1) Hospitalization.

22 “(2) Outpatient hospital and outpatient clinic
23 services, including emergency department services.

24 “(3) Professional services of physicians and
25 other health professionals.

26 “(4) Medical and surgical care.

1 “(5) Such services, equipment, and supplies in-
2 cident to the services of a physician’s or a health
3 professional’s delivery of care in institutional set-
4 tings, physician offices, patients’ homes or place of
5 residence, or other settings, as appropriate.

6 “(6) Prescription drugs.

7 “(7) Rehabilitative and habilitative services.

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

10 “(9) Preventive services, including those serv-
11 ices recommended with a grade of A or B by the
12 United States Preventive Services Task Force and
13 those vaccines recommended for use by the Advisory
14 Committee on Immunization Practices (an advisory
15 committee established by the Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention).

18 “(10) Maternity benefits.

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

22 “(c) REQUIREMENTS RELATING TO COST-SHAR-
23 ING.—

24 “(1) NO COST-SHARING FOR PREVENTIVE SERV-
25 ICES.—There shall be no cost-sharing under an es-

1 essential benefits package for preventive items and
2 services described in subsection (b)(9).

3 “(2) ANNUAL LIMITATION ON COST-SHARING.—

4 “(A) 2013.—The cost-sharing incurred
5 under an essential benefits package with respect
6 to self-only coverage or coverage other than
7 self-only coverage for a plan year beginning in
8 2013 shall not exceed the dollar amounts in ef-
9 fect under section 223(c)(2)(A) of the Internal
10 Revenue Code of 1986 for self-only and family
11 coverage, respectively, for taxable years begin-
12 ning in 2013.

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

17 “(i) in the case of self-only coverage,
18 be equal to the dollar amount under sub-
19 paragraph (A) for self-only coverage, in-
20 creased by an amount equal to the product
21 of that amount and the premium adjust-
22 ment percentage under paragraph (7) for
23 the calendar year; and

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

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

4 “(3) ANNUAL LIMITATION ON DEDUCTIBLES
5 FOR EMPLOYER-SPONSORED PLANS.—

6 “(A) IN GENERAL.—In the case of a health
7 benefits plan offered in the small group market,
8 the deductible under an essential benefits pack-
9 age shall not exceed—

10 “(i) \$2,000 in the case of a plan cov-
11 ering a single individual; and

12 “(ii) \$4,000 in the case of any other
13 plan.

14 The amounts under clauses (i) and (ii) may be
15 increased by the maximum amount of reim-
16 bursement which is reasonably available to a
17 participant under a flexible spending arrange-
18 ment described in section 106(c)(2) of the In-
19 ternal Revenue Code of 1986 (determined with-
20 out regard to any salary reduction arrange-
21 ment).

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

1 “(i) the dollar amount under subpara-
2 graph (A)(i) shall be increased by an
3 amount equal to the product of that
4 amount and the premium adjustment per-
5 centage under paragraph (7) for the cal-
6 endar year; and

7 “(ii) the dollar amount under sub-
8 paragraph (A)(ii) shall be increased to an
9 amount equal to twice the amount in effect
10 under subparagraph (A)(i) for plan years
11 beginning in the calendar year, determined
12 after application of clause (i).

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

16 “(C) LIMITATIONS.—

17 “(i) ACTUARIAL VALUE.—The limita-
18 tion under this paragraph shall be applied
19 in such a manner so as to not affect the
20 actuarial value of any qualified health ben-
21 efits plan, including a plan in the bronze
22 level.

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

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

7 “(5) SPECIAL RULE FOR VALUE-BASED DE-
8 SIGN.—

9 “(A) IN GENERAL.—Paragraphs (1) and
10 (4) shall not apply in the case of a health bene-
11 fits plan for which a value-based design is used.

12 “(B) VALUE-BASED DESIGN.—For pur-
13 poses of subparagraph (A), a value-based de-
14 sign is a methodology under which—

15 “(i) clinically beneficial preventive
16 screenings, lifestyle interventions, medica-
17 tions, immunizations, diagnostic tests and
18 procedures, and treatments are identified;
19 and

20 “(ii) cost-sharing for items and serv-
21 ices described in clause (i) is reduced or
22 eliminated to reflect the high value and ef-
23 fectiveness of the items and services.

24 “(6) COST-SHARING.—In this title, the term
25 ‘cost-sharing’ includes deductibles, coinsurance, co-

1 payments, and similar charges but does not include
2 premiums or any network payment differential for
3 covered services or spending for non-covered serv-
4 ices.

5 “(7) PREMIUM ADJUSTMENT PERCENTAGE.—
6 For purposes of paragraphs (2)(B)(i) and (3)(B)(i),
7 the premium adjustment percentage for any cal-
8 endar year is the percentage (if any) by which the
9 average per capita premium for health insurance
10 coverage in the United States for the preceding cal-
11 endar year (as estimated by the Secretary no later
12 than October 1 of such preceding calendar year) ex-
13 ceeds such average per capita premium for 2012 (as
14 determined by the Secretary).

15 “(d) SPECIFIC ITEMS AND SERVICES.—

16 “(1) PRESCRIPTION DRUGS.—An essential ben-
17 efits package shall at least meet the class and cov-
18 erage requirements of part D of title XVIII of this
19 Act with respect to prescription drugs.

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

1 ment limitations applicable to such services comply
2 with the requirements of section 9812(a) of the In-
3 ternal Revenue Code of 1986 in the same manner as
4 such requirements apply to a group health plan.

5 “(3) TOBACCO CESSATION PROGRAMS.—If a
6 health benefits plan varies its premium on the basis
7 of tobacco use, an essential benefits package shall
8 include coverage for tobacco cessation programs, in-
9 cluding counseling and pharmacotherapy (involving
10 either prescription or nonprescription drugs).

11 “(4) OTHER ITEMS AND SERVICES.—An essen-
12 tial benefits package shall include coverage of day
13 surgery and related anaesthesia, diagnostic images
14 and screening (including x-rays), and radiation and
15 chemotherapy.

16 “(5) PEDIATRIC DENTAL BENEFITS.—If a
17 health benefits plan described in section 2231(e)(2)
18 (relating to stand-alone dental benefits plans) is of-
19 fered through an exchange, another health benefits
20 plan offered through such exchange shall not fail to
21 be treated as a qualified health benefits plan solely
22 because the plan does not offer coverage of benefits
23 offered through the stand-alone plan that are other-
24 wise required under subsection (b)(11).

1 “(6) SPECIAL RULES FOR EMERGENCY DEPART-
2 MENT SERVICES.—A health benefits plan shall not
3 be treated as meeting the requirements of subsection
4 (b)(2) to provide coverage for emergency department
5 services unless the plan provides that—

6 “(A) coverage for such services will be pro-
7 vided without regard to any requirement under
8 the plan for prior authorization of services or
9 any limitation on coverage where the provider
10 of services does not have a contractual relation-
11 ship with the plan for the providing of services;
12 and

13 “(B) if such services are provided out-of-
14 network, any cost-sharing required by the plan
15 does not exceed the cost-sharing that would be
16 required if such services were provided in-net-
17 work.

18 “(e) SPECIFICATION AND ANNUAL UPDATE.—

19 “(1) IN GENERAL.—Not later than July 1,
20 2012, the Secretary shall—

21 “(A) define the benefit categories estab-
22 lished under subsection (b) for qualified health
23 benefits plans offered in the individual market
24 within a State; and

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

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

6 “(2) ANNUAL UPDATES.—The Secretary shall
7 annually update the benefits coverage determined
8 under paragraph (1). The Secretary may address
9 any gaps in access to coverage or changes in the evi-
10 dence base by modifying or adding any category of
11 benefits and covered treatments, items, and services.

12 “(3) LIMITATION.—The Secretary shall ensure
13 that the scope of the benefits coverage under this
14 subsection is not more extensive than the scope of
15 the benefits provided under a typical employer plan,
16 as determined by the Secretary and certified by the
17 Chief Actuary of the Centers for Medicare & Med-
18 icaid Services.

19 “(4) FLEXIBILITY IN PLAN DESIGN.—The Sec-
20 retary shall allow flexibility in plan design to the ex-
21 tent such flexibility does not result in adverse selec-
22 tion.

23 “(f) EXCHANGE REQUIREMENT.—Each State shall
24 ensure that at least 1 plan offered in each exchange estab-
25 lished in the State shall offer qualified health benefits

1 plans that are at least actuarially equivalent to the stand-
2 ard option Blue Cross Blue Shield plan offered under the
3 Federal Employees Health Benefits Program chapter 89
4 of title 5, United States Code.

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

14 **“SEC. 2243. LEVELS OF COVERAGE.**

15 “(a) IN GENERAL.—Except as provided in sub-
16 sections (c) and (d), a health benefits plan shall provide
17 a bronze, silver, gold, or platinum level of coverage.

18 “(b) LEVELS OF COVERAGE DEFINED.—In this title,
19 a health benefits plan providing an essential benefits pack-
20 age shall be assigned to 1 of the following levels of cov-
21 erage:

22 “(1) BRONZE LEVEL.—A plan in the bronze
23 level shall provide a level of coverage that is de-
24 signed to provide benefits that are actuarially equiv-
25 alent to 65 percent of the full actuarial value of the

1 benefits provided under the essential benefits pack-
2 age.

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

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

13 “(4) PLATINUM LEVEL.—A plan in the plat-
14 inum level shall provide a level of coverage that is
15 designed to provide benefits that are actuarially
16 equivalent to 90 percent of the full actuarial value
17 of the benefits provided under the essential benefits
18 package.

19 “(c) CATASTROPHIC PLAN FOR YOUNG INDIVID-
20 UALS.—

21 “(1) IN GENERAL.—A health benefits plan not
22 providing a bronze, silver, gold, or platinum level of
23 coverage shall be treated as meeting the require-
24 ments of this section with respect to any plan year
25 if—

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

6 “(B) the plan provides an essential bene-
7 fits package meeting the requirements of sec-
8 tion 2242, except that, subject to paragraph
9 (2), the plan provides no benefits for any plan
10 year until the individual has incurred cost-shar-
11 ing expenses in an amount equal to the annual
12 limitation in effect under section 2242(c)(2) for
13 the plan year.

14 “(2) PREVENTIVE SERVICES.—A health benefits
15 plan shall not be treated as described in paragraph
16 (1) unless the plan requires no cost-sharing with re-
17 spect to preventive services described in section
18 2242(b)(9).

19 “(3) INDIVIDUALS WITHOUT AFFORDABLE COV-
20 ERAGE.—If an individual has a certification in effect
21 for any plan year under section 2236(f) that the in-
22 dividual is exempt from the requirement under sec-
23 tion 5000A of the Internal Revenue Code of 1986 by
24 reason of section 5000A(e)(2), such individual shall

1 be eligible to enroll for the plan year in a plan de-
2 scribed in paragraph (1).

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

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

9 “(2) have attained the age of 21 but are the de-
10 pendent of another person.

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

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

20 **“SEC. 2244. APPLICATION OF CERTAIN RULES TO PLANS IN**
21 **GROUP MARKETS.**

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

1 sonable annual or lifetime limits (within the meaning of
2 section 223 of the Internal Revenue Code of 1986) on en-
3 rollees in the plan. This subsection shall not apply to a
4 grandfathered health benefits plan or to a qualified health
5 benefits plan in the small group market.

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

10 “(1) to meet the requirements of section
11 2243(e)(2) (relating to annual limits on cost-shar-
12 ing); and

13 “(2) to provide preventive items and services
14 described in section 2243(b)(9) and except as pro-
15 vided in section 2243(e)(5), to require no cost-shar-
16 ing for such items and services.

17 “(c) AUTO ENROLLMENT.—Each State shall require
18 any large employer that has more than 200 employees and
19 that offers employees enrollment in 1 or more health bene-
20 fits plans to automatically enroll new full-time employees
21 in one of the plans and to continue the enrollment of cur-
22 rent employees in a health benefits plan offered through
23 the employer. Any automatic enrollment program shall in-
24 clude adequate notice and the opportunity for an employee

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

3 **“SEC. 2245. SPECIAL RULES RELATING TO COVERAGE OF**
4 **ABORTION SERVICES.**

5 “(a) VOLUNTARY CHOICE OF COVERAGE OF ABOR-
6 TION SERVICES.—

7 “(1) IN GENERAL.—Notwithstanding any other
8 provision of this subpart and subject to paragraph
9 (3)—

10 “(A) nothing in this subpart shall be con-
11 strued to require a health benefits plan to pro-
12 vide coverage of services described in paragraph
13 (2)(A) or (2)(B) as part of its essential benefits
14 package for any plan year; and

15 “(B) the offeror of a health benefits plan
16 shall determine whether or not the plan pro-
17 vides coverage of services described in para-
18 graph (2)(A) or (2)(B) as part of such package
19 for the plan year.

20 “(2) ABORTION SERVICES.—

21 “(A) ABORTIONS FOR WHICH PUBLIC
22 FUNDING IS PROHIBITED.—The services de-
23 scribed in this subparagraph are abortions for
24 which the expenditure of Federal funds appro-
25 priated for the Department of Health and

1 Human Services is not permitted, based on the
2 law as in effect as of the date that is 6 months
3 before the beginning of the plan year involved.

4 “(B) ABORTIONS FOR WHICH PUBLIC
5 FUNDING IS ALLOWED.—The services described
6 in this subparagraph are abortions for which
7 the expenditure of Federal funds appropriated
8 for the Department of Health and Human
9 Services is permitted, based on the law as in ef-
10 fect as of the date that is 6 months before the
11 beginning of the plan year involved.

12 “(3) ASSURED AVAILABILITY OF VARIED COV-
13 ERAGE THROUGH EXCHANGES.—

14 “(A) IN GENERAL.—The Secretary shall
15 assure that with respect to qualified health ben-
16 efits plans offered in any exchange established
17 pursuant to this title—

18 “(i) there is at least one such plan
19 that provides coverage of services described
20 in subparagraphs (A) and (B) of para-
21 graph (2); and

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

1 “(B) SPECIAL RULES.—For purposes of
2 subparagraph (A)—

3 “(i) a plan shall be treated as de-
4 scribed in subparagraph (A)(ii) if the plan
5 does not provide coverage of services de-
6 scribed in either paragraph (2)(A) or
7 (2)(B); and

8 “(ii) if a State has one exchange cov-
9 ering both the individual and small group
10 markets, the Secretary shall meet the re-
11 quirements of subparagraph (A) separately
12 with respect to each such market.

13 “(b) PROHIBITION OF USE OF FEDERAL FUNDS.—

14 “(1) IN GENERAL.—If a qualified health bene-
15 fits plan provides coverage of services described in
16 subsection (a)(2)(A), the offeror of the plan shall
17 not use any amount attributable to any of the fol-
18 lowing for purposes of paying for such services:

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

23 “(B) Any cost-sharing subsidy under sec-
24 tion 2247.

1 “(2) SEGREGATION OF FUNDS.—In the case of
2 a plan to which paragraph (1) applies, the offeror of
3 the plan shall, out of amounts not described in para-
4 graph (1), segregate an amount equal to the actu-
5 arial amounts determined under paragraph (3) for
6 all enrollees from the amounts described in para-
7 graph (1).

8 “(3) ACTUARIAL VALUE OF OPTIONAL SERVICE
9 COVERAGE.—

10 “(A) IN GENERAL.—The Secretary shall
11 estimate the basic per enrollee, per month cost,
12 determined on an average actuarial basis, for
13 including coverage under a qualified health ben-
14 efits plan of the services described in subsection
15 (a)(2)(A).

16 “(B) CONSIDERATIONS.—In making such
17 estimate, the Secretary—

18 “(i) may take into account the impact
19 on overall costs of the inclusion of such
20 coverage, but may not take into account
21 any cost reduction estimated to result from
22 such services, including prenatal care, de-
23 livery, or postnatal care;

1 “(ii) shall estimate such costs as if
2 such coverage were included for the entire
3 population covered; and

4 “(iii) may not estimate such a cost at
5 less than \$1 per enrollee, per month.

6 “(c) NO DISCRIMINATION ON THE BASIS OF PROVI-
7 SION OF ABORTION.—A qualified health benefits plan may
8 not discriminate against any individual health care pro-
9 vider or health care facility because of its willingness or
10 unwillingness to provide, pay for, provide coverage of, or
11 refer for abortions.”.

12 **SEC. 1202. APPLICATION OF STATE AND FEDERAL LAWS RE-**
13 **GARDING ABORTION.**

14 (a) NO PREEMPTION OF STATE LAWS REGARDING
15 ABORTION.—Nothing in this Act shall be construed to
16 preempt or otherwise have any effect on State laws regard-
17 ing the prohibition of (or requirement of) coverage, fund-
18 ing, or procedural requirements on abortions, including
19 parental notification or consent for the performance of an
20 abortion on a minor.

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

23 (1) IN GENERAL.—Nothing in this Act shall be
24 construed to have any effect on Federal laws regard-
25 ing—

1 (A) conscience protection;

2 (B) willingness or refusal to provide abor-
3 tion; and

4 (C) discrimination on the basis of the will-
5 ingness or refusal to provide, pay for, cover, or
6 refer for abortion or to provide or participate in
7 training to provide abortion.

8 (c) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—
9 Nothing in this section shall alter the rights and obliga-
10 tions of employees and employers under title VII of the
11 Civil Rights Act of 1964.

12 **SEC. 1203. APPLICATION OF EMERGENCY SERVICES LAWS.**

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

1 **PART II—PREMIUM CREDITS, COST-SHARING**

2 **SUBSIDIES, AND SMALL BUSINESS CREDITS**

3 **Subpart A—Premium Credits and Cost-sharing**

4 **Subsidies**

5 **SEC. 1205. REFUNDABLE CREDIT PROVIDING PREMIUM AS-**

6 **SISTANCE FOR COVERAGE UNDER A QUALI-**

7 **FIED HEALTH BENEFITS PLAN.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-
9 chapter A of chapter 1 of the Internal Revenue Code of
10 1986 (relating to refundable credits) is amended by insert-
11 ing after section 36A the following new section:

12 **“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A**

13 **QUALIFIED HEALTH BENEFITS PLAN.**

14 “(a) IN GENERAL.—In the case of an applicable tax-
15 payer, there shall be allowed as a credit against the tax
16 imposed by this subtitle for any taxable year an amount
17 equal to the premium assistance credit amount of the tax-
18 payer for the taxable year.

19 “(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For
20 purposes of this section—

21 “(1) IN GENERAL.—The term ‘premium assist-
22 ance credit amount’ means, with respect to any tax-
23 able year, the sum of the premium assistance
24 amounts determined under paragraph (2) with re-
25 spect to all coverage months of the taxpayer occur-
26 ring during the taxable year.

1 “(2) PREMIUM ASSISTANCE AMOUNT.—The pre-
2 mium assistance amount determined under this sub-
3 section with respect to any coverage month is the
4 amount equal to the excess (if any) of—

5 “(A) the lesser of—

6 “(i) the monthly premiums for such
7 month for 1 or more qualified health bene-
8 fits plans offered in the individual market
9 within a State which cover the taxpayer,
10 the taxpayer’s spouse, or any dependent
11 (as defined in section 152) of the taxpayer
12 and which were enrolled in through an ex-
13 change established by the State under sub-
14 part B of title XXII of the Social Security
15 Act, or

16 “(ii) the adjusted monthly premium
17 for such month for the applicable second
18 lowest cost silver plan with respect to the
19 taxpayer, over

20 “(B) an amount equal to 1/12 of the prod-
21 uct of the applicable percentage and the tax-
22 payer’s household income for the taxable year.

23 “(3) OTHER TERMS AND RULES RELATING TO
24 PREMIUM ASSISTANCE AMOUNTS.—For purposes of
25 paragraph (2)—

1 “(A) APPLICABLE PERCENTAGE.—

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

9 “(I) the taxpayer’s household in-
10 come for the taxable year in excess of
11 100 percent of the poverty line for a
12 family of the size involved, bears to

13 “(II) an amount equal to 200
14 percent of the poverty line for a fam-
15 ily of the size involved.

16 “(ii) INDEXING.—In the case of tax-
17 able years beginning in any calendar year
18 after 2013, the Secretary shall adjust the
19 initial and final applicable percentages for
20 the calendar year to reflect the excess of
21 the rate of premium growth between the
22 preceding calendar year and 2012 over the
23 rate of income growth for such period.

24 “(B) APPLICABLE SECOND LOWEST COST
25 SILVER PLAN.—The applicable second lowest

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

4 “(i) is offered through the same ex-
5 change through which the qualified health
6 benefits plans taken into account under
7 paragraph (2)(A)(i) were offered, and

8 “(ii) in the case of—

9 “(I) an applicable taxpayer whose
10 tax for the taxable year is determined
11 under section 1(c) (relating to unmar-
12 ried individuals other than surviving
13 spouses and heads of households),
14 provides self-only coverage, and

15 “(II) any other applicable tax-
16 payer, provides family coverage.

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

24 “(C) ADJUSTED MONTHLY PREMIUM.—

25 The adjusted monthly premium for an applica-

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

10 “(4) REDUCTION TO ELIMINATE FEDERAL
11 BUDGET DEFICIT.—The premium assistance credit
12 amount (determined without regard to this para-
13 graph) with respect to a month in a plan year for
14 which a reduction is required in such amount under
15 section 1209 of the America’s Healthy Future Act
16 of 2009 shall be reduced by the percentage specified
17 in such section.

18 “(c) DEFINITION AND RULES RELATING TO APPLI-
19 CABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED
20 HEALTH BENEFITS PLAN.—For purposes of this sec-
21 tion—

22 “(1) APPLICABLE TAXPAYER.—

23 “(A) IN GENERAL.—The term ‘applicable
24 taxpayer’ means, with respect to any taxable
25 year, a taxpayer whose household income for

1 the taxable year exceeds 100 percent (133 per-
2 cent in the case of taxable years beginning in
3 2013) but does not exceed 400 percent of an
4 amount equal to the poverty line for a family of
5 the size involved.

6 “(B) SPECIAL RULE FOR CERTAIN INDI-
7 VIDUALS LAWFULLY PRESENT IN THE UNITED
8 STATES.—In the case of any taxable year begin-
9 ning after December 31, 2013, if—

10 “(i) a taxpayer has a household in-
11 come which is not greater than 100 per-
12 cent of an amount equal to the poverty line
13 for a family of the size involved, and

14 “(ii) the taxpayer is an alien lawfully
15 admitted to the United States for perma-
16 nent residence, or an alien lawfully present
17 in the United States, but is not eligible for
18 the medicaid program under title XIX of
19 the Social Security Act by reason of such
20 alien status,

21 the taxpayer shall be treated as an applicable
22 taxpayer.

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

1 taxable year, the taxpayer shall be treated as an
2 applicable taxpayer only if the taxpayer and the
3 taxpayer's spouse file a joint return for the tax-
4 able year.

5 “(D) DENIAL OF CREDIT TO DEPEND-
6 ENTS.—No credit shall be allowed under this
7 section to any individual with respect to whom
8 a deduction under section 151 is allowable to
9 another taxpayer for a taxable year beginning
10 in the calendar year in which such individual's
11 taxable year begins.

12 “(2) COVERAGE MONTH.—For purposes of this
13 subsection—

14 “(A) IN GENERAL.—The term ‘coverage
15 month’ means, with respect to an applicable
16 taxpayer, any month if—

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

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

1 the credit under subsection (a) under sec-
2 tion 2248 of the Social Security Act).

3 “(B) EXCEPTION FOR ESSENTIAL HEALTH
4 BENEFITS COVERAGE.—

5 “(i) IN GENERAL.—The term ‘cov-
6 erage month’ shall not include any month
7 with respect to an individual if for such
8 month the individual is eligible for essen-
9 tial health benefits coverage other than eli-
10 gibility for coverage under a qualified
11 health benefits plan in the individual mar-
12 ket offered through an exchange.

13 “(ii) ESSENTIAL HEALTH BENEFITS
14 COVERAGE.—The term ‘essential health
15 benefits coverage’ has the meaning given
16 such term by section 5000A.

17 “(C) SPECIAL RULE FOR EMPLOYER-SPON-
18 SORED ESSENTIAL COVERAGE.—For purposes
19 of subparagraph (B)—

20 “(i) COVERAGE MUST BE AFFORD-
21 ABLE.—Except as provided in clause (iii),
22 an employee shall not be treated as eligible
23 for essential health benefits coverage if
24 such coverage—

1 “(I) consists of an eligible em-
2 ployer-sponsored plan (as defined in
3 section 5000A(f)(2)) or a grand-
4 fathered health benefits plan main-
5 tained by the employee’s employer,
6 and

7 “(II) the employee’s required
8 contribution (within the meaning of
9 section 5000A(e)(2)) with respect to
10 the plan exceeds 10 percent of the ap-
11 plicable taxpayer’s household income.

12 This clause shall also apply to an indi-
13 vidual who is eligible to enroll in the plan
14 by reason of a relationship the individual
15 bears to the employee.

16 “(ii) COVERAGE MUST PROVIDE MIN-
17 IMUM VALUE.—Except as provided in
18 clause (iii), an employee shall not be treat-
19 ed as eligible for essential health benefits
20 coverage if such coverage consists of an eli-
21 gible employer-sponsored plan (as defined
22 in section 5000A(f)(2)) or a grandfathered
23 health benefits plan maintained by the em-
24 ployee’s employer and the plan’s share of
25 the total allowed costs of benefits provided

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

3 “(iii) EMPLOYEE OR FAMILY MUST
4 NOT BE COVERED UNDER EMPLOYER
5 PLAN.—Clauses (i) and (ii) shall not apply
6 if the employee (or any individual de-
7 scribed in the last sentence of clause (i)) is
8 covered under the eligible employer-spon-
9 sored plan or the grandfathered health
10 benefits plan.

11 “(iv) INDEXING.—In the case of plan
12 years beginning in any calendar year after
13 2013, clause (i)(II) shall be applied by
14 substituting for 10 percent a percentage
15 equal to the sum of—

16 “(I) 10 percent, plus

17 “(II) 10 percent multiplied by
18 the premium adjustment percentage
19 (as defined in section 2242(c)(7) of
20 the Social Security Act) for the cal-
21 endar year.

22 “(D) SPECIAL RULE FOR MEDICAID INDI-
23 VIDUALS.—An individual shall not be treated as
24 eligible for essential health benefits coverage if
25 under title XIX of the Social Security Act the

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

9 “(3) DEFINITIONS.—For purposes of this para-
10 graph—

11 “(A) QUALIFIED HEALTH BENEFITS
12 PLAN.—The term ‘qualified health benefits
13 plan’ has the meaning given such term by sec-
14 tion 2201(b) of the Social Security Act.

15 “(B) GRANDFATHERED HEALTH BENEFITS
16 PLAN.—The term ‘grandfathered health bene-
17 fits plan’ has the meaning given such term by
18 section 2221 of the Social Security Act.

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

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

1 allowance of deduction for personal exemptions) for
2 the taxable year.

3 “(2) HOUSEHOLD INCOME.—

4 “(A) IN GENERAL.—The term ‘household
5 income’ means, with respect to any taxpayer, an
6 amount equal to the sum of—

7 “(i) the modified gross income of the
8 taxpayer, plus

9 “(ii) the aggregate modified gross in-
10 comes of all other individuals taken into
11 account in determining the taxpayer’s fam-
12 ily size under paragraph (1).

13 “(B) MODIFIED GROSS INCOME.—The
14 term ‘modified gross income’ means gross in-
15 come—

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

19 “(ii) increased by the amount of inter-
20 est received or accrued during the taxable
21 year which is exempt from tax imposed by
22 this chapter, and

23 “(iii) determined without regard to
24 sections 911, 931, and 933.

25 “(3) POVERTY LINE.—

1 “(A) IN GENERAL.—The term ‘poverty
2 line’ has the meaning given that term in section
3 2110(c)(5) of the Social Security Act (42
4 U.S.C. 1397jj(c)(5)).

5 “(B) POVERTY LINE USED.—In the case of
6 any qualified health benefits plan offered
7 through an exchange for coverage during a tax-
8 able year beginning in a calendar year, the pov-
9 erty line used shall be the most recently pub-
10 lished poverty line as of the 1st day of the reg-
11 ular enrollment period for coverage during such
12 calendar year.

13 “(e) RULES FOR UNDOCUMENTED ALIENS.—

14 “(1) IN GENERAL.—If any individual for whom
15 the taxpayer is allowed a deduction under section
16 151 (relating to allowance of deduction for personal
17 exemptions) for the taxable year is an undocumented
18 alien—

19 “(A) no credit shall be allowed under sub-
20 section (a) with respect to any portion of any
21 premium taken into account under clause (i) or
22 (ii) of subsection (b)(2)(A) which is attributable
23 to the individual, and

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

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

4 “(2) UNDOCUMENTED ALIEN.—For purposes of
5 this section—

6 “(A) The term ‘undocumented alien’
7 means an individual who is not, or who is rea-
8 sonably not expected to be for the entire taxable
9 year, a citizen or national of the United States,
10 an alien lawfully admitted to the United States
11 for permanent residence, or an alien lawfully
12 present in the United States.

13 “(B) IDENTIFICATION REQUIREMENT.—An
14 individual shall be treated as an undocumented
15 alien unless the information required under sec-
16 tion 2238(b)(2) of the Social Security Act has
17 been provided with respect to such individual.

18 “(f) RECONCILIATION OF CREDIT AND ADVANCE
19 CREDIT.—

20 “(1) IN GENERAL.—The amount of the credit
21 allowed under this section for any taxable year shall
22 be reduced (but not below zero) by the amount of
23 any advance payment of such credit under section
24 2248 of the Social Security Act.

25 “(2) EXCESS ADVANCE PAYMENTS.—

1 “(A) IN GENERAL.—If the advance pay-
2 ments to a taxpayer under section 2248 of the
3 Social Security Act for a taxable year exceed
4 the credit allowed by this section (determined
5 without regard to paragraph (1)), the tax im-
6 posed by this chapter for the taxable year shall
7 be increased by the amount of such excess.

8 “(B) LIMITATION ON INCREASE WHERE
9 INCOME LESS THAN 300 PERCENT OF POVERTY
10 LINE.—In the case of an applicable taxpayer
11 whose household income is less than 300 per-
12 cent of the poverty line for the size of the fam-
13 ily involved for the taxable year, the amount of
14 the increase under subparagraph (A) shall in no
15 event exceed \$400 (\$250 in the case of a tax-
16 payer whose tax is determined under section
17 1(e) for the taxable year).

18 “(g) REGULATIONS.—The Secretary shall prescribe
19 such regulations as may be necessary to carry out the pro-
20 visions of this section, including regulations which provide
21 for—

22 “(1) the coordination of the credit allowed
23 under this section with the program for advance
24 payment of the credit under section 2248 of the So-
25 cial Security Act,

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

5 “(3) the application of subsection (f) where the
6 filing status of the taxpayer for a taxable year is dif-
7 ferent from such status used for determining the ad-
8 vance payment of the credit.”.

9 (b) DISALLOWANCE OF DEDUCTION.—Section 280C
10 of the Internal Revenue Code of 1986 is amended by add-
11 ing at the end the following new subsection:

12 “(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—
13 No deduction shall be allowed for the portion of the pre-
14 miums paid by the taxpayer for coverage of 1 or more
15 individuals under a qualified health benefits plan which
16 is equal to the amount of the credit determined for the
17 taxable year under section 36B(a) with respect to such
18 premiums.”.

19 (c) TREATMENT OF FAILURE TO PROVIDE DOCU-
20 MENTATION AS MATHEMATICAL ERROR.—Section
21 6213(g)(2) of the Internal Revenue Code of 1986 is
22 amended by striking “and” at the end of subparagraph
23 (M), by striking the period at the end of subparagraph
24 (N) and inserting “, and”, and by inserting after subpara-
25 graph (N) the following new subparagraph:

1 “(O) the omission of identifying informa-
2 tion described in section 2238(b)(1) of the So-
3 cial Security Act and required under section
4 36B(e)(2)(B).”.

5 (d) STUDY.—Not later than 5 years after the date
6 of the enactment of this Act, the Secretary of the Treas-
7 ury, in consultation with the Secretary of Health and
8 Human Services, shall conduct a study of whether the per-
9 centage of household income used for purposes of section
10 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as
11 added by this section) is the appropriate level for deter-
12 mining whether employer-provided coverage is affordable
13 for an employee and whether such level may be lowered
14 without significantly increasing the costs to the Federal
15 Government and reducing employer-provided coverage.
16 The Secretary shall report the results of such study to
17 the appropriate committees of Congress, including any
18 recommendations for legislative changes.

19 (e) CONFORMING AMENDMENTS.—

20 (1) Paragraph (2) of section 1324(b) of title
21 31, United States Code, is amended by inserting
22 “36B,” after “36A,”.

23 (2) The table of sections for subpart C of part
24 IV of subchapter A of chapter 1 of the Internal Rev-

1 venue Code of 1986 is amended by inserting after the
2 item relating to section 36A the following new item:

 “Sec. 36B. Refundable credit for coverage under a qualified health benefits
 plan.”.

3 (f) **EFFECTIVE DATE.**—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 2012.

6 **SEC. 1206. COST-SHARING SUBSIDIES AND ADVANCE PAY-**
7 **MENTS OF PREMIUM CREDITS AND COST-**
8 **SHARING SUBSIDIES.**

9 Title XXII of the Social Security Act (as added by
10 section 1001 and amended by sections 1101 and 1201)
11 is amended by adding at the end the following:

12 **“Subpart 2—Premium Credits and Cost-sharing**
13 **Subsidies**

14 **“SEC. 2246. PREMIUM CREDITS.**

15 “For refundable tax credit providing premium assist-
16 ance for individuals with income less than 400 percent of
17 the Federal poverty line, see section 36B of the Internal
18 Revenue Code of 1986 (as added by section 1205 of the
19 America’s Healthy Future Act of 2009).

20 **“SEC. 2247. COST-SHARING SUBSIDIES FOR INDIVIDUALS**
21 **ENROLLING IN QUALIFIED HEALTH BENEFIT**
22 **PLANS.**

23 “(a) **IN GENERAL.**—In the case of an eligible insured
24 enrolled in a qualified health benefits plan with respect

1 to which a credit is allowed to the insured (or an applica-
2 ble taxpayer on behalf of the insured) under section 36B
3 of the Internal Revenue Code of 1986—

4 “(1) the Secretary shall notify the offeror of the
5 plan of the eligible insured’s eligibility for a reduc-
6 tion in cost-sharing under this section; and

7 “(2) the offeror shall reduce the cost-sharing
8 under the plan at the level and in the manner speci-
9 fied in subsection (c).

10 “(b) ELIGIBLE INSURED.—In this section, the term
11 ‘eligible insured’ means an individual—

12 “(1) who enrolls in a qualified health benefits
13 plan in the silver level of coverage in the individual
14 market offered through an exchange under part B;
15 and

16 “(2) whose household income exceeds 100 per-
17 cent (133 percent in the case of taxable years begin-
18 ning in 2013) but does not exceed 400 percent of
19 the poverty line for a family of the size involved.

20 In the case of an individual described in section
21 36B(c)(1)(B) of the Internal Revenue Code of 1986 for
22 any taxable year beginning after December 31, 2013, the
23 individual shall be treated as having household income
24 equal to 100 percent of such poverty line for purposes of
25 applying this section.

1 “(c) DETERMINATION OF REDUCTION IN COST-SHAR-
2 ING.—

3 “(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

4 The reduction in cost-sharing under this subsection
5 shall first be achieved by reducing the applicable
6 out-of pocket limit under section 2242(c)(2) in the
7 case of—

8 “(A) an eligible insured whose household
9 income is more than 100 percent but not more
10 than 200 percent of the poverty line for a fam-
11 ily of the size involved, by two-thirds;

12 “(B) an eligible insured whose household
13 income is more than 200 percent but not more
14 than 300 percent of the poverty line for a fam-
15 ily of the size involved, by one-half; and

16 “(C) an eligible insured whose household
17 income is more than 300 percent but not more
18 than 400 percent of the poverty line for a fam-
19 ily of the size involved, by one-third.

20 The reduction under this paragraph shall not result
21 in an increase in the plan’s share of the total al-
22 lowed costs of benefits provided under the plan
23 above 80 percent (90 percent in the case of an eligi-
24 ble insured described in subparagraph (A)) of such
25 costs

1 “(2) ADDITIONAL REDUCTION FOR LOWER IN-
2 COME INSUREDS.—The Secretary shall establish pro-
3 cedures under which the offeror of a qualified health
4 benefits plan to which this section applies shall fur-
5 ther reduce cost-sharing under the plan in a manner
6 sufficient to—

7 “(A) in the case of an eligible insured
8 whose household income is not less than 100
9 percent but not more than 150 percent of the
10 poverty line for a family of the size involved, in-
11 crease the plan’s share of the total allowed
12 costs of benefits provided under the plan to 90
13 percent of such costs; and

14 “(B) in the case of an eligible insured
15 whose household income is more than 150 per-
16 cent but not more than 200 percent of the pov-
17 erty line for a family of the size involved, in-
18 crease the plan’s share of the total allowed
19 costs of benefits provided under the plan to 80
20 percent of such costs.

21 “(3) REDUCTION TO ELIMINATE FEDERAL
22 BUDGET DEFICIT.—The reduction in cost-sharing
23 under this section (determined without regard to
24 this paragraph) with respect to a plan year for
25 which a reduction is required in such amount under

1 section 1209 of the America’s Healthy Future Act
2 of 2009 shall be reduced by the percentage specified
3 in such section.

4 “(4) METHODS FOR PROVIDING SUBSIDY.—

5 “(A) IN GENERAL.—An offeror of a quali-
6 fied health benefits plan making reductions
7 under this subsection shall notify the Secretary
8 of such reductions and the Secretary shall make
9 periodic and timely payments to the offeror
10 equal to the value of the reductions.

11 “(B) CAPITATED PAYMENTS.—The Sec-
12 retary may establish a capitated payment sys-
13 tem to carry out the payment of subsidies
14 under this section. Any such system shall take
15 into account the value of the subsidies and
16 make appropriate risk adjustments to such pay-
17 ments.

18 “(d) SPECIAL RULES FOR INDIANS.—

19 “(1) INDIANS UNDER 300 PERCENT OF POV-
20 ERTY.—If an individual enrolled in any qualified
21 health benefits plan in the individual market
22 through an exchange is an Indian (as defined in sec-
23 tion 4 of the Indian Health Care Improvement Act)
24 whose household income is not more than 300 per-

1 cent of the poverty line for a family of the size in-
2 volved, then, for purposes of this section—

3 “(A) such individual shall be treated as an
4 eligible insured; and

5 “(B) the offeror of the plan shall eliminate
6 any cost-sharing under the plan.

7 “(2) ITEMS OR SERVICES FURNISHED THROUGH
8 INDIAN HEALTH PROVIDERS.—If an Indian (as so
9 defined) enrolled in a qualified health benefits plan
10 is furnished an item or service directly by the Indian
11 Health Service, an Indian Tribe, Tribal Organiza-
12 tion, or Urban Indian Organization or through refer-
13 ral under contract health services—

14 “(A) no cost-sharing under the plan shall
15 be imposed under the plan for such item or
16 service; and

17 “(B) the offeror of the plan shall not re-
18 duce the payment to any such entity for such
19 item or service by the amount of any cost-shar-
20 ing that would be due from the Indian but for
21 subparagraph (A).

22 “(3) PAYMENT.—The Secretary shall pay to the
23 offeror of a qualified health benefits plan the
24 amount necessary to reflect the increase in actuarial

1 value of the plan required by reason of this sub-
2 section.

3 “(e) RULES FOR UNDOCUMENTED ALIENS.—

4 “(1) IN GENERAL.—In the case of an individual
5 who is undocumented alien—

6 “(A) no cost-sharing reduction under this
7 subsection shall apply with respect to any item
8 or service provided to the individual; and

9 “(B) the individual shall not be taken into
10 account in determining the family size involved
11 but the individual’s modified gross income shall
12 be taken into account in determining household
13 income.

14 “(2) IDENTIFICATION REQUIREMENT.—An indi-
15 vidual shall be treated as an undocumented alien un-
16 less the information required under section
17 2238(b)(2) of the Social Security Act has been pro-
18 vided with respect to such individual.

19 “(f) DEFINITIONS AND SPECIAL RULES.—In this
20 section:

21 “(1) IN GENERAL.—Any term used in this sec-
22 tion which is also used in section 36B of the Inter-
23 nal Revenue Code of 1986 shall have the meaning
24 given such term by such section.

1 “(2) LIMITATIONS ON SUBSIDY.—No subsidy
2 shall be allowed under this section with respect to
3 coverage for any month if such month would not be
4 treated as a coverage month under section 36B(e)(2)
5 of such Code.

6 **“SEC. 2248. ADVANCE DETERMINATION AND PAYMENT OF**
7 **PREMIUM CREDITS AND COST-SHARING SUB-**
8 **SIDIES.**

9 “(a) IN GENERAL.—The Secretary, in consultation
10 with the Secretary of the Treasury, shall establish a pro-
11 gram under which—

12 “(1) upon request of an exchange, advance de-
13 terminations are made under section 2238 with re-
14 spect to the income eligibility of individuals enrolling
15 in a qualified health benefits plan in the individual
16 market through the exchange for the credit allowable
17 under section 36B of the Internal Revenue Code of
18 1986 and the cost-sharing subsidy under section
19 2247;

20 “(2) the Secretary notifies the exchange and
21 the Secretary of the Treasury of the advance deter-
22 minations; and

23 “(3) the Secretary of the Treasury makes ad-
24 vance payments of such credit or subsidy to the
25 offerors of the qualified health benefits plans in

1 order to reduce the premiums payable by individuals
2 eligible for such credit.

3 “(b) ADVANCE DETERMINATIONS.—

4 “(1) IN GENERAL.—The Secretary shall provide
5 under the program established under subsection (a)
6 that advance determination of eligibility with respect
7 to any individual shall be made—

8 “(A) during the annual open enrollment
9 period applicable to the individual (or such
10 other enrollment period as may be specified by
11 the Secretary); and

12 “(B) on the basis of the individual’s house-
13 hold income for the second taxable year pre-
14 ceeding the taxable year in which enrollment
15 through such enrollment period first takes ef-
16 fect.

17 “(2) CHANGES IN CIRCUMSTANCES.—The Sec-
18 retary shall provide procedures for making advance
19 determinations on the basis of information other
20 than that described in paragraph (1)(B) in cases
21 where information included with an application form
22 demonstrates substantial changes in income, changes
23 in family size or other household circumstances,
24 change in filing status, the filing of an application

1 for unemployment benefits, or other significant
2 changes affecting eligibility, including—

3 “(A) allowing an individual claiming a de-
4 crease of 20 percent or more in income, or fil-
5 ing an application for unemployment benefits,
6 to have eligibility for the credit determined on
7 the basis of household income for a later period
8 or on the basis of the individual’s estimate of
9 such income for the taxable year; and

10 “(B) the determination of household in-
11 come in cases where the taxpayer was not re-
12 quired to file a return of tax imposed by this
13 chapter for the second preceding taxable year.

14 “(c) PAYMENT OF PREMIUM CREDITS.—

15 “(1) IN GENERAL.—The Secretary shall notify
16 the Secretary of the Treasury and the exchange
17 through which the individual is enrolling of the ad-
18 vance determination under section 2238.

19 “(2) PREMIUM CREDIT.—

20 “(A) IN GENERAL.—The Secretary of the
21 Treasury shall make the advance payment
22 under this section of any credit allowed under
23 section 36B of the Internal Revenue Code of
24 1986 to the offeror of a qualified health bene-

1 fits plan on a monthly basis (or such other peri-
2 odic basis as the Secretary may provide).

3 “(B) OFFEROR RESPONSIBILITIES.—An
4 offeror of a qualified health benefits plan receiv-
5 ing an advance payment with respect to an indi-
6 vidual enrolled in the plan shall—

7 “(i) reduce the premium charged the
8 insured for any period by the amount of
9 the advance payment for the period;

10 “(ii) notify the exchange and the Sec-
11 retary of such reduction; and

12 “(iii) in the case of any nonpayment
13 of premiums by the insured—

14 “(I) notify the Secretary of such
15 nonpayment; and

16 “(II) allow a 3-month grace pe-
17 riod for nonpayment of premiums be-
18 fore discontinuing coverage.

19 “(d) COORDINATION WITH VERIFICATION OF LAW-
20 FUL PRESENCE.—No advance payment shall be made
21 under this section unless there has been a verification
22 under section 2238 of the individual’s citizenship or na-
23 tionality or lawful presence in the United States.”.

1 **SEC. 1207. DISCLOSURES TO CARRY OUT ELIGIBILITY RE-**
2 **QUIREMENTS FOR CERTAIN PROGRAMS.**

3 (a) DISCLOSURE OF TAXPAYER RETURN INFORMA-
4 TION AND SOCIAL SECURITY NUMBERS.—

5 (1) TAXPAYER RETURN INFORMATION.—Sub-
6 section (l) of section 6103 of the Internal Revenue
7 Code of 1986 is amended by adding at the end the
8 following new paragraph:

9 “(21) DISCLOSURE OF RETURN INFORMATION
10 TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR
11 CERTAIN PROGRAMS.—

12 “(A) IN GENERAL.—The Secretary, upon
13 written request from the Secretary of Health
14 and Human Services, shall disclose to officers,
15 employees, and contractors of the Department
16 of Health and Human Services return informa-
17 tion of any taxpayer whose income is relevant
18 in determining any credit under section 36B or
19 any cost-sharing subsidy under section 2247 of
20 the Social Security Act or eligibility for partici-
21 pation in a State medicaid program under title
22 XIX of such Act, a State’s children’s health in-
23 surance program under title XXI of such Act,
24 or a basic health program under section 2228
25 of such Act. Such return information shall be
26 limited to—

1 “(i) taxpayer identity information
2 with respect to such taxpayer,

3 “(ii) the filing status of such tax-
4 payer,

5 “(iii) the number of individuals for
6 whom a deduction is allowed under section
7 151 with respect to the taxpayer (including
8 the taxpayer and the taxpayer’s spouse),

9 “(iv) the modified gross income (as
10 defined in section 36B) of such taxpayer
11 and each of the other individuals included
12 under clause (iii),

13 “(v) such other information as is pre-
14 scribed by the Secretary by regulation as
15 might indicate whether the taxpayer is eli-
16 gible for such credit or subsidy (and the
17 amount thereof), and

18 “(vi) the taxable year with respect to
19 which the preceding information relates or,
20 if applicable, the fact that such informa-
21 tion is not available.

22 “(B) INFORMATION TO EXCHANGE AND
23 STATE AGENCIES.—The Secretary of Health
24 and Human Services may disclose to an ex-
25 change established under title XXII of the So-

1 cial Security Act or its contractors, or to a
2 State agency administering a State program de-
3 scribed in subparagraph (A) or its contractors,
4 any inconsistency between the information pro-
5 vided by the exchange or State agency to the
6 Secretary and the information provided to the
7 Secretary under subparagraph (A).

8 “(C) RESTRICTION ON USE OF DISCLOSED
9 INFORMATION.—Return information disclosed
10 under subparagraph (A) or (B) may be used by
11 officers, employees, and contractors of the De-
12 partment of Health and Human Services, an
13 exchange, or a State agency only for the pur-
14 poses of, and to the extent necessary in—

15 “(i) establishing eligibility for partici-
16 pation in the exchange, and verifying the
17 appropriate amount of, any credit or sub-
18 sidy described in subparagraph (A),

19 “(ii) determining eligibility for partici-
20 pation in the State programs described in
21 subparagraph (A).”.

22 (2) SOCIAL SECURITY NUMBERS.—Section
23 205(c)(2)(C) of the Social Security Act is amended
24 by adding at the end the following new clause:

1 “(x) The Secretary of Health and
2 Human Services, and the exchanges estab-
3 lished under title XXII, are authorized to
4 collect and use the names and social secu-
5 rity account numbers of individuals as re-
6 quired to administer the provisions of, and
7 the amendments made by, America’s
8 Healthy Future Act of 2009.”.

9 (b) CONFIDENTIALITY AND DISCLOSURE.—Para-
10 graph (3) of section 6103(a) of such Code is amended by
11 striking “or (20)” and inserting “(20), or (21)”.

12 (c) PROCEDURES AND RECORDKEEPING RELATED
13 TO DISCLOSURES.—Paragraph (4) of section 6103(p) of
14 such Code is amended—

15 (1) by inserting “, or any entity described in
16 subsection (l)(21),” after “or (20)” in the matter
17 preceding subparagraph (A),

18 (2) by inserting “or any entity described in sub-
19 section (l)(21),” after “or (o)(1)(A)” in subpara-
20 graph (F)(ii), and

21 (3) by inserting “or any entity described in sub-
22 section (l)(21),” after “or (20)” both places it ap-
23 pears in the matter after subparagraph (F).

1 (d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—
2 Paragraph (2) of section 7213(a) of such Code is amended
3 by striking “or (20)” and inserting “(20), or (21)”.

4 **SEC. 1208. PREMIUM CREDIT AND SUBSIDY REFUNDS AND**
5 **PAYMENTS DISREGARDED FOR FEDERAL**
6 **AND FEDERALLY-ASSISTED PROGRAMS.**

7 For purposes of determining the eligibility of any in-
8 dividual for benefits or assistance, or the amount or extent
9 of benefits or assistance, under any Federal program or
10 under any State or local program financed in whole or in
11 part with Federal funds—

12 (1) any credit or refund allowed or made to any
13 individual by reason of section 36B of the Internal
14 Revenue Code of 1986 (as added by section 1205)
15 shall not be taken into account as income and shall
16 not be taken into account as resources for the month
17 of receipt and the following 2 months; and

18 (2) any cost-sharing subsidy payment or ad-
19 vance payment of the credit allowed under such sec-
20 tion 36B that is made under section 2247 or 2248
21 of the Social Security Act (as added by section
22 1206) shall be treated as made to the qualified
23 health benefits plan in which an individual is en-
24 rolled and not to that individual.

1 **SEC. 1209. FAIL-SAFE MECHANISM TO PREVENT INCREASE**
2 **IN FEDERAL BUDGET DEFICIT.**

3 (a) ESTIMATE AND CERTIFICATION OF EFFECT OF
4 ACT ON BUDGET DEFICIT.—

5 (1) IN GENERAL.—The President shall include
6 in the submission under section 1105 of title 31,
7 United States Code, of the budget of the United
8 States Government for fiscal year 2013 and each fis-
9 cal year thereafter an estimate of the budgetary ef-
10 fects for the fiscal year of the provisions of (and the
11 amendments made by) this Act, based on the infor-
12 mation available as of the date of such submission.

13 (2) CERTIFICATION.—The President shall in-
14 clude with the estimate under paragraph (1) for any
15 fiscal year a certification as to whether the sum of
16 the decreases in revenues and increases in outlays
17 for the fiscal year by reason of the provisions of
18 (and the amendments made by) this Act exceed (or
19 do not exceed) the sum of the increases in revenues
20 and decreases in outlays for the fiscal year by reason
21 of the provisions and amendments.

22 (b) EFFECT OF DEFICIT.—If the President certifies
23 an excess under subsection (a)(2) for any fiscal year—

24 (1) the President shall include with the certifi-
25 cation the percentage by which the credits allowable
26 under section 36B of the Internal Revenue Code of

1 1986 and the cost-sharing subsidies under section
2 2247 of the Social Security Act must be reduced for
3 plan years beginning during such fiscal year such
4 that there is an aggregate decrease in the amount
5 of such credits and subsidies equal to the amount of
6 such excess; and

7 (2) the President shall instruct the Secretary of
8 Health and Human Services and the Secretary of
9 the Treasury to reduce such credits and subsidies
10 for such plan years by such percentage for purposes
11 of applying section 36B(b)(4) of such Code and sec-
12 tion 2247(c)(3) of such Act.

13 **Subpart B—Credit for Small Employers**

14 **SEC. 1221. CREDIT FOR EMPLOYEE HEALTH INSURANCE**
15 **EXPENSES OF SMALL BUSINESSES.**

16 (a) IN GENERAL.—Subpart D of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code of
18 1986 (relating to business-related credits) is amended by
19 inserting after section 45Q the following:

20 **“SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF**
21 **SMALL EMPLOYERS.**

22 “(a) GENERAL RULE.—For purposes of section 38,
23 in the case of an eligible small employer, the small em-
24 ployer health insurance credit determined under this sec-

1 tion for any taxable year in the credit period is the amount
2 determined under subsection (b).

3 “(b) HEALTH INSURANCE CREDIT AMOUNT.—Sub-
4 ject to subsection (c), the amount determined under this
5 subsection with respect to any eligible small employer is
6 equal to 50 percent (35 percent in the case of a tax-exempt
7 eligible small employer) of the lesser of—

8 “(1) the aggregate amount of nonelective con-
9 tributions the employer made on behalf of its em-
10 ployees during the taxable year under the arrange-
11 ment described in subsection (d)(4) for premiums
12 for qualified health benefits plans offered by the em-
13 ployer to its employees through an exchange, or

14 “(2) the aggregate amount of nonelective con-
15 tributions which the employer would have made dur-
16 ing the taxable year under the arrangement if each
17 employee taken into account under paragraph (1)
18 had enrolled in a qualified health benefits plan which
19 had a premium equal to the average premium (as
20 determined by the Secretary of Health and Human
21 Services) for the small group market in the exchange
22 through which the employee is eligible for coverage.

23 In the case of a taxable year beginning in 2013, the credit
24 determined under this section shall be determined only

1 with respect to premiums for coverage after June 30,
2 2013.

3 “(c) LIMITATIONS ON CREDIT.—

4 “(1) PHASEOUT OF CREDIT AMOUNT BASED ON
5 NUMBER OF EMPLOYEES AND AVERAGE WAGES.—

6 The amount of the credit determined under sub-
7 section (b) without regard to this subsection shall be
8 reduced (but not below zero) by the sum of the fol-
9 lowing amounts:

10 “(A) Such amount multiplied by a fraction
11 the numerator of which is the total number of
12 full-time equivalent employees of the employer
13 in excess of 10 and the denominator of which
14 is 15.

15 “(B) Such amount multiplied by a fraction
16 the numerator of which is the average annual
17 wages of the employer in excess of the dollar
18 amount in effect under subsection (d)(3)(B)
19 and the denominator of which is \$20,000.

20 “(2) STATE FAILURE TO ADOPT INSURANCE
21 RATING REFORMS.—No credit shall be determined
22 under this section with respect to contributions by
23 the employer for any qualified health benefits plans
24 purchased through an exchange for any month of
25 coverage before the first month the State estab-

1 lishing the exchange has in effect the insurance rat-
2 ing reforms described in subtitle A of title XXII of
3 the Social Security Act.

4 “(d) ELIGIBLE SMALL EMPLOYER.—For purposes of
5 this section—

6 “(1) IN GENERAL.—The term ‘eligible small
7 employer’ means, with respect to any taxable year,
8 an employer—

9 “(A) which has no more than 25 full-time
10 equivalent employees for the taxable year,

11 “(B) the average annual wages of which do
12 not exceed an amount equal to the amount in
13 effect under paragraph (3)(B) for the taxable
14 year plus \$20,000, and

15 “(C) which has in effect an arrangement
16 described in paragraph (4).

17 “(2) FULL-TIME EQUIVALENT EMPLOYEES.—

18 “(A) IN GENERAL.—The term ‘full-time
19 equivalent employees’ means a number of em-
20 ployees equal to the number determined by di-
21 viding—

22 “(i) the total number of hours for
23 which wages were paid by the employer to
24 employees during the taxable year, by

25 “(ii) 2,080.

1 Such number shall be rounded to the next low-
2 est whole number if not otherwise a whole num-
3 ber.

4 “(B) EXCESS HOURS NOT COUNTED.—If
5 an employee works in excess of 2,080 hours
6 during any taxable year, such excess shall not
7 be taken into account under subparagraph (A).

8 “(C) SPECIAL RULES.—The Secretary
9 shall prescribe such regulations, rules, and
10 guidance as may be necessary to apply this
11 paragraph to employees who are not com-
12 pensated on an hourly basis.

13 “(3) AVERAGE ANNUAL WAGES.—

14 “(A) IN GENERAL.—The average annual
15 wages of an eligible small employer for any tax-
16 able year is the amount determined by divid-
17 ing—

18 “(i) the aggregate amount of wages
19 which were paid by the employer to em-
20 ployees during the taxable year, by

21 “(ii) the number of full-time equiva-
22 lent employees of the employee determined
23 under paragraph (2) for the taxable year.

1 Such amount shall be rounded to the next low-
2 est multiple of \$1,000 if not otherwise such a
3 multiple.

4 “(B) DOLLAR AMOUNT.—For purposes of
5 paragraph (1)(B)—

6 “(i) 2010.—The dollar amount in ef-
7 fect under this paragraph for taxable years
8 beginning in 2010 is \$20,000.

9 “(ii) SUBSEQUENT YEARS.—In the
10 case of a taxable year beginning in a cal-
11 endar year after 2010, the dollar amount
12 in effect under this paragraph shall be
13 equal to \$20,000, multiplied by the cost-of-
14 living adjustment determined under section
15 1(f)(3) for the calendar year, determined
16 by substituting ‘calendar year 2009’ for
17 ‘calendar year 1992’ in subparagraph (B)
18 thereof.

19 “(4) CONTRIBUTION ARRANGEMENT.—An ar-
20 rangement is described in this paragraph if it re-
21 quires an eligible small employer to make a nonelec-
22 tive contribution on behalf of each employee who en-
23 rolls in a qualified health benefits plan offered to
24 employees by the employer through an exchange in
25 an amount equal to a uniform percentage (not less

1 than 50 percent) of the premium cost of the quali-
2 fied health benefits plan.

3 “(5) SEASONAL WORKER HOURS AND WAGES
4 NOT COUNTED.—For purposes of this subsection—

5 “(A) IN GENERAL.—The number of hours
6 worked by, and wages paid to, a seasonal work-
7 er of an employer shall not be taken into ac-
8 count in determining the full-time equivalent
9 employees and average annual wages of the em-
10 ployer.

11 “(B) DEFINITION OF SEASONAL WORK-
12 ER.—The term ‘seasonal worker’ means an in-
13 dividual who performs labor or services on a
14 seasonal basis where, ordinarily, the employ-
15 ment pertains to or is of the kind exclusively
16 performed at certain seasons or periods of the
17 year and which, from its nature, may not be
18 continuous or carried on throughout the year.

19 “(e) OTHER RULES AND DEFINITIONS.—For pur-
20 poses of this section—

21 “(1) EMPLOYEE.—

22 “(A) CERTAIN EMPLOYEES EXCLUDED.—
23 The term ‘employee’ shall not include—

24 “(i) an employee within the meaning
25 of section 401(c)(1),

1 “(ii) any 2-percent shareholder (as de-
2 fined in section 1372(b)) of an eligible
3 small business which is an S corporation,

4 “(iii) any 5-percent owner (as defined
5 in section 416(i)(1)(B)(i)) of an eligible
6 small business, or

7 “(iv) any individual who bears any of
8 the relationships described in subpara-
9 graphs (A) through (G) of section
10 152(d)(2) to, or is a dependent described
11 in section 152(d)(2)(H) of, an individual
12 described in clause (i), (ii), or (iii).

13 “(B) LEASED EMPLOYEES.—The term
14 ‘employee’ shall include a leased employee with-
15 in the meaning of section 414(n).

16 “(2) CREDIT PERIOD.—The term ‘credit period’
17 means, with respect to any eligible small employer,
18 the 2-consecutive-taxable year period beginning with
19 the 1st taxable year in which the employer (or any
20 predecessor) offers 1 or more qualified health bene-
21 fits plans to its employees through an exchange. If
22 no credit is allowed to an employer (or predecessor)
23 under this section by reason of subsection (c)(2) (re-
24 lating to failure by States to adopt insurance rating
25 reforms), the credit period with respect to the em-

1 ployer shall not begin until the 1st taxable year fol-
2 lowing the taxable year in which the State has in ef-
3 fect the insurance rating reforms described in such
4 subsection.

5 “(3) NONELECTIVE CONTRIBUTION.—The term
6 ‘nonelective contribution’ means an employer con-
7 tribution other than an employer contribution pursu-
8 ant to a salary reduction arrangement.

9 “(4) WAGES.—The term ‘wages’ has the mean-
10 ing given such term by section 3121(a) (determined
11 without regard to any dollar limitation contained in
12 such section).

13 “(5) AGGREGATION AND OTHER RULES MADE
14 APPLICABLE.—

15 “(A) AGGREGATION RULES.—All employ-
16 ers treated as a single employer under sub-
17 section (b), (c), (m), or (o) of section 414 shall
18 be treated as a single employer for purposes of
19 this section.

20 “(B) OTHER RULES.—Rules similar to the
21 rules of subsections (c), (d), and (e) of section
22 52 shall apply.

23 “(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELI-
24 GIBLE SMALL EMPLOYERS.—

1 “(1) IN GENERAL.—In the case of a tax-exempt
2 eligible small employer, there shall be treated as a
3 credit allowable under subpart C (and not allowable
4 under this subpart) the lesser of— —

5 “(A) the amount of the credit determined
6 under this section with respect to such em-
7 ployer, or

8 “(B) the amount of the payroll taxes of the
9 employer during the calendar year in which the
10 taxable year begins.

11 “(2) TAX-EXEMPT ELIGIBLE SMALL EM-
12 PLOYER.—For purposes of this section, the term
13 ‘tax-exempt eligible small employer’ means an eligi-
14 ble small employer which is any organization de-
15 scribed in section 501(c) which is exempt from tax-
16 ation under section 501(a).

17 “(3) PAYROLL TAXES.—For purposes of this
18 subsection—

19 “(A) IN GENERAL.—The term ‘payroll
20 taxes’ means—

21 “(i) amounts required to be withheld
22 from the employees of the tax-exempt eligi-
23 ble small employer under section 3401(a),

1 “(ii) amounts required to be withheld
2 from such employees under section
3 3101(b), and

4 “(iii) amounts of the taxes imposed on
5 the tax-exempt eligible small employer
6 under section 3111(b).

7 “(B) SPECIAL RULE.—A rule similar to
8 the rule of section 24(d)(2)(C) shall apply for
9 purposes of subparagraph (A).

10 “(g) APPLICATION OF SECTION FOR CALENDAR
11 YEARS 2011 AND 2012.—In the case of any taxable year
12 beginning in 2011 or 2012, the following modifications to
13 this section shall apply in determining the amount of the
14 credit under subsection (a):

15 “(1) NO CREDIT PERIOD REQUIRED.—The
16 credit shall be determined without regard to whether
17 the taxable year is in a credit period and for pur-
18 poses of applying this section to taxable years begin-
19 ning after 2012, no credit period shall be treated as
20 beginning with a taxable year beginning before
21 2013.

22 “(2) AMOUNT OF CREDIT.—The amount of the
23 credit determined under subsection (b) shall be de-
24 termined—

1 “(A) by substituting ‘35 percent (25 per-
2 cent in the case of a tax-exempt eligible small
3 employer)’ for ‘50 percent (35 percent in the
4 case of a tax-exempt eligible small employer)’,

5 “(B) by reference to an eligible small em-
6 ployer’s nonelective contributions for premiums
7 paid for health insurance coverage (within the
8 meaning of section 9832(b)(1)) of an employee,
9 and

10 “(C) by substituting for the average pre-
11 mium determined under subsection (b)(2) the
12 amount the Secretary of Health and Human
13 Services determines is the average premium for
14 the small group market in the State in which
15 the employer is offering health insurance cov-
16 erage (or for such area within the State as is
17 specified by the Secretary).

18 “(3) STATE RATING REFORM LIMITATION.—The
19 limitation of paragraph (2) of subsection (c) shall
20 not apply.

21 “(4) CONTRIBUTION ARRANGEMENT.—An ar-
22 rangement shall not fail to meet the requirements of
23 subsection (d)(4) solely because it provides for the
24 offering of insurance outside of an exchange.

1 “(h) INSURANCE DEFINITIONS.—Any term used in
2 this section which is also used in title XXII of the Social
3 Security Act shall have the meaning given such term by
4 such title.

5 “(i) REGULATIONS.—The Secretary shall prescribe
6 such regulations as may be necessary to carry out the pro-
7 visions of this section, including regulations to prevent the
8 avoidance of the 2-year limit on the credit period through
9 the use of successor entities and the avoidance of the limi-
10 tations under paragraphs (1) and (2) of subsection (c)
11 through the use of multiple entities.”.

12 (b) CREDIT TO BE PART OF GENERAL BUSINESS
13 CREDIT.—Section 38(b) of the Internal Revenue Code of
14 1986 (relating to current year business credit) is amended
15 by striking “plus” at the end of paragraph (34), by strik-
16 ing the period at the end of paragraph (35) and inserting
17 “, plus”, and by inserting after paragraph (35) the fol-
18 lowing:

19 “(36) the small employer health insurance cred-
20 it determined under section 45R.”.

21 (c) CREDIT ALLOWED AGAINST ALTERNATIVE MIN-
22 IMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue
23 Code of 1986 (defining specified credits) is amended by
24 redesignating clauses (vi), (vii), and (viii) as clauses (vii),

1 (viii), and (ix), respectively, and by inserting after clause
2 (v) the following new clause:

3 “(vi) the credit determined under sec-
4 tion 45R.”.

5 (d) DISALLOWANCE OF DEDUCTION FOR CERTAIN
6 EXPENSES FOR WHICH CREDIT ALLOWED.—

7 (1) IN GENERAL.—Section 280C of the Internal
8 Revenue Code of 1986 (relating to disallowance of
9 deduction for certain expenses for which credit al-
10 lowed), as amended by section 1205(b), is amended
11 by adding at the end the following new subsection:

12 “(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE
13 EXPENSES OF SMALL EMPLOYERS.—No deduction shall
14 be allowed for that portion of the premiums for qualified
15 health benefits plans (as defined in section 2201(b) of the
16 Social Security Act) paid by an employer which is equal
17 to the amount of the credit determined under section
18 45R(a).”.

19 (2) DEDUCTION FOR EXPIRING CREDITS.—Sec-
20 tion 196(c) of such Code is amended by striking
21 “and” at the end of paragraph (12), by striking the
22 period at the end of paragraph (13) and inserting “,
23 and”, and by adding at the end the following new
24 paragraph:

1 “(14) the small employer health insurance cred-
2 it determined under section 45R(a).”.

3 (e) CLERICAL AMENDMENT.—The table of sections
4 for subpart D of part IV of subchapter A of chapter 1
5 of the Internal Revenue Code of 1986 is amended by add-
6 ing at the end the following:

“Sec. 45R. Employee health insurance expenses of small employers.”.

7 (f) EFFECTIVE DATES.—

8 (1) IN GENERAL.—The amendments made by
9 this section shall apply to amounts paid or incurred
10 in taxable years beginning after December 31, 2010.

11 (2) MINIMUM TAX.—The amendments made by
12 subsection (c) shall apply to credits determined
13 under section 45R of the Internal Revenue Code of
14 1986 in taxable years beginning after December 31,
15 2010, and to carrybacks of such credits.

16 **Subtitle D—Shared Responsibility**

17 **PART I—INDIVIDUAL RESPONSIBILITY**

18 **SEC. 1301. EXCISE TAX ON INDIVIDUALS WITHOUT ESSEN-** 19 **TIAL HEALTH BENEFITS COVERAGE.**

20 (a) IN GENERAL.—Subtitle D of the Internal Rev-
21 enue Code of 1986 is amended by adding at the end the
22 following new chapter:

23 **“CHAPTER 48—MAINTENANCE OF** 24 **ESSENTIAL HEALTH BENEFITS COVERAGE**

“Sec. 5000A. Failure to maintain essential health benefits coverage.

1 **“SEC. 5000A. FAILURE TO MAINTAIN ESSENTIAL HEALTH**
2 **BENEFITS COVERAGE.**

3 “(a) REQUIREMENT TO MAINTAIN ESSENTIAL
4 HEALTH BENEFITS COVERAGE.—If an individual is an
5 applicable individual for any month beginning after June
6 30, 2013, the individual is required to be covered by essen-
7 tial health benefits coverage for such month.

8 “(b) IMPOSITION OF TAX.—

9 “(1) IN GENERAL.—If an applicable individual
10 fails to meet the requirement of subsection (a) for
11 1 or more months during any calendar year begin-
12 ning after 2013, then, except as provided in sub-
13 section (d), there is hereby imposed a tax with re-
14 spect to the individual in the amount determined
15 under subsection (c).

16 “(2) INCLUSION WITH INCOME TAX RETURN.—
17 Any tax imposed by this section with respect to any
18 month shall be included with a taxpayer’s return of
19 tax imposed by chapter 1 for the taxable year which
20 includes such month.

21 “(3) LIABILITY FOR TAX.—If an individual with
22 respect to whom tax is imposed by this section for
23 any month—

24 “(A) is a dependent (as defined in section
25 152) of another taxpayer for the other tax-

1 payer's taxable year including such month, such
2 other taxpayer shall be liable for such tax, or

3 “(B) files a joint return for the taxable
4 year including such month, such individual and
5 the spouse of such individual shall be jointly lia-
6 ble for such tax.

7 “(c) AMOUNT OF TAX.—

8 “(1) IN GENERAL.—The tax determined under
9 this subsection for any month with respect to any in-
10 dividual is an amount equal to $\frac{1}{12}$ of the applicable
11 dollar amount for the calendar year.

12 “(2) DOLLAR LIMITATION.—The amount of the
13 tax imposed by this section on any taxpayer for any
14 taxable year with respect to all individuals for whom
15 the taxpayer is liable under subsection (b)(3) shall
16 not exceed an amount equal to twice the applicable
17 dollar amount for the calendar year with or within
18 which the taxable year ends.

19 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
20 poses of paragraph (1)—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), the applicable dollar amount
23 is \$750.

1 “(B) PHASE IN.—The applicable dollar
2 amount is \$200 for 2014, \$400 for 2015, and
3 \$600 for 2016.

4 “(C) INDEXING OF AMOUNT.—In the case
5 of any calendar year beginning after 2017, the
6 applicable dollar amount shall be equal to \$750,
7 increased by an amount equal to—

8 “(i) \$750, multiplied by

9 “(ii) the cost-of-living adjustment de-
10 termined under section 1(f)(3) for the cal-
11 endar year, determined by substituting
12 ‘calendar year 2016’ for ‘calendar year
13 1992’ in subparagraph (B) thereof.

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

17 “(4) TERMS RELATING TO INCOME AND FAMI-
18 LIES.—For purposes of this section—

19 “(A) FAMILY SIZE.—The family size in-
20 volved with respect to any taxpayer shall be
21 equal to the number of individuals for whom
22 the taxpayer is allowed a deduction under sec-
23 tion 151 (relating to allowance of deduction for
24 personal exemptions) for the taxable year.

1 section 2110(c)(5) of the Social Security
2 Act (42 U.S.C. 1397jj(c)(5)).

3 “(ii) POVERTY LINE USED.—In the
4 case of any taxable year ending with or
5 within a calendar year, the poverty line
6 used shall be the most recently published
7 poverty line as of the 1st day of the such
8 calendar year.

9 “(d) APPLICABLE INDIVIDUAL.—For purposes of this
10 section—

11 “(1) IN GENERAL.—The term ‘applicable indi-
12 vidual’ means, with respect to any month, any indi-
13 vidual who has attained the age of 18 before the be-
14 ginning of the month other than an individual de-
15 scribed in paragraph (2) or (3).

16 “(2) RELIGIOUS EXEMPTIONS.—

17 “(A) RELIGIOUS CONSCIENCE EXEMP-
18 TION.—Such term shall not include any indi-
19 vidual for any month if such individual has in
20 effect an exemption under section 2236(f) of
21 the Social Security Act which certifies that such
22 individual is a member of a recognized religious
23 sect or division thereof described in section
24 1402(g)(1) and an adherent of established te-

1 nets or teachings of such sect or division as de-
2 scribed in such section.

3 “(B) HEALTH CARE SHARING MINISTRY.—

4 “(i) IN GENERAL.—Such term shall
5 not include any individual for any month if
6 such individual is a member of a health
7 care sharing ministry for the month.

8 “(ii) HEALTH CARE SHARING MIN-
9 ISTRY.—The term ‘health care sharing
10 ministry’ means an organization—

11 “(I) which is described in section
12 501(c)(3) and is exempt from taxation
13 under section 501(a),

14 “(II) members of which share a
15 common set of ethical or religious be-
16 liefs and share medical expenses
17 among members in accordance with
18 those beliefs and without regard to
19 the State in which a member resides
20 or is employed,

21 “(III) members of which retain
22 membership even after they develop a
23 medical condition,

24 “(IV) which (or a predecessor of
25 which) has been in existence at all

1 times since December 31, 1999, and
2 medical expenses of its members have
3 been shared during the entire period
4 of its existence, and

5 “(V) which conducts an annual
6 audit which is performed by an inde-
7 pendent certified public accounting
8 firm in accordance with generally ac-
9 cepted accounting principles and
10 which is made available to the public
11 upon request.

12 “(3) UNDOCUMENTED ALIENS.—Such term
13 shall not include an individual for any month if for
14 the month the individual is not a citizen or national
15 of the United States, an alien lawfully admitted to
16 the United States for permanent residence, or an
17 alien lawfully present in the United States.

18 “(e) EXEMPTIONS FROM TAX.—No tax shall be im-
19 posed under subsection (a) with respect to—

20 “(1) MONTHS DURING SHORT COVERAGE
21 GAPS.—Any month the last day of which occurred
22 during a period in which the applicable individual
23 was not covered by essential health benefits coverage
24 for a period of less than 3 months.

202

1 “(2) INDIVIDUALS WHO CANNOT AFFORD COV-
2 ERAGE.—

3 “(A) IN GENERAL.—Any applicable indi-
4 vidual if the applicable individual’s required
5 contribution for a calendar year exceeds 8 per-
6 cent of such individual’s household income for
7 the second taxable year preceding the taxable
8 year described in subsection (b)(2). For pur-
9 poses of applying this subparagraph, the tax-
10 payer’s household income shall be increased by
11 any exclusion from gross income for any portion
12 of the required contribution made through a
13 salary reduction arrangement.

14 “(B) REQUIRED CONTRIBUTION.—For
15 purposes of this paragraph, the term ‘required
16 contribution’ means—

17 “(i) in the case of an individual eligi-
18 ble to purchase health insurance coverage
19 through an employer other than through
20 an exchange, the portion of the annual pre-
21 mium which would be paid by the indi-
22 vidual (without regard to whether paid
23 through salary reduction or otherwise) for
24 health insurance coverage which is the low-

1 est cost coverage offered through the em-
2 ployer, or

3 “(ii) in the case of any individual not
4 described in clause (i), the annual pre-
5 mium for the lowest cost bronze plan avail-
6 able in the individual market through the
7 exchange in the State in which the indi-
8 vidual resides (without regard to whether
9 the individual is eligible to purchase a
10 qualified health benefits plan through the
11 exchange), reduced by the amount of the
12 credit allowable under section 36B for the
13 taxable year (determined as if the indi-
14 vidual was covered by a qualified health
15 benefits plan offered through the exchange
16 for the entire taxable year).

17 “(C) SPECIAL RULE FOR INDIVIDUALS ELI-
18 GIBLE FOR COVERAGE THROUGH EMPLOYEE.—
19 If an applicable individual is eligible for cov-
20 erage through an employer by reason of a rela-
21 tionship to an employee, the determination
22 under subparagraph (B)(i) shall be made by
23 reference to the affordability of the coverage to
24 the employee.

1 “(D) INDEXING.—In the case of plan years
2 beginning in any calendar year after 2013, sub-
3 paragraph (A) shall be applied by substituting
4 for ‘8 percent’ the percentage the Secretary of
5 Health and Human Services determines reflects
6 the excess of the rate of premium growth be-
7 tween the preceding calendar year and 2012
8 over the rate of income growth for such period.

9 “(3) TAXPAYERS WITH INCOME UNDER 100
10 PERCENT OF POVERTY LINE.—Any applicable indi-
11 vidual who has a household income for the for the
12 second taxable year preceding the taxable year de-
13 scribed in subsection (b)(2) which is less than 100
14 percent of the poverty line for the size of the family
15 involved (determined in the same manner as under
16 subsection (b)(4)).

17 “(4) NATIVE AMERICANS.—Any applicable indi-
18 vidual who is an Indian as defined in section 4 of
19 the Indian Health Care Improvement Act.

20 “(5) HARDSHIPS.—Any applicable individual
21 who is determined by the Secretary to have suffered
22 a hardship with respect to the capability to obtain
23 coverage under a qualified health benefits plan.

24 “(f) ESSENTIAL HEALTH BENEFITS COVERAGE.—

25 For purposes of this section—

1 “(1) IN GENERAL.—The term ‘essential health
2 benefits coverage’ means any of the following:

3 “(A) QUALIFIED HEALTH BENEFITS PLAN
4 COVERAGE.—Coverage under a qualified health
5 benefits plan.

6 “(B) GRANDFATHERED HEALTH BENEFITS
7 PLAN.—Coverage under a grandfathered health
8 benefits plan (as defined in section 2221(c) of
9 the Social Security Act).

10 “(C) EMPLOYER-SPONSORED PLAN.—Cov-
11 erage under an eligible employer-sponsored
12 plan.

13 “(D) MEDICARE.—Coverage under part A
14 of title XVIII of the Social Security Act.

15 “(E) MEDICAID.—Coverage for medical as-
16 sistance under title XIX of the Social Security
17 Act.

18 “(F) MEMBERS OF THE ARMED FORCES
19 AND DEPENDENTS (INCLUDING TRICARE).—
20 Coverage under chapter 55 of title 10, United
21 States Code, including similar coverage fur-
22 nished under section 1781 of title 38 of such
23 Code.

24 “(G) VA.—Coverage under the veteran’s
25 health care program under chapter 17 of title

1 38, United States Code, but only if the cov-
2 erage for the individual involved is determined
3 by the Secretary of Health and Human Services
4 in coordination with the Secretary to be not less
5 than a level specified by the Secretary of Health
6 and Human Services, based on the individual's
7 priority for services as provided under section
8 1705(a) of such title.

9 “(H) FEDERAL EMPLOYEES COVERAGE.—
10 Coverage under the Federal employees health
11 benefits program under chapter 89 of title 5,
12 United States Code.

13 “(I) OTHER COVERAGE.—Such other
14 health benefits coverage, such as a State health
15 benefits risk pool or coverage while incarcerated,
16 as the Secretary of Health and Human
17 Services, in coordination with the Secretary,
18 recognizes for purposes of this subsection.

19 “(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—
20 The term ‘eligible employer-sponsored plan’ means,
21 with respect to any employee, a health benefits plan
22 (other than a grandfathered health benefits plan) of-
23 fered by an employer to the employee, but only if—

24 “(A) in the case of a small employer, the
25 plan is a qualified health benefits plan, and

1 “(B) in the case of a large employer plan,
2 the plan meets the requirements of section
3 2244 of the Social Security Act.

4 “(3) INSURANCE-RELATED TERMS.—Any term
5 used in this section which is also used in title XXII
6 of the Social Security Act shall have the same mean-
7 ing as when used in such title.

8 “(g) MODIFICATIONS OF SUBTITLE F.—Notwith-
9 standing any other provision of law—

10 “(1) WAIVER OF CRIMINAL AND CIVIL PEN-
11 ALTIES AND INTEREST.—In the case of any failure
12 by a taxpayer to timely pay any tax imposed by this
13 section—

14 “(A) such taxpayer shall not be subject to
15 any criminal prosecution or penalty with respect
16 to such failure, and

17 “(B) no penalty, addition to tax, or inter-
18 est shall be imposed with respect to such failure
19 or such tax.

20 “(2) LIMITED COLLECTION ACTIONS PER-
21 MITTED.—In the case of the assessment of any tax
22 imposed by this section, the Secretary shall not take
23 any action with respect to the collection of such tax
24 other than—

1 “(A) giving notice and demand for such
2 tax under section 6303,

3 “(B) crediting under section 6402(a) the
4 amount of any overpayment of the taxpayer
5 against such tax, and

6 “(C) offsetting any payment owed by any
7 Federal agency to the taxpayer against such tax
8 under the Treasury offset program.”.

9 (b) CLERICAL AMENDMENT.—The table of chapters
10 for subtitle D of the Internal Revenue Code of 1986 is
11 amended by inserting after the item relating to chapter
12 47 the following new item:

 “CHAPTER 48—MAINTENANCE OF ESSENTIAL HEALTH BENEFITS
 COVERAGE”.

13 (c) STUDY ON AFFORDABLE COVERAGE.—

14 (1) STUDY AND REPORT.—

15 (A) IN GENERAL.—The Comptroller Gen-
16 eral shall conduct a study on the affordability
17 of health insurance coverage, including—

18 (i) the impact of the tax credit for
19 qualified health insurance coverage of indi-
20 viduals under section 36B of the Internal
21 Revenue Code of 1986 and the tax credit
22 for employee health insurance expenses of
23 small employers under section 45R of such

1 Code on maintaining and expanding the
2 health insurance coverage of individuals,
3 (ii) the availability of affordable
4 health benefits plans, and
5 (iii) the ability of individuals to main-
6 tain essential health benefits coverage (as
7 defined in section 5000A(f) of the Internal
8 Revenue Code of 1986).

9 (B) REPORT.—Not later than February 1,
10 2014, the Comptroller General shall submit to
11 the appropriate committees of Congress a re-
12 port on the study conducted under subpara-
13 graph (A), together with legislative rec-
14 ommendations relating to the matters studied
15 under such subparagraph.

16 (2) CONGRESSIONAL CONSIDERATION OF REC-
17 OMMENDATIONS.—

18 (A) COMMITTEE CONSIDERATION OF PRO-
19 POSAL; DISCHARGE; CONTINGENCY FOR INTRO-
20 Duction.—Not later than April 1, 2014, the
21 appropriate committees of Congress shall report
22 legislation implementing the recommendations
23 contained in the report described in paragraph
24 (1)(B). If, with respect to the House involved,
25 any such committee has not reported such legis-

1 lation by such date, such committees shall be
2 deemed to be discharged from further consider-
3 ation of the proposal and any member of the
4 House of Representatives or the Senate, respec-
5 tively, may introduce legislation implementing
6 the recommendations contained in the proposal
7 and such legislation shall be placed on the ap-
8 propriate calendar of the House involved.

9 (B) EXPEDITED PROCEDURE.—

10 (i) CONSIDERATION.—If legislation is
11 reported out of committee or legislation is
12 introduced under subparagraph (A), not
13 later than 15 calendar days after the date
14 on which a committee has been or could
15 have been discharged from consideration of
16 such legislation or such legislation is intro-
17 duced, the Speaker of the House of Rep-
18 resentatives, or the Speaker's designee, or
19 the majority leader of the Senate, or the
20 leader's designee, shall move to proceed to
21 the consideration of the legislation. It shall
22 also be in order for any member of the
23 Senate or the House of Representatives,
24 respectively, to move to proceed to the con-
25 sideration of the legislation at any time

1 after the conclusion of such 15-day period.
2 All points of order against the legislation
3 (and against consideration of the legisla-
4 tion) with the exception of points of order
5 under the Congressional Budget Act of
6 1974 are waived. A motion to proceed to
7 the consideration of the legislation is privi-
8 leged in the Senate and highly privileged in
9 the House of Representatives and is not
10 debatable. The motion is not subject to
11 amendment, to a motion to postpone con-
12 sideration of the legislation, or to a motion
13 to proceed to the consideration of other
14 business. A motion to reconsider the vote
15 by which the motion to proceed is agreed
16 to or not agreed to shall not be in order.
17 If the motion to proceed is agreed to, the
18 Senate or the House of Representatives, as
19 the case may be, shall immediately proceed
20 to consideration of the legislation in ac-
21 cordance with the Standing Rules of the
22 Senate or the House of Representatives, as
23 the case may be, without intervening mo-
24 tion, order, or other business, and the reso-
25 lution shall remain the unfinished business

1 of the Senate or the House of Representa-
2 tives, as the case may be, until disposed of.

3 (ii) CONSIDERATION BY OTHER
4 HOUSE.—If, before the passage by one
5 House of the legislation that was intro-
6 duced in such House, such House receives
7 from the other House legislation as passed
8 by such other House—

9 (I) the legislation of the other
10 House shall not be referred to a com-
11 mittee and shall immediately displace
12 the legislation that was reported or in-
13 troduced in the House in receipt of
14 the legislation of the other House; and

15 (II) the legislation of the other
16 House shall immediately be considered
17 by the receiving House under the
18 same procedures applicable to legisla-
19 tion reported by or discharged from a
20 committee or introduced under sub-
21 paragraph (A).

22 Upon disposition of legislation that is re-
23 ceived by one House from the other House,
24 it shall no longer be in order to consider

1 the legislation that was reported or intro-
2 duced in the receiving House.

3 (iii) SENATE LIMITS ON DEBATE.—In
4 the Senate, consideration of the legislation
5 and on all debatable motions and appeals
6 in connection therewith shall not exceed a
7 total of 30 hours, which shall be divided
8 equally between those favoring and those
9 opposing the legislation. A motion further
10 to limit debate on the legislation is in
11 order and is not debatable. Any debatable
12 motion or appeal is debatable for not to ex-
13 ceed 1 hour, to be divided equally between
14 those favoring and those opposing the mo-
15 tion or appeal. All time used for consider-
16 ation of the legislation, including time used
17 for quorum calls and voting, shall be
18 counted against the total 30 hours of con-
19 sideration.

20 (iv) CONSIDERATION IN CON-
21 FERENCE.—Immediately upon a final pas-
22 sage of the legislation that results in a dis-
23 agreement between the two Houses of Con-
24 gress with respect to the legislation, con-
25 ferees shall be appointed and a conference

1 convened. Not later than 15 days after the
2 date on which conferees are appointed (ex-
3 cluding periods in which one or both
4 Houses are in recess), the conferees shall
5 file a report with the Senate and the
6 House of Representatives resolving the dif-
7 ferences between the Houses on the legisla-
8 tion. Notwithstanding any other rule of the
9 Senate or the House of Representatives, it
10 shall be in order to immediately consider a
11 report of a committee of conference on the
12 legislation filed in accordance with this
13 subsection. Debate in the Senate and the
14 House of Representatives on the con-
15 ference report shall be limited to 10 hours,
16 equally divided and controlled by the ma-
17 jority and minority leaders of the Senate
18 or their designees and the Speaker of the
19 House of Representatives and the minority
20 leader of the House of Representatives or
21 their designees. A vote on final passage of
22 the conference report shall occur imme-
23 diately at the conclusion or yielding back
24 of all time for debate on the conference re-
25 port.

1 (C) RULES OF THE SENATE AND HOUSE
2 OF REPRESENTATIVES.—This paragraph is en-
3 acted by Congress—

4 (i) as an exercise of the rulemaking
5 power of the Senate and House of Rep-
6 resentatives, respectively, and is deemed to
7 be part of the rules of each House, respec-
8 tively, but applicable only with respect to
9 the procedure to be followed in that House
10 in the case of legislation under this section,
11 and it supersedes other rules only to the
12 extent that it is inconsistent with such
13 rules; and

14 (ii) with full recognition of the con-
15 stitutional right of either House to change
16 the rules (so far as they relate to the pro-
17 cedure of that House) at any time, in the
18 same manner, and to the same extent as in
19 the case of any other rule of that House.

20 (3) APPROPRIATE COMMITTEES OF CON-
21 GRESS.—In this subsection, the term “appropriate
22 committees of Congress” means the Committee on
23 Ways and Means, the Committee on Education and
24 Labor, and the Committee on Energy and Com-
25 merce of the House of Representatives and the Com-

1 mittee on Finance and the Committee on Health,
2 Education, Labor and Pensions of the Senate.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years ending after De-
5 cember 31, 2012.

6 **SEC. 1302. REPORTING OF HEALTH INSURANCE COVERAGE.**

7 (a) IN GENERAL.—Part III of subchapter A of chap-
8 ter 61 of the Internal Revenue Code of 1986 is amended
9 by inserting after subpart C the following new subpart:

10 **“Subpart D—Information Regarding Health**
11 **Insurance Coverage**

“Sec. 6055. Reporting of health insurance coverage.

12 **“SEC. 6055. REPORTING OF HEALTH INSURANCE COV-**
13 **ERAGE.**

14 “(a) IN GENERAL.—Every person who provides es-
15 sential health benefits coverage to an individual during a
16 calendar year shall, at such time as the Secretary may
17 prescribe, make a return described in subsection (b).

18 “(b) FORM AND MANNER OF RETURN.—

19 “(1) IN GENERAL.—A return is described in
20 this subsection if such return—

21 “(A) is in such form as the Secretary may
22 prescribe, and

23 “(B) contains—

1 “(i) the name, address and TIN of
2 the primary insured and the name of each
3 other individual obtaining coverage under
4 the policy,

5 “(ii) the dates during which such indi-
6 vidual was covered under essential health
7 benefits coverage during the calendar year,

8 “(iii) the amount (if any) of any ad-
9 vance payment under section 2248 of the
10 Social Security Act of any cost-sharing
11 subsidy under section 2247 of such Act or
12 of any premium credit under section 36B
13 with respect to such coverage, and

14 “(iv) such other information as the
15 Secretary may require.

16 “(2) INFORMATION RELATING TO EMPLOYER-
17 PROVIDED COVERAGE.—If essential health benefits
18 coverage provided to an individual under subsection
19 (a) consists of health insurance coverage of a health
20 insurance issuer provided through a group health
21 plan of an employer, a return described in this sub-
22 section shall include—

23 “(A) the name, address, and employer
24 identification number of the employer maintain-
25 ing the plan,

1 “(B) the portion of the premium (if any)
2 required to be paid by the employer, and

3 “(C) if the health insurance coverage is a
4 qualified health benefits plan in the small group
5 market offered through an exchange, such other
6 information as the Secretary may require for
7 administration of the credit under section 45R
8 (relating to credit for employee health insurance
9 expenses of small employers).

10 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
11 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
12 PORTED.—

13 “(1) IN GENERAL.—Every person required to
14 make a return under subsection (a) shall furnish to
15 each individual whose name is required to be set
16 forth in such return a written statement showing—

17 “(A) the name and address of the person
18 required to make such return and the phone
19 number of the information contact for such per-
20 son, and

21 “(B) the information required to be shown
22 on the return with respect to such individual.

23 “(2) TIME FOR FURNISHING STATEMENTS.—
24 The written statement required under paragraph (1)
25 shall be furnished on or before January 31 of the

1 year following the calendar year for which the return
2 under subsection (a) was required to be made.

3 “(d) COVERAGE PROVIDED BY GOVERNMENTAL
4 UNITS.—In the case of coverage provided by any govern-
5 mental unit or any agency or instrumentality thereof, the
6 officer or employee who enters into the agreement to pro-
7 vide such coverage (or the person appropriately designated
8 for purposes of this section) shall make the returns and
9 statements required by this section.

10 “(e) ESSENTIAL HEALTH BENEFITS COVERAGE.—
11 For purposes of this section, the term ‘essential health
12 benefits coverage’ has the meaning given such term by sec-
13 tion 5000A(f).”.

14 (b) ASSESSABLE PENALTIES.—

15 (1) Subparagraph (B) of section 6724(d)(1) of
16 the Internal Revenue Code of 1986 (relating to defi-
17 nitions) is amended by striking “or” at the end of
18 clause (xxii), by striking “and” at the end of clause
19 (xxiii) and inserting “or”, and by inserting after
20 clause (xxiii) the following new clause:

21 “(xxiv) section 6055 (relating to re-
22 turns relating to information regarding
23 health insurance coverage), and”.

24 (2) Paragraph (2) of section 6724(d) of such
25 Code is amended by striking “or” at the end of sub-

1 paragraph (EE), by striking the period at the end
2 of subparagraph (FF) and inserting “, or” and by
3 inserting after subparagraph (FF) the following new
4 subparagraph:

5 “(GG) section 6055(c) (relating to state-
6 ments relating to information regarding health
7 insurance coverage).”.

8 (c) CONFORMING AMENDMENT.—The table of sub-
9 parts for part III of subchapter A of chapter 61 of such
10 Code is amended by inserting after the item relating to
11 subpart C the following new item:

“SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to calendar years beginning after
14 2012.

15 **PART II—EMPLOYER RESPONSIBILITY**

16 **SEC. 1306. EMPLOYER SHARED RESPONSIBILITY REQUIRE-** 17 **MENT.**

18 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
19 enue Code of 1986 is amended by adding at the end the
20 following:

21 **“SEC. 4980H. EMPLOYER RESPONSIBILITY TO PROVIDE** 22 **HEALTH COVERAGE.**

23 “(a) IMPOSITION OF EXCISE TAX.—If—

24 “(1) an applicable large employer fails to meet
25 the health insurance coverage requirements of sub-

1 section (c) with respect to its full-time employees,
2 and

3 “(2) any such full-time employee of the em-
4 ployer is enrolled for any month during the period
5 of such failure in a qualified health benefits plan
6 with respect to which an applicable premium credit
7 or cost-sharing subsidy is allowed or paid with re-
8 spect to the employee,

9 there is hereby imposed on such failure with respect to
10 each such employee for each such month a tax in the
11 amount determined under subsection (b).

12 “(b) AMOUNT OF TAX.—

13 “(1) IN GENERAL.—The tax determined under
14 this subsection with respect to a failure involving an
15 employee for any month described in subsection
16 (a)(2) shall be equal to $\frac{1}{12}$ of the dollar amount
17 which the Secretary of Health and Human Services
18 determines (on the basis of the most recent data
19 available) is equal to the sum of the average annual
20 credit allowed under section 36B and the average
21 annual cost-sharing subsidy under section 2247 of
22 the Social Security Act for taxable years beginning
23 in the calendar year preceding the calendar year in
24 which such month occurs. In the case of a month oc-
25 ccurring during 2013, the Secretary shall determine

1 the average annual credit and subsidy on the basis
2 of the aggregate amount of credits and subsidies
3 (expressed as an annual amount) for which appli-
4 cants were determined eligible during the initial
5 open enrollment period under section 2237(d)(2)(A)
6 of the Social Security Act.

7 “(2) OVERALL LIMITATION.—

8 “(A) IN GENERAL.—The aggregate
9 amount of tax determined under paragraph (1)
10 with respect to all employees of an applicable
11 large employer for any month shall not exceed
12 $\frac{1}{12}$ of the product of—

13 “(i) \$400, and

14 “(ii) the average number of full-time
15 employees of the employer on business
16 days during the calendar year preceding
17 the calendar year in which such month oc-
18 curs (determined in the same manner as
19 under subsection (d)(1)).

20 “(B) INDEXING.—In the case of any cal-
21 endar year after 2013, the \$400 amount under
22 subparagraph (A)(i) shall be increased by an
23 amount equal to the product of—

24 “(i) \$400, and

1 “(ii) the premium adjustment percent-
2 age (as defined in section 2242(c)(7) of
3 the Social Security Act) for the calendar
4 year.

5 If the amount of any increase under this sub-
6 paragraph is not a multiple of \$10, such in-
7 crease shall be rounded to the next lowest mul-
8 tiple of \$10.

9 “(c) HEALTH INSURANCE COVERAGE REQUIRE-
10 MENTS.—For purposes of this section—

11 “(1) IN GENERAL.—An applicable large em-
12 ployer meets the health insurance coverage require-
13 ments of this subsection if the employer—

14 “(A) in the case of an employer in the
15 small group market in a State, offers to its full-
16 time employees (and their dependents) the op-
17 portunity to enroll in a qualified health benefits
18 plan or a grandfathered health benefits plan,
19 and

20 “(B) in the case of an employer in the
21 large group market in a State, offers to its full-
22 time employees (and their dependents) the op-
23 portunity to enroll in a group health plan meet-
24 ing the requirements of section 2244 of the So-

1 cial Security Act or a grandfathered health ben-
2 efits plan.

3 “(2) EXCEPTION WHERE COVERAGE IS
4 UNAFFORDABLE OR FAILS TO PROVIDE MINIMUM
5 VALUE.—An employer shall not be treated as meet-
6 ing the requirements of this subsection with respect
7 to any employee if—

8 “(A) the employee is eligible for the credit
9 allowable under section 36B because the em-
10 ployee’s required contribution under the plan
11 described in paragraph (1) is determined to be
12 unaffordable under section 36B(c)(2)(C), or

13 “(B) in the case of a plan (other than a
14 qualified health benefits plan) offered under
15 paragraph (1), the plan’s share of the total al-
16 lowed costs of benefits provided under the plan
17 is less than 65 percent of such costs.

18 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
19 poses of this section—

20 “(1) APPLICABLE LARGE EMPLOYER.—

21 “(A) IN GENERAL.—The term ‘applicable
22 large employer’ means, with respect to a cal-
23 endar year, an employer who employed an aver-
24 age of at least 50 employees on business days
25 during the preceding calendar year.

1 “(B) RULES FOR DETERMINING EM-
2 PLOYER SIZE.—For purposes of this para-
3 graph—

4 “(i) APPLICATION OF AGGREGATION
5 RULE FOR EMPLOYERS.—All persons treat-
6 ed as a single employer under subsection
7 (b), (c), (m), or (o) of section 414 of the
8 Internal Revenue Code of 1986 shall be
9 treated as 1 employer.

10 “(ii) EMPLOYERS NOT IN EXISTENCE
11 IN PRECEDING YEAR.—In the case of an
12 employer which was not in existence
13 throughout the preceding calendar year,
14 the determination of whether such em-
15 ployer is an applicable large employer shall
16 be based on the average number of employ-
17 ees that it is reasonably expected such em-
18 ployer will employ on business days in the
19 current calendar year.

20 “(iii) PREDECESSORS.—Any reference
21 in this subsection to an employer shall in-
22 clude a reference to any predecessor of
23 such employer.

1 “(2) APPLICABLE PREMIUM CREDIT AND COST-
2 SHARING SUBSIDY.—The term ‘applicable premium
3 credit and cost-sharing subsidy’ means—

4 “(A) any premium credit allowed under
5 section 36B (and any advance payment of the
6 credit under section 2248 of the Social Security
7 Act), and

8 “(B) any cost-sharing subsidy payment
9 under section 2247 of such Act.

10 “(3) FULL-TIME EMPLOYEE.—

11 “(A) IN GENERAL.—The term ‘full-time
12 employee’ means an employee who is employed
13 on average at least 30 hours per week.

14 “(B) SPECIAL RULES.—The Secretary
15 shall prescribe such regulations, rules, and
16 guidance as may be necessary to apply this
17 paragraph to employees who are not com-
18 pensated on an hourly basis.

19 “(4) OTHER DEFINITIONS.—Any term used in
20 this section which is also used in title XXII of the
21 Social Security Act shall have the same meaning as
22 when used in such title.

23 “(5) TAX NONDEDUCTIBLE.—For denial of de-
24 duction for the tax imposed by this section, see sec-
25 tion 275(a)(6).

1 “(e) TIME FOR PAYMENT OF TAX.—The Secretary
2 may provide for the payment of the tax imposed by this
3 section on an annual, monthly, or other periodic basis as
4 the Secretary may prescribe.”.

5 (b) CLERICAL AMENDMENT.—The table of sections
6 for chapter 43 of such Code is amended by adding at the
7 end the following new item:

“Sec. 4980H. Employer responsibility to provide health coverage.”.

8 (c) STUDY AND REPORT OF EFFECT OF TAX ON
9 WORKERS’ WAGES.—

10 (1) IN GENERAL.—The Secretary of Labor shall
11 conduct a study to determine whether employees’
12 wages are reduced by reason of the application of
13 the tax imposed under section 4980H of the Internal
14 Revenue Code of 1986 (as added by the amendments
15 made by this section). The Secretary shall make
16 such determination on the basis of the National
17 Compensation Survey published by the Bureau of
18 Labor Statistics.

19 (2) REPORT.—The Secretary shall report the
20 results of the study under paragraph (1) to the
21 Committee on Ways and Means of the House of
22 Representatives and to the Committee on Finance of
23 the Senate.

1 (d) **EFFECTIVE DATE.**—The amendments made by
2 this section shall apply to periods beginning after June
3 30, 2013.

4 **SEC. 1307. REPORTING OF EMPLOYER HEALTH INSURANCE**
5 **COVERAGE.**

6 (a) **IN GENERAL.**—Subpart D of part III of sub-
7 chapter A of chapter 61 of the Internal Revenue Code of
8 1986, as added by section 1302, is amended by inserting
9 after section 6055 the following new section:

10 **“SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON**
11 **HEALTH INSURANCE COVERAGE.**

12 “(a) **IN GENERAL.**—Every applicable large employer
13 required to meet the requirements of section 4980H(c)
14 with respect to its full-time employees during a calendar
15 year shall, at such time as the Secretary may prescribe,
16 make a return described in subsection (b).

17 “(b) **FORM AND MANNER OF RETURN.**—A return is
18 described in this subsection if such return—

19 “(1) is in such form as the Secretary may pre-
20 scribe, and

21 “(2) contains—

22 “(A) the name, date, and employer identi-
23 fication number of the employer,

24 “(B) a certification as to whether the em-
25 ployer offers to its full-time employees (and

1 their dependents) the opportunity to enroll in a
2 health benefits plan or a grandfathered health
3 benefits plan described in section 4980H(c) and
4 applicable to the employer,

5 “(C) if the employer certifies that the em-
6 ployer did offer to its full-time employees (and
7 their dependents) the opportunity to so enroll—

8 “(i) the months during the calendar
9 year for which coverage was available, and

10 “(ii) the monthly premium for the
11 lowest cost option in each of the enroll-
12 ment categories under each health benefits
13 plan offered to employees,

14 “(D) the name, address, and TIN of each
15 full-time employee during the calendar year and
16 the months (if any) during which such employee
17 (and any dependents) were covered under any
18 such health benefits plans and,

19 “(E) such other information as the Sec-
20 retary may require.

21 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
22 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
23 PORTED.—

24 “(1) IN GENERAL.—Every person required to
25 make a return under subsection (a) shall furnish to

1 each full-time employee whose name is required to
2 be set forth in such return under subsection
3 (b)(2)(D) a written statement showing—

4 “(A) the name and address of the person
5 required to make such return and the phone
6 number of the information contact for such per-
7 son, and

8 “(B) the information required to be shown
9 on the return with respect to such individual.

10 “(2) TIME FOR FURNISHING STATEMENTS.—

11 The written statement required under paragraph (1)
12 shall be furnished on or before January 31 of the
13 year following the calendar year for which the return
14 under subsection (a) was required to be made.

15 “(d) COORDINATION WITH OTHER REQUIRE-
16 MENTS.—To the maximum extent feasible, the Secretary
17 may provide that—

18 “(1) any return or statement required to be
19 provided under this section may be provided as part
20 of any return or statement required under section
21 6051 or 6055, and

22 “(2) in the case of an applicable large employer
23 offering a health benefits plan of a health insurance
24 issuer, the employer may enter into an agreement
25 with the issuer to include information required

1 under this section with the return and statement re-
2 quired to be provided by the issuer under section
3 6055.

4 “(e) COVERAGE PROVIDED BY GOVERNMENTAL
5 UNITS.—In the case of any applicable large employer
6 which is a governmental unit or any agency or instrumen-
7 tality thereof, the person appropriately designated for pur-
8 poses of this section shall make the returns and state-
9 ments required by this section.

10 “(f) DEFINITIONS.—For purposes of this section, any
11 term used in this section which is also used in section
12 4980H shall have the meaning given such term by section
13 4980H.”

14 (b) ASSESSABLE PENALTIES.—

15 (1) Subparagraph (B) of section 6724(d)(1) of
16 the Internal Revenue Code of 1986 (relating to defi-
17 nitions), as amended by section 1302, is amended by
18 striking “or” at the end of clause (xxiii), by striking
19 “and” at the end of clause (xxiv) and inserting “or”,
20 and by inserting after clause (xxiv) the following
21 new clause:

22 “(xxv) section 6056 (relating to re-
23 turns relating to large employers required
24 to report on health insurance coverage),
25 and”.

1 (2) Paragraph (2) of section 6724(d) of such
2 Code, as so amended, is amended by striking “or”
3 at the end of subparagraph (FF), by striking the pe-
4 riod at the end of subparagraph (GG) and inserting
5 “, or” and by inserting after subparagraph (GG) the
6 following new subparagraph:

7 “(HH) section 6056(c) (relating to state-
8 ments relating to large employers required to
9 report on health insurance coverage).”.

10 (c) CONFORMING AMENDMENT.—The table of sec-
11 tions for subpart D of part III of subchapter A of chapter
12 61 of such Code, as added by section 1302, is amended
13 by adding at the end the following new item:

“Sec. 6056. Large employers required to report on health insurance coverage.”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to periods beginning after June
16 30, 2013.

17 **Subtitle E—Federal Program for** 18 **Health Care Cooperatives**

19 **SEC. 1401. ESTABLISHMENT OF FEDERAL PROGRAM FOR** 20 **HEALTH CARE COOPERATIVES.**

21 (a) IN GENERAL.—Title XXII of the Social Security
22 Act (as added by section 1001 and amended by sections
23 1101 and 1201) is amended by adding at the end the fol-
24 lowing:

1 **“PART D—FEDERAL PROGRAM FOR HEALTH**
2 **CARE COOPERATIVES**

3 **“SEC. 2251. FEDERAL PROGRAM TO ASSIST ESTABLISH-**
4 **MENT AND OPERATION OF NONPROFIT, MEM-**
5 **BER-RUN HEALTH INSURANCE ISSUERS.**

6 “(a) ESTABLISHMENT OF PROGRAM.—

7 “(1) IN GENERAL.—The Secretary shall estab-
8 lish a program to carry out the purposes of this sec-
9 tion to be known as the Consumer Operated and
10 Oriented Plan (CO-OP) program.

11 “(2) PURPOSE.—It is the purpose of the CO-
12 OP program to foster the creation of qualified non-
13 profit health insurance issuers to offer qualified
14 health benefits plans in the individual and small
15 group markets in the States in which the issuers are
16 licensed to offer such plans.

17 “(b) LOANS AND GRANTS UNDER THE CO-OP PRO-
18 GRAM.—

19 “(1) IN GENERAL.—The Secretary shall provide
20 through the CO-OP program for the awarding to
21 persons applying to become qualified nonprofit
22 health insurance issuers of—

23 “(A) loans to provide assistance to such
24 person in meeting its start-up costs; and

25 “(B) grants to provide assistance to such
26 person in meeting any solvency requirements of

1 States in which the person seeks to be licensed
2 to issue qualified health benefits plans.

3 “(2) REQUIREMENTS FOR AWARDING LOANS
4 AND GRANTS.—

5 “(A) IN GENERAL.—In awarding loans and
6 grants under the CO-OP program, the Sec-
7 retary shall—

8 “(i) take into account the rec-
9 ommendations of the advisory board estab-
10 lished under paragraph (3);

11 “(ii) give priority to applicants that
12 will offer qualified health benefits plans on
13 a Statewide basis, will utilize integrated
14 care models, and have significant private
15 support; and

16 “(iii) ensure that there is sufficient
17 funding to establish at least 1 qualified
18 nonprofit health insurance issuer in each
19 State, except that nothing in this clause
20 shall prohibit the Secretary from funding
21 the establishment of multiple qualified
22 nonprofit health insurance issuers in any
23 State if the funding is sufficient to do so.

24 “(B) STATES WITHOUT ISSUERS IN PRO-
25 GRAM.—If no health insurance issuer applies to

1 be a qualified nonprofit health insurance issuer
2 within a State, the Secretary may use amounts
3 appropriated under this section for the award-
4 ing of grants to encourage the establishment of
5 a qualified nonprofit health insurance issuer
6 within the State or the expansion of a qualified
7 nonprofit health insurance issuer from another
8 State to the State.

9 “(C) AGREEMENT.—

10 “(i) IN GENERAL.—The Secretary
11 shall require any person receiving a loan or
12 grant under the CO-OP program to enter
13 into an agreement with the Secretary
14 which requires such person to meet (and to
15 continue to meet)—

16 “(I) any requirement under this
17 section for such person to be treated
18 as a qualified nonprofit health insur-
19 ance issuer; and

20 “(II) any requirements contained
21 in the agreement for such person to
22 receive such loan or grant.

23 “(ii) RESTRICTIONS ON USE OF FED-
24 ERAL FUNDS.—The agreement shall in-
25 clude a requirement that no portion of the

1 funds made available by any loan or grant
2 under this section may be used—

3 “(I) for carrying on propaganda,
4 or otherwise attempting, to influence
5 legislation; or

6 “(II) for marketing.

7 Nothing in this clause shall be construed
8 to allow a person to take any action pro-
9 hibited by section 501(c)(29) of the Inter-
10 nal Revenue Code of 1986.

11 “(iii) FAILURE TO MEET REQUIRE-
12 MENTS.—If the Secretary determines that
13 a person has failed to meet any require-
14 ment described in clause (i) or (ii) and has
15 failed to correct such failure within a rea-
16 sonable period of time of when the person
17 first knows (or reasonably should have
18 known) of such failure, such person shall
19 repay to the Secretary an amount equal to
20 the sum of—

21 “(I) 110 percent of the aggregate
22 amount of loans and grants received
23 under this section; plus

24 “(II) interest on the aggregate
25 amount of loans and grants received

1 under this section for the period the
2 loans or grants were outstanding.

3 The Secretary shall notify the Secretary of
4 the Treasury of any determination under
5 this section of a failure that results in the
6 termination of an issuer's tax-exempt sta-
7 tus under section 501(c)(29) of such Code.

8 “(D) TIME FOR AWARDING LOANS AND
9 GRANTS.—The Secretary shall not later than
10 January 1, 2012, award the loans and grants
11 under the CO-OP program and begin the dis-
12 tribution of amounts awarded under such loans
13 and grants.

14 “(3) ADVISORY BOARD.—

15 “(A) IN GENERAL.—The advisory board
16 under this paragraph shall consist of 15 mem-
17 bers appointed by the Comptroller General of
18 the United States from among individuals with
19 qualifications described in section 1805(c)(2).

20 “(B) RULES RELATING TO APPOINT-
21 MENTS.—

22 “(i) STANDARDS.—Any individual ap-
23 pointed under subparagraph (A) shall meet
24 ethics and conflict of interest standards

1 protecting against insurance industry in-
2 volvement and interference.

3 “(ii) ORIGINAL APPOINTMENTS.—The
4 original appointment of board members
5 under subparagraph (A)(ii) shall be made
6 no later than 3 months after the date of
7 enactment of this title.

8 “(C) VACANCY.—Any vacancy on the advi-
9 sory board shall be filled in the same manner
10 as the original appointment.

11 “(D) PAY AND REIMBURSEMENT.—

12 “(i) NO COMPENSATION FOR MEM-
13 BERS OF ADVISORY BOARD.—Except as
14 provided in clause (ii), a member of the ad-
15 visory board may not receive pay, allow-
16 ances, or benefits by reason of their service
17 on the board.

18 “(ii) TRAVEL EXPENSES.—Each
19 member shall receive travel expenses, in-
20 cluding per diem in lieu of subsistence
21 under subchapter I of chapter 57 of title 5,
22 United States Code.

23 “(E) APPLICATION OF FACA.—The Federal
24 Advisory Committee Act (5 U.S.C. App.) shall

1 apply to the advisory board, except that section
2 14 of such Act shall not apply.

3 “(F) TERMINATION.—The advisory board
4 shall terminate on the earlier of the date that
5 it completes its duties under this section or De-
6 cember 31, 2015.

7 “(c) QUALIFIED NONPROFIT HEALTH INSURANCE
8 ISSUER.—For purposes of this section—

9 “(1) IN GENERAL.—The term ‘qualified non-
10 profit health insurance issuer’ means a health insur-
11 ance issuer that is an organization—

12 “(A) that is organized under State law as
13 a nonprofit, member corporation;

14 “(B) substantially all of the activities of
15 which consist of the issuance of qualified health
16 benefits plans in the individual and small group
17 markets in each State in which it is licensed to
18 issue such plans; and

19 “(C) that meets the other requirements of
20 this subsection.

21 “(2) CERTAIN ORGANIZATIONS PROHIBITED.—
22 An organization shall not be treated as a qualified
23 nonprofit health insurance issuer if—

1 “(A) the organization or a related entity
2 (or any predecessor of either) was a health in-
3 surance issuer on July 16, 2009; or

4 “(B) the organization is sponsored by a
5 State or local government, any political subdivi-
6 sion thereof, or any instrumentality of such
7 government or political subdivision.

8 “(3) GOVERNANCE REQUIREMENTS.—An orga-
9 nization shall not be treated as a qualified nonprofit
10 health insurance issuer unless—

11 “(A) the governance of the organization is
12 subject to a majority vote of its members;

13 “(B) its governing documents incorporate
14 ethics and conflict of interest standards pro-
15 tecting against insurance industry involvement
16 and interference; and

17 “(C) as provided in regulations promul-
18 gated by the Secretary, the organization is re-
19 quired to operate with a strong consumer focus,
20 including timeliness, responsiveness, and ac-
21 countability to members.

22 “(4) PROFITS INURE TO BENEFIT OF MEM-
23 BERS.—An organization shall not be treated as a
24 qualified nonprofit health insurance issuer unless
25 any profits made by the organization are required to

1 be used to lower premiums, to improve benefits, or
2 for other programs intended to improve the quality
3 of health care delivered to its members.

4 “(5) COMPLIANCE WITH STATE INSURANCE
5 LAWS.—An organization shall not be treated as a
6 qualified nonprofit health insurance issuer unless the
7 organization meets all the requirements that other
8 offerors of qualified health benefits are required to
9 meet in any State where the issuer offers a qualified
10 health benefits plan, including solvency and licensure
11 requirements, rules on payments to providers, and
12 compliance with network adequacy rules, rate and
13 form filing rules, and any applicable State premium
14 assessments.

15 “(6) COORDINATION WITH STATE INSURANCE
16 REFORMS.—An organization shall not be treated as
17 a qualified nonprofit health insurance issuer unless
18 the organization does not offer a health benefits plan
19 in a State until that State has in effect the Model
20 Regulation, Federal standard, or State law described
21 in section 2225(a)(2).

22 “(d) ESTABLISHMENT OF PRIVATE PURCHASING
23 COUNCIL.—

24 “(1) IN GENERAL.—Qualified nonprofit health
25 insurance issuers participating in the CO-OP pro-

1 gram under this section may establish a private pur-
2 chasing council to enter into collective purchasing
3 arrangements for items and services that increase
4 administrative and other cost efficiencies, including
5 claims administration, administrative services, health
6 information technology, and actuarial services.

7 “(2) COUNCIL MAY NOT SET PAYMENT
8 RATES.—The private purchasing council established
9 under paragraph (1) shall not set payment rates for
10 health care facilities or providers participating in
11 health insurance coverage provided by qualified non-
12 profit health insurance issuers.

13 “(3) CONTINUED APPLICATION OF ANTITRUST
14 LAWS.—

15 “(A) IN GENERAL.—Nothing in this sec-
16 tion shall be construed to limit the application
17 of the antitrust laws to any private purchasing
18 council (whether or not established under this
19 subsection) or to any qualified nonprofit health
20 insurance issuer participating in such a council.

21 “(B) ANTITRUST LAWS.—For purposes of
22 this subparagraph, the term ‘antitrust laws’ has
23 the meaning given the term in subsection (a) of
24 the first section of the Clayton Act (15 U.S.C.
25 12(a)). Such term also includes section 5 of the

1 Federal Trade Commission Act (15 U.S.C. 45)
2 to the extent that such section 5 applies to un-
3 fair methods of competition.

4 “(e) LIMITATION ON PARTICIPATION.—No represent-
5 ative of any Federal, State, or local government (or of any
6 political subdivision or instrumentality thereof), and no
7 representative of a person described in subsection
8 (c)(2)(A), may serve on the board of directors of a quali-
9 fied nonprofit health insurance issuer or with a private
10 purchasing council established under subsection (d).

11 “(f) LIMITATIONS ON SECRETARY.—

12 “(1) IN GENERAL.—The Secretary shall not—

13 “(A) participate in any negotiations be-
14 tween 1 or more qualified nonprofit health in-
15 surance issuers (or a private purchasing council
16 established under subsection (d)) and any
17 health care facilities or providers, including any
18 drug manufacturer, pharmacy, or hospital; and

19 “(B) establish or maintain a price struc-
20 ture for reimbursement of any health benefits
21 covered by such issuers.

22 “(2) COMPETITION.—Nothing in this section
23 shall be construed as authorizing the Secretary to
24 interfere with the competitive nature of providing

1 health benefits through qualified nonprofit health in-
2 surance issuers.

3 “(g) STATE.—For purposes of this section, the term
4 ‘State’ means each of the 50 States and the District of
5 Columbia.

6 “(h) APPROPRIATIONS.—There are hereby appro-
7 priated, out of any funds in the Treasury not otherwise
8 appropriated, \$6,000,000,000 to carry out this section.”.

9 (b) TAX EXEMPTION FOR QUALIFIED NONPROFIT
10 HEALTH INSURANCE ISSUER.—

11 (1) IN GENERAL.—Section 501(c) of the Inter-
12 nal Revenue Code of 1986 (relating to list of exempt
13 organizations) is amended by adding at the end the
14 following:

15 “(29) CO-OP HEALTH INSURANCE ISSUERS.—

16 “(A) IN GENERAL.—A qualified nonprofit
17 health insurance issuer (within the meaning of
18 section 2251 of the Social Security Act) which
19 has received a loan or grant under the CO-OP
20 program under such section, but only with re-
21 spect to periods for which the issuer is in com-
22 pliance with the requirements of such section
23 and any agreement with respect to the loan or
24 grant.

1 “(B) CONDITIONS FOR EXEMPTION.—Sub-
2 paragraph (A) shall apply to an organization
3 only if—

4 “(i) the organization has given notice
5 to the Secretary, in such manner as the
6 Secretary may by regulations prescribe,
7 that it is applying for recognition of its
8 status under this paragraph,

9 “(ii) except as provided in section
10 2251(c)(4) of the Social Security Act, no
11 part of the net earnings of which inures to
12 the benefit of any private shareholder or
13 individual,

14 “(iii) no substantial part of the activi-
15 ties of which is carrying on propaganda, or
16 otherwise attempting, to influence legisla-
17 tion, and

18 “(iv) the organization does not par-
19 ticipate in, or intervene in (including the
20 publishing or distributing of statements),
21 any political campaign on behalf of (or in
22 opposition to) any candidate for public of-
23 fice.”.

24 (2) ADDITIONAL REPORTING REQUIREMENT.—
25 Section 6033 of such Code (relating to returns by

1 exempt organizations) is amended by redesignating
2 subsection (m) as subsection (n) and by inserting
3 after subsection (l) the following:

4 “(m) **ADDITIONAL INFORMATION REQUIRED FROM**
5 **CO-OP INSURERS.**—An organization described in section
6 501(c)(29) shall include on the return required under sub-
7 section (a) the following information:

8 “(1) The amount of the reserves required by
9 each State in which the organization is licensed to
10 issue qualified health benefits plans.

11 “(2) The amount of reserves on hand.”.

12 (3) **APPLICATION OF TAX ON EXCESS BENEFIT**
13 **TRANSACTIONS.**—Section 4958(e)(1) of such Code
14 (defining applicable tax-exempt organization) is
15 amended by striking “paragraph (3) or (4)” and in-
16 serting “paragraph (3), (4), or (29)”.

17 (c) **GAO STUDY AND REPORT.**—

18 (1) **STUDY.**—The Comptroller General of the
19 General Accountability Office shall conduct an ongo-
20 ing study on competition and market concentration
21 in the health insurance market in the United States
22 after the implementation of the reforms in such
23 market under the provisions of, and the amendments
24 made by, this Act. Such study shall include an anal-

1 ysis of new offerors of health insurance in such mar-
2 ket.

3 (2) REPORT.—The Comptroller General shall,
4 not later than December 31 of each even-numbered
5 year (beginning with 2014), report to the appro-
6 priate committees of the Congress the results of the
7 study conducted under paragraph (1), including any
8 recommendations for administrative or legislative
9 changes the Comptroller General determines nec-
10 essary or appropriate to increase competition in the
11 health insurance market.

12 **Subtitle F—Transparency and** 13 **Accountability**

14 **SEC. 1501. PROVISIONS ENSURING TRANSPARENCY AND** 15 **ACCOUNTABILITY.**

16 (a) IN GENERAL.—Title XXII of the Social Security
17 Act, as added by subtitle A, is amended by adding at the
18 end of subpart 4 of part A the following new section:

19 **“SEC. 2229. REQUIREMENTS RELATING TO TRANSPARENCY** 20 **AND ACCOUNTABILITY.**

21 “(a) OMBUDSMEN.—Each State shall establish an
22 ombudsmen program to address complaints related to
23 health benefits plans issued within the State. Such pro-
24 gram shall—

1 “(1) require each offeror of a health benefits
2 plan within a State to provide an internal claims ap-
3 peal process meeting the requirements of section
4 2226(e); and

5 “(2) authorize an individual covered by such a
6 health benefits plan to have access to the services of
7 an ombudsman—

8 “(A) if such an internal appeal lasts more
9 than 3 months or involves a life threatening
10 issue; or

11 “(B) to resolve problems with obtaining
12 premium credits under section 36B of the In-
13 ternal Revenue Code of 1986 or cost-sharing
14 assistance under section 2247.

15 “(b) HEALTH INSURANCE CONSUMER ASSISTANCE
16 GRANTS.—

17 “(1) IN GENERAL.—Each State shall establish
18 a program to provide grants to eligible entities to de-
19 velop, support, and evaluate consumer assistance
20 programs related to navigating options for health
21 benefits plan coverage and selecting the appropriate
22 health benefits plan coverage. Such program shall
23 include a fair and open application process and shall
24 attempt to ensure regional and geographic equity.

1 “(2) DATA COLLECTION.—As a condition of re-
2 ceiving a grant under paragraph (1), an organization
3 shall be required to collect and report data to the
4 Secretary on the types of problems and inquiries en-
5 countered by consumers served by the consumer as-
6 sistance programs.

7 “(3) FUNDING.—

8 “(A) INITIAL FUNDING.—There is hereby
9 appropriated to the Secretary, out of any funds
10 in the Treasury not otherwise appropriated,
11 \$30,000,000 for the fiscal year 2014 to carry
12 out this subsection. Such amount shall remain
13 available without fiscal year limitation.

14 “(B) AUTHORIZATION FOR SUBSEQUENT
15 YEARS.—There are authorized to be appro-
16 priated to the Secretary for each fiscal year fol-
17 lowing the fiscal year described in subparagraph
18 (A) such sums as may be necessary to carry out
19 this subsection.

20 “(4) ELIGIBLE ENTITIES.—In this section, the
21 term ‘eligible entity’ means any public, private, or
22 not-for-profit consumer assistance organizations.
23 Such term includes—

24 “(A) any commercial fishing organization,
25 any ranching or farming organization, or any

1 other organization capable of conducting com-
2 munity-based health care outreach and enroll-
3 ment assistance for workers who are hard to
4 reach or employed in rural areas; and

5 “(B) any Small Business Development
6 Center that is capable of assisting small busi-
7 nesses in getting access to health benefits
8 plans.”.

9 (b) CONFORMING AMENDMENT.—The table of sec-
10 tions for subpart 4 of part A of title XXII of the Social
11 Security Act, as added by subtitle A, is amended by adding
12 at the end the following new item:

“Sec. 2229. Requirements relating to transparency and accountability.”.

13 **SEC. 1502. REPORTING ON UTILIZATION OF PREMIUM DOL-**
14 **LARS AND STANDARD HOSPITAL CHARGES.**

15 (a) UTILIZATION OF PREMIUM DOLLARS.—

16 (1) IN GENERAL.—Each offeror of a health
17 benefits plan offering health insurance coverage
18 within the United States shall, with respect to each
19 plan year beginning after December 31, 2009, report
20 to the Secretary of Health and Human Services the
21 percentage of the premiums collected for such cov-
22 erage that are used to pay for items other than med-
23 ical care.

24 (2) SECRETARIAL AUTHORITY.—An offeror
25 shall make the report under paragraph (1) at such

1 time and in such manner as the Secretary of Health
2 and Human Services may prescribe by regulations.

3 (b) STANDARD HOSPITAL CHARGES.—Each hospital
4 operating within the United States shall for each calendar
5 year after 2009 establish (and update) a list of the hos-
6 pital’s standard charges for items and services provided
7 by the hospital, including for each diagnosis-related group
8 established under section 1886(d)(4) of the Social Secu-
9 rity Act (42 U.S.C. 1395ww).

10 **SEC. 1503. DEVELOPMENT AND UTILIZATION OF UNIFORM**
11 **OUTLINE OF COVERAGE DOCUMENTS.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall request the National Association of
14 Insurance Commissioners (referred to, in this section as
15 the “NAIC”) to develop, and submit to the Secretary not
16 later than 12 months after the date of enactment of this
17 Act, standards for use by health insurance issuers in com-
18 piling and providing to enrollees an outline of coverage
19 that accurately describes the coverage under the applicable
20 health insurance plan. In developing such standards, the
21 NAIC shall consult with a working group composed of rep-
22 resentatives of consumer advocacy organizations, issuers
23 of health insurance plans, and other qualified individuals.

1 (b) REQUIREMENTS.—The standards for the outline
2 of coverage developed under subsection (a) shall provide
3 for the following:

4 (1) APPEARANCE.—The standards shall ensure
5 that the outline of coverage is presented in a uni-
6 form format that does not exceed 4 pages in length
7 and does not include print smaller than 12-point
8 font.

9 (2) LANGUAGE.—The standards shall ensure
10 that the language used is presented in a manner de-
11 termined to be understandable by the average health
12 plan enrollee.

13 (3) CONTENTS.—The standards shall ensure
14 that the outline of coverage includes—

15 (A) the uniform definitions of standard in-
16 surance terms developed under section 1504;

17 (B) a description of the coverage, including
18 dollar amounts for coverage of—

19 (i) daily hospital room and board;

20 (ii) miscellaneous hospital services;

21 (iii) surgical services;

22 (iv) anesthesia services;

23 (v) physician services;

24 (vi) prevention and wellness services;

25 (vii) prescription drugs; and

1 (viii) other benefits, as identified by
2 the NAIC;

3 (C) the exceptions, reductions, and limita-
4 tions on coverage;

5 (D) the cost-sharing provisions, including
6 deductible, coinsurance, and co-payment obliga-
7 tions;

8 (E) the renewability and continuation of
9 coverage provisions;

10 (F) a statement that the outline is a sum-
11 mary of the policy or certificate and that the
12 coverage document itself should be consulted to
13 determine the governing contractual provisions;
14 and

15 (G) a contact number for the consumer to
16 call with additional questions and a web link
17 where a copy of the actual individual coverage
18 policy or group certificate of coverage can be re-
19 viewed and obtained.

20 For individual policies issued prior to January 1,
21 2014, the health insurance issuer will be deemed
22 compliant with the web link requirement if the
23 issuer makes a copy of the actual policy available
24 upon request.

25 (c) REGULATIONS.—

1 (1) SUBMISSION.—If, not later than 12 months
2 after the date of enactment of this Act, the NAIC
3 submits to the Secretary of Health and Human
4 Service the standards provided for under subsection
5 (a), the Secretary shall, not later than 60 days after
6 the date on which such standards are submitted,
7 promulgate regulations to apply such standards to
8 entities described in subsection (d)(3).

9 (2) FAILURE TO SUBMIT.—If the NAIC fails to
10 submit to the Secretary the standards under sub-
11 section (a) within the 12-month period provided for
12 in paragraph (1), the Secretary shall, not later than
13 90 days after the expiration of such 12-month pe-
14 riod, promulgate regulations providing for the appli-
15 cation of Federal standards for outlines of coverage
16 to entities described in subsection (d)(3).

17 (d) REQUIREMENT TO PROVIDE.—

18 (1) IN GENERAL.—Not later than 24 months
19 after the date of enactment of this Act, each entity
20 described in paragraph (3) shall deliver an outline of
21 coverage pursuant to the standards promulgated
22 by the Secretary under subsection (c) to—

23 (A) an applicant at the time of application;

24 (B) an enrollee at the time of enrollment;

25 or

1 (C) a policyholder or certificate holder at
2 the time of issuance of the policy or delivery of
3 the certificate.

4 (2) COMPLIANCE.—An entity described in para-
5 graph (3) is deemed in compliance with this section
6 if the outline of coverage is provided in paper or
7 electronic form.

8 (3) ENTITIES IN GENERAL.—An entity de-
9 scribed in this paragraph is—

10 (A) a health insurance issuer (including a
11 group health plan) offering health insurance
12 coverage within the United States (including
13 carriers under the Federal Employee Health
14 Benefits Program under chapter 89 of title 5,
15 United States Code); and

16 (B) the Secretary with respect to coverage
17 under the Medicare, Medicaid, and CHIP pro-
18 grams under titles XVIII, XIX, and XXI of the
19 Social Security Act (42 U.S.C. 1395, 1396,
20 1397aa et seq.).

21 (e) PREEMPTION.—The standards promulgated
22 under subsection (c) shall preempt any related State
23 standards that require an outline of coverage.

24 (f) FAILURE TO PROVIDE.—An entity described in
25 subsection (d)(3) that willfully fails to provide the infor-

1 mation required under this section shall be subject to a
2 fine of not more than \$1,000 for each such failure. Such
3 failure with respect to each enrollee shall constitute a sep-
4 arate offense for purposes of this subsection.

5 (g) DEFINITIONS.—For purposes of this section, any
6 term used in this section that is also used in title XXII
7 of the Social Security Act shall have the same meaning
8 as when used in such title.

9 **SEC. 1504. DEVELOPMENT OF STANDARD DEFINITIONS,**
10 **PERSONAL SCENARIOS, AND ANNUAL PER-**
11 **SONALIZED STATEMENTS.**

12 (a) DEFINING INSURANCE TERMS.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services shall, by regulations, provide for
15 the development of standards for the definitions of
16 terms used in health insurance coverage, including
17 insurance-related terms (including the insurance-re-
18 lated terms described in paragraph (2)) and medical
19 terms (including the medical terms described in
20 paragraph (3)).

21 (2) INSURANCE-RELATED TERMS.—The insur-
22 ance-related terms described in this paragraph are
23 premium, deductible, co-insurance, co-payment, out-
24 of-pocket limit, preferred provider, non-preferred
25 provider, out-of-network co-payments, UCR (usual,

1 customary and reasonable) fees, excluded services,
2 grievance and appeals, and such other terms as the
3 Secretary determines are important to define so that
4 consumers may compare health insurance coverage
5 and understand the terms of their coverage.

6 (3) MEDICAL TERMS.—The medical terms de-
7 scribed in this paragraph are hospitalization, hos-
8 pital outpatient care, emergency room care, physi-
9 cian services, prescription drug coverage, durable
10 medical equipment, home health care, skilled nursing
11 care, rehabilitation services, hospice services, emer-
12 gency medical transportation, and such other terms
13 as the Secretary determines are important to define
14 so that consumers may compare the medical benefits
15 offered by insurance health insurance and under-
16 stand the extent of those medical benefits (or excep-
17 tions to those benefits).

18 (b) COVERAGE FACTS LABELS FOR PATIENT CLAIMS
19 SCENARIOS.—The Secretary of Health and Human Serv-
20 ices shall, by regulations, develop standards for coverage
21 facts labels based on patient claims scenarios described in
22 the regulations, which include information on estimated
23 out-of-pocket cost-sharing and significant exclusions or
24 benefit limits for such scenarios.

1 (c) PERSONALIZED STATEMENT.—The Secretary of
2 Health and Human Services shall, by regulations, develop
3 standards for an annual personalized statement that sum-
4 marizes use of health care services and payment of claims
5 with respect to an enrollee (and covered dependents) under
6 health insurance coverage in the preceding year.

7 **Subtitle G—Role of Public**
8 **Programs**

9 **PART I—MEDICAID COVERAGE FOR THE LOWEST**
10 **INCOME POPULATIONS**

11 **SEC. 1601. MEDICAID COVERAGE FOR THE LOWEST INCOME**
12 **POPULATIONS.**

13 (a) COVERAGE FOR INDIVIDUALS WITH INCOME AT
14 OR BELOW 133 PERCENT OF THE POVERTY LINE.—

15 (1) BEGINNING 2014.—Section
16 1902(a)(10)(A)(i) of the Social Security Act (42
17 U.S.C. 1396a) is amended—

18 (A) by striking “or” at the end of sub-
19 clause (VI);

20 (B) by adding “or” at the end of subclause
21 (VII); and

22 (C) by inserting after subclause (VII) the
23 following:

24 “(VIII) beginning January 1,
25 2014, who are under 65 years of age,

1 not pregnant, and are not described in
2 a previous subclause of this clause,
3 and whose income (as determined
4 under subsection (e)(14)) does not ex-
5 ceed 133 percent of the poverty line
6 (as defined in section 2110(c)(5)) ap-
7 plicable to a family of the size in-
8 volved, subject to subsection (k);”.

9 (2) COVERAGE OF, AT A MINIMUM, ESSENTIAL
10 BENEFITS; INDIVIDUALS WITH INCOME EXCEEDING
11 100, BUT LESS THAN 133 PERCENT OF THE POVERTY
12 LINE MAY ELECT SUBSIDIZED EXCHANGE COVERAGE
13 INSTEAD OF MEDICAID.—Section 1902 of such Act
14 (42 U.S.C. 1396a) is amended by inserting after
15 subsection (j) the following:

16 “(k)(1) The medical assistance provided to an indi-
17 vidual described in subclause (VIII) of subsection
18 (a)(10)(A)(i) shall consist of benchmark coverage de-
19 scribed in section 1937(b)(1) or benchmark equivalent
20 coverage described in section 1937(b)(2). Such medical as-
21 sistance shall be provided subject to the requirements of
22 section 1937, without regard to whether a State otherwise
23 has elected the option to provide medical assistance
24 through coverage under that section, unless an individual
25 described in subclause (VIII) of subsection (a)(10)(A)(i)

1 is also an individual for whom, under subparagraph (B)
2 of section 1937(a)(2), the State may not require enroll-
3 ment in benchmark coverage described in subsection
4 (b)(1) of section 1937 or benchmark equivalent coverage
5 described in subsection (b)(2) of that section, or the indi-
6 vidual is a non-pregnant, non-elderly adult whose income
7 exceeds 100, but does not exceed 133 percent of the pov-
8 erty line (as defined in section 2110(c)(5)) applicable to
9 a family of the size involved, who has elected under section
10 1943(c) to enroll in a qualified health benefits plan
11 through an exchange established by the State under sec-
12 tion 2235.”.

13 (3) FEDERAL FUNDING FOR COST OF COVERING
14 NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of
15 the Social Security Act (42 U.S.C. 1396d), is
16 amended—

17 (A) in subsection (b), in the first sentence,
18 by inserting “subsection (y) and” before “sec-
19 tion 1933(d)”;

20 (B) by adding at the end the following new
21 subsection:

22 “(y) INCREASED FMAP FOR MEDICAL ASSISTANCE
23 FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

24 “(1) AMOUNT OF INCREASE.—

25 “(A) INITIAL EXPANSION PERIOD.—

1 “(i) IN GENERAL.—During the period
2 that begins on January 1, 2014, and ends
3 on December 31, 2018, notwithstanding
4 subsection (b) and subject to subpara-
5 graphs (C) and (D) and section
6 1902(gg)(5), the Federal medical assist-
7 ance percentage determined for a State
8 that is one of the 50 States or the District
9 of Columbia for each fiscal year quarter
10 occurring during that period with respect
11 to amounts expended for medical assist-
12 ance for newly eligible individuals de-
13 scribed in subclause (VIII) of section
14 1902(a)(10)(A)(i), shall be increased by
15 the applicable percentage point increase
16 specified in clause (ii) for the quarter and
17 the State.

18 “(ii) APPLICABLE PERCENTAGE POINT
19 INCREASE.—

20 “(I) IN GENERAL.—For purposes
21 of clause (i), the applicable percentage
22 point increase for a quarter is the fol-
23 lowing:

1 demonstration program authorized
2 under section 1938. A State that of-
3 fers health benefits coverage to only
4 parents or only nonpregnant childless
5 adults described in the preceding sen-
6 tence shall not be considered to be an
7 expansion State.

8 “(B) 2019 AND SUCCEEDING YEARS.—Be-
9 ginning January 1, 2019, notwithstanding sub-
10 section (b) but subject to subparagraph (C), the
11 Federal medical assistance percentage deter-
12 mined for a State that is one of the 50 States
13 or the District of Columbia for each fiscal year
14 quarter occurring during that period with re-
15 spect to amounts expended for medical assist-
16 ance for newly eligible individuals described in
17 subclause (VIII) of section 1902(a)(10)(A)(i),
18 shall be increased by 32.3 percentage points.

19 “(C) LIMITATION.—The Federal medical
20 assistance percentage determined for a State
21 under subparagraph (A) or (B) shall in no case
22 be more than 95 percent.

23 “(D) HIGH-NEED STATES.—Notwith-
24 standing subparagraph (A), in the case of a
25 high-need State, during the period that begins

1 on January 1, 2014, and ends on December 31,
2 2018, the Federal medical assistance percent-
3 age determined for each fiscal year quarter oc-
4 ccurring during that period with respect to
5 amounts expended for medical assistance for
6 newly eligible individuals described in subclause
7 (VIII) of section 1902(a)(10)(A)(i), shall be
8 equal to 100 percent. For purposes of the pre-
9 ceding sentence, the term ‘high-need State’
10 means a State that is one of the 50 States or
11 the District of Columbia, on the date of the en-
12 actment of the America’s Healthy Future Act
13 of 2009, has a total Medicaid enrollment under
14 the State plan under this title and under any
15 waiver of the plan that is below the national av-
16 erage for Medicaid enrollment as a percentage
17 of State population, and for August 2009, has
18 a seasonally-adjusted unemployment rate that is
19 at least 12 percent, as determined by the Bu-
20 reau of Labor Statistics of the Department of
21 Labor.

22 “(2) DEFINITIONS.—In this subsection:

23 “(A) NEWLY ELIGIBLE.—The term ‘newly
24 eligible’ means, with respect to an individual de-
25 scribed in subclause (VIII) of section

1 1902(a)(10)(A)(i), an individual who is not
2 under 19 years of age (or such higher age as
3 the State may have elected under section
4 1902(l)(1)(D)) and who, on the date of enact-
5 ment of the America’s Healthy Future Act of
6 2009, is not eligible under the State plan or
7 under a waiver of the plan for full benefits or
8 for benchmark coverage described in subpara-
9 graph (A), (B), or (C) of section 1937(b)(1) or
10 benchmark equivalent coverage described in sec-
11 tion 1937(b)(2) that has an aggregate actuarial
12 value that is at least actuarially equivalent to
13 benchmark coverage described in subparagraph
14 (A), (B), or (C) of section 1937(b)(1), or is eli-
15 gible but not enrolled (or is on a waiting list)
16 for such benefits or coverage through a waiver
17 under the plan that has a capped or limited en-
18 rollment that is full.

19 “(B) FULL BENEFITS.—The term ‘full
20 benefits’ means, with respect to an individual,
21 medical assistance for all services covered under
22 the State plan under this title that is not less
23 in amount, duration, or scope, or is determined
24 by the Secretary to be substantially equivalent,

1 to the medical assistance available for an indi-
2 vidual described in section 1902(a)(10)(A)(i).”.

3 (4) STATE OPTION TO OFFER COVERAGE EAR-
4 LIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN
5 REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE
6 ELIGIBLE.—Subsection (k) of section 1902 of the
7 Social Security Act (as added by paragraph (2)), is
8 amended by inserting after paragraph (1) the fol-
9 lowing:

10 “(2) A State may elect through a State plan amend-
11 ment to provide medical assistance to individuals described
12 in subclause (VIII) of subsection (a)(10)(A)(i) beginning
13 with the first day of any fiscal year quarter that begins
14 on or after January 1, 2011, and before January 1, 2014.
15 A State may elect to phase-in the extension of eligibility
16 for medical assistance to such individuals based on in-
17 come, so long as the State does not extend such eligibility
18 to individuals described in such subclause with higher in-
19 come before making individuals described in such sub-
20 clause with lower income eligible for medical assistance.

21 “(3) If the State has elected the option to provide
22 for a period of presumptive eligibility under section 1920
23 or 1920A, the State may elect to provide for a period of
24 presumptive eligibility for medical assistance (not to ex-
25 ceed 60 days) for individuals described in subclause (VIII)

1 of subsection (a)(10)(A)(i) in the same manner as the
2 State provides for such a period under that section, sub-
3 ject to such guidance as the Secretary shall establish.

4 “(4) If an individual described in subclause (VIII) of
5 subsection (a)(10)(A)(i) is the parent of a child who is
6 under 19 years of age (or such higher age as the State
7 may have elected under section 1902(l)(1)(D)) who is eli-
8 gible for medical assistance under the State plan or under
9 a waiver of such plan, the individual may not be enrolled
10 under the State plan unless the individual’s child is en-
11 rolled under the State plan or under a waiver of the plan
12 or is enrolled in other health insurance coverage. For pur-
13 poses of the preceding sentence, the term ‘parent’ includes
14 an individual treated as a caretaker relative for purposes
15 of carrying out section 1931 and a noncustodial parent.”.

16 (5) CONFORMING AMENDMENTS.—

17 (A) Section 1902(a)(10) of such Act (42
18 U.S.C. 1396a(a)(10)) is amended in the matter
19 following subparagraph (G), by striking “and
20 (XIV)” and inserting “(XIV)” and by inserting
21 “and (XV) the medical assistance made avail-
22 able to an individual described in subparagraph
23 (A)(i)(VIII) shall be limited to medical assist-
24 ance described in subsection (k)(1)” before the
25 semicolon.

1 (B) Section 1902(l)(2)(C) of such Act (42
2 U.S.C. 1396a(l)(2)(C)) is amended by striking
3 “100” and inserting “133”.

4 (C) Section 1905(a) of such Act (42
5 U.S.C. 1396d(a)) is amended in the matter pre-
6 ceding paragraph (1)—

7 (i) by striking “or” at the end of
8 clause (xii);

9 (ii) by inserting “or” at the end of
10 clause (xiii); and

11 (iii) by inserting after clause (xiii) the
12 following:

13 “(xiv) individuals described in section
14 1902(a)(10)(A)(i)(VIII),”.

15 (D) Section 1903(f)(4) of such Act (42
16 U.S.C. 1396b(f)(4)) is amended by inserting
17 “1902(a)(10)(A)(i)(VIII),” after
18 “1902(a)(10)(A)(i)(VII),”.

19 (E) Section 1937(a)(1)(B) of such Act (42
20 U.S.C. 1396u-7(a)(1)(B)) is amended by in-
21 serting “subclause (VIII) of section
22 1902(a)(10)(A)(i) or under” after “eligible
23 under”.

1 (b) MAINTENANCE OF MEDICAID INCOME ELIGI-
2 BILITY.—Section 1902 of the Social Security Act (42
3 U.S.C. 1396a) is amended—

4 (1) in subsection (a)—

5 (A) by striking “and” at the end of para-
6 graph (72);

7 (B) by striking the period at the end of
8 paragraph (73) and inserting “; and”; and

9 (C) by inserting after paragraph (73) the
10 following new paragraph:

11 “(74) provide for maintenance of effort under
12 the State plan or under any waiver of the plan in
13 accordance with subsection (gg).”; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(gg) MAINTENANCE OF EFFORT.—

17 “(1) GENERAL REQUIREMENT TO MAINTAIN
18 ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS
19 FULLY OPERATIONAL.—Subject to the succeeding
20 paragraphs of this subsection, during the period that
21 begins on the date of enactment of the America’s
22 Healthy Future Act of 2009 and ends on the date
23 on which the Secretary determines that an exchange
24 established by the State under section 2235 is fully
25 operational, as a condition for receiving any Federal

1 payments under section 1903(a) for calendar quar-
2 ters occurring during such period, a State shall not
3 have in effect eligibility standards, methodologies, or
4 procedures under the State plan under this title or
5 under any waiver of such plan that is in effect dur-
6 ing that period, that are more restrictive than the
7 eligibility standards, methodologies, or procedures,
8 respectively, under the plan or waiver that are in ef-
9 fect on the date of enactment of the America's
10 Healthy Future Act of 2009.

11 “(2) CONTINUATION OF ELIGIBILITY STAND-
12 ARDS FOR ADULTS WITH INCOME AT OR BELOW 133
13 PERCENT OF POVERTY UNTIL JANUARY 1, 2014.—
14 The requirement under paragraph (1) shall continue
15 to apply to a State through December 31, 2013,
16 with respect to the eligibility standards, methodolo-
17 gies, and procedures under the State plan under this
18 title or under any waiver of such plan that are appli-
19 cable to determining the eligibility for medical assist-
20 ance of adults whose income does not exceed 133
21 percent of the poverty line (as defined in section
22 2110(e)(5)).

23 “(3) CONTINUATION OF ELIGIBILITY STAND-
24 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The
25 requirement under paragraph (1) shall continue to

1 apply to a State through September 30, 2019, with
2 respect to the eligibility standards, methodologies,
3 and procedures under the State plan under this title
4 or under any waiver of such plan that are applicable
5 to determining the eligibility for medical assistance
6 of any child who is under 19 years of age (or such
7 higher age as the State may have elected under sec-
8 tion 1902(1)(1)(D)).

9 “(4) NONAPPLICATION.—During the period
10 that begins on January 1, 2011, and ends on De-
11 cember 31, 2013, the requirement under paragraph
12 (1) shall not apply to a State with respect to non-
13 pregnant, nondisabled adults who are eligible for
14 medical assistance under the State plan or under a
15 waiver of the plan at the option of the State and
16 whose income exceeds 133 percent of the poverty
17 line (as defined in section 2110(c)(5)) applicable to
18 a family of the size involved if, on or after December
19 31, 2010, the State certifies to the Secretary that,
20 with respect to the State fiscal year during which
21 the certification is made, the State has a budget def-
22 icit, or with respect to the succeeding State fiscal
23 year, the State is projected to have a budget deficit.
24 Upon submission of such a certification to the Sec-
25 retary, the requirement under paragraph (1) shall

1 not apply to the State with respect to any remaining
2 portion of the period described in the preceding sen-
3 tence.

4 “(5) ADDITIONAL FEDERAL FINANCIAL PAR-
5 TICIPATION.—

6 “(A) IN GENERAL.—During the period
7 that begins on October 1, 2013, and ends on
8 September 30, 2019, notwithstanding section
9 1905(b), the Federal medical assistance per-
10 centage otherwise determined for a State under
11 such section with respect to a fiscal year for
12 amounts expended for medical assistance for in-
13 dividuals who are not newly eligible (as defined
14 in section 1905(y)(2)(A)) individuals described
15 in subclause (VIII) of section
16 1902(a)(10)(A)(i), shall—

17 “(i) in the case of a State that is one
18 of the 50 States or the District of Colum-
19 bia, be increased by 0.15 percentage point;
20 and

21 “(ii) in the case of any other State, be
22 increased by 0.075 percentage point.

23 “(B) SCOPE OF APPLICATION.—The in-
24 crease in the Federal medical assistance per-
25 centage for a State under subparagraph (A)

1 shall apply only for purposes of this title and
2 shall not apply with respect to—

3 “(i) disproportionate share hospital
4 payments described in section 1923;

5 “(ii) payments under title IV;

6 “(iii) payments under title XXI; and

7 “(iv) payments under this title that
8 are based on the enhanced FMAP de-
9 scribed in section 2105(b).

10 “(6) DETERMINATION OF COMPLIANCE.—

11 “(A) STATES SHALL APPLY MODIFIED
12 GROSS INCOME.—A State’s determination of in-
13 come in accordance with subsection (e)(14)
14 shall not be considered to be eligibility stand-
15 ards, methodologies, or procedures that are
16 more restrictive than the standards, methodolo-
17 gies, or procedures in effect under the State
18 plan or under a waiver of the plan on the date
19 of enactment of the America’s Healthy Future
20 Act of 2009 for purposes of determining com-
21 pliance with the requirements of paragraph (1),
22 (2), or (3).

23 “(B) STATES MAY EXPAND ELIGIBILITY OR
24 MOVE WAIVERED POPULATIONS INTO COVERAGE
25 UNDER THE STATE PLAN.—With respect to any

1 period applicable under paragraph (1), (2), or
2 (3), a State that applies eligibility standards,
3 methodologies, or procedures under the State
4 plan under this title or under any waiver of the
5 plan that are less restrictive than the eligibility
6 standards, methodologies, or procedures, ap-
7 plied under the State plan or under a waiver of
8 the plan on the date of enactment of the Amer-
9 ica's Healthy Future Act of 2009, or that
10 makes individuals who, on such date of enact-
11 ment, are eligible for medical assistance under
12 a waiver of the State plan, after such date of
13 enactment eligible for medical assistance
14 through a State plan amendment with an in-
15 come eligibility level that is not less than the in-
16 come eligibility level that applied under the
17 waiver, or as a result of the application of sub-
18 clause (VIII) of section 1902(a)(10)(A)(i), shall
19 not be considered to have in effect eligibility
20 standards, methodologies, or procedures that
21 are more restrictive than the standards, meth-
22 odologies, or procedures in effect under the
23 State plan or under a waiver of the plan on the
24 date of enactment of the America's Healthy Fu-
25 ture Act of 2009 for purposes of determining

1 compliance with the requirements of paragraph
2 (1), (2), or (3).”.

3 (c) MEDICAID BENCHMARK BENEFITS MUST CON-
4 SIST OF AT LEAST ESSENTIAL BENEFITS.—Section
5 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amend-
6 ed—

7 (1) in paragraph (1), in the matter preceding
8 subparagraph (A), by inserting “subject to para-
9 graphs (5) and (6),” before “each”;

10 (2) in paragraph (2)—

11 (A) in the matter preceding subparagraph
12 (A), by inserting “subject to paragraphs (5)
13 and (6)” after “subsection (a)(1),”;

14 (B) in subparagraph (A)—

15 (i) by redesignating clauses (iv) and
16 (v) as clauses (v) and (vi), respectively;
17 and

18 (ii) by inserting after clause (iii), the
19 following:

20 “(IV) Coverage of prescription
21 drugs.”; and

22 (C) in subparagraph (C)—

23 (i) by striking clauses (i) and (ii); and

24 (ii) by redesignating clauses (iii) and

25 (iv) as clauses (i) and (ii), respectively; and

1 (3) by adding at the end the following new
2 paragraphs:

3 “(5) MINIMUM STANDARDS.—Effective January
4 1, 2014, any benchmark benefit package under para-
5 graph (1) or benchmark equivalent coverage under
6 paragraph (2) must provide at least essential bene-
7 fits described in section 2242 (as defined and speci-
8 fied annually by the Secretary in accordance with
9 subsection (e) of that section).

10 “(6) MENTAL HEALTH SERVICES PARITY.—

11 “(A) IN GENERAL.—In the case of any
12 benchmark benefit package under paragraph
13 (1) or benchmark equivalent coverage under
14 paragraph (2) that provides both medical and
15 surgical benefits and mental health or sub-
16 stance use disorder benefits, such plan shall en-
17 sure that the financial requirements and treat-
18 ment limitations applicable to such mental
19 health or substance use disorder benefits com-
20 ply with the requirements of section 2705(a) of
21 the Public Health Service Act in the same man-
22 ner as such requirements apply to a group
23 health plan.

24 “(B) DEEMED COMPLIANCE.—Coverage
25 provided with respect to an individual described

1 in section 1905(a)(4)(B) and covered under the
2 State plan under section 1902(a)(10)(A) of the
3 services described in section 1905(a)(4)(B) (re-
4 lating to early and periodic screening, diag-
5 nostic, and treatment services defined in section
6 1905(r)) and provided in accordance with sec-
7 tion 1902(a)(43), shall be deemed to satisfy the
8 requirements of subparagraph (A).”.

9 (d) ANNUAL REPORTS ON MEDICAID ENROLL-
10 MENT.—

11 (1) STATE REPORTS.—Section 1902(a) of the
12 Social Security Act (42 U.S.C. 1396a(a)), as amend-
13 ed by subsection (b), is amended—

14 (A) by striking “and” at the end of para-
15 graph (73);

16 (B) by striking the period at the end of
17 paragraph (74) and inserting “; and”; and

18 (C) by inserting after paragraph (74) the
19 following new paragraph:

20 “(75) provide that, beginning January 2015,
21 and annually thereafter, the State shall submit a re-
22 port to the Secretary that contains—

23 “(A) the total number of newly enrolled in-
24 dividuals in the State plan or under a waiver of
25 the plan for the fiscal year ending on Sep-

1 tember 30 of the preceding calendar year,
2 disaggregated by population, including children,
3 parents, nonpregnant childless adults, disabled
4 individuals, elderly individuals, and such other
5 categories or sub-categories of individuals eligi-
6 ble for medical assistance under the State plan
7 or under a waiver of the plan as the Secretary
8 may require; and

9 “(B) a description of the outreach and en-
10 rollment processes used by the State during
11 such fiscal year.”.

12 (2) REPORTS TO CONGRESS.—Beginning April
13 2015, and annually thereafter, the Secretary of
14 Health and Human Services shall submit a report to
15 the appropriate committees of Congress on the total
16 new enrollment in Medicaid for the fiscal year end-
17 ing on September 30 of the preceding calendar year
18 on a national and State-by-State basis, and shall in-
19 clude in each such report such recommendations for
20 administrative or legislative changes to improve en-
21 rollment in the Medicaid program as the Secretary
22 determines appropriate.

23 (e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS
24 WITH INCOME THAT EXCEEDS 133 PERCENT OF THE
25 POVERTY LINE.—

1 (1) COVERAGE AS OPTIONAL CATEGORICALLY
2 NEEDY GROUP.—Section 1902 of the Social Security
3 Act (42 U.S.C. 1396a) is amended—

4 (A) in subsection (a)(10)(A)(ii)—

5 (i) in subclause (XVIII), by striking
6 “or” at the end;

7 (ii) in subclause (XIX), by adding
8 “or” at the end; and

9 (iii) by adding at the end the fol-
10 lowing new subclause:

11 “(XX) beginning January 1,
12 2014, who are under 65 years of age
13 and are not described in a previous
14 subclause of this clause, and whose in-
15 come (as determined under subsection
16 (e)(14)) exceeds 133 percent of the
17 poverty line (as defined in section
18 2110(c)(5)) applicable to a family of
19 the size involved but does not exceed
20 the highest income eligibility level es-
21 tablished under the State plan or
22 under a waiver of the plan, subject to
23 subsection (hh);” and

24 (B) by adding at the end the following new
25 subsection:

1 “(hh)(1) A State may elect to phase-in the extension
2 of eligibility for medical assistance to individuals described
3 in subclause (XX) of subsection (a)(10)(A)(ii) based on
4 income, so long as the State does not extend such eligi-
5 bility to individuals described in such subclause with high-
6 er income before making individuals described in such sub-
7 clause with lower income eligible for medical assistance.

8 “(2) If the State has elected the option to provide
9 for a period of presumptive eligibility under section 1920
10 or 1920A, the State may elect to provide for a period of
11 presumptive eligibility for medical assistance (not to ex-
12 ceed 60 days) for individuals described in subclause (XX)
13 of subsection (a)(10)(A)(ii) in the same manner as the
14 State provides for such a period under that section, sub-
15 ject to such guidance as the Secretary shall establish.

16 “(3) If an individual described in subclause (XX) of
17 subsection (a)(10)(A)(ii) is the parent of a child who is
18 under 19 years of age (or such higher age as the State
19 may have elected under section 1902(l)(1)(D)) who is eli-
20 gible for medical assistance under the State plan or under
21 a waiver of such plan, the individual may not be enrolled
22 under the State plan unless the individual’s child is en-
23 rolled under the State plan or under a waiver of the plan
24 or is enrolled in other health insurance coverage. For pur-
25 poses of the preceding sentence, the term ‘parent’ includes

1 an individual treated as a caretaker relative for purposes
2 of carrying out section 1931 and a noncustodial parent.”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) Section 1905(a) of such Act (42
5 U.S.C. 1396d(a)), as amended by subsection
6 (a)(5)(C), is amended in the matter preceding
7 paragraph (1)—

8 (i) by striking “or” at the end of
9 clause (xiii);

10 (ii) by inserting “or” at the end of
11 clause (xiv); and

12 (iii) by inserting after clause (xiv) the
13 following:

14 “(xv) individuals described in section
15 1902(a)(10)(A)(ii)(XX),”.

16 (B) Section 1903(f)(4) of such Act (42
17 U.S.C. 1396b(f)(4)) is amended by inserting
18 “1902(a)(10)(A)(ii)(XX),” after
19 “1902(a)(10)(A)(ii)(XIX),”.

20 **SEC. 1602. INCOME ELIGIBILITY FOR NONELDERLY DETER-**
21 **MINED USING MODIFIED GROSS INCOME.**

22 (a) IN GENERAL.—Section 1902(e) of the Social Se-
23 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
24 the end the following:

1 “(14) INCOME DETERMINED USING MODIFIED
2 GROSS INCOME.—

3 “(A) IN GENERAL.—Notwithstanding sub-
4 section (r) or any other provision of this title,
5 except as provided in subparagraph (D), the
6 modified gross income of an individual or fam-
7 ily, as determined for purposes of allowing a
8 premium credit assistance amount for the pur-
9 chase of a qualified health benefits plan under
10 section 36B of the Internal Revenue Code of
11 1986, shall be used for purposes of determining
12 income eligibility for medical assistance under
13 the State plan and under any waiver of such
14 plan, and for any other purpose applicable
15 under the plan or waiver for which a determina-
16 tion of income is required, including imposition
17 of premiums and cost-sharing.

18 “(B) NO INCOME OR EXPENSE DIS-
19 REGARDS.—No type of expense, block, or other
20 income disregard shall be applied by a State in
21 determining the modified gross income of an in-
22 dividual or family under the State plan or
23 under a waiver of the plan.

24 “(C) NO ASSETS TEST.—A State shall not
25 apply any assets or resources test for purposes

1 of determining the eligibility for medical assist-
2 ance under the State plan or under a waiver of
3 the plan of an individual or family.

4 “(D) EXCEPTIONS.—

5 “(i) INDIVIDUALS ELIGIBLE BECAUSE
6 OF OTHER AID OR ASSISTANCE, ELDERLY
7 INDIVIDUALS, MEDICALLY NEEDY INDIVID-
8 UALS, INDIVIDUALS ELIGIBLE FOR MEDI-
9 CARE COST-SHARING, AND OPTIONAL TAR-
10 GETED LOW-INCOME CHILDREN.—Sub-
11 paragraphs (A), (B), and (C) shall not
12 apply to the determination of eligibility
13 under the State plan or under a waiver for
14 medical assistance for the following:

15 “(I) Individuals who are eligible
16 for medical assistance under the State
17 plan or under a waiver of the plan on
18 a basis that does not require a deter-
19 mination of income by the State agen-
20 cy administering the State plan or
21 waiver, including as a result of eligi-
22 bility for, or receipt of, other Federal
23 or State aid or assistance, individuals
24 who are eligible on the basis of receiv-
25 ing (or being treated as if receiving)

1 supplemental security income benefits
2 under title XVI, and individuals who
3 are eligible as a result of being or
4 being deemed to be a child in foster
5 care under the responsibility of the
6 State.

7 “(II) Individuals who have at-
8 tained age 65 or who are title II dis-
9 ability beneficiaries (as defined in sec-
10 tion 1148(k)(3)).

11 “(III) Individuals described in
12 subsection (a)(10)(C).

13 “(IV) Individuals described in
14 any clause of subsection (a)(10)(E).

15 “(V) Optional targeted low-in-
16 come children described in section
17 1905(u)(2)(B).

18 “(ii) EXPRESS LANE AGENCY FIND-
19 INGS.—In the case of a State that elects
20 the Express Lane option under paragraph
21 (13), notwithstanding subparagraphs (A),
22 (B), and (C), the State may rely on a find-
23 ing made by an Express Lane agency in
24 accordance with that paragraph relating to
25 the income of an individual for purposes of

1 determining the individual's eligibility for
2 medical assistance under the State plan or
3 under a waiver of the plan.

4 “(iii) MEDICARE PRESCRIPTION DRUG
5 SUBSIDIES DETERMINATIONS.—Subpara-
6 graphs (A), (B), and (C) shall not apply to
7 any determinations of eligibility for pre-
8 mium and cost-sharing subsidies under
9 and in accordance with section 1860D–14
10 made by the State pursuant to section
11 1935(a)(2).

12 “(iv) LONG-TERM CARE.—Subpara-
13 graphs (A), (B), and (C) shall not apply to
14 any determinations of eligibility of individ-
15 uals for purposes of medical assistance for
16 services described in section 1917(c)(1)(C).

17 “(v) GRANDFATHER OF CURRENT EN-
18 ROLLEES UNTIL DATE OF NEXT REGULAR
19 REDETERMINATION.—An individual who,
20 on July 1, 2013, is enrolled in the State
21 plan or under a waiver of the plan and who
22 would be determined ineligible for medical
23 assistance solely because of the application
24 of the modified gross income standard de-
25 scribed in subparagraph (A), shall remain

1 eligible for medical assistance under the
2 State plan or waiver (and subject to the
3 same premiums and cost-sharing as ap-
4 plied to the individual on that date)
5 through March 31, 2014, or the date on
6 which the individual's next regularly sched-
7 uled redetermination of eligibility is to
8 occur, whichever is later.

9 “(E) LIMITATION ON SECRETARIAL AU-
10 THORITY.—The Secretary shall not waive com-
11 pliance with the requirements of this paragraph
12 except to the extent necessary to permit a State
13 to coordinate eligibility requirements for dual
14 eligible individuals (as defined in section
15 1915(h)(2)(B)) under the State plan or under
16 a waiver of the plan and under title XVIII and
17 individuals who require the level of care pro-
18 vided in a hospital, a nursing facility, or an in-
19 termediate care facility for the mentally re-
20 tarded.”.

21 (b) CONFORMING AMENDMENT.—Section
22 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is
23 amended by inserting “(e)(14),” before “(l)(3)”.

24 (c) EFFECTIVE DATE.—The amendments made by
25 subsections (a) and (b) take effect on July 1, 2013.

1 **SEC. 1603. REQUIREMENT TO OFFER PREMIUM ASSIST-**
2 **ANCE FOR EMPLOYER-SPONSORED INSUR-**
3 **ANCE.**

4 (a) IN GENERAL.—Section 1906A of such Act (42
5 U.S.C. 1396e–1) is amended—

6 (1) in subsection (a)—

7 (A) by striking “may elect to” and insert-
8 ing “shall”;

9 (B) by striking “under age 19”; and

10 (C) by inserting “, in the case of an indi-
11 vidual under age 19,” after “(and”;

12 (2) in subsection (c), in the first sentence, by
13 striking “under age 19”; and

14 (3) in subsection (d)(2)—

15 (A) in the first sentence, by striking
16 “under age 19”; and

17 (B) by striking the third sentence and in-
18 serting “A State may not require, as a condi-
19 tion of an individual (or the individual’s parent)
20 being or remaining eligible for medical assist-
21 ance under this title, that the individual (or the
22 individual’s parent) apply for enrollment in
23 qualified employer-sponsored coverage under
24 this section.”.

1 (b) CONFORMING AMENDMENT.—The heading for
2 section 1906A of such Act (42 U.S.C. 1396e–1) is amend-
3 ed by striking “OPTION FOR CHILDREN”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section take effect on July 1, 2013.

6 **SEC. 1604. PAYMENTS TO TERRITORIES.**

7 (a) INCREASE IN LIMIT ON PAYMENTS.—Section
8 1108(g) of the Social Security Act (42 U.S.C. 1308(g))
9 is amended—

10 (1) in paragraph (2), in the matter preceding
11 subparagraph (A), by striking “paragraph (3)” and
12 inserting “paragraphs (3) and (5)”;

13 (2) in paragraph (4), by striking “and (3)” and
14 inserting “(3), and (4)”;

15 (3) by adding at the end the following para-
16 graph:

17 “(5) FISCAL YEAR 2011 AND THEREAFTER.—
18 The amounts otherwise determined under this sub-
19 section for Puerto Rico, the Virgin Islands, Guam,
20 the Northern Mariana Islands, and American Samoa
21 for the second, third, and fourth quarters of fiscal
22 year 2011, and for each fiscal year after fiscal year
23 2011 (after the application of subsection (f) and the
24 preceding paragraphs of this subsection), shall be in-
25 creased by 30 percent.”.

1 (b) DISREGARD OF PAYMENTS FOR MANDATORY EX-
2 PANDED ENROLLMENT.—Section 1108(g)(4) of such Act
3 (42 U.S.C. 1308(g)) is amended—

4 (1) by striking “to fiscal years beginning” and
5 inserting “to—

6 “(A) fiscal years beginning”;

7 (2) by striking the period at the end and insert-
8 ing “; and”; and

9 (3) by adding at the end the following:

10 “(B) fiscal years beginning with fiscal year
11 2014, payments made to Puerto Rico, the Vir-
12 gin Islands, Guam, the Northern Mariana Is-
13 lands, or American Samoa on the basis of the
14 Federal medical assistance percentage as in-
15 creased under section 1902(gg)(5), and pay-
16 ments made with respect to amounts expended
17 for medical assistance for newly eligible (as de-
18 fined in section 1905(y)(2)) nonpregnant child-
19 less adults who are eligible under subclause
20 (VIII) of section 1902(a)(10)(A)(i) and whose
21 income (as determined under section
22 1902(e)(14)) does not exceed (in the case of
23 each such commonwealth and territory respec-
24 tively) the income eligibility level in effect for
25 that population under title XIX or under a

1 waiver on the date of enactment of the Amer-
2 ica’s Healthy Future Act of 2009, shall not be
3 taken into account in applying subsection (f)
4 (as increased in accordance with paragraphs
5 (1), (2), (3), and (5) of this subsection) to such
6 commonwealth or territory for such fiscal
7 year.”.

8 (c) INCREASED FMAP.—

9 (1) IN GENERAL.—The first sentence of section
10 1905(b) of the Social Security Act (42 U.S.C.
11 1396d(b)) is amended by striking “shall be 50 per
12 centum” and inserting “shall be 55 percent”.

13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) takes effect on January 1, 2011.

15 **SEC. 1605. MEDICAID IMPROVEMENT FUND RESCISSION.**

16 (a) RESCISSION.—Any amounts available to the Med-
17 icaid Improvement Fund established under section 1941
18 of the Social Security Act (42 U.S.C. 1396w–1) for any
19 of fiscal years 2014 through 2018 that are available for
20 expenditure from the Fund and that are not so obligated
21 as of the date of the enactment of this Act are rescinded.

22 (b) CONFORMING AMENDMENTS.—Section
23 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–
24 1(b)(1)) is amended—

1 (1) in subparagraph (A), by striking
2 “\$100,000,000” and inserting “\$0”; and

3 (2) in subparagraph (B), by striking
4 “\$150,000,000” and inserting “\$0”.

5 **PART II—CHILDREN’S HEALTH INSURANCE**

6 **PROGRAM**

7 **SEC. 1611. ADDITIONAL FEDERAL FINANCIAL PARTICIPA-**
8 **TION FOR CHIP.**

9 (a) IN GENERAL.—Section 2105(b) of the Social Se-
10 curity Act (42 U.S.C. 1397ee(b)) is amended by adding
11 at the end the following: “Notwithstanding the preceding
12 sentence, during the period that begins on October 1,
13 2013, and ends on September 30, 2019, the enhanced
14 FMAP determined for a State for a fiscal year (or for
15 any portion of a fiscal year occurring during such period)
16 shall be increased by 23 percentage points, but in no case
17 shall exceed 100 percent. The increase in the enhanced
18 FMAP under the preceding sentence shall not apply with
19 respect to determining the payment to a State under sub-
20 section (a)(1) for expenditures described in subparagraph
21 (D)(iv), paragraphs (8), (9), (11) of subsection (c), or
22 clause (4) of the first sentence of section 1905(b).”.

23 (b) MAINTENANCE OF EFFORT.—Section 2105(d) of
24 the Social Security Act (42 U.S.C. 1397ee(d)) is amended
25 by adding at the end the following:

1 “(3) CONTINUATION OF ELIGIBILITY STAND-
2 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—Dur-
3 ing the period that begins on the date of enactment
4 of the America’s Healthy Future Act of 2009 and
5 ends on September 30, 2019, a State shall not have
6 in effect eligibility standards, methodologies, or pro-
7 cedures under its State child health plan (including
8 any waiver under such plan) for children that are
9 more restrictive than the eligibility standards, meth-
10 odologies, or procedures, respectively, under such
11 plan (or waiver) as in effect on the date of enact-
12 ment of that Act. The preceding sentence shall not
13 be construed as preventing a State during such pe-
14 riod from—

15 “(A) applying eligibility standards, meth-
16 odologies, or procedures for children under the
17 State child health plan or under any waiver of
18 the plan that are less restrictive than the eligi-
19 bility standards, methodologies, or procedures,
20 respectively, for children under the plan or
21 waiver that are in effect on the date of enact-
22 ment of such Act; or

23 “(B) imposing a limitation described in
24 section 2112(b)(7) for a fiscal year in order to
25 limit expenditures under the State child health

1 plan to those for which Federal financial par-
2 ticipation is available under this section for the
3 fiscal year.”.

4 (c) NO ENROLLMENT BONUS PAYMENTS FOR CHIL-
5 DREN ENROLLED AFTER FISCAL YEAR 2013.—Section
6 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C.
7 1397ee(a)(3)(F)(iii)) is amended by inserting “or any chil-
8 dren enrolled on or after October 1, 2013” before the pe-
9 riod.

10 (d) APPLICATION OF STREAMLINED ENROLLMENT
11 SYSTEM.—Section 2107(e)(1) of the Social Security Act
12 (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end
13 the following:

14 “(M) Section 1943(b) (relating to coordi-
15 nation with State health insurance exchanges
16 and the State Medicaid agency).”.

17 **SEC. 1612. TECHNICAL CORRECTIONS.**

18 (a) CHIPRA.—Effective as if included in the enact-
19 ment of the Children’s Health Insurance Program Reau-
20 thorization Act of 2009 (Public Law 111–3) (in this sec-
21 tion referred to as “CHIPRA”):

22 (1) Section 2104(m) of the Social Security Act,
23 as added by section 102 of CHIPRA, is amended—

24 (A) by redesignating paragraph (7) as
25 paragraph (8); and

1 (B) by inserting after paragraph (6), the
2 following:

3 “(7) ADJUSTMENT OF FISCAL YEARS 2009 AND
4 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN
5 PROJECTED SPENDING FOR CERTAIN PREVIOUSLY
6 APPROVED EXPANSION PROGRAMS.—In the case of
7 one of the 50 States or the District of Columbia that
8 has an approved State plan amendment effective
9 January 1, 2006, to provide child health assistance
10 through the provision of benefits under the State
11 plan under title XIX for children from birth through
12 age 5 whose family income does not exceed 200 per-
13 cent of the poverty line, the Secretary shall increase
14 the allotments otherwise determined for the State
15 for fiscal years 2009 and 2010 under paragraphs (1)
16 and (2)(A)(i) in order to take into account changes
17 in the projected total Federal payments to the State
18 under this title for such fiscal years that are attrib-
19 utable to the provision of such assistance to such
20 children.”.

21 (2) Section 605 of CHIPRA is amended by
22 striking “legal residents” and insert “lawfully resid-
23 ing in the United States”.

24 (3) Subclauses (I) and (II) of paragraph
25 (3)(C)(i) of section 2105(a) of the Social Security

1 Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by sec-
2 tion 104 of CHIPRA, are each amended by striking
3 “, respectively”.

4 (4) Section 2105(a)(3)(E)(ii) of the Social Se-
5 curity Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added
6 by section 104 of CHIPRA, is amended by striking
7 subclause (IV).

8 (5) Section 2105(c)(9)(B) of the Social Security
9 Act (42 U.S.C. 1397e(c)(9)(B)), as added by section
10 211(c)(1) of CHIPRA, is amended by striking “sec-
11 tion 1903(a)(3)(F)” and inserting “section
12 1903(a)(3)(G)”.

13 (6) Section 2109(b)(2)(B) of the Social Secu-
14 rity Act (42 U.S.C. 1397ii(b)(2)(B)), as added by
15 section 602 of CHIPRA, is amended by striking
16 “the child population growth factor under section
17 2104(m)(5)(B)” and inserting “a high-performing
18 State under section 2111(b)(3)(B)”.

19 (7) Section 211(a)(1)(B) of CHIPRA is amend-
20 ed—

21 (A) by striking “is amended” and all that
22 follows through “adding” and inserting “is
23 amended by adding”; and

24 (B) by redesignating the new subpara-
25 graph to be added by such section to section

1 1903(a)(3) of the Social Security Act as a new
2 subparagraph (H).

3 (b) ARRA.—Effective as if included in the enactment
4 of section 5006(a) of division B of the American Recovery
5 and Reinvestment Act of 2009 (Public Law 111–5), the
6 second sentence of section 1916A(a)(1) of the Social Secu-
7 rity Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking
8 “or (i)” and inserting “, (i), or (j)”.

9 **PART III—ENROLLMENT SIMPLIFICATION**

10 **SEC. 1621. ENROLLMENT SIMPLIFICATION AND COORDINA-**
11 **TION WITH STATE HEALTH INSURANCE EX-**
12 **CHANGES.**

13 Title XIX of the Social Security Act (42 U.S.C.
14 1397aa et seq.) is amended by adding at the end the fol-
15 lowing:

16 **“SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDI-**
17 **NATION WITH STATE HEALTH INSURANCE EX-**
18 **CHANGES.**

19 “(a) **CONDITION FOR PARTICIPATION IN MED-**
20 **ICAID.**—As a condition of the State plan under this title
21 and receipt of any Federal financial assistance under sec-
22 tion 1903(a) for calendar quarters beginning after Janu-
23 ary 1, 2013, a State shall ensure that the requirements
24 of subsections (b), (c), and (d) are met.

1 “(b) ENROLLMENT SIMPLIFICATION AND COORDINA-
2 TION WITH STATE HEALTH INSURANCE EXCHANGES AND
3 CHIP.—

4 “(1) IN GENERAL.—A State shall establish pro-
5 cedures for—

6 “(A) enabling individuals, through an
7 Internet website that meets the requirements of
8 paragraph (4), to apply for medical assistance
9 under the State plan or under a waiver of the
10 plan, to be enrolled in the State plan or waiver,
11 to renew their enrollment in the plan or waiver,
12 and to consent to enrollment or reenrollment in
13 the State plan through electronic signature;

14 “(B) enrolling, without any further deter-
15 mination by the State and through such
16 website, individuals who are identified by an ex-
17 change established by the State under section
18 2235 as being eligible for—

19 “(i) medical assistance under the
20 State plan or under a waiver of the plan;
21 or

22 “(ii) child health assistance under the
23 State child health plan under title XXI;

24 “(C) ensuring that individuals who apply
25 for but are determined to be ineligible for med-

1 ical assistance under the State plan or a waiver
2 or ineligible for child health assistance under
3 the State child health plan under title XXI, are
4 able to apply for, and be enrolled in, coverage
5 through such an exchange and, if applicable,
6 obtain premium assistance for the purchase of
7 a qualified health benefits plan under section
8 36B of the Internal Revenue Code of 1986
9 (and, if applicable, advance payment of such as-
10 sistance under section 2248 of this Act), with-
11 out having to submit an additional or separate
12 application, and receive information regarding
13 any other assistance or subsidies available for
14 coverage obtained through the exchange;

15 “(D) ensuring that the State agency re-
16 sponsible for administering the State plan
17 under this title (in this section referred to as
18 the ‘State Medicaid agency’), the State agency
19 responsible for administering the State child
20 health plan under title XXI (in this section re-
21 ferred to as the ‘State CHIP agency’) and an
22 exchange established by the State under section
23 2235 utilize a secure electronic interface suffi-
24 cient to allow for a determination of an individ-
25 ual’s eligibility for such medical assistance,

1 child health assistance, or premium assistance,
2 as appropriate; and

3 “(E) coordinating, for individuals who are
4 enrolled in the State plan or under a waiver of
5 the plan and who are also enrolled in a quali-
6 fied health benefits plan offered through such
7 an exchange, and for individuals who are en-
8 rolled in the State child health plan under title
9 XXI and who are also enrolled in a qualified
10 health benefits plan, the provision of medical
11 assistance or child health assistance to such in-
12 dividuals with the coverage provided under the
13 qualified health benefits plan in which they are
14 enrolled.

15 “(2) AGREEMENTS WITH STATE HEALTH IN-
16 SURANCE EXCHANGES.—The State Medicaid agency
17 and the State CHIP agency may enter into an
18 agreement with an exchange established by the State
19 under section 2235 under which the State Medicaid
20 agency or State CHIP agency may determine wheth-
21 er a State resident is eligible for premium assistance
22 for the purchase of a qualified health benefits plan
23 under section 36B of the Internal Revenue Code of
24 1986 (and, if applicable, advance payment of such
25 assistance under section 2248 of this Act), so long

1 as the agreement meets such conditions and require-
2 ments as the Secretary of the Treasury may pre-
3 scribe to reduce administrative costs and the likeli-
4 hood of eligibility errors and disruptions in coverage.

5 “(3) STREAMLINED ENROLLMENT SYSTEM.—
6 The State Medicaid agency and State CHIP agency
7 shall participate in and comply with the require-
8 ments for the system established under section 2239
9 (relating to streamlined procedures for enrollment
10 through an exchange, Medicaid, and CHIP).

11 “(4) ENROLLMENT WEBSITE REQUIREMENTS.—
12 The procedures established by State under para-
13 graph (1) shall include establishing and having in
14 operation, not later than January 1, 2013, an Inter-
15 net website that is linked to any website of an ex-
16 change established by the State under section 2235
17 and to the State CHIP agency (if different from the
18 State Medicaid agency) and allows an individual who
19 is eligible for medical assistance under the State
20 plan or under a waiver of the plan and who is eligi-
21 ble to receive premium credit assistance for the pur-
22 chase of a qualified health benefits plan under sec-
23 tion 36B of the Internal Revenue Code of 1986 to
24 compare the benefits, premiums, and cost-sharing
25 applicable to the individual under the State plan or

1 waiver with the benefits, premiums, and cost-sharing
2 available to the individual under a qualified health
3 benefits plan offered through such an exchange, in-
4 cluding, in the case of a child, the coverage that
5 would be provided for the child through the State
6 plan or waiver with the coverage that would be pro-
7 vided to the child through enrollment in family cov-
8 erage under that plan and as supplemental coverage
9 by the State under the State plan or waiver.

10 “(5) CONTINUED NEED FOR ASSESSMENT FOR
11 HOME AND COMMUNITY-BASED SERVICES.—Nothing
12 in paragraph (1) shall limit or modify the require-
13 ment that the State assess an individual for pur-
14 poses of providing home and community-based serv-
15 ices under the State plan or under any waiver of
16 such plan for individuals described in subsection
17 (a)(10)(A)(ii)(VI).

18 “(c) OPTION FOR CERTAIN MEDICAID-ELIGIBLE
19 POPULATIONS TO ELECT SUBSIDIZED EXCHANGE COV-
20 ERAGE.—

21 “(1) IN GENERAL.—The State shall establish
22 procedures to ensure that a non-pregnant, non-
23 elderly adult whose income exceeds 100, but does
24 not exceed 133 percent of the poverty line (as de-
25 fined in section 2110(e)(5)) who is eligible for med-

1 ical assistance under the State plan or under a waiv-
2 er of the plan and who is eligible to receive premium
3 assistance for the purchase of a qualified health ben-
4 efits plan under section 36B of the Internal Revenue
5 Code of 1986 (and advance payment of the assist-
6 ance under section 2248 of this Act) is—

7 “(A) provided with the option to elect to
8 enroll themselves, or if applicable, their family,
9 in such a plan through an exchange established
10 by the State under section 2235 instead of en-
11 rolling in the State plan under this title or a
12 waiver of the plan and, in the case of the adult,
13 to waive, as a result of making such an election,
14 receipt of any medical assistance (including
15 medical assistance for premiums and cost-shar-
16 ing) under the State plan or waiver;

17 “(B) provided with—

18 “(i) information, including through
19 the State website established under section
20 1902(e)(15), comparing the benefits and
21 cost-sharing that would be available under
22 the State plan for the adult, and if applica-
23 ble, the adult’s family, with the benefits
24 and cost-sharing available to the adult, and
25 if applicable, the adult’s family, through

1 qualified health benefits plans offered
2 through such an exchange (including with
3 respect to the various levels of coverage
4 available to the adult or family); and

5 “(ii) an explanation of the key dif-
6 ferences between the benefits and cost-
7 sharing available for the adult, and if ap-
8 plicable, the adult’s family, under the State
9 plan or a waiver and the benefits and cost-
10 sharing available to the adult or family
11 through qualified health benefits plans of-
12 fered through such an exchange for each of
13 the levels of coverage available to the adult
14 or family; and

15 “(C) if the adult elects to enroll themselves
16 or their family in a plan through such an ex-
17 change, provided with assistance in selecting
18 and enrolling in such a plan.

19 “(2) SUPPLEMENTAL COVERAGE, INCLUDING
20 EPSDT BENEFITS, FOR CHILDREN.—The State shall
21 establish procedures to ensure that any child who is
22 eligible for medical assistance under the State plan
23 or under a waiver who is enrolled in a qualified
24 health benefits plan through such an exchange is
25 provided with supplemental coverage for items and

1 services for which medical assistance is available
2 under the State plan or waiver and for which bene-
3 fits are not available under the qualified health bene-
4 fits plan in which the child is enrolled, including
5 services described in section 1905(a)(4)(B) (relating
6 to early and periodic screening, diagnostic, and
7 treatment services defined in section 1905(r)) and
8 provided in accordance with the requirements of sec-
9 tion 1902(a)(43) and medical assistance for pre-
10 miums and cost-sharing imposed that exceed the
11 amounts permitted under the State plan or waiver
12 and to assure coordination of coverage for the child
13 under the State plan or waiver and under the quali-
14 fied health benefits plan in which the child is en-
15 rolled.

16 “(3) WAIVER OF RECEIPT OF MEDICAL ASSIST-
17 ANCE FOR ELECTING ADULTS.—A nonpregnant,
18 nonelderly adult whose income exceeds 100, but does
19 not exceed 133 percent of the poverty line (as de-
20 fined in section 2110(c)(5)) who elects to enroll in
21 a qualified health benefits plan through an exchange
22 established by the State under section 2235 shall
23 waive, as a result of making such an election, being
24 provided with medical assistance for themselves (in-
25 cluding medical assistance for premiums and cost-

1 sharing) under the State plan or waiver while en-
2 rolled in the qualified health benefits plan.

3 “(d) STATE CONTRIBUTION FOR MEDICAID-ELIGIBLE
4 INDIVIDUALS ELECTING COVERAGE THROUGH A STATE
5 EXCHANGE.—

6 “(1) IN GENERAL.—Each of the 50 States and
7 the District of Columbia shall make an annual pay-
8 ment (beginning with 2014) to the Secretary equal
9 to the sum of the following products determined with
10 respect to each month of the preceding year for each
11 population described in paragraph (2):

12 “(A) For each such month, the total num-
13 ber of individuals in the population eligible for
14 medical assistance under the State plan or
15 under a waiver of the plan for full benefits (as
16 defined in section 1905(y)(2)(B)) who were en-
17 rolled in coverage through an exchange estab-
18 lished by the State under section 2235 for any
19 portion of the month.

20 “(B) Subject to paragraph (3), for each
21 such month, the average cost of providing med-
22 ical assistance for the population under the
23 State plan or a waiver of the plan for the pre-
24 ceding year.

1 “(C) For each such month, the State per-
2 centage applicable under subsection (b) or (y)
3 of section 1905 to expenditures for providing
4 medical assistance to individuals within the
5 population for that month.

6 “(2) POPULATIONS DESCRIBED.—The popu-
7 lations described in this paragraph are the following:

8 “(A) Children.

9 “(B) Nondisabled, childless adults under
10 age 65.

11 “(C) Nondisabled adults under age 65 who
12 are parents.

13 “(D) Disabled, childless adults under age
14 65.

15 “(E) Disabled adults under age 65 who are
16 parents.

17 “(3) AVERAGE COST OF MEDICAL ASSISTANCE
18 FOR CHILDREN.—With respect to children, the aver-
19 age cost of providing medical assistance under the
20 State plan or under a waiver of the plan for the pre-
21 ceding year shall be equal to the average cost of pro-
22 viding children under the State plan or waiver essen-
23 tial benefits described in section 2242 (as defined
24 and specified by the Secretary for that year in ac-
25 cordance with subsection (e) of that section).”.

1 **SEC. 1622. PERMITTING HOSPITALS TO MAKE PRESUMP-**
2 **TIVE ELIGIBILITY DETERMINATIONS FOR**
3 **ALL MEDICAID ELIGIBLE POPULATIONS.**

4 (a) IN GENERAL.—Section 1902(a)(47) of the Social
5 Security Act (42 U.S.C. 1396a(a)(47)) is amended—

6 (1) by striking “at the option of the State, pro-
7 vide” and inserting “provide—

8 “(A) at the option of the State,”;

9 (2) by inserting “and” after the semicolon; and

10 (3) by adding at the end the following:

11 “(B) that any hospital that is a partici-
12 pating provider under the State plan may elect
13 to be a qualified entity for purposes of deter-
14 mining, on the basis of preliminary information,
15 whether any individual is eligible for medical as-
16 sistance under the State plan or under a waiver
17 of the plan for purposes of providing the indi-
18 vidual with medical assistance during a pre-
19 sumptive eligibility period, in the same manner,
20 and subject to the same requirements, as apply
21 to the State options with respect to populations
22 described in section 1920, 1920A, or 1920B
23 (but without regard to whether the State has
24 elected to provide for a presumptive eligibility
25 period under any such sections), subject to such
26 guidance as the Secretary shall establish;”.

1 (b) CONFORMING AMENDMENT.—Section
2 1903(u)(1)(D)(v) of such Act (42 U.S.C.
3 1396b(u)(1)(D)v)) is amended—

4 (1) by striking “or for” and inserting “for”;
5 and

6 (2) by inserting before the period at the end the
7 following: “, or for medical assistance provided to an
8 individual during a presumptive eligibility period re-
9 sulting from a determination of presumptive eligi-
10 bility made by a hospital that elects under section
11 1902(a)(47)(B) to be a qualified entity for such pur-
12 pose”.

13 (c) EFFECTIVE DATE.—

14 (1) Except as provided in paragraph (2), the
15 amendment made by subsection (a) shall apply to
16 services furnished on or after January 1, 2014,
17 without regard to whether or not final regulations to
18 carry out such amendment have been promulgated
19 by such date.

20 (2) In the case of a State plan for medical as-
21 sistance under title XIX of the Social Security Act
22 which the Secretary of Health and Human Services
23 determines requires State legislation (other than leg-
24 islation appropriating funds) in order for the plan to
25 meet the additional requirement imposed by the

1 amendment made by this section, the State plan
2 shall not be regarded as failing to comply with the
3 requirements of such title solely on the basis of its
4 failure to meet this additional requirement before
5 the first day of the first calendar quarter beginning
6 after the close of the first regular session of the
7 State legislature that begins after the date of the en-
8 actment of this Act. For purposes of the previous
9 sentence, in the case of a State that has a 2-year
10 legislative session, each year of such session shall be
11 deemed to be a separate regular session of the State
12 legislature.

13 **SEC. 1623. PROMOTING TRANSPARENCY IN THE DEVELOP-**
14 **MENT, IMPLEMENTATION, AND EVALUATION**
15 **OF MEDICAID AND CHIP WAIVERS AND SEC-**
16 **TION 1937 STATE PLAN AMENDMENTS.**

17 (a) WAIVER TRANSPARENCY.—

18 (1) IN GENERAL.—Section 1115 of the Social
19 Security Act (42 U.S.C. 1315) is amended by insert-
20 ing after subsection (c) the following:

21 “(d) In the case of any experimental, pilot, or dem-
22 onstration project undertaken under subsection (a) to pro-
23 mote the objectives of title XIX or XXI in a State that
24 would result in an impact on eligibility, enrollment, bene-
25 fits, cost-sharing, or financing with respect to a State pro-

1 gram under title XIX or XXI (in this subsection referred
2 to as a ‘Medicaid demonstration project’ and a ‘CHIP
3 demonstration project’, respectively,) the following shall
4 apply:

5 “(1) The Secretary may not approve a proposal
6 for a Medicaid demonstration project, CHIP dem-
7 onstration project, or a renewal of or an amendment
8 to a previously approved Medicaid demonstration
9 project or CHIP demonstration project unless the
10 State requesting approval certifies that the following
11 process was used to develop the proposal:

12 “(A) At least 30 days prior to publication
13 of the notice required under subparagraph (C),
14 the State provided notice (which may have been
15 accomplished by electronic mail) of the State’s
16 intent to develop the proposal to the medical
17 care advisory committee established for the
18 State for purposes of complying with section
19 1902(a)(4) and any individual or organization
20 that requests or has requested such notice.

21 “(B) Subsequent to providing the notice
22 required under subparagraph (A) and prior to
23 the notice required under subparagraph (C), the
24 State convened at least 1 meeting of such med-
25 ical care advisory committee at which the pro-

1 posal and any modifications of the proposal
2 were the primary items considered and dis-
3 cussed.

4 “(C) At least 60 days prior to the date
5 that the State submits the proposal to the Sec-
6 retary, the State published for written comment
7 (in accordance with the State’s procedure for
8 issuing regulations) a notice of the proposal
9 that contained at least the following:

10 “(i) Information regarding how the
11 public may submit comments to the State
12 on the proposal.

13 “(ii) A statement of the State’s pro-
14 jections regarding the likely effect and im-
15 pact of the proposal on any individuals
16 who are then eligible for, or receiving,
17 medical assistance, child health assistance,
18 or other health benefits coverage under a
19 State program under title XIX or XXI and
20 the State’s assumptions on which such pro-
21 jections are based.

22 “(iii) A statement of the likely fiscal
23 impact of the proposal, including all rel-
24 evant calculations, showing how Federal
25 and State spending on the project will

1 compare to the amount of Federal and
2 State funds that would have been expended
3 had the project not been implemented.

4 “(D) Concurrent with the publication of
5 the notice required under subparagraph (C), the
6 State—

7 “(i) posted the proposal (and any
8 modifications of the proposal) on the
9 State’s official Medicaid or CHIP Internet
10 website; and

11 “(ii) provided the notice required
12 under subparagraph (B) (which may have
13 been accomplished by electronic mail) to
14 the medical care advisory committee re-
15 ferred to in subparagraph (A) and to any
16 individual or organization that requested
17 such notice.

18 “(E) Not later than 30 days after publica-
19 tion of the notice required under subparagraph
20 (C), the State convened at least 1 open meeting
21 of the medical care advisory committee referred
22 to in subparagraph (A), at which the proposal
23 and any modifications of the proposal were the
24 primary items considered and discussed.

1 “(F) After publication of the notice re-
2 quired under subparagraph (C), the State—

3 “(i) held at least 2 public hearings on
4 the proposal and any modifications of the
5 proposal; and

6 “(ii) held the last such public hearing
7 no more than 30 days before the State
8 submitted the proposal to the Secretary.

9 “(G) The State has a record of all public
10 comments submitted in response to the notice
11 required under subparagraph (B) or at any
12 hearings or meetings required under this para-
13 graph regarding the proposal.

14 “(2) A State shall include with any proposal
15 submitted to the Secretary for a Medicaid dem-
16 onstration project, CHIP demonstration project, or
17 a renewal of or an amendment to a previously ap-
18 proved Medicaid demonstration project or CHIP
19 demonstration project, the following:

20 “(A) A detailed description of the public
21 notice and input process used to develop the
22 proposal in accordance with the requirements of
23 paragraph (1).

24 “(B) Copies of all notices required under
25 paragraph (1).

1 “(C) The dates of all meetings and hear-
2 ings required under paragraph (1).

3 “(D) A summary of the public comments
4 received in response to the notices required
5 under paragraph (1) or at any hearings or
6 meetings required under that paragraph regard-
7 ing the proposal and the State’s response to the
8 comments.

9 “(E) A summary of any changes in the
10 proposal that were made in response to the
11 comments.

12 “(F) A certification that the State com-
13 plied with any applicable notification require-
14 ments with respect to Indian tribes during the
15 development of the proposal in accordance with
16 paragraph (1).

17 “(3) The Secretary shall return to a State with-
18 out action any proposal for a Medicaid demonstra-
19 tion project, CHIP demonstration project, or a re-
20 newal of or an amendment to a previously approved
21 Medicaid demonstration project or CHIP demonstra-
22 tion project, that fails to demonstrate compliance
23 with the requirements of paragraphs (1) and (2).

24 “(4) With respect to all proposals for Medicaid
25 demonstration projects, CHIP demonstration

1 projects, or renewal of or amendments to a pre-
2 viously approved Medicaid or CHIP demonstration
3 project, received by the Secretary the following shall
4 apply:

5 “(A) On or before the 10th day of each
6 month, the Secretary shall publish a notice in
7 the Federal Register identifying all of the pro-
8 posals for such demonstration projects or
9 amendments that were received by the Sec-
10 retary during the preceding month.

11 “(B) The notice required under subpara-
12 graph (A) shall provide information regarding
13 the method by which comments on the pro-
14 posals will be received from the public.

15 “(C) Not later than 7 days after receipt of
16 a proposal for a Medicaid demonstration
17 project, CHIP demonstration project, or a re-
18 newal of or an amendment to a previously ap-
19 proved Medicaid or CHIP demonstration
20 project, the Secretary shall—

21 “(i) provide notice (which may be ac-
22 complished by electronic mail) to any indi-
23 vidual or organization that requests or has
24 requested such notification;

1 “(ii) publish on the official Internet
2 website of the Centers for Medicare &
3 Medicaid Services a copy of the proposal,
4 including any appendices or modifications
5 of the proposal; and

6 “(iii) ensure that the information
7 posted on the website is updated at least
8 monthly to accurately reflect the current
9 nature and status of the proposal.

10 “(D) The Secretary shall provide for a pe-
11 riod of not less than 30 days from the later of
12 the date of publication of the notice required
13 under subparagraph (A) that first identifies re-
14 ceipt of the proposal or the date on which an
15 official Internet website containing the informa-
16 tion required under subparagraph (C)(ii) with
17 respect to the proposal is first published, in
18 which written comments on the proposal may be
19 submitted from all interested parties.

20 “(E) After the completion of the public
21 comment period required under subparagraph
22 (D), if the Secretary intends to approve the
23 proposal, as originally submitted or revised, the
24 Secretary shall—

1 “(i) publish and post on the official
2 Internet website for the Centers for Medi-
3 care & Medicaid Services the proposed
4 terms and conditions for such approval and
5 updated versions of the statements re-
6 quired to be published by the State under
7 clauses (ii) and (iii) of paragraph (1)(C);

8 “(ii) provide at least a 15-day period
9 for the submission of written comments
10 from all interested parties on such pro-
11 posed terms and conditions and such state-
12 ments; and

13 “(iii) retain, and make available upon
14 request, all comments received concerning
15 the proposal, the terms and conditions for
16 approval of the proposal, or the statements
17 required to be published by the State
18 under clauses (ii) and (iii) of paragraph
19 (1)(C).

20 “(F) In no event may the Secretary ap-
21 prove a proposal for a Medicaid or CHIP dem-
22 onstration project or renewal of or an amend-
23 ment to a previously approved Medicaid or
24 CHIP demonstration project unless the Sec-

1 retary determines that the proposal, renewal, or
2 the amendment—

3 “(i) is based on a reasonable hypoth-
4 esis which the Secretary has determined is
5 likely to assist in promoting the objectives
6 of title XIX or XXI; and

7 “(ii) will be evaluated no less fre-
8 quently than every 3 years in accordance
9 with paragraph (6).

10 “(G) Not later than 3 business days after
11 the approval of any proposal for a Medicaid
12 demonstration project, CHIP demonstration
13 project, or renewal of or amendment to a pre-
14 viously approved Medicaid or CHIP demonstra-
15 tion project, the Secretary shall post on the of-
16 ficial Internet website for the Centers for Medi-
17 care & Medicaid Services the following:

18 “(i) The text of the approved Med-
19 icaid demonstration project, CHIP dem-
20 onstration project, or renewal of or amend-
21 ment to a previously approved Medicaid or
22 CHIP demonstration project.

23 “(ii) A list identifying each provision
24 of title XIX or XXI, and each regulation
25 relating to either such title, for which com-

1 pliance is waived under the approved dem-
2 onstration project or amendment and any
3 costs that would otherwise not be per-
4 mitted that will be allowed under the dem-
5 onstration project or amendment.

6 “(iii) The terms and conditions for
7 approval of the demonstration project or
8 amendment.

9 “(iv) The approval letter.

10 “(v) The operations protocol for the
11 demonstration project or amendment.

12 “(vi) The evaluation design for the
13 demonstration project or amendment.

14 “(vii) Any item required to be posted
15 under this subparagraph that is not avail-
16 able within 3 business days of the approval
17 of the demonstration project or amend-
18 ment shall be posted as soon as the item
19 becomes available,

20 “(H) On or before the 10th day of each
21 month the Secretary shall publish a notice in
22 the Federal Register that identifies any pro-
23 posals for Medicaid demonstration projects,
24 CHIP demonstration projects, or renewal of or
25 amendments to a previously approved Medicaid

1 or CHIP demonstration project that were ap-
2 proved, denied, or returned to the State without
3 action during the preceding month.

4 “(I) The Secretary shall post on the offi-
5 cial Internet website for the Centers for Medi-
6 care and Medicaid Services all quarterly reports
7 submitted by the State (including data on
8 whether the State is meeting its budget neu-
9 trality targets), evaluations, and other informa-
10 tion the Secretary determines to be appropriate,
11 on Medicaid or CHIP demonstration projects
12 that are operational.

13 “(5) Any provision under title XIX or XXI, or
14 under any regulation in effect that relates to either
15 such title, that is not explicitly waived by the Sec-
16 retary and identified in the list required under para-
17 graph (4)(G)(ii) when approving the Medicaid dem-
18 onstration project, CHIP demonstration project, or
19 renewal of or amendment to any such demonstration
20 project, is not waived and a State shall continue to
21 comply with any such requirement.

22 “(6)(A) In the case of a proposal for a Med-
23 icaid demonstration project or CHIP demonstration
24 project, the Secretary shall, by contract with a quali-
25 fied research organization described in subparagraph

1 (B), conduct an independent evaluation consistent
2 with the evaluation criteria described in subpara-
3 graph (C) applicable to the individual project.

4 “(B) A qualified research organization de-
5 scribed in this subparagraph is an entity that the
6 Secretary determines—

7 “(i) has staff with demonstrated expertise
8 regarding Medicaid or CHIP beneficiaries, poli-
9 cies, and data systems (as applicable), and re-
10 search design and methodology; and

11 “(ii) does not and did not in the past 24
12 months, by contract or subcontract, directly or
13 indirectly, receive funds from the State that has
14 proposed the demonstration project.

15 “(C) The evaluation criteria described in this
16 subparagraph shall include, but not be limited to,
17 the following:

18 “(i) The use of services by beneficiaries
19 under the project.

20 “(ii) The amount of out-of-pocket costs for
21 health care services incurred by beneficiaries
22 under the project.

23 “(iii) The extent to which special popu-
24 lations such as adults with disabilities, adults
25 with chronic illness, and children with special

1 health care needs are able to access needed
2 health care services.

3 “(iv) If children are enrolled in the project,
4 the extent to which such children are able to ac-
5 cess early and periodic screening, diagnostic,
6 and treatment services described in section
7 1905(r).

8 “(v) The level of satisfaction of bene-
9 ficiaries under the project with respect to the
10 accessibility, quality, and cost of care, including
11 the extent to which beneficiaries under the
12 project understand the choices of health care
13 coverage available to them.

14 “(vi) The cost of health care services in-
15 curred by the State agency administering the
16 project, whether through fee-for-service pay-
17 ments, premium payments, or otherwise.

18 “(vii) Administrative costs incurred by the
19 State agency administering the project and by
20 any administrative contractors.

21 “(D) The Secretary shall not approve a pro-
22 posal for a Medicaid demonstration project or a
23 CHIP demonstration project, or a proposal for the
24 extension of such a demonstration project, unless the
25 State agency proposing to administer the demonstra-

1 tion project agrees to cooperate fully with the Sec-
2 retary to the extent necessary to enable the Sec-
3 retary to conduct the independent evaluation de-
4 scribed in subparagraph (B) including collecting,
5 verifying the accuracy of, and submitting to the or-
6 ganization on a timely basis data needed to conduct
7 the independent evaluation.

8 “(E) The State agency administering the
9 project shall be allowed at least 30 days prior to
10 publication of the independent evaluation to submit
11 comments to the Secretary, and the State agency’s
12 comments shall be included in the results of the
13 evaluation.

14 “(F) The results of all evaluations conducted
15 under this paragraph with respect to a Medicaid
16 demonstration project or CHIP demonstration
17 project shall be submitted to the Committee on Fi-
18 nance of the Senate and the Committee on Energy
19 and Commerce of the House of Representatives not
20 later than 6 months prior to the completion of the
21 initial term of a demonstration project and shall
22 thereafter be posted on the official Internet website
23 of the Centers for Medicare & Medicaid Services.

24 “(G) Out of any money in the Treasury of the
25 United States not otherwise appropriated, there are

1 appropriated to the Secretary, \$4,500,000 for fiscal
2 year 2010 and each fiscal year thereafter, for the
3 purpose of carrying out the independent evaluations
4 required under this paragraph. Amounts appro-
5 priated under this subparagraph for a fiscal year
6 shall remain available until expended.”.

7 (2) RULE OF CONSTRUCTION.—Nothing in the
8 amendment made by subsection (a) shall be con-
9 strued to—

10 (A) authorize the waiver of any provision
11 of title XIX or XXI of the Social Security Act
12 (42 U.S.C. 1396 et seq., 1397aa et seq.) that
13 is not otherwise authorized to be waived under
14 such titles or under title XI of such Act (42
15 U.S.C. 1301 et seq.) as of the date of enact-
16 ment of this Act; or

17 (B) imply congressional approval of any
18 experimental, pilot, or demonstration project af-
19 fecting the Medicaid program under title XIX
20 of the Social Security Act or the Children’s
21 health insurance program under title XXI of
22 such Act that has been approved as of such
23 date of enactment.

1 (b) TRANSPARENCY FOR CERTAIN STATE PLAN
2 AMENDMENTS.—Section 1937 of such Act (42 U.S.C.
3 1396u–7) is amended by adding at the end the following:

4 “(d) STATE PLAN AMENDMENT APPROVAL RE-
5 QUIREMENTS.—In the case of any State plan amendment
6 proposed under subsection (a) that would limit the bene-
7 fits eligible individuals would receive, the following shall
8 apply:

9 “(1) The Secretary may not approve a proposal
10 for the amendment unless the State requesting ap-
11 proval certifies that the following process was used
12 to develop the amendment:

13 “(A) Prior to publication of the notice re-
14 quired under subparagraph (B), the State—

15 “(i) provided notice (which may have
16 been accomplished by electronic mail) of
17 the State’s intent to develop the State plan
18 amendment to the medical care advisory
19 committee established for the State for
20 purposes of complying with section
21 1902(a)(4) and any individual or organiza-
22 tion that requests such notice; and

23 “(ii) convened at least 1 meeting of
24 such medical care advisory committee at

1 which the State plan amendment was con-
2 sidered and discussed.

3 “(B) At least 60 days prior to the date
4 that the State submits the State plan amend-
5 ment to the Secretary, the State published for
6 written comment (in accordance with the
7 State’s procedure for issuing regulations) a no-
8 tice of the proposal that contains at least the
9 following:

10 “(i) Information regarding how the
11 public may submit comments to the State
12 on the State plan amendment.

13 “(ii) A statement of the State’s pro-
14 jections regarding the likely effect and im-
15 pact of the proposal on any individuals
16 who are eligible for, or receiving, medical
17 assistance, under the State program under
18 this title and the State’s assumptions on
19 which the projections are based.

20 “(C) Concurrent with the publication of
21 the notice required under subparagraph (B),
22 the State—

23 “(i) posted the State plan amendment
24 on the State’s official Medicaid or CHIP
25 Internet website; and

1 “(ii) provided the notice (which may
2 have been accomplished by electronic mail)
3 to the medical care advisory committee re-
4 ferred to in subparagraph (A)(i) and to
5 any individual or organization that re-
6 quested such notice.

7 “(D) Not later than 30 days after publica-
8 tion of the notice required under subparagraph
9 (B), the State convened at least 1 open meeting
10 of the medical care advisory committee referred
11 to in subparagraph (A)(i), at which the State
12 plan amendment was considered and discussed.

13 “(2) A State shall include with any State plan
14 amendment submitted to the Secretary for approval
15 the following:

16 “(A) A detailed description of the public
17 notice and input process used to develop the
18 State plan amendment in accordance with the
19 requirements of paragraph (1).

20 “(B) Copies of all notices required under
21 paragraph (1).

22 “(C) The dates of all meetings required
23 under paragraph (1).

24 “(D) A certification that the State com-
25 plied with any applicable notification require-

1 ments with respect to Indian tribes during the
2 development of the proposal in accordance with
3 paragraph (1).

4 “(3) The Secretary shall return to a State with-
5 out action any State plan amendment that fails to
6 satisfy the requirements of paragraphs (1) and (2).

7 “(4) With respect to all State plan amendments
8 submitted for approval to the Secretary under this
9 section the following shall apply:

10 “(A) On or before the 10th day of each
11 month the Secretary shall publish a notice in
12 the Federal Register identifying all the State
13 plan amendments submitted for approval dur-
14 ing the preceding month.

15 “(B) The notice required under subpara-
16 graph (A) shall provide information regarding
17 the method by which comments on the pro-
18 posals will be received from the public.

19 “(C) Not later than 7 days after submis-
20 sion of a State plan amendment for approval
21 the Secretary shall—

22 “(i) provide notice (which may be ac-
23 complished by electronic mail) to any indi-
24 vidual or organization that has requested
25 such notification; and

1 “(ii) publish on the official Internet
2 website of the Centers for Medicare &
3 Medicaid Services a copy of the State plan
4 amendment.

5 “(D) The Secretary shall provide for a pe-
6 riod of not less than 30 days from the later of
7 the date of publication of the notice required
8 under subparagraph (A) that first identifies re-
9 ceipt of the State plan amendment or the date
10 on which an official Internet website containing
11 the information required under subparagraph
12 (C)(ii) with respect to the State plan amend-
13 ment is first published, in which written com-
14 ments on the State plan amendment may be
15 submitted from all interested parties.

16 “(E) On or before the 10th day of each
17 month the Secretary shall publish a notice in
18 the Federal Register that identifies any State
19 plan amendments that were approved, denied,
20 or returned to the State without action during
21 the preceding month.”.

22 (c) EFFECTIVE DATES.—

23 (1) SECTION 1115 REQUIREMENTS.—Subject to
24 paragraph (2), the amendment made by subsection

1 (a) shall take effect on the date of enactment of this
2 Act and shall apply to—

3 (A) any proposal to conduct any experi-
4 mental, pilot or demonstration project affecting
5 the Medicaid program under title XIX of the
6 Social Security Act or the State Children’s
7 Health Insurance Program under title XXI of
8 such Act that is pending on the date of enact-
9 ment or that is submitted to the Secretary after
10 the date of enactment;

11 (B) any proposal to extend such a project
12 that is pending on the date of enactment or
13 that is submitted to the Secretary after the
14 date of enactment; and

15 (C) any proposal to amend such a project
16 that is pending on the date of enactment or
17 that is submitted to the Secretary after the
18 date of enactment.

19 (2) EVALUATION REQUIREMENTS APPLICABLE
20 TO NEW WAIVERS.—The requirements of section
21 1115(d)(6) of the Social Security Act (relating to
22 evaluation), as added by subsection (a), shall apply
23 only to a proposal described in paragraph (1)(A) of
24 this subsection.

1 (3) CERTAIN STATE PLAN AMENDMENTS.—The
2 amendment made by subsection (b) shall take effect
3 on the date of enactment of this Act and shall apply
4 to any State plan amendment for which approval is
5 pending on the date of enactment or that is sub-
6 mitted to the Secretary of Health and Human Serv-
7 ices for approval after the date of enactment of this
8 Act.

9 **SEC. 1624. STANDARDS AND BEST PRACTICES TO IMPROVE**
10 **ENROLLMENT OF VULNERABLE AND UNDER-**
11 **SERVED POPULATIONS.**

12 (a) IN GENERAL.—Not later than April 1, 2011, the
13 Secretary of Health and Human Services shall issue guid-
14 ance to States regarding standards and best practices for
15 conducting outreach to and enrolling vulnerable and un-
16 derserved populations eligible for medical assistance under
17 Medicaid under title XIX of the Social Security Act or
18 for child health assistance under CHIP under title XXI
19 of such Act, including children, unaccompanied homeless
20 youth, children and youth with special health care needs,
21 pregnant women, racial and ethnic minorities, rural popu-
22 lations, victims of abuse or trauma, individuals with men-
23 tal health or substance-related disorders, and individuals
24 with HIV/AIDS.

25 (b) REQUIREMENTS.—

1 (1) IN GENERAL.—The guidance issued under
2 subsection (a) shall—

3 (A) detail effective ways to inform vulner-
4 able populations about coverage available under
5 Medicaid and CHIP;

6 (B) identify ways to assist vulnerable pop-
7 ulations to enroll in the programs;

8 (C) identify ways that application and en-
9 rollment barriers for such populations can be
10 eliminated; and

11 (D) address specific methods for outreach
12 and enrollment, including outstationing of eligi-
13 bility workers, the Express Lane eligibility op-
14 tion, residency requirements, documentation of
15 income and assets, presumptive eligibility, con-
16 tinuous eligibility, and automatic renewal.

17 (2) DEVELOPMENT AND IMPLEMENTATION.—
18 The Secretary of Health and Human Services may
19 use all available legal authority and shall work with
20 appropriate stakeholders, including representatives
21 of States and children’s groups, to ensure that the
22 guidance issued under subsection (a) is developed
23 and implemented effectively.

24 (3) REPORT TO CONGRESS.—Not later than 2
25 years after the enactment of this Act and annually

1 thereafter, the Secretary of Health and Human
2 Services shall review and report to Congress on the
3 progress made by States in implementing the stand-
4 ards and best practices identified in the guidance
5 issued under subsection (a) and increasing the en-
6 rollment of vulnerable populations under Medicaid
7 and CHIP.

8 **PART IV—MEDICAID SERVICES**

9 **SEC. 1631. COVERAGE FOR FREESTANDING BIRTH CENTER**
10 **SERVICES.**

11 (a) IN GENERAL.—Section 1905 of the Social Secu-
12 rity Act (42 U.S.C. 1396d), is amended—

13 (1) in subsection (a)—

14 (A) in paragraph (27), by striking “and”
15 at the end;

16 (B) by redesignating paragraph (28) as
17 paragraph (29); and

18 (C) by inserting after paragraph (27) the
19 following new paragraph:

20 “(28) freestanding birth center services (as de-
21 fined in subsection (l)(3)(A)) and other ambulatory
22 services that are offered by a freestanding birth cen-
23 ter (as defined in subsection (l)(3)(B)) and that are
24 otherwise included in the plan; and”;

1 (2) in subsection (1), by adding at the end the
2 following new paragraph:

3 “(3)(A) The term ‘freestanding birth center services’
4 means services furnished to an individual at a freestanding
5 birth center (as defined in subparagraph (B)) at such cen-
6 ter.

7 “(B) The term ‘freestanding birth center’ means a
8 health facility—

9 “(i) that is not a hospital;

10 “(ii) where childbirth is planned to occur away
11 from the pregnant woman’s residence;

12 “(iii) that is licensed or otherwise approved by
13 the State to provide prenatal labor and delivery or
14 postpartum care and other ambulatory services that
15 are included in the plan; and

16 “(iv) that complies with such other require-
17 ments relating to the health and safety of individuals
18 furnished services by the facility as the State shall
19 establish.

20 “(C) A State shall provide separate payments to pro-
21 viders administering prenatal labor and delivery or
22 postpartum care in a freestanding birth center (as defined
23 in subparagraph (B)), such as nurse midwives and other
24 providers of services such as birth attendants recognized
25 under State law, as determined appropriate by the Sec-

1 retary. For purposes of the preceding sentence, the term
2 ‘birth attendant’ means an individual who is recognized
3 or registered by the State involved to provide health care
4 at childbirth and who provides such care within the scope
5 of practice under which the individual is legally authorized
6 to perform such care under State law (or the State regu-
7 latory mechanism provided by State law), regardless of
8 whether the individual is under the supervision of, or asso-
9 ciated with, a physician or other health care provider.
10 Nothing in this subparagraph shall be construed as chang-
11 ing State law requirements applicable to a birth attend-
12 ant.”.

13 (b) CONFORMING AMENDMENT.—Section
14 1902(a)(10)(A) of the Social Security Act (42 U.S.C.
15 1396a(a)(10)(A)), is amended in the matter preceding
16 clause (i) by striking “and (21)” and inserting “, (21),
17 and (28)”.

18 (c) EFFECTIVE DATE.—

19 (1) IN GENERAL.—Except as provided in para-
20 graph (2), the amendments made by this section
21 shall take effect on the date of the enactment of this
22 Act and shall apply to services furnished on or after
23 such date.

24 (2) EXCEPTION IF STATE LEGISLATION RE-
25 QUIRED.—In the case of a State plan for medical as-

1 sistance under title XIX of the Social Security Act
2 which the Secretary of Health and Human Services
3 determines requires State legislation (other than leg-
4 islation 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
7 shall not be regarded as failing to comply with the
8 requirements of such title solely on the basis of its
9 failure to meet this additional requirement before
10 the first day of the first calendar quarter beginning
11 after the close of the first regular session of the
12 State legislature that begins after the date of the en-
13 actment of this Act. For purposes of the previous
14 sentence, in the case of a State that has a 2-year
15 legislative session, each year of such session shall be
16 deemed to be a separate regular session of the State
17 legislature.

18 **SEC. 1632. CONCURRENT CARE FOR CHILDREN.**

19 Section 1905(o)(1) of the Social Security Act (42
20 U.S.C. 1396d(o)(1)) is amended—

21 (1) in subparagraph (A), by striking “subpara-
22 graph (B)” and inserting “subparagraphs (B) and
23 (C)”;

24 (2) by adding at the end the following new sub-
25 paragraph:

1 “(C) A voluntary election to have payment made for
2 hospice care for a child (as defined by the State) shall
3 not constitute a waiver of any rights of the child to be
4 provided with, or to have payment made under this title
5 for, services that are related to the treatment of the child’s
6 condition for which a diagnosis of terminal illness has been
7 made.”.

8 **SEC. 1633. FUNDING TO EXPAND STATE AGING AND DIS-**
9 **ABILITY RESOURCE CENTERS.**

10 Out of any funds in the Treasury not otherwise ap-
11 propriated, there is appropriated to the Secretary of
12 Health and Human Services, acting through the Assistant
13 Secretary for Aging, \$10,000,000 for each of fiscal years
14 2010 through 2014, to carry out subsections
15 (a)(20)(B)(iii) and (b)(8) of section 202 of the Older
16 Americans Act of 1965 (42 U.S.C. 3012).

17 **SEC. 1634. COMMUNITY FIRST CHOICE OPTION.**

18 Section 1915 of the Social Security Act (42 U.S.C.
19 1396n) is amended by adding at the end the following:

20 “(k) STATE PLAN OPTION TO PROVIDE HOME AND
21 COMMUNITY-BASED ATTENDANT SERVICES AND SUP-
22 PORTS.—

23 “(1) IN GENERAL.—Subject to the succeeding
24 provisions of this subsection, during the 5-year pe-
25 riod that begins on January 1, 2014, a State may

1 provide through a State plan amendment for the
2 provision of medical assistance for home and com-
3 munity-based attendant services and supports for in-
4 dividuals who are eligible for medical assistance
5 under the State plan whose income does not exceed
6 150 percent of the poverty line (as defined in section
7 2110(e)(5)) or, if greater, the income level applicable
8 for an individual who has been determined to require
9 an institutional level of care to be eligible for nurs-
10 ing facility services under the State plan and with
11 respect to whom there has been a determination
12 that, but for the provision of such services, the indi-
13 viduals would require the level of care provided in a
14 hospital, a nursing facility, an intermediate care fa-
15 cility for the mentally retarded, or an institution for
16 mental diseases, the cost of which could be reim-
17 bursed under the State plan, but only if the indi-
18 vidual chooses to receive such home and community-
19 based attendant services and supports, and only if
20 the State meets the following requirements:

21 “(A) AVAILABILITY.—The State shall
22 make available home and community-based at-
23 tendant services and supports to eligible indi-
24 viduals, as needed, to assist in accomplishing
25 activities of daily living, instrumental activities

1 of daily living, and health-related tasks through
2 hands-on assistance, supervision, or cueing—

3 “(i) under a person-centered plan of
4 services and supports that is based on an
5 assessment of functional need and that is
6 agreed to in writing by the individual or,
7 as appropriate, the individual’s representa-
8 tive;

9 “(ii) in a home or community setting,
10 which does not include a nursing facility,
11 institution for mental diseases, or an inter-
12 mediate care facility for the mentally re-
13 tardated;

14 “(iii) under an agency-provider model
15 or other model (as defined in paragraph
16 (6)(C)); and

17 “(iv) the furnishing of which—

18 “(I) is selected, managed, and
19 dismissed by the individual, or, as ap-
20 propriate, with assistance from the in-
21 dividual’s representative;

22 “(II) is controlled, to the max-
23 imum extent possible, by the indi-
24 vidual or where appropriate, the indi-
25 vidual’s representative, regardless of

1 who may act as the employer of
2 record; and

3 “(III) provided by an individual
4 who is qualified to provide such serv-
5 ices, including family members (as de-
6 fined by the Secretary).

7 “(B) INCLUDED SERVICES AND SUP-
8 PORTS.—In addition to assistance in accom-
9 plishing activities of daily living, instrumental
10 activities of daily living, and health related
11 tasks, the home and community-based attend-
12 ant services and supports made available in-
13 clude—

14 “(i) the acquisition, maintenance, and
15 enhancement of skills necessary for the in-
16 dividual to accomplish activities of daily
17 living, instrumental activities of daily liv-
18 ing, and health related tasks;

19 “(ii) back-up systems or mechanisms
20 (such as the use of beepers or other elec-
21 tronic devices) to ensure continuity of serv-
22 ices and supports; and

23 “(iii) voluntary training on how to se-
24 lect, manage, and dismiss attendants.

1 “(C) EXCLUDED SERVICES AND SUP-
2 PORTS.—Subject to subparagraph (D), the
3 home and community-based attendant services
4 and supports made available do not include—

5 “(i) room and board costs for the in-
6 dividual;

7 “(ii) special education and related
8 services provided under the Individuals
9 with Disabilities Education Act and voca-
10 tional rehabilitation services provided
11 under the Rehabilitation Act of 1973;

12 “(iii) assistive technology devices and
13 assistive technology services other than
14 those under (1)(B)(ii);

15 “(iv) medical supplies and equipment;
16 or

17 “(v) home modifications.

18 “(D) PERMISSIBLE SERVICES AND SUP-
19 PORTS.—The home and community-based at-
20 tendant services and supports may include—

21 “(i) expenditures for transition costs
22 such as rent and utility deposits, first
23 month’s rent and utilities, bedding, basic
24 kitchen supplies, and other necessities re-
25 quired for an individual to make the tran-

1 sition from a nursing facility, institution
2 for mental diseases, or intermediate care
3 facility for the mentally retarded to a com-
4 munity-based home setting where the indi-
5 vidual resides; and

6 “(ii) expenditures relating to a need
7 identified in an individual’s person-cen-
8 tered plan of services that increase inde-
9 pendence or substitute for human assist-
10 ance, to the extent that expenditures would
11 otherwise be made for the human assist-
12 ance.

13 “(2) INCREASED FEDERAL FINANCIAL PARTICI-
14 PATION.—For purposes of payments to a State
15 under section 1903(a)(1), with respect to amounts
16 expended by the State to provide medical assistance
17 under the State plan for home and community-based
18 attendant services and supports to eligible individ-
19 uals in accordance with this subsection during a fis-
20 cal year quarter occurring during the period de-
21 scribed in paragraph (1), the Federal medical assist-
22 ance percentage applicable to the State (as deter-
23 mined under sections 1905(b) and 1902(gg)(5))
24 shall be increased by 6 percentage points.

1 “(3) STATE REQUIREMENTS.—In order for a
2 State plan amendment to be approved under this
3 subsection, the State shall—

4 “(A) develop and implement such amend-
5 ment in collaboration with a Development and
6 Implementation Council established by the
7 State that includes a majority of members with
8 disabilities, elderly individuals, and their rep-
9 resentatives and consults and collaborates with
10 such individuals;

11 “(B) provide consumer controlled home
12 and community-based attendant services and
13 supports to individuals on a statewide basis, in
14 a manner that provides such services and sup-
15 ports in the most integrated setting appropriate
16 to the individual’s needs, and without regard to
17 the individual’s age, type or nature of disability,
18 severity of disability, or the form of home and
19 community-based attendant services and sup-
20 ports that the individual requires in order to
21 lead an independent life;

22 “(C) with respect to expenditures during
23 the first full fiscal year in which the State plan
24 amendment is implemented, maintain or exceed
25 the level of State expenditures for medical as-

1 sistance that is provided under section 1905(a),
2 section 1915, section 1115, or otherwise to indi-
3 viduals with disabilities or elderly individuals
4 attributable to the preceding fiscal year;

5 “(D) establish and maintain a comprehen-
6 sive, continuous quality assurance system with
7 respect to community- based attendant services
8 and supports that—

9 “(i) includes standards for agency-
10 based and other delivery models with re-
11 spect to training, appeals for denials and
12 reconsideration procedures of an individual
13 plan, and other factors as determined by
14 the Secretary;

15 “(ii) incorporates feedback from con-
16 sumers and their representatives, disability
17 organizations, providers, families of dis-
18 abled or elderly individuals, members of
19 the community, and others and maximizes
20 consumer independence and consumer con-
21 trol;

22 “(iii) monitors the health and well-
23 being of each individual who receives home
24 and community-based attendant services
25 and supports, including a process for the

1 mandatory reporting, investigation, and
2 resolution of allegations of neglect, abuse,
3 or exploitation in connection with the pro-
4 vision of such services and supports; and

5 “(iv) provides information about the
6 provisions of the quality assurance re-
7 quired under clauses (i) through (iii) to
8 each individual receiving such services; and

9 “(E) collect and report information, as de-
10 termined necessary by the Secretary, for the
11 purposes of approving the State plan amend-
12 ment, providing Federal oversight, and con-
13 ducting an evaluation under paragraph (5)(A),
14 including data regarding how the State provides
15 home and community-based attendant services
16 and supports and other home and community-
17 based services, the cost of such services and
18 supports, and how the State provides individ-
19 uals with disabilities who otherwise qualify for
20 institutional care under the State plan or under
21 a waiver the choice to instead receive home and
22 community-based services in lieu of institutional
23 care.

24 “(4) COMPLIANCE WITH CERTAIN LAWS.—A
25 State shall ensure that, regardless of whether the

1 State uses an agency-provider model or other models
2 to provide home and community-based attendant
3 services and supports under a State plan amend-
4 ment under this subsection, such services and sup-
5 ports are provided in accordance with the require-
6 ments of the Fair Labor Standards Act of 1938 and
7 applicable Federal and State laws regarding—

8 “(A) withholding and payment of Federal
9 and State income and payroll taxes;

10 “(B) the provision of unemployment and
11 workers compensation insurance;

12 “(C) maintenance of general liability insur-
13 ance; and

14 “(D) occupational health and safety.

15 “(5) EVALUATION, DATA COLLECTION, AND RE-
16 PORT TO CONGRESS.—

17 “(A) EVALUATION.—The Secretary shall
18 conduct an evaluation of the provision of home
19 and community-based attendant services and
20 supports under this subsection in order to de-
21 termine the effectiveness of the provision of
22 such services and supports in allowing the indi-
23 viduals receiving such services and supports to
24 lead an independent life to the maximum extent
25 possible; the impact on the physical and emo-

1 tional health of the individuals who receive such
2 services; and an comparative analysis of the
3 costs of services provided under the State plan
4 amendment under this subsection and those
5 provided under institutional care in a nursing
6 facility, institution for mental diseases, or an
7 intermediate care facility for the mentally re-
8 tarded.

9 “(B) DATA COLLECTION.—The State shall
10 provide the Secretary with the following infor-
11 mation regarding the provision of home and
12 community-based attendant services and sup-
13 ports under this subsection for each fiscal year
14 for which such services and supports are pro-
15 vided:

16 “(i) The number of individuals who
17 are estimated to receive home and commu-
18 nity-based attendant services and supports
19 under this subsection during the fiscal
20 year.

21 “(ii) The number of individuals that
22 received such services and supports during
23 the preceding fiscal year.

24 “(iii) The specific number of individ-
25 uals served by type of disability, age, gen-

1 der, education level, and employment sta-
2 tus.

3 “(iv) Whether the specific individuals
4 have been previously served under any
5 other home and community based services
6 program under the State plan or under a
7 waiver.

8 “(C) REPORTS.—Not later than—

9 “(i) December 31, 2017, the Sec-
10 retary shall submit to Congress and make
11 available to the public an interim report on
12 the findings of the evaluation under sub-
13 paragraph (A); and

14 “(ii) December 31, 2019, the Sec-
15 retary shall submit to Congress and make
16 available to the public a final report on the
17 findings of the evaluation under subpara-
18 graph (A).

19 “(6) DEFINITIONS.—In this subsection:

20 “(A) ACTIVITIES OF DAILY LIVING.—The
21 term ‘activities of daily living’ includes tasks
22 such as eating, toileting, grooming, dressing,
23 bathing, and transferring.

24 “(B) CONSUMER CONTROLLED.—The term
25 ‘consumer controlled’ means a method of select-

1 ing and providing services and supports that
2 allow the individual, or where appropriate, the
3 individual’s representative, maximum control of
4 the home and community-based attendant serv-
5 ices and supports, regardless of who acts as the
6 employer of record.

7 “(C) DELIVERY MODELS.—

8 “(i) AGENCY-PROVIDER MODEL.—The
9 term ‘agency-provider model’ means, with
10 respect to the provision of home and com-
11 munity-based attendant services and sup-
12 ports for an individual, subject to para-
13 graph (4), a method of providing consumer
14 controlled services and supports under
15 which entities contract for the provision of
16 such services and supports.

17 “(ii) OTHER MODELS.—The term
18 ‘other models’ means, subject to paragraph
19 (4), methods, other than an agency-pro-
20 vider model, for the provision of consumer
21 controlled services and supports. Such
22 models may include the provision of vouch-
23 ers, direct cash payments, or use of a fiscal
24 agent to assist in obtaining services.

1 “(D) HEALTH-RELATED TASKS.—The
2 term ‘health-related tasks’ means specific tasks
3 related to the needs of an individual, which can
4 be delegated or assigned by licensed health-care
5 professionals under State law to be performed
6 by an attendant.

7 “(E) INDIVIDUAL’S REPRESENTATIVE.—
8 The term ‘individual’s representative’ means a
9 parent, family member, guardian, advocate, or
10 other authorized representative of an individual

11 “(F) INSTRUMENTAL ACTIVITIES OF DAILY
12 LIVING.—The term ‘instrumental activities of
13 daily living’ includes (but is not limited to) meal
14 planning and preparation, managing finances,
15 shopping for food, clothing, and other essential
16 items, performing essential household chores,
17 communicating by phone or other media, and
18 traveling around and participating in the com-
19 munity.”.

20 **SEC. 1635. PROTECTION FOR RECIPIENTS OF HOME AND**
21 **COMMUNITY-BASED SERVICES AGAINST**
22 **SPOUSAL IMPOVERISHMENT.**

23 During the 5-year period that begins on January 1,
24 2014, section 1924(h)(1)(A) of the Social Security Act (42
25 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though “is

1 eligible for medical assistance for home and community-
2 based services provided under subsection (c), (d), or (i)
3 of section 1915, under a waiver approved under section
4 1115, or who is eligible for such medical assistance by rea-
5 son of being determined eligible under section
6 1902(a)(10)(C) or by reason of section 1902(f) or other-
7 wise on the basis of a reduction of income based on costs
8 incurred for medical or other remedial care, or who is eligi-
9 ble for medical assistance for home and community-based
10 attendant services and supports under section 1915(k)”
11 were substituted in such section for “(at the option of the
12 State) is described in section 1902(a)(10)(A)(ii)(VI)”.

13 **SEC. 1636. INCENTIVES FOR STATES TO OFFER HOME AND**
14 **COMMUNITY-BASED SERVICES AS A LONG-**
15 **TERM CARE ALTERNATIVE TO NURSING**
16 **HOMES.**

17 (a) STATE BALANCING INCENTIVE PAYMENTS PRO-
18 GRAM.—Notwithstanding section 1905(b) of the Social Se-
19 curity Act (42 U.S.C. 1396d(b)), in the case of a bal-
20 ancing incentive payment State, as defined in subsection
21 (b), that meets the conditions described in subsection (c),
22 during the balancing incentive period, the Federal medical
23 assistance percentage determined for the State under sec-
24 tion 1905(b) of such Act and increased under section
25 1902(gg)(5) shall be increased by the applicable percent-

1 age points determined under subsection (d) with respect
2 to eligible medical assistance expenditures described in
3 subsection (e).

4 (b) BALANCING INCENTIVE PAYMENT STATE.—A
5 balancing incentive payment State is a State—

6 (1) in which less than 50 percent of the total
7 expenditures for medical assistance under the State
8 Medicaid program for fiscal year 2009 for long-term
9 services and supports (as defined by the Secretary
10 under subsection (f))(1)) are for non-institutionally-
11 based long-term services and supports described in
12 subsection (f)(1)(B);

13 (2) that submits an application and meets the
14 conditions described in subsection (c); and

15 (3) that is selected by the Secretary to partici-
16 pate in the State balancing incentive payment pro-
17 gram established under this section.

18 (c) CONDITIONS.—The conditions described in this
19 subsection are the following:

20 (1) APPLICATION.—The State submits an appli-
21 cation to the Secretary that includes, in addition to
22 such other information as the Secretary shall re-
23 quire—

24 (A) a proposed budget that details the
25 State's plan to expand and diversify medical as-

1 sistance for non-institutionally-based long-term
2 services and supports described in subsection
3 (f)(1)(B) under the State Medicaid program
4 during the balancing incentive period and
5 achieve the target spending percentage applica-
6 ble to the State under paragraph (2), including
7 through structural changes to how the State
8 furnishes such assistance, such as through the
9 establishment of a “no wrong door - single
10 entry point system”, optional presumptive eligi-
11 bility, case management services, and the use of
12 core standardized assessment instruments, and
13 that includes a description of the new or ex-
14 panded offerings of such services that the State
15 will provide and the projected costs of such
16 services; and

17 (B) in the case of a State that proposes to
18 expand the provision of home and community-
19 based services under its State Medicaid pro-
20 gram through a State plan amendment under
21 section 1915(i) of the Social Security Act, at
22 the option of the State, an election to increase
23 the income eligibility for such services from 150
24 percent of the poverty line to such higher per-
25 centage as the State may establish for such

1 purpose, not to exceed 300 percent of the sup-
2 plemental security income benefit rate estab-
3 lished by section 1611(b)(1) of the Social Secu-
4 rity Act (42 U.S.C. 1382(b)(1)).

5 (2) TARGET SPENDING PERCENTAGES.—

6 (A) In the case of a balancing incentive
7 payment State in which less than 25 percent of
8 the total expenditures for home and community-
9 based services under the State Medicaid pro-
10 gram for fiscal year 2009 are for such services,
11 the target spending percentage for the State to
12 achieve by not later than October 1, 2015, is
13 that 25 percent of the total expenditures for
14 home and community-based services under the
15 State Medicaid program are for such services.

16 (B) In the case of any other balancing in-
17 centive payment State, the target spending per-
18 centage for the State to achieve by not later
19 than October 1, 2015, is that 50 percent of the
20 total expenditures for home and community-
21 based services under the State Medicaid pro-
22 gram are for such services.

23 (3) MAINTENANCE OF ELIGIBILITY REQUIRE-
24 MENTS.—The State does not apply eligibility stand-
25 ards, methodologies, or procedures for determining

1 eligibility for medical assistance for non-institution-
2 ally-based long-term services and supports described
3 in subsection (f)(1)(B) under the State Medicaid
4 program that are more restrictive than the eligibility
5 standards, methodologies, or procedures in effect for
6 such purposes on December 31, 2010.

7 (4) USE OF ADDITIONAL FUNDS.—The State
8 agrees to use the additional Federal funds paid to
9 the State as a result of this section only for pur-
10 poses of providing new or expanded offerings of non-
11 institutionally-based long-term services and supports
12 described in subsection (f)(1)(B) under the State
13 Medicaid program.

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

18 (A) “NO WRONG DOOR”—SINGLE ENTRY
19 POINT SYSTEM.—Development of a statewide
20 system to enable consumers to access all long-
21 term services and supports through an agency,
22 organization, coordinated network, or portal, in
23 accordance with such standards as the State
24 shall establish and that shall provide informa-
25 tion regarding the availability of such services,

1 how to apply for such services, and referral
2 services for services and supports otherwise
3 available in the community ; and determinations
4 of financial and functional eligibility for such
5 services and supports, or assistance with assess-
6 ment processes for financial and functional eli-
7 gibility.

8 (B) CONFLICT-FREE CASE MANAGEMENT
9 SERVICES.—Conflict-free case management
10 services to develop a service plan, arrange for
11 services and supports, support the beneficiary
12 (and, if appropriate, the beneficiary’s care-
13 givers) in directing the provision of services and
14 supports, for the beneficiary, and conduct ongo-
15 ing monitoring to assure that services and sup-
16 ports are delivered to meet the beneficiary’s
17 needs and achieve intended outcomes.

18 (C) CORE STANDARDIZED ASSESSMENT IN-
19 STRUMENTS.—Development of core standard-
20 ized assessment instruments for determining
21 eligibility for non-institutionally-based long-term
22 services and supports described in subsection
23 (f)(1)(B), which shall be used in a uniform
24 manner throughout the State, to determine a
25 beneficiary’s needs for training, support serv-

1 ices, medical care, transportation, and other
2 services, and develop an individual service plan
3 to address such needs.

4 (6) DATA COLLECTION.—The State agrees to
5 collect from providers of services and through such
6 other means as the State determines appropriate the
7 following data:

8 (A) SERVICES DATA.—Services data from
9 providers of non-institutionally-based long-term
10 services and supports described in subsection
11 (f)(1)(B) on a per-beneficiary basis and in ac-
12 cordance with such standardized coding proce-
13 dures as the State shall establish in consulta-
14 tion with the Secretary.

15 (B) QUALITY DATA.—Quality data on a se-
16 lected set of core quality measures agreed upon
17 by the Secretary and the State that are linked
18 to population-specific outcomes measures and
19 accessible to providers.

20 (C) OUTCOMES MEASURES.—Outcomes
21 measures data on a selected set of core popu-
22 lation-specific outcomes measures agreed upon
23 by the Secretary and the State that are acces-
24 sible to providers and include—

1 (i) measures of beneficiary and family
2 caregiver experience with providers;

3 (ii) measures of beneficiary and family
4 caregiver satisfaction with services; and

5 (iii) measures for achieving desired
6 outcomes appropriate to a specific bene-
7 ficiary, including employment, participa-
8 tion in community life, health stability, and
9 prevention of loss in function.

10 (d) APPLICABLE PERCENTAGE POINTS INCREASE IN
11 FMAP.—The applicable percentage points increase is—

12 (1) in the case of a balancing incentive payment
13 State subject to the target spending percentage de-
14 scribed in subsection (c)(2)(A), 5 percentage points;
15 and

16 (2) in the case of any other balancing incentive
17 payment State, 2 percentage points.

18 (e) ELIGIBLE MEDICAL ASSISTANCE EXPENDI-
19 TURES.—

20 (1) IN GENERAL.—Subject to paragraph (2),
21 medical assistance described in this subsection is
22 medical assistance for non-institutionally-based long-
23 term services and supports described in subsection
24 (f)(1)(B) that is provided by a balancing incentive

1 payment State under its State Medicaid program
2 during the balancing incentive payment period.

3 (2) LIMITATION ON PAYMENTS.—In no case
4 may the aggregate amount of payments made by the
5 Secretary to balancing incentive payment States
6 under this section during the balancing incentive pe-
7 riod exceed \$3,000,000,000.

8 (f) DEFINITIONS.—In this section:

9 (1) LONG-TERM SERVICES AND SUPPORTS DE-
10 FINED.—The term “long-term services and sup-
11 ports” has the meaning given that term by Secretary
12 and shall include the following (as defined with for
13 purposes of State Medicaid programs under title
14 XIX of the Social Security Act):

15 (A) INSTITUTIONALLY-BASED LONG-TERM
16 SERVICES AND SUPPORTS.—Services provided
17 in an institution, including the following:

18 (i) Nursing facility services.

19 (ii) Services in an intermediate care
20 facility for the mentally retarded described
21 in subsection (a)(15) of section 1905 of
22 such Act.

23 (B) NON-INSTITUTIONALLY-BASED LONG-
24 TERM SERVICES AND SUPPORTS.—Services not

1 provided in an institution, including the fol-
2 lowing:

3 (i) Home and community-based serv-
4 ices provided under subsection (c), (d), or
5 (i), of section 1915 of such Act or under
6 a waiver under section 1115 of such Act.

7 (ii) Home health care services.

8 (iii) Personal care services.

9 (iv) Services described in subsection
10 (a)(26) of section 1905 of such Act (relat-
11 ing to PACE program services).

12 (v) Self-directed personal assistance
13 services described in section 1915(j) of
14 such Act.

15 (2) BALANCING INCENTIVE PERIOD.—The term
16 “balancing incentive period” means the period that
17 begins on October 1, 2011, and ends on September
18 30, 2015.

19 (3) POVERTY LINE.—The term “poverty line”
20 has the meaning given that term in section
21 2110(c)(5) of the Social Security Act (42 U.S.C.
22 1397jj(c)(5)).

23 (4) STATE MEDICAID PROGRAM.—The term
24 “State Medicaid program” means the State program
25 for medical assistance provided under a State plan

1 under title XIX of the Social Security Act and under
2 any waiver approved with respect to such State plan.

3 **SEC. 1636A. REMOVAL OF BARRIERS TO PROVIDING HOME**
4 **AND COMMUNITY-BASED SERVICES.**

5 (a) OVERSIGHT AND ASSESSMENT OF THE ADMINIS-
6 TRATION OF HOME AND COMMUNITY-BASED SERVICES.—

7 The Secretary of Health and Human Services shall pro-
8 mulgate regulations to ensure that all States develop serv-
9 ice systems that are designed to—

10 (1) allocate resources for services in a manner
11 that is responsive to the changing needs and choices
12 of beneficiaries receiving non-institutionally-based
13 long-term services and supports described in section
14 1936(f)(1)(B) (including such services and supports
15 that are provided under programs other the State
16 Medicaid program), and that provides strategies for
17 beneficiaries receiving such services to maximize
18 their independence;

19 (2) provide the support and coordination needed
20 for a beneficiary in need of such services (and their
21 family caregivers or representative, if applicable) to
22 design an individualized, self-directed, community-
23 supported life; and

1 (3) improve coordination among all providers of
2 such services under federally and State-funded pro-
3 grams in order to—

4 (A) achieve a more consistent administra-
5 tion of policies and procedures across programs
6 in relation to the provision of such services; and

7 (B) oversee and monitor all service system
8 functions to assure—

9 (i) coordination of, and effectiveness
10 of, eligibility determinations and individual
11 assessments; and

12 (ii) development and service moni-
13 toring of a complaint system, a manage-
14 ment system, a system to qualify and mon-
15 itor providers, and systems for role-setting
16 and individual budget determinations.

17 (b) ADDITIONAL STATE OPTIONS.—Section 1915(i)
18 of the Social Security Act (42 U.S.C. 1396n(i)) is amend-
19 ed by adding at the end the following new paragraphs:

20 “(6) STATE OPTION TO PROVIDE HOME AND
21 COMMUNITY-BASED SERVICES TO INDIVIDUALS ELI-
22 GIBLE FOR SERVICES UNDER A WAIVER.—

23 “(A) IN GENERAL.—A State that provides
24 home and community-based services in accord-
25 ance with this subsection to individuals who

1 satisfy the needs-based criteria for the receipt
2 of such services established under paragraph
3 (1)(A) may, in addition to continuing to provide
4 such services to such individuals, elect to pro-
5 vide home and community-based services in ac-
6 cordance with the requirements of this para-
7 graph to individuals who are eligible for home
8 and community-based services under a waiver
9 approved for the State under subsection (c),
10 (d), or (e) or under section 1115 to provide
11 such services, but only for those individuals
12 whose income does not exceed 300 percent of
13 the supplemental security income benefit rate
14 established by section 1611(b)(1).

15 “(B) APPLICATION OF SAME REQUIRE-
16 MENTS FOR INDIVIDUALS SATISFYING NEEDS-
17 BASED CRITERIA.—Subject to subparagraph
18 (C), a State shall provide home and community-
19 based services to individuals under this para-
20 graph in the same manner and subject to the
21 same requirements as apply under the other
22 paragraphs of this subsection to the provision
23 of home and community-based services to indi-
24 viduals who satisfy the needs-based criteria es-
25 tablished under paragraph (1)(A).

1 “(C) AUTHORITY TO OFFER DIFFERENT
2 TYPE, AMOUNT, DURATION, OR SCOPE OF HOME
3 AND COMMUNITY-BASED SERVICES.—A State
4 may offer home and community-based services
5 to individuals under this paragraph that differ
6 in type, amount, duration, or scope from the
7 home and community-based services offered for
8 individuals who satisfy the needs-based criteria
9 established under paragraph (1)(A), so long as
10 such services are within the scope of services
11 described in paragraph (4)(B) of subsection (c)
12 for which the Secretary has the authority to ap-
13 prove a waiver and do not include room or
14 board.

15 “(7) STATE OPTION TO OFFER HOME AND COM-
16 MUNITY-BASED SERVICES TO SPECIFIC, TARGETED
17 POPULATIONS.—

18 “(A) IN GENERAL.—A State may elect in
19 a State plan amendment under this subsection
20 to target the provision of home and community-
21 based services under this subsection to specific
22 populations and to differ the type, amount, du-
23 ration, or scope of such services to such specific
24 populations.

25 “(B) 5-YEAR TERM.—

1 under paragraph (1)(A) of section
2 1915(i), or who are eligible for home
3 and community-based services under
4 paragraph (6) of such section, and
5 who will receive home and community-
6 based services pursuant to a State
7 plan amendment under such sub-
8 section;”.

9 (2) CONFORMING AMENDMENTS.—

10 (A) Section 1903(f)(4) of the Social Secu-
11 rity Act (42 U.S.C. 1396b(f)(4)), as amended
12 by section 1639(a)(4)(B), is amended in the
13 matter preceding subparagraph (A), by insert-
14 ing “1902(a)(10)(A)(ii)(XXII),” after
15 “1902(a)(10)(A)(ii)(XXI),”.

16 (B) Section 1905(a) of the Social Security
17 Act (42 U.S.C. 1396d(a)) , as so amended, is
18 amended in the matter preceding paragraph
19 (1)—

20 (i) in clause (xv), by striking “or” at
21 the end;

22 (ii) in clause (xvi), by adding “or” at
23 the end; and

24 (iii) by inserting after clause (xvi) the
25 following new clause:

1 “(xvii) individuals who are eligible for home and
2 community-based services under needs-based criteria
3 established under paragraph (1)(A) of section
4 1915(i), or who are eligible for home and commu-
5 nity-based services under paragraph (6) of such sec-
6 tion, and who will receive home and community-
7 based services pursuant to a State plan amendment
8 under such subsection,”.

9 (e) ELIMINATION OF OPTION TO LIMIT NUMBER OF
10 ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR
11 GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA
12 IS MODIFIED.—Paragraph (1) of section 1915(i) of such
13 Act (42 U.S.C. 1396n(i)) is amended—

14 (1) by striking subparagraph (C) and inserting
15 the following:

16 “(C) PROJECTION OF NUMBER OF INDI-
17 VIDUALS TO BE PROVIDED HOME AND COMMU-
18 NITY-BASED SERVICES.—The State submits to
19 the Secretary, in such form and manner, and
20 upon such frequency as the Secretary shall
21 specify, the projected number of individuals to
22 be provided home and community-based serv-
23 ices.”; and

24 (2) in subclause (II) of subparagraph (D)(ii),
25 by striking “to be eligible for such services for a pe-

1 riod of at least 12 months beginning on the date the
2 individual first received medical assistance for such
3 services” and inserting “to continue to be eligible for
4 such services after the effective date of the modifica-
5 tion and until such time as the individual no longer
6 meets the standard for receipt of such services under
7 such pre-modified criteria”.

8 (f) ELIMINATION OF OPTION TO WAIVE
9 STATEWIDENESS; ADDITION OF OPTION TO WAIVE COM-
10 PARABILITY.—Paragraph (3) of section 1915(i) of such
11 Act (42 U.S.C. 1396n(3)) is amended by striking
12 “1902(a)(1) (relating to statewideness)” and inserting
13 “1902(a)(10)(B) (relating to comparability)”.

14 (g) EFFECTIVE DATE.—The amendments made by
15 subsections (b) through (f) take effect on the first day of
16 the first fiscal year quarter that begins after the date of
17 enactment of this Act.

18 **SEC. 1637. MONEY FOLLOWS THE PERSON REBALANCING**

19 **DEMONSTRATION.**

20 (a) EXTENSION OF DEMONSTRATION.—

21 (1) IN GENERAL.—Section 6071(h) of the Def-
22 icit Reduction Act of 2005 (42 U.S.C. 1396a note)
23 is amended—

1 (A) in paragraph (1)(E), by striking “fis-
2 cal year 2011” and inserting “each of fiscal
3 years 2011 through 2016”; and

4 (B) in paragraph (2), by striking “2011”
5 and inserting “2016”.

6 (2) EVALUATION.—Paragraphs (2) and (3) of
7 section 6071(g) of such Act is amended are each
8 amended by striking “2011” and inserting “2016”.

9 (b) REDUCTION OF INSTITUTIONAL RESIDENCY PE-
10 RIOD.—

11 (1) IN GENERAL.—Section 6071(b)(2) of the
12 Deficit Reduction Act of 2005 (42 U.S.C. 1396a
13 note) is amended—

14 (A) in subparagraph (A)(i), by striking “,
15 for a period of not less than 6 months or for
16 such longer minimum period, not to exceed 2
17 years, as may be specified by the State” and in-
18 serting “for a period of not less than 90 con-
19 secutive days”; and

20 (B) by adding at the end the following:
21 “Any days that an individual resides in an institu-
22 tion on the basis of having been admitted solely for
23 purposes of receiving short-term rehabilitative serv-
24 ices for a period for which payment for such services
25 is limited under title XVIII shall not be taken into

1 account for purposes of determining the 90-day pe-
2 riod required under subparagraph (A)(i).”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by this subsection take effect 30 days after the date
5 of enactment of this Act.

6 **SEC. 1638. CLARIFICATION OF DEFINITION OF MEDICAL AS-**
7 **SISTANCE.**

8 Section 1905(a) of the Social Security Act (42 U.S.C.
9 1396d(a)) is amended by inserting “or the care and serv-
10 ices themselves, or both” before “(if provided in or after”.

11 **SEC. 1639. STATE ELIGIBILITY OPTION FOR FAMILY PLAN-**
12 **NING SERVICES.**

13 (a) COVERAGE AS OPTIONAL CATEGORICALLY
14 NEEDY GROUP.—

15 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
16 of the Social Security Act (42 U.S.C.
17 1396a(a)(10)(A)(ii)), as amended by section
18 1601(e), is amended—

19 (A) in subclause (XIX), by striking “or” at
20 the end;

21 (B) in subclause (XX), by adding “or” at
22 the end; and

23 (C) by adding at the end the following new
24 subclause:

1 “(XXI) who are described in sub-
2 section (ii) (relating to individuals
3 who meet certain income standards);”.

4 (2) GROUP DESCRIBED.—Section 1902 of such
5 Act (42 U.S.C. 1396a), as amended by section
6 1601(d), is amended by adding at the end the fol-
7 lowing new subsection:

8 “(ii)(1) Individuals described in this subsection are
9 individuals—

10 “(A) whose income does not exceed an in-
11 come eligibility level established by the State
12 that does not exceed the highest income eligi-
13 bility level established under the State plan
14 under this title (or under its State child health
15 plan under title XXI) for pregnant women; and

16 “(B) who are not pregnant.

17 “(2) At the option of a State, individuals de-
18 scribed in this subsection may include individuals
19 who, had individuals applied on or before January 1,
20 2007, would have been made eligible pursuant to the
21 standards and processes imposed by that State for
22 benefits described in clause (XV) of the matter fol-
23 lowing subparagraph (G) of section subsection
24 (a)(10) pursuant to a waiver granted under section
25 1115.

1 “(3) At the option of a State, for purposes of
2 subsection (a)(17)(B), in determining eligibility for
3 services under this subsection, the State may con-
4 sider only the income of the applicant or recipient.”.

5 (3) LIMITATION ON BENEFITS.—Section
6 1902(a)(10) of the Social Security Act (42 U.S.C.
7 1396a(a)(10)), as amended by section
8 1601(a)(5)(A), is amended in the matter following
9 subparagraph (G)—

10 (A) by striking “and (XV)” and inserting
11 “(XV)”; and

12 (B) by inserting “, and (XVI) the medical
13 assistance made available to an individual de-
14 scribed in subsection (ii) shall be limited to
15 family planning services and supplies described
16 in section 1905(a)(4)(C) including medical di-
17 agnosis and treatment services that are pro-
18 vided pursuant to a family planning service in
19 a family planning setting” before the semicolon.

20 (4) CONFORMING AMENDMENTS.—

21 (A) Section 1905(a) of the Social Security
22 Act (42 U.S.C. 1396d(a)), as amended by sec-
23 tion 1601(e)(2)(A), is amended in the matter
24 preceding paragraph (1)—

1 (i) in clause (xiv), by striking “or” at
2 the end;

3 (ii) in clause (xv), by adding “or” at
4 the end; and

5 (iii) by inserting after clause (xv) the
6 following:

7 “(xvi) individuals described in section
8 1902(ii),”.

9 (B) Section 1903(f)(4) of such Act (42
10 U.S.C. 1396b(f)(4)), as amended by section
11 1601(e)(2)(B), is amended by inserting
12 “1902(a)(10)(A)(ii)(XXI),” after
13 “1902(a)(10)(A)(ii)(XX),”.

14 (b) PRESUMPTIVE ELIGIBILITY.—

15 (1) IN GENERAL.—Title XIX of the Social Se-
16 curity Act (42 U.S.C. 1396 et seq.) is amended by
17 inserting after section 1920B the following:

18 “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING

19 SERVICES

20 “SEC. 1920C. (a) STATE OPTION.—State plan ap-
21 proved under section 1902 may provide for making med-
22 ical assistance available to an individual described in sec-
23 tion 1902(ii) (relating to individuals who meet certain in-
24 come eligibility standard) during a presumptive eligibility
25 period. In the case of an individual described in section
26 1902(ii), such medical assistance shall be limited to family

1 planning services and supplies described in 1905(a)(4)(C)
2 and, at the State’s option, medical diagnosis and treat-
3 ment services that are provided in conjunction with a fam-
4 ily planning service in a family planning setting.

5 “(b) DEFINITIONS.—For purposes of this section:

6 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
7 term ‘presumptive eligibility period’ means, with re-
8 spect to an individual described in subsection (a),
9 the period that—

10 “(A) begins with the date on which a
11 qualified entity determines, on the basis of pre-
12 liminary information, that the individual is de-
13 scribed in section 1902(ii); and

14 “(B) ends with (and includes) the earlier
15 of—

16 “(i) the day on which a determination
17 is made with respect to the eligibility of
18 such individual for services under the State
19 plan; or

20 “(ii) in the case of such an individual
21 who does not file an application by the last
22 day of the month following the month dur-
23 ing which the entity makes the determina-
24 tion referred to in subparagraph (A), such
25 last day.

1 “(2) QUALIFIED ENTITY.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), the term ‘qualified entity’ means
4 any entity that—

5 “(i) is eligible for payments under a
6 State plan approved under this title; and

7 “(ii) is determined by the State agen-
8 cy to be capable of making determinations
9 of the type described in paragraph (1)(A).

10 “(B) RULE OF CONSTRUCTION.—Nothing
11 in this paragraph shall be construed as pre-
12 venting a State from limiting the classes of en-
13 tities that may become qualified entities in
14 order to prevent fraud and abuse.

15 “(c) ADMINISTRATION.—

16 “(1) IN GENERAL.—The State agency shall pro-
17 vide qualified entities with—

18 “(A) such forms as are necessary for an
19 application to be made by an individual de-
20 scribed in subsection (a) for medical assistance
21 under the State plan; and

22 “(B) information on how to assist such in-
23 dividuals in completing and filing such forms.

24 “(2) NOTIFICATION REQUIREMENTS.—A quali-
25 fied entity that determines under subsection

1 (b)(1)(A) that an individual described in subsection
2 (a) is presumptively eligible for medical assistance
3 under a State plan shall—

4 “(A) notify the State agency of the deter-
5 mination within 5 working days after the date
6 on which determination is made; and

7 “(B) inform such individual at the time
8 the determination is made that an application
9 for medical assistance is required to be made by
10 not later than the last day of the month fol-
11 lowing the month during which the determina-
12 tion is made.

13 “(3) APPLICATION FOR MEDICAL ASSIST-
14 ANCE.—In the case of an individual described in
15 subsection (a) who is determined by a qualified enti-
16 ty to be presumptively eligible for medical assistance
17 under a State plan, the individual shall apply for
18 medical assistance by not later than the last day of
19 the month following the month during which the de-
20 termination is made.

21 “(d) PAYMENT.—Notwithstanding any other provi-
22 sion of law, medical assistance that—

23 “(1) is furnished to an individual described in
24 subsection (a)—

1 “(A) during a presumptive eligibility pe-
2 riod; and

3 “(B) by a entity that is eligible for pay-
4 ments under the State plan; and

5 “(2) is included in the care and services covered
6 by the State plan,

7 shall be treated as medical assistance provided by such
8 plan for purposes of clause (4) of the first sentence of
9 section 1905(b).”.

10 (2) CONFORMING AMENDMENTS.—

11 (A) Section 1902(a)(47) of the Social Se-
12 curity Act (42 U.S.C. 1396a(a)(47)), as amend-
13 ed by section 1622(a), is amended—

14 (i) in subparagraph (A), by inserting
15 before the semicolon at the end the fol-
16 lowing: “and provide for making medical
17 assistance available to individuals described
18 in subsection (a) of section 1920C during
19 a presumptive eligibility period in accord-
20 ance with such section”; and

21 (ii) in subparagraph (B), by striking
22 “or 1920B” and inserting “1920B, or
23 1920C”.

24 (B) Section 1903(u)(1)(D)(v) of such Act
25 (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by

1 section 1622(b), is amended by inserting “or
2 for medical assistance provided to an individual
3 described in subsection (a) of section 1920C
4 during a presumptive eligibility period under
5 such section,” after “1920B during a presump-
6 tive eligibility period under such section,”.

7 (c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
8 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
9 Social Security Act (42 U.S.C. 1396u–7(b)), as amended
10 by section 1601(c), is amended by adding at the end the
11 following:

12 “(7) COVERAGE OF FAMILY PLANNING SERV-
13 ICES AND SUPPLIES.—Notwithstanding the previous
14 provisions of this section, a State may not provide
15 for medical assistance through enrollment of an indi-
16 vidual with benchmark coverage or benchmark-equiv-
17 alent coverage under this section unless such cov-
18 erage includes for any individual described in section
19 1905(a)(4)(C), medical assistance for family plan-
20 ning services and supplies in accordance with such
21 section.”.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section take effect on the date of the enactment of
24 this Act and shall apply to items and services furnished
25 on or after such date.

1 **SEC. 1640. GRANTS FOR SCHOOL-BASED HEALTH CENTERS.**

2 Title XIX of the Social Security Act (42 U.S.C.
3 1397aa et seq.), as amended by section 1621, is amended
4 by adding at the end the following:

5 **“SEC. 1944. GRANTS FOR SCHOOL-BASED HEALTH CEN-**
6 **TERS.**

7 “(a) PROGRAM.—The Secretary shall establish a pro-
8 gram to award grants to eligible entities to support the
9 operation of school-based health centers (as defined in sec-
10 tion 2110(c)(9)).

11 “(b) ELIGIBILITY.—To be eligible for a grant under
12 this section, an entity shall—

13 “(1) be a school-based health center or a spon-
14 soring facility (as defined in section 2110(c)(9)(B))
15 of a school-based health center; and

16 “(2) submit an application at such time, in
17 such manner, and containing such information as
18 the Secretary may require, including at a minimum
19 an assurance that funds awarded under the grant
20 shall not be used to provide any service that is not
21 authorized or allowed by Federal, State, or local law.

22 “(c) PREFERENCE.—In awarding grants under this
23 section, the Secretary shall give preference to awarded
24 grants for school-based health centers that serve a large
25 population of children eligible for medical assistance under
26 the State plan under this title or under a waiver of the

1 plan or children eligible for child health assistance under
2 the State child health plan under title XXI.

3 “(d) APPROPRIATIONS.—Out of any funds in the
4 Treasury not otherwise appropriated, there is appro-
5 priated for each of fiscal years 2010 and 2011,
6 \$100,000,000 for the purpose of carrying out this section.
7 Funds appropriated under this subsection shall remain
8 available until expended.”.

9 **SEC. 1641. THERAPEUTIC FOSTER CARE.**

10 Section 1905 of the Social Security Act (42 U.S.C.
11 1396d), as amended by sections 1601(a)(3) and 1636, is
12 amended by adding at the end the following:

13 “(aa)(1) Nothing in subsection (a) shall be construed
14 as limiting a State from providing medical assistance for
15 therapeutic foster care for children in foster care under
16 the responsibility of the State in out-of-home placements.

17 “(2) The term ‘therapeutic foster care’ means a fos-
18 ter care program that provides—

19 “(A) to a child in foster care under the respon-
20 sibility of the State—

21 “(i) structured daily activities that develop,
22 improve, monitor, and reinforce age-appropriate
23 social, communications, and behavioral skills;

24 “(ii) crisis intervention and crisis support
25 services;

1 “(iii) medication monitoring;

2 “(iv) counseling; and

3 “(v) case management services; and

4 “(B) specialized training for the foster parent
5 and consultation with the foster parent on the man-
6 agement of children with mental illnesses and re-
7 lated health and developmental conditions.”.

8 **SEC. 1642. SENSE OF THE SENATE REGARDING LONG-TERM**
9 **CARE.**

10 (a) FINDINGS.—The Senate makes the following
11 findings:

12 (1) Nearly 2 decades have passed since Con-
13 gress seriously considered long-term care reform.
14 The United States Bipartisan Commission on Com-
15 prehensive Health Care, also know as the “Pepper
16 Commission”, released its “Call for Action” blue-
17 print for health reform in September 1990. In the
18 20 years since those recommendations were made,
19 Congress has never acted on the report.

20 (2) In 1999, under the United States Supreme
21 Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581
22 (1999), individuals with disabilities have the right to
23 choose to receive their long-term services and sup-
24 ports in the community, rather than in an institu-
25 tional setting.

1 (3) Despite the Pepper Commission and
2 *Olmstead* decision, the long-term care provided to
3 our Nation's elderly and disabled has not improved.
4 In fact, for many, it has gotten far worse.

5 (4) In 2007, 69 percent of Medicaid long-term
6 care spending for elderly individuals and adults with
7 physical disabilities paid for institutional services.
8 Only 6 states spent 50 percent or more of their
9 Medicaid long-term care dollars on home and com-
10 munity-based services for elderly individuals and
11 adults with physical disabilities while ½ of the
12 States spent less than 25 percent. This disparity
13 continues even though, on average, it is estimated
14 that Medicaid dollars can support nearly 3 elderly
15 individuals and adults with physical disabilities in
16 home and community-based services for every indi-
17 vidual in a nursing home. Although every State has
18 chosen to provide certain services under home and
19 community-based waivers, these services are un-
20 evenly available within and across States, and reach
21 a small percentage of eligible individuals.

22 (b) SENSE OF THE SENATE.—It is the sense of the
23 Senate that—

24 (1) during the 111th session of Congress, Con-
25 gress should address long-term services and supports

1 in a comprehensive way that guarantees elderly and
2 disabled individuals the care they need; and

3 (2) long term services and supports should be
4 made available in the community in addition to in
5 institutions.

6 **PART V—MEDICAID PRESCRIPTION DRUG**

7 **COVERAGE**

8 **SEC. 1651. PRESCRIPTION DRUG REBATES.**

9 (a) INCREASE IN MINIMUM REBATE PERCENTAGE
10 FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE
11 SOURCE DRUGS.—Section 1927(c)(1)(B) of the Social Se-
12 curity Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

13 (1) in clause (i)—

14 (A) in subclause (IV), by striking “and” at
15 the end;

16 (B) in subclause (V)—

17 (i) by inserting “and before January
18 1, 2010” after “December 31, 1995,”; and

19 (ii) by striking the period at the end
20 and inserting “; and”; and

21 (C) by adding at the end the following new
22 subclause:

23 “(VI) except as provided in
24 clause (iii), after December 31, 2009,
25 23.1 percent.”; and

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

3 “(iii) MINIMUM REBATE PERCENTAGE
4 FOR CERTAIN DRUGS.—

5 “(I) IN GENERAL.—In the case
6 of a single source drug or an inno-
7 vator multiple source drug described
8 in subclause (II), the minimum rebate
9 percentage for rebate periods specified
10 in clause (i)(VI) is 17.1 percent.

11 “(II) DRUG DESCRIBED.—For
12 purposes of subclause (I), a single
13 source drug or an innovator multiple
14 source drug described in this sub-
15 clause is any of the following drugs:

16 “(aa) A clotting factor for
17 which a separate furnishing pay-
18 ment is made under section
19 1842(o)(5) and which is included
20 on a list of such factors specified
21 and updated regularly by the
22 Secretary.

23 “(bb) A drug approved by
24 the Food and Drug Administra-

1 “(xiii) such contract provides that (I)
2 covered outpatient drugs dispensed to indi-
3 viduals eligible for medical assistance who
4 are enrolled with the entity shall be subject
5 to the same rebate required by the agree-
6 ment entered into under section 1927 as
7 the State is subject to and that the State
8 shall collect such rebates from manufactur-
9 ers, (II) capitation rates paid to the entity
10 shall be based on actual cost experience re-
11 lated to rebates and subject to the Federal
12 regulations requiring actuarially sound
13 rates, and (III) the entity shall report to
14 the State, on such timely and periodic
15 basis as specified by the Secretary, infor-
16 mation on the total number of units of
17 each dosage form and strength and pack-
18 age size by National Drug Code of each
19 covered outpatient drug dispensed to indi-
20 viduals eligible for medical assistance who
21 are enrolled with the entity and for which
22 the entity is responsible for coverage of
23 such drug under this subsection.”.

24 (2) CONFORMING AMENDMENTS.—Section 1927
25 (42 U.S.C. 1396r–8) is amended—

1 (A) in subsection (d)(4), by inserting after
2 subparagraph (E) the following:

3 “(F) Notwithstanding the preceding sub-
4 paragraphs of this paragraph, any formulary
5 established by medicaid managed care organiza-
6 tion with a contract under section 1903(m) may
7 be based on positive inclusion of drugs selected
8 by a formulary committee consisting of physi-
9 cians, pharmacists, and other individuals with
10 appropriate clinical experience as long as drugs
11 excluded from the formulary are available
12 through prior authorization, as described in
13 paragraph (5).”; and

14 (B) in subsection (j), by striking para-
15 graph (1) and inserting the following:

16 “(1) Covered outpatient drugs are not subject
17 to the requirements of this section if such drugs
18 are—

19 “(A) dispensed by health maintenance or-
20 ganizations, including Medicaid managed care
21 organizations that contract under section
22 1903(m); and

23 “(B) subject to discounts under section
24 340B of the Public Health Service Act.”.

1 (d) ADDITIONAL REBATE FOR NEW FORMULATIONS
2 OF EXISTING DRUGS.—

3 (1) IN GENERAL.—Section 1927(c)(2) of the
4 Social Security Act (42 U.S.C. 1396r–8(c)(2)) is
5 amended by adding at the end the following new
6 subparagraph:

7 “(C) TREATMENT OF NEW FORMULA-
8 TIONS.—

9 “(i) IN GENERAL.—Except as pro-
10 vided in clause (ii), in the case of a drug
11 that is a new formulation, such as an ex-
12 tended-release formulation, of a single
13 source drug or an innovator multiple
14 source drug, the rebate obligation with re-
15 spect to the drug under this section shall
16 be the amount computed under this section
17 for the new formulation of the drug or, if
18 greater, the product of—

19 “(I) the average manufacturer
20 price of the new formulation of the
21 single source drug or innovator mul-
22 tiple source drug;

23 “(II) the highest additional re-
24 bate (calculated as a percentage of av-
25 erage manufacturer price) under this

1 section for any strength of the origi-
2 nal single source drug or innovator
3 multiple source drug; and

4 “(III) the total number of units
5 of each dosage form and strength of
6 the new formulation paid for under
7 the State plan in the rebate period (as
8 reported by the State).

9 “(ii) NO APPLICATION TO NEW FOR-
10 MULATIONS OF ORPHAN DRUGS.—Clause
11 (i) shall not apply to a new formulation of
12 a covered outpatient drug that is or has
13 been designated under section 526 of the
14 Federal Food, Drug, and Cosmetic Act (21
15 U.S.C. 360bb) for a rare disease or condi-
16 tion, without regard to whether the period
17 of market exclusivity for the drug under
18 section 527 of such Act has expired or the
19 specific indication for use of the drug.”.

20 (2) EFFECTIVE DATE.—The amendment made
21 by paragraph (1) shall apply to drugs dispensed
22 after December 31, 2009.

23 (e) MAXIMUM REBATE AMOUNT.—Section
24 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as

1 amended by subsection (d), is amended by adding at the
2 end the following new subparagraph:

3 “(D) MAXIMUM REBATE AMOUNT.—In no
4 case shall the sum of the amounts applied
5 under paragraph (1)(A)(ii) and this paragraph
6 with respect to each dosage form and strength
7 of a single source drug or an innovator multiple
8 source drug for a rebate period beginning after
9 December 31, 2009, exceed 100 percent of the
10 average manufacturer price of the drug.”.

11 (f) CONFORMING AMENDMENTS.—

12 (1) IN GENERAL.—Section 340B of the Public
13 Health Service Act (42 U.S.C. 256b) is amended—

14 (A) in subsection (a)(2)(B)(i), by striking
15 “1927(c)(4)” and inserting “1927(c)(3)”; and

16 (B) by striking subsection (c); and

17 (C) redesignating subsection (d) as sub-
18 section (e).

19 (2) EFFECTIVE DATE.—The amendments made
20 by this subsection take effect on January 1, 2010.

21 **SEC. 1652. ELIMINATION OF EXCLUSION OF COVERAGE OF**
22 **CERTAIN DRUGS.**

23 (a) IN GENERAL.—Section 1927(d) of the Social Se-
24 curity Act (42 U.S.C. 1397r-8(d)) is amended—

25 (1) in paragraph (2)—

1 (A) by striking subparagraphs (E), (I),
2 and (J), respectively; and

3 (B) by redesignating subparagraphs (F),
4 (G), (H), and (K) as subparagraphs (E), (F),
5 (G), and (H), respectively; and

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

8 “(7) NON-EXCLUDABLE DRUGS.—The following
9 drugs or classes of drugs, or their medical uses, shall
10 not be excluded from coverage:

11 “(A) Agents when used to promote smok-
12 ing cessation.

13 “(B) Barbiturates.

14 “(C) Benzodiazepines.”

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to services furnished on or after
17 January 1, 2014.

18 **SEC. 1653. PROVIDING ADEQUATE PHARMACY REIMBURSE-**
19 **MENT.**

20 (a) PHARMACY REIMBURSEMENT LIMITS.—

21 (1) IN GENERAL.—Section 1927(e) of the So-
22 cial Security Act (42 U.S.C. 1396r-8(e)) is amend-
23 ed—

24 (A) in paragraph (4), by striking “(or, ef-
25 fective January 1, 2007, two or more)”; and

1 (B) by striking paragraph (5) and insert-
2 ing the following:

3 “(5) USE OF AMP IN UPPER PAYMENT LIM-
4 ITS.—The Secretary shall calculate the Federal
5 upper reimbursement limit established under para-
6 graph (4) as no less than 175 percent of the weight-
7 ed average (determined on the basis of utilization) of
8 the most recently reported monthly average manu-
9 facturer prices for pharmaceutically and therapeuti-
10 cally equivalent multiple source drug products that
11 are available for purchase by retail community phar-
12 macies on a nationwide basis. The Secretary shall
13 implement a smoothing process for average manu-
14 facturer prices. Such process shall be similar to the
15 smoothing process used in determining the average
16 sales price of a drug or biological under section
17 1847A.”.

18 (2) DEFINITION OF AMP.—Section 1927(k)(1)
19 of such Act (42 U.S.C. 1396r–8(k)(1)) is amend-
20 ed—

21 (A) in subparagraph (A), by striking “by”
22 and all that follows through the period and in-
23 serting “by—

24 “(i) wholesalers for drugs distributed
25 to retail community pharmacies; and

1 “(ii) retail community pharmacies
2 that purchase drugs directly from the man-
3 ufacturer.”; and

4 (B) by striking subparagraph (B) and in-
5 serting the following:

6 “(B) EXCLUSION OF CUSTOMARY PROMPT
7 PAY DISCOUNTS AND OTHER PAYMENTS.—

8 “(i) IN GENERAL.—The average man-
9 ufacturer price for a covered outpatient
10 drug shall exclude—

11 “(I) customary prompt pay dis-
12 counts extended to wholesalers;

13 “(II) bona fide service fees paid
14 by manufacturers to wholesalers or re-
15 tail community pharmacies, including
16 (but not limited to) distribution serv-
17 ice fees, inventory management fees,
18 product stocking allowances, and fees
19 associated with administrative services
20 agreements and patient care programs
21 (such as medication compliance pro-
22 grams and patient education pro-
23 grams);

24 “(III) reimbursement by manu-
25 facturers for recalled, damaged, ex-

1 manufacturer price for a covered out-
2 patient drug.”; and

3 (C) in subparagraph (C), by striking “the
4 retail pharmacy class of trade” and inserting
5 “retail community pharmacies”.

6 (3) DEFINITION OF MULTIPLE SOURCE
7 DRUG.—Section 1927(k)(7) of such Act (42 U.S.C.
8 1396r–8(k)(7)) is amended—

9 (A) in subparagraph (A)(i)(III), by strik-
10 ing “the State” and inserting “the United
11 States”; and

12 (B) in subparagraph (C)—

13 (i) in clause (i), by inserting “and”
14 after the semicolon;

15 (ii) in clause (ii), by striking “; and”
16 and inserting a period; and

17 (iii) by striking clause (iii).

18 (4) DEFINITIONS OF RETAIL COMMUNITY PHAR-
19 MACY; WHOLESALER.—Section 1927(k) of such Act
20 (42 U.S.C. 1396r–8(k)) is amended by adding at the
21 end the following new paragraphs:

22 “(10) RETAIL COMMUNITY PHARMACY.—The
23 term ‘retail community pharmacy’ means an inde-
24 pendent pharmacy, a chain pharmacy, a super-
25 market pharmacy, or a mass merchandiser phar-

1 macy that is licensed as a pharmacy by the State
2 and that dispenses medications to the general public
3 at retail prices. Such term does not include a phar-
4 macy that dispenses prescription medications to pa-
5 tients primarily through the mail, nursing home
6 pharmacies, long-term care facility pharmacies, hos-
7 pital pharmacies, clinics, charitable or not-for-profit
8 pharmacies, government pharmacies, or pharmacy
9 benefit managers.

10 “(11) WHOLESALER.—The term ‘wholesaler’
11 means a drug wholesaler that is engaged in whole-
12 sale distribution of prescription drugs to retail com-
13 munity pharmacies, including (but not limited to)
14 manufacturers, repackers, distributors, own-label
15 distributors, private-label distributors, jobbers, bro-
16 kers, warehouses (including manufacturer’s and dis-
17 tributor’s warehouses, chain drug warehouses, and
18 wholesale drug warehouses) independent wholesale
19 drug traders, and retail community pharmacies that
20 conduct wholesale distributions.”.

21 (b) DISCLOSURE OF PRICE INFORMATION TO THE
22 PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C.
23 1396r–8(b)(3)) is amended—

24 (1) in subparagraph (A)—

1 (A) in clause (i), in the matter preceding
2 subclause (I), by inserting “month of a” after
3 “each”; and

4 (B) in the second sentence, by inserting
5 “(relating to the weighted average of the most
6 recently reported monthly average manufacturer
7 prices)” after “(D)(v)”; and

8 (2) in subparagraph (D)(v), by striking “aver-
9 age manufacturer prices” and inserting “the weight-
10 ed average of the most recently reported monthly av-
11 erage manufacturer prices and the average retail
12 survey price determined for each multiple source
13 drug in accordance with subsection (f)”.

14 (c) CLARIFICATION OF APPLICATION OF SURVEY OF
15 RETAIL PRICES.—Section 1927(f)(1) of such Act (42
16 U.S.C. 1396r–8(b)(1)) is amended—

17 (1) in subparagraph (A)(i), by inserting “with
18 respect to a retail community pharmacy,” before
19 “the determination”; and

20 (2) in subparagraph (C)(ii), by striking “retail
21 pharmacies” and inserting “retail community phar-
22 macies”.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect on the first day of the first
25 calendar year quarter that begins at least 180 days after

1 the date of enactment of this Act, without regard to
2 whether or not final regulations to carry out such amend-
3 ments have been promulgated by such date.

4 **SEC. 1654. STUDY OF BARRIERS TO APPROPRIATE UTILIZA-**
5 **TION OF GENERIC MEDICINE IN FEDERAL**
6 **HEALTH CARE PROGRAMS.**

7 (a) STUDY.—The Comptroller General of the United
8 States shall conduct a study of State laws that have a
9 negative impact on generic drug utilization in Federal
10 health care programs (as defined in section 1128B(f) of
11 the Social Security Act (42 U.S.C. 1320a–7b(f))) due to
12 restrictions such as (but not limited to) limits on phar-
13 macists’ ability to provide a generic drug substitute for
14 a prescribed name brand drug and carve-outs of certain
15 classes of drugs from generic substitution.

16 (b) REPORT.—Not later than April 1, 2012, the
17 Comptroller General of the United States shall submit a
18 report to Congress on the results of the study conducted
19 under subsection (a).

20 **PART VI—MEDICAID DISPROPORTIONATE SHARE**
21 **HOSPITAL (DSH) PAYMENTS**

22 **SEC. 1655. DISPROPORTIONATE SHARE HOSPITAL PAY-**
23 **MENTS.**

24 (a) IN GENERAL.—Section 1923(f) of the Social Se-
25 curity Act (42 U.S.C. 1396r–4(f)) is amended—

1 (1) in paragraph (1), by striking “and (3)” and
2 inserting “, (3), and (7)”;

3 (2) in paragraph (3)(A), by striking “paragraph
4 (6)” and inserting “paragraphs (6) and (7)”;

5 (3) by redesignating paragraph (7) as para-
6 graph (8); and

7 (4) by inserting after paragraph (6) the fol-
8 lowing new paragraph:

9 “(7) REDUCTION OF STATE DSH ALLOTMENTS
10 ONCE REDUCTION IN UNINSURED THRESHOLD
11 REACHED.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (E), the DSH allotment for a State for
14 fiscal years beginning with the fiscal year de-
15 scribed in subparagraph (C) (with respect to
16 the State), is equal to the DSH allotment that
17 would be determined under this subsection for
18 the State for the fiscal year without application
19 of this paragraph (but after the application of
20 subparagraph (D)), reduced by the applicable
21 percentage determined for the State for the fis-
22 cal year under subparagraph (B).

23 “(B) APPLICABLE PERCENTAGE.—For
24 purposes of subparagraph (A), the applicable

1 percentage for a State for a fiscal year is the
2 following:

3 “(i) UNINSURED REDUCTION THRESH-
4 OLD FISCAL YEAR.—In the case of the first
5 fiscal year described in subparagraph (C)
6 with respect to the State—

7 “(I) if the State is a low DSH
8 State described in paragraph (5)(B),
9 the applicable percentage is equal to
10 25 percent; and

11 “(II) if the State is any other
12 State, the applicable percentage is 50
13 percent.

14 “(ii) SUBSEQUENT FISCAL YEARS IN
15 WHICH THE PERCENTAGE OF UNINSURED
16 DECREASES.—In the case of any fiscal
17 year after the first fiscal year described in
18 subparagraph (C) with respect to a State,
19 if the Secretary determines on the basis of
20 the most recent American Community Sur-
21 vey of the Bureau of the Census, that the
22 percentage of uncovered individuals resid-
23 ing in the State is less than the percentage
24 of such individuals determined for the
25 State for the preceding fiscal year—

1 “(I) if the State is a low DSH
2 State described in paragraph (5)(B),
3 the applicable percentage is equal to
4 the product of the amount by which
5 the percentage of uncovered individ-
6 uals for the fiscal year is less than the
7 percentage of such individuals for the
8 preceding fiscal year and 17.5 per-
9 cent; and

10 “(II) if the State is any other
11 State, the applicable percentage is
12 equal to the product of the amount by
13 which the percentage of uncovered in-
14 dividuals for the fiscal year is less
15 than the percentage of such individ-
16 uals for the preceding fiscal year and
17 35 percent.

18 “(C) FISCAL YEAR DESCRIBED.—For pur-
19 poses of subparagraph (A), the fiscal year de-
20 scribed in this subparagraph with respect to a
21 State is the first fiscal year that occurs after
22 fiscal year 2012 for which the Secretary deter-
23 mines, on the basis of the most recent Amer-
24 ican Community Survey of the Bureau of the
25 Census, that the percentage of uncovered indi-

1 viduals residing in the State is at least 50 per-
2 cent less than the percentage of such individ-
3 uals determined for the State for fiscal year
4 2009.

5 “(D) EXCLUSION OF PORTIONS DIVERTED
6 FOR COVERAGE EXPANSIONS.—For purposes of
7 applying the applicable percentage reduction
8 under subparagraph (A) to the DSH allotment
9 for a State for a fiscal year, the DSH allotment
10 for a State that would be determined under this
11 subsection for the State for the fiscal year with-
12 out the application of this paragraph (and prior
13 to any such reduction) shall not include any
14 portion of the allotment for which the Secretary
15 has approved the State’s diversion to the costs
16 of providing medical assistance or other health
17 benefits coverage under a waiver that is in ef-
18 fect on July 2009.

19 “(E) MINIMUM ALLOTMENT.—In no event
20 shall the DSH allotment determined for a State
21 in accordance with this paragraph for fiscal
22 year 2013 or any succeeding fiscal year be less
23 than the amount equal to 35 percent of the
24 DSH allotment determined for the State for fis-
25 cal year 2012 under this subsection (and after

1 the application of this paragraph, if applicable),
2 increased by the percentage change in the con-
3 sumer price index for all urban consumers (all
4 items, U.S. city average) for each previous fis-
5 cal year occurring before the fiscal year.

6 “(F) UNCOVERED INDIVIDUALS.—In this
7 paragraph, the term ‘uncovered individuals’
8 means individuals with no health insurance (as
9 defined in section 2791 of the Public Health
10 Service Act) at any time during a year.”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 subsection (a) take effect on October 1, 2011.

13 **PART VII—DUAL ELIGIBLES**

14 **SEC. 1661. 5-YEAR PERIOD FOR DEMONSTRATION**
15 **PROJECTS.**

16 (a) IN GENERAL.—Section 1915(h) of the Social Se-
17 curity Act (42 U.S.C. 1396n(h)) is amended—

18 (1) by inserting “(1)” after “(h)”;

19 (2) by inserting “, or a waiver described in
20 paragraph (2)” after “(e)”; and

21 (3) by adding at the end the following new
22 paragraph:

23 “(2)(A) Notwithstanding subsections (c)(3) and (d)
24 (3), any waiver under subsection (b), (c), or (d), or a waiv-
25 er under section 1115, that provides medical assistance

1 for dual eligible individuals (including any such waivers
2 under which non dual eligible individuals may be enrolled
3 in addition to dual eligible individuals) may be conducted
4 for a period of 5 years and, upon the request of the State,
5 may be extended for additional 5-year periods unless the
6 Secretary determines that for the previous waiver period
7 the conditions for the waiver have not been met or it would
8 no longer be cost-effective and efficient, or consistent with
9 the purposes of this title, to extend the waiver.

10 “(B) In this paragraph, the term ‘dual eligible indi-
11 vidual’ means an individual who is entitled to, or enrolled
12 for, benefits under part A of title XVIII, or enrolled for
13 benefits under part B of title XVIII, and is eligible for
14 medical assistance under the State plan under this title
15 or under a waiver of such plan.”.

16 (b) CONFORMING AMENDMENTS.—

17 (1) Section 1915 of such Act (42 U.S.C.
18 1396n) is amended—

19 (A) in subsection (b), by adding at the end
20 the following new sentence: “Subsection (h)(2)
21 shall apply to a waiver under this subsection.”;

22 (B) in subsection (c)(3), in the second sen-
23 tence, by inserting “(other than a waiver de-
24 scribed in subsection (h)(2))” after “A waiver
25 under this subsection”;

1 (C) in subsection (d)(3), in the second sen-
2 tence, by inserting “(other than a waiver de-
3 scribed in subsection (h)(2))” after “A waiver
4 under this subsection”.

5 (2) Section 1115 of such Act (42 U.S.C. 1315)
6 is amended—

7 (A) in subsection (e)(2), by inserting “(5
8 years, in the case of a waiver described in sec-
9 tion 1915(h)(2))” after “3 years”; and

10 (B) in subsection (f)(6), by inserting “(5
11 years, in the case of a waiver described in sec-
12 tion 1915(h)(2))” after “3 years”.

13 **SEC. 1662. PROVIDING FEDERAL COVERAGE AND PAYMENT**
14 **COORDINATION FOR LOW-INCOME MEDICARE**
15 **BENEFICIARIES.**

16 (a) ESTABLISHMENT OF FEDERAL COORDINATED
17 HEALTH CARE OFFICE.—

18 (1) IN GENERAL.—Not later than March 1,
19 2010, the Secretary of Health and Human Services
20 (in this section referred to as the “Secretary”) shall
21 establish a Federal Coordinated Health Care Office.

22 (2) ESTABLISHMENT AND REPORTING TO CMS
23 ADMINISTRATOR.—The Federal Coordinated Health
24 Care Office—

1 (A) shall be established within the Centers
2 for Medicare & Medicaid Services; and

3 (B) have as the Office a Director who shall
4 be appointed by, and be in direct line of author-
5 ity to, the Administrator of the Centers for
6 Medicare & Medicaid Services.

7 (b) PURPOSE.—The purpose of the Federal Coordi-
8 nated Health Care Office is to bring together officers and
9 employees of the Medicare and Medicaid programs at the
10 Centers for Medicare & Medicaid Services in order to—

11 (1) more effectively integrate benefits under the
12 Medicare program under title XVIII of the Social
13 Security Act and the Medicaid program under title
14 XIX of such Act; and

15 (2) improve the coordination between the Fed-
16 eral Government and States for individuals eligible
17 for benefits under both such programs in order to
18 ensure that such individuals get full access to the
19 items and services to which they are entitled under
20 titles XVIII and XIX of the Social Security Act.

21 (c) GOALS.—The goals of the Federal Coordinated
22 Health Care Office are as follows:

23 (1) Providing dual eligible individuals full ac-
24 cess to the benefits to which such individuals are en-
25 titled under the Medicare and Medicaid programs.

1 (2) Simplifying the processes for dual eligible
2 individuals to access the items and services they are
3 entitled to under the Medicare and Medicaid pro-
4 grams.

5 (3) Improving the quality of health care and
6 long-term services for dual eligible individuals.

7 (4) Increasing dual eligible individuals' under-
8 standing of and satisfaction with coverage under the
9 Medicare and Medicaid programs.

10 (5) Eliminating regulatory conflicts between
11 rules under the Medicare and Medicaid programs.

12 (6) Improving care continuity and ensuring safe
13 and effective care transitions for dual eligible indi-
14 viduals.

15 (7) Eliminating cost-shifting between the Medi-
16 care and Medicaid program and among related
17 health care providers.

18 (8) Improving the quality of performance of
19 providers of services and suppliers under the Medi-
20 care and Medicaid programs.

21 (d) SPECIFIC RESPONSIBILITIES.—The specific re-
22 sponsibilities of the Federal Coordinated Health Care Of-
23 fice are as follows:

24 (1) Providing States, specialized MA plans for
25 special needs individuals (as defined in section

1 1859(b)(6) of the Social Security Act (42 U.S.C.
2 1395w-28(b)(6))), physicians and other relevant en-
3 tities or individuals with the education and tools nec-
4 essary for developing programs that align benefits
5 under the Medicare and Medicaid programs for dual
6 eligible individuals.

7 (2) Supporting State efforts to coordinate and
8 align acute care and long-term care services for dual
9 eligible individuals with other items and services fur-
10 nished under the Medicare program.

11 (3) Providing support for coordination of con-
12 tracting and oversight by States and the Centers for
13 Medicare & Medicaid Services with respect to the in-
14 tegration of the Medicare and Medicaid programs in
15 a manner that is supportive of the goals described
16 in paragraph (3).

17 (4) To consult and coordinate with the Medi-
18 care Payment Advisory Commission established
19 under section 1805 of the Social Security Act (42
20 U.S.C. 1395b-6) and the Medicaid and CHIP Pay-
21 ment and Access Commission established under sec-
22 tion 1900 of such Act (42 U.S.C. 1396) with respect
23 to policies relating to the enrollment in, and provi-
24 sion of, benefits to dual eligible individuals under the
25 Medicare program under title XVIII of the Social

1 Security Act and the Medicaid program under title
2 XIX of such Act.

3 (e) REPORT.—The Secretary shall, as part of the
4 budget transmitted under section 1105(a) of title 31,
5 United States Code, submit to Congress an annual report
6 containing recommendations for legislation that would im-
7 prove care coordination and benefits for dual eligible indi-
8 viduals.

9 (f) DUAL ELIGIBLE DEFINED.—In this section, the
10 term “dual eligible individual” means an individual who
11 is entitled to, or enrolled for, benefits under part A of title
12 XVIII of the Social Security Act, or enrolled for benefits
13 under part B of title XVIII of such Act, and is eligible
14 for medical assistance under a State plan under title XIX
15 of such Act or under a waiver of such plan.

16 **PART VIII—MEDICAID QUALITY**

17 **SEC. 1671. ADULT HEALTH QUALITY MEASURES.**

18 Title XI of the Social Security Act (42 U.S.C. 1301
19 et seq.), as amended by section 401 of the Children’s
20 Health Insurance Program Reauthorization Act of 2009
21 (Public Law 111-3), is amended by inserting after section
22 1139A the following new section:

23 **“SEC. 1139B. ADULT HEALTH QUALITY MEASURES.**

24 “(a) DEVELOPMENT OF CORE SET OF HEALTH CARE
25 QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENE-

1 FITS UNDER MEDICAID.—The Secretary shall identify
2 and publish a recommended core set of adult health qual-
3 ity measures for Medicaid eligible adults in the same man-
4 ner as the Secretary identifies and publishes a core set
5 of child health quality measures under section 1139A, in-
6 cluding with respect to identifying and publishing existing
7 adult health quality measures that are in use under public
8 and privately sponsored health care coverage arrange-
9 ments, or that are part of reporting systems that measure
10 both the presence and duration of health insurance cov-
11 erage over time, that may be applicable to Medicaid eligi-
12 ble adults.

13 “(b) DEADLINES.—

14 “(1) RECOMMENDED MEASURES.—Not later
15 than January 1, 2011, the Secretary shall identify
16 and publish for comment a recommended core set of
17 adult health quality measures for Medicaid eligible
18 adults.

19 “(2) DISSEMINATION.—Not later than January
20 1, 2012, the Secretary shall publish an initial core
21 set of adult health quality measures that are appli-
22 cable to Medicaid eligible adults.

23 “(3) STANDARDIZED REPORTING.—Not later
24 than January 1, 2013, the Secretary, in consultation
25 with States, shall develop a standardized format for

1 reporting information based on the initial core set of
2 adult health quality measures and create procedures
3 to encourage States to use such measures to volun-
4 tarily report information regarding the quality of
5 health care for Medicaid eligible adults.

6 “(4) REPORTS TO CONGRESS.—Not later than
7 January 1, 2014, and every 3 years thereafter, the
8 Secretary shall include in the report to Congress re-
9 quired under section 1139A(a)(6) information simi-
10 lar to the information required under that section
11 with respect to the measures established under this
12 section.

13 “(5) ESTABLISHMENT OF MEDICAID QUALITY
14 MEASUREMENT PROGRAM.—

15 “(A) IN GENERAL.—Not later than 12
16 months after the release of the recommended
17 core set of adult health quality measures under
18 paragraph (1)), the Secretary shall establish a
19 Medicaid Quality Measurement Program in the
20 same manner as the Secretary establishes the
21 pediatric quality measures program under sec-
22 tion 1139A(b). The aggregate amount awarded
23 by the Secretary for grants and contracts for
24 the development, testing, and validation of
25 emerging and innovative evidence-based meas-

1 ures under such program shall equal the aggre-
2 gate amount awarded by the Secretary for
3 grants under section 1139A(b)(4)(A)

4 “(B) REVISING, STRENGTHENING, AND IM-
5 PROVING INITIAL CORE MEASURES.—Beginning
6 not later than 24 months after the establish-
7 ment of the Medicaid Quality Measurement
8 Program, and annually thereafter, the Sec-
9 retary shall publish recommended changes to
10 the initial core set of adult health quality meas-
11 ures that shall reflect the results of the testing,
12 validation, and consensus process for the devel-
13 opment of adult health quality measures.

14 “(c) CONSTRUCTION.—Nothing in this section shall
15 be construed as supporting the restriction of coverage,
16 under title XIX or XXI or otherwise, to only those services
17 that are evidence-based, or in anyway limiting available
18 services.

19 “(d) ANNUAL STATE REPORTS REGARDING STATE-
20 SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER
21 MEDICAID.—

22 “(1) ANNUAL STATE REPORTS.—Each State
23 with a State plan or waiver approved under title
24 XIX shall annually report (separately or as part of

1 the annual report required under section 1139A(c)),
2 to the Secretary on the—

3 “(A) State-specific adult health quality
4 measures applied by the State under the such
5 plan, including measures described in sub-
6 section (a)(5); and

7 “(B) State-specific information on the
8 quality of health care furnished to Medicaid eli-
9 gible adults under such plan, including informa-
10 tion collected through external quality reviews
11 of managed care organizations under section
12 1932 and benchmark plans under section 1937.

13 “(2) PUBLICATION.—Not later than September
14 30, 2014, and annually thereafter, the Secretary
15 shall collect, analyze, and make publicly available the
16 information reported by States under paragraph (1).

17 “(e) APPROPRIATION.—Out of any funds in the
18 Treasury not otherwise appropriated, there is appro-
19 priated for each of fiscal years 2010 through 2014,
20 \$60,000,000 for the purpose of carrying out this section.
21 Funds appropriated under this subsection shall remain
22 available until expended.”.

1 **SEC. 1672. PAYMENT ADJUSTMENT FOR HEALTH CARE-AC-**
2 **QUIRED CONDITIONS.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (in this subsection referred to as the
5 “Secretary”) shall conduct surveys to identify current
6 State practices that prohibit payment for health care-ac-
7 quired conditions and shall promulgate regulations, to be
8 effective as of July 1, 2011, to prohibit payments to States
9 under section 1903 of the Social Security Act for any
10 amounts expended for providing medical assistance for
11 such conditions. Such regulations shall ensure that a pro-
12 hibition on payment for health care-acquired conditions
13 shall not affect care or services provided to a Medicaid
14 beneficiary.

15 (b) HEALTH CARE-ACQUIRED CONDITION.—In this
16 section, the term “health care-acquired condition” means
17 a medical condition for which an individual was diagnosed
18 that could be identified by a secondary diagnostic code de-
19 scribed in section 1886(d)(4)(D)(iv) of the Social Security
20 Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

21 (c) MEDICARE PROVISIONS.—In carrying out this
22 section, the Secretary may elect to apply to State plans
23 (or waivers) under title XIX of the Social Security Act
24 the regulations promulgated pursuant to section
25 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D))
26 relating to the prohibition of payments based on the pres-

1 ence of a secondary diagnosis code specified by the Sec-
2 retary in such regulations. The Secretary may exclude cer-
3 tain conditions identified under title XVIII of the Social
4 Security Act for non-payment under title XIX of such Act
5 when the Secretary finds the inclusion of such conditions
6 to be inapplicable to beneficiaries under title XIX.

7 **SEC. 1673. DEMONSTRATION PROJECT TO EVALUATE INTE-**
8 **GRATED CARE AROUND A HOSPITALIZATION.**

9 (a) **AUTHORITY TO CONDUCT PROJECT.**—The Sec-
10 retary of Health and Human Services (in this section re-
11 ferred to as the “Secretary”) shall establish a demonstra-
12 tion project under title XIX of the Social Security Act to
13 evaluate the use of bundled payments for the provision of
14 integrated care for a Medicaid beneficiary—

15 (1) with respect to an episode of care that in-
16 cludes a hospitalization; and

17 (2) for concurrent physicians services provided
18 during a hospitalization.

19 (b) **REQUIREMENTS.**—The demonstration project
20 shall be conducted in accordance with the following:

21 (1) The demonstration project shall be con-
22 ducted in up to 8 States, determined by the Sec-
23 retary based on consideration of the potential to
24 lower costs under the Medicaid program while im-
25 proving care for Medicaid beneficiaries. A State se-

1 lected to participate in the demonstration project
2 may target the demonstration project to particular
3 categories of beneficiaries, beneficiaries with par-
4 ticular diagnoses, or particular geographic regions of
5 the State, but the Secretary shall insure that, as a
6 whole, the demonstration project is, to the greatest
7 extent possible, representative of the demographic
8 and geographic composition of Medicaid beneficiaries
9 nationally.

10 (2) The demonstration project shall focus on
11 conditions where there is evidence of an opportunity
12 for providers of services and suppliers to improve the
13 quality of care furnished to Medicaid beneficiaries
14 while reducing total expenditures under the State
15 Medicaid programs selected to participate, as deter-
16 mined by the Secretary.

17 (3) A State selected to participate in the dem-
18 onstration project shall specify the 1 or more epi-
19 sodes of care the State proposes to address in the
20 project, the services to be included in the bundled
21 payments, and the rationale for the selection of such
22 episodes of care and services. The Secretary may
23 modify the episodes of care as well as the services
24 to be included in the bundled payments prior to or
25 after approving the project. The Secretary may also

1 vary such factors among the different States partici-
2 pating in the demonstration project.

3 (4) The Secretary shall ensure that payments
4 made under the demonstration project are adjusted
5 for severity of illness and other characteristics of
6 Medicaid beneficiaries within a category or having a
7 diagnosis targeted as part of the demonstration
8 project. States shall ensure that Medicaid bene-
9 ficiaries are not liable for any additional cost sharing
10 than if their care had not been subject to payment
11 under the demonstration project.

12 (5) Hospitals participating in the demonstration
13 project shall have or establish robust discharge plan-
14 ning programs to ensure that Medicaid beneficiaries
15 requiring post-acute care are appropriately placed in,
16 or have ready access to, post-acute care settings.

17 (6) The Secretary and each State selected to
18 participate in the demonstration project shall ensure
19 that the demonstration project does not result in the
20 Medicaid beneficiaries whose care is subject to pay-
21 ment under the demonstration project being pro-
22 vided with less items and services for which medical
23 assistance is provided under the State Medicaid pro-
24 gram than the items and services for which medical
25 assistance would have been provided to such bene-

1 ficiaries under the State Medicaid program in the
2 absence of the demonstration project.

3 (c) WAIVER OF PROVISIONS.—Notwithstanding sec-
4 tion 1115(a) of the Social Security Act (42 U.S.C.
5 1315(a)), the Secretary may waive such provisions of titles
6 XIX, XVIII, and XI of that Act as may be necessary to
7 accomplish the goals of the demonstration, ensure bene-
8 ficiary access to acute and post-acute care, and maintain
9 quality of care.

10 (d) EVALUATION AND REPORT.—

11 (1) DATA.—Each State selected to participate
12 in the demonstration project under this section shall
13 provide to the Secretary, in such form and manner
14 as the Secretary shall specify, relevant data nec-
15 essary to monitor outcomes, costs, and quality, and
16 evaluate the rationales for selection of the episodes
17 of care and services specified by States under sub-
18 section (b)(3).

19 (2) REPORT.—Not later than 1 year after the
20 conclusion of the demonstration project, the Sec-
21 retary shall submit a report to Congress on the re-
22 sults of the demonstration project.

1 **SEC. 1674. MEDICAID GLOBAL PAYMENT SYSTEM DEM-**
2 **ONSTRATION PROJECT.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the “Sec-
5 retary”) shall, in coordination with the Innovation Center
6 (as established under section 3021), establish the Med-
7 icaid Global Payment System Demonstration Project
8 under which a participating State shall adjust the pay-
9 ments made to an eligible safety net hospital system or
10 network from a fee-for-service payment structure to a
11 global capitated payment model.

12 (b) DURATION AND SCOPE.—The demonstration
13 project conducted under this section shall operate during
14 a period of fiscal years 2010 through 2012. The Secretary
15 shall select not more than 5 States to participate in the
16 demonstration project.

17 (c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR
18 NETWORK.—For purposes of this section, the term “eligi-
19 ble safety net hospital system or network” means a large,
20 safety net hospital system or network (as defined by the
21 Secretary) that operates within a State selected by the
22 Secretary under subsection (b).

23 (d) EVALUATION.—

24 (1) TESTING.—The Innovation Center shall test
25 and evaluate the demonstration project conducted
26 under this section to examine any changes in health

1 care quality outcomes and spending by the eligible
2 safety net hospital systems or networks.

3 (2) BUDGET NEUTRALITY.—During the testing
4 period under paragraph (1), any budget neutrality
5 requirements under section 1115A(b)(3) of the So-
6 cial Security Act (as added by section 3021) shall
7 not be applicable.

8 (3) MODIFICATION.—During the testing period
9 under paragraph (1), the Secretary may, in the Sec-
10 retary’s discretion, modify or terminate the dem-
11 onstration project conducted under this section.

12 (e) REPORT.—Not later than 12 months after the
13 date of completion of the demonstration project under this
14 section, the Secretary shall submit to Congress a report
15 containing the results of the evaluation and testing con-
16 ducted under subsection (d), together with recommenda-
17 tions for such legislation and administrative action as the
18 Secretary determines appropriate.

19 (f) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated such sums as are nec-
21 essary to carry out this section.

22 **SEC. 1675. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION**
23 **DEMONSTRATION PROJECT.**

24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services (referred to in this section as the “Sec-

1 retary”) shall establish the Pediatric Accountable Care
2 Organization Demonstration Project to authorize a par-
3 ticipating State to allow pediatric medical providers that
4 meet specified requirements to be recognized as an ac-
5 countable care organization for purposes of receiving in-
6 centive payments (as described under subsection (d)), in
7 the same manner as an accountable care organization is
8 recognized and provided with incentive payments under
9 section 1899 of the Social Security Act (as added by sec-
10 tion 3022).

11 (b) APPLICATION.—A State that desires to partici-
12 pate in the demonstration project under this section shall
13 submit to the Secretary an application at such time, in
14 such manner, and containing such information as the Sec-
15 retary may require.

16 (c) REQUIREMENTS.—

17 (1) PERFORMANCE GUIDELINES.—The Sec-
18 retary, in consultation with the States and pediatric
19 providers, shall establish guidelines to ensure that
20 the quality of care delivered to individuals by a pro-
21 vider recognized as an accountable care organization
22 under this section is not less than the quality of care
23 that would have otherwise been provided to such in-
24 dividuals.

1 (2) SAVINGS REQUIREMENT.—A participating
2 State, in consultation with the Secretary, shall es-
3 tablish an annual minimal level of savings in expend-
4 itures for items and services covered under the Med-
5 icaid program under title XIX of the Social Security
6 Act and the CHIP program under title XXI of such
7 Act that must be reached by an accountable care or-
8 ganization in order for such organization to receive
9 an incentive payment under subsection (d).

10 (d) INCENTIVE PAYMENT.—An accountable care or-
11 ganization that meets the performance guidelines estab-
12 lished by the Secretary under subsection (c)(1) and
13 achieves savings greater than the annual minimal savings
14 level established by the State under subsection (c)(2) shall
15 receive an incentive payment for such year equal to a por-
16 tion (as determined appropriate by the Secretary) of the
17 amount of such excess savings. The Secretary may estab-
18 lish an annual cap on incentive payments for an account-
19 able care organization.

20 (e) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as are nec-
22 essary to carry out this section.

1 **SEC. 1676. MEDICAID EMERGENCY PSYCHIATRIC DEM-**
2 **ONSTRATION PROJECT.**

3 (a) **AUTHORITY TO CONDUCT DEMONSTRATION**
4 **PROJECT.**—The Secretary of Health and Human Services
5 (in this section referred to as the “Secretary”) shall estab-
6 lish a demonstration project for up to 8 States under
7 which an eligible State (as described in subsection (c))
8 shall provide reimbursement under the State Medicaid
9 plan under title XIX of the Social Security Act to an insti-
10 tution for mental diseases (as defined in section 1905(i)
11 of such Act) that is not publicly owned or operated and
12 that is subject to the requirements of section 1867 of the
13 Social Security Act (42 U.S.C. 1395dd) for the provision
14 of medical assistance available under such plan to an indi-
15 vidual who—

16 (1) has attained age 21, but has not attained
17 age 65;

18 (2) is eligible for medical assistance under such
19 plan; and

20 (3) requires such medical assistance to stabilize
21 a psychiatric emergency medical condition, as evi-
22 denced by the expression of suicidal or homicidal
23 thoughts or gestures determined dangerous to the
24 individual or others.

25 (b) **IN-STAY REVIEW.**—The Secretary shall establish
26 a mechanism for in-stay review to determine whether or

1 not the patient has been stabilized (as defined in sub-
2 section (h)(5)). This mechanism shall commence before
3 the third day of the inpatient stay. States participating
4 in the demonstration project may manage the provision
5 of these benefits under the project through utilization re-
6 view, authorization, or management practices, or the ap-
7 plication of medical necessity and appropriateness criteria
8 applicable to behavioral health.

9 (c) ELIGIBLE STATE DEFINED.—

10 (1) APPLICATION.—Upon approval of an appli-
11 cation submitted by a State described in paragraph
12 (2), the State shall be an eligible State for purposes
13 of conducting a demonstration project under this
14 section.

15 (2) STATE DESCRIBED.—States shall be se-
16 lected by the Secretary in a manner so as to provide
17 geographic diversity on the basis of the application
18 to conduct a demonstration project under this sec-
19 tion submitted by such States.

20 (d) LENGTH OF DEMONSTRATION PROJECT.—The
21 demonstration project established under this section shall
22 be conducted for a period of 3 consecutive years.

23 (e) LIMITATIONS ON FEDERAL FUNDING.—

24 (1) APPROPRIATION.—

1 (A) IN GENERAL.—Out of any funds in the
2 Treasury not otherwise appropriated, there is
3 appropriated to carry out this section,
4 \$75,000,000 for fiscal year 2010.

5 (B) BUDGET AUTHORITY.—Subparagraph
6 (A) constitutes budget authority in advance of
7 appropriations Act and represents the obliga-
8 tion of the Federal Government to provide for
9 the payment of the amounts appropriated under
10 that subparagraph.

11 (2) 3-YEAR AVAILABILITY.—Funds appro-
12 priated under paragraph (1) shall remain available
13 for obligation through December 31, 2012.

14 (3) LIMITATION ON PAYMENTS.—In no case
15 may—

16 (A) the aggregate amount of payments
17 made by the Secretary to eligible States under
18 this section exceed \$75,000,000; or

19 (B) payments be provided by the Secretary
20 under this section after December 31, 2012.

21 (4) FUNDS ALLOCATED TO STATES.—The Sec-
22 retary shall allocate funds to eligible States based on
23 their applications and the availability of funds.

24 (5) PAYMENTS TO STATES.—The Secretary
25 shall pay to each eligible State, from its allocation

1 under paragraph (4), an amount each quarter equal
2 to the Federal medical assistance percentage of ex-
3 penditures in the quarter for medical assistance de-
4 scribed in subsection (a).

5 (f) REPORTS.—

6 (1) ANNUAL PROGRESS REPORTS.—The Sec-
7 retary shall submit annual reports to Congress on
8 the progress of the demonstration project conducted
9 under this section.

10 (2) FINAL REPORT AND RECOMMENDATION.—
11 An evaluation should be conducted of the demonstra-
12 tion project's impact on the functioning of the health
13 and mental health service system and on individuals
14 enrolled in the Medicaid program. This evaluation
15 should include collection of baseline data for one-
16 year prior to the initiation of the demonstration
17 project as well as collection of data from matched
18 comparison states not participating in the dem-
19 onstration. The evaluation measures shall include
20 the following:

21 (A) A determination, by State, as to
22 whether the demonstration project resulted in
23 increased access to inpatient mental health
24 services under the Medicaid program and
25 whether average length of stays were longer (or

1 shorter) for individuals admitted under the
2 demonstration project compared with individ-
3 uals otherwise admitted in comparison sites.

4 (B) An analysis by State, regarding wheth-
5 er the demonstration project produced a signifi-
6 cant reduction in emergency room visits for in-
7 dividuals eligible for assistance under the Med-
8 icaid program or in the duration of emergency
9 room lengths of stay.

10 (C) An assessment of discharge planning
11 by participating hospitals that ensures access to
12 further (non-emergency) inpatient or residential
13 care as well as continuity of care for those dis-
14 charged to outpatient care.

15 (D) An assessment of the impact of the
16 demonstration project on the costs of the full
17 range of mental health services (including inpa-
18 tient, emergency and ambulatory care) under
19 the plan as contrasted with the comparison
20 areas.

21 (E) Data on the percentage of consumers
22 with Medicaid coverage who are admitted to in-
23 patient facilities as a result of the demonstra-
24 tion project as compared to those admitted to
25 these same facilities through other means.

1 (F) A recommendation regarding whether
2 the demonstration project should be continued
3 after December 31, 2012, and expanded on a
4 national basis.

5 (g) WAIVER AUTHORITY.—

6 (1) IN GENERAL.—The Secretary shall waive
7 the limitation of subdivision (B) following paragraph
8 (28) of section 1905(a) of the Social Security Act
9 (42 U.S.C. 1396d(a)) (relating to limitations on pay-
10 ments for care or services for individuals under 65
11 years of age who are patients in an institution for
12 mental diseases) for purposes of carrying out the
13 demonstration project under this section.

14 (2) LIMITED OTHER WAIVER AUTHORITY.—The
15 Secretary may waive other requirements of titles XI
16 and XIX of the Social Security Act (including the
17 requirements of sections 1902(a)(1) (relating to
18 statewideness) and 1902(1)(10)(B) (relating to com-
19 parability)) only to extent necessary to carry out the
20 demonstration project under this section.

1 **PART IX—IMPROVEMENTS TO THE MEDICAID**
2 **AND CHIP PAYMENT AND ACCESS COMMIS-**
3 **SION (MACPAC)**

4 **SEC. 1681. MACPAC ASSESSMENT OF POLICIES AFFECTING**
5 **ALL MEDICAID BENEFICIARIES.**

6 (a) IN GENERAL.—Section 1900 of the Social Secu-
7 rity Act (42 U.S.C. 1396) is amended—

8 (1) in subsection (b)—

9 (A) in paragraph (1)—

10 (i) in the paragraph heading, by in-
11 sserting “FOR ALL STATES” before “AND
12 ANNUAL”; and

13 (ii) in subparagraph (A), by striking
14 “children’s”;

15 (iii) in subparagraph (B), by inserting
16 “, the Secretary, and States” after “Con-
17 gress”;

18 (iv) in subparagraph (C), by striking
19 “March 1” and inserting “March 15”; and

20 (v) in subparagraph (D), by striking
21 “June 1” and inserting “June 15”;

22 (B) in paragraph (2)—

23 (i) in subparagraph (A)—

24 (I) in clause (i)—

1 (aa) by inserting “the effi-
2 cient provision of” after “expend-
3 itures for”; and

4 (bb) by striking “hospital,
5 skilled nursing facility, physician,
6 Federally-qualified health center,
7 rural health center, and other
8 fees” and inserting “payments to
9 medical, dental, and health pro-
10 fessionals, hospitals, residential
11 and long-term care providers,
12 providers of home and commu-
13 nity based services, Federally-
14 qualified health centers and rural
15 health clinics, managed care enti-
16 ties, and providers of other cov-
17 ered items and services”; and

18 (II) in clause (iii), by inserting
19 “(including how such factors and
20 methodologies enable such bene-
21 ficiaries to obtain the services for
22 which they are eligible, affect provider
23 supply, and affect providers that serve
24 a disproportionate share of low-income

1 and other vulnerable populations)”
2 after “beneficiaries”;

3 (ii) by redesignating subparagraphs
4 (B) and (C) as subparagraphs (F) and
5 (H), respectively;

6 (iii) by inserting after subparagraph
7 (A), the following:

8 “(B) ELIGIBILITY POLICIES.—Medicaid
9 and CHIP eligibility policies, including a deter-
10 mination of the degree to which Federal and
11 State policies provide health care coverage to
12 needy populations.

13 “(C) ENROLLMENT AND RETENTION PROC-
14 ESSES.—Medicaid and CHIP enrollment and
15 retention processes, including a determination
16 of the degree to which Federal and State poli-
17 cies encourage the enrollment of individuals
18 who are eligible for such programs and screen
19 out individuals who are ineligible, while mini-
20 mizing the share of program expenses devoted
21 to such processes.

22 “(D) COVERAGE POLICIES.—Medicaid and
23 CHIP benefit and coverage policies, including a
24 determination of the degree to which Federal
25 and State policies provide access to the services

1 enrollees require to improve and maintain their
2 health and functional status.

3 “(E) QUALITY OF CARE.—Medicaid and
4 CHIP policies as they relate to the quality of
5 care provided under those programs, including
6 a determination of the degree to which Federal
7 and State policies achieve their stated goals and
8 interact with similar goals established by other
9 purchasers of health care services.”;

10 (iv) by inserting after subparagraph
11 (F) (as redesignated by clause (ii) of this
12 subparagraph), the following:

13 “(G) INTERACTIONS WITH MEDICARE AND
14 MEDICAID.—Consistent with paragraph (11),
15 the interaction of policies under Medicaid and
16 the Medicare program under title XVIII, in-
17 cluding with respect to how such interactions
18 affect access to services, payments, and dual el-
19 igible individuals.” and

20 (v) in subparagraph (H) (as so redesi-
21 gnated), by inserting “and preventive,
22 acute, and long-term services and sup-
23 ports” after “barriers”;

1 (C) by redesignating paragraphs (3)
2 through (9) as paragraphs (4) through (10), re-
3 spectively;

4 (D) by inserting after paragraph (2), the
5 following new paragraph:

6 “(3) RECOMMENDATIONS AND REPORTS OF
7 STATE-SPECIFIC DATA.—MACPAC shall—

8 “(A) review national and State-specific
9 Medicaid and CHIP data; and

10 “(B) submit reports and recommendations
11 to Congress, the Secretary, and States based on
12 such reviews.”;

13 (E) in paragraph (4), as redesignated by
14 subparagraph (C), by striking “or any other
15 problems” and all that follows through the pe-
16 riod and inserting “, as well as other factors
17 that adversely affect, or have the potential to
18 adversely affect, access to care by, or the health
19 care status of, Medicaid and CHIP bene-
20 ficiaries. MACPAC shall include in the annual
21 report required under paragraph (1)(D) a de-
22 scription of all such areas or problems identi-
23 fied with respect to the period addressed in the
24 report.”;

1 (F) in paragraph (5), as so redesignig-
2 nated,—

3 (i) in the paragraph heading, by in-
4 sserting “AND REGULATIONS” after “RE-
5 PORTS”; and

6 (ii) by striking “If” and inserting the
7 following:

8 “(A) CERTAIN SECRETARIAL REPORTS.—
9 If”; and

10 (iii) in the second sentence, by insert-
11 ing “and the Secretary” after “appropriate
12 committees of Congress”; and

13 (iv) by adding at the end the fol-
14 lowing:

15 “(B) REGULATIONS.—MACPAC shall re-
16 view Medicaid and CHIP regulations and may
17 comment through submission of a report to the
18 appropriate committees of Congress and the
19 Secretary, on any such regulations that affect
20 access, quality, or efficiency of health care.”;

21 (G) in paragraph (10), as so redesignated,
22 by inserting “, and shall submit with any rec-
23 ommendations, a report on the Federal and
24 State-specific budget consequences of the rec-
25 ommendations” before the period; and

1 (H) by adding at the end the following:

2 “(11) CONSULTATION AND COORDINATION
3 WITH MEDPAC.—

4 “(A) IN GENERAL.—MACPAC shall regu-
5 larly consult with the Medicare Payment Advi-
6 sory Commission (in this paragraph referred to
7 as ‘MedPAC’) established under section 1805 in
8 carrying out its duties under this section, par-
9 ticularly with respect to the issues specified in
10 paragraph (2) as they relate to those Medicaid
11 beneficiaries who are dually eligible for Med-
12 icaid and the Medicare program under title
13 XVIII, adult Medicaid beneficiaries (who are
14 not dually eligible for Medicare), and bene-
15 ficiaries under Medicare. Responsibility for
16 analysis of and recommendations to change
17 Medicare policy regarding Medicare bene-
18 ficiaries, including Medicare beneficiaries who
19 are dually eligible for Medicare and Medicaid,
20 shall rest with MedPAC.

21 “(B) INFORMATION SHARING.—MACPAC
22 and MedPAC shall have access to deliberations
23 and records of the other such entity, respec-
24 tively, upon the request of the other such enti-
25 ty.

1 “(12) CONSULTATION WITH STATES.—
2 MACPAC shall regularly consult with States in car-
3 rying out its duties under this section, including
4 with respect to developing processes for carrying out
5 such duties, and shall ensure that input from States
6 is taken into account and represented in MACPAC’s
7 recommendations and reports.

8 “(13) COORDINATE AND CONSULT WITH THE
9 FEDERAL COORDINATED HEALTH CARE OFFICE.—
10 MACPAC shall coordinate and consult with the Fed-
11 eral Coordinated Health Care Office established
12 under section 1662 of the America’s Healthy Future
13 Act of 2009 before making any recommendations re-
14 garding dual eligible individuals.

15 “(14) PROGRAMMATIC OVERSIGHT VESTED IN
16 THE SECRETARY.—MACPAC’s authority to make
17 recommendations in accordance with this section
18 shall not affect, or be considered to duplicate, the
19 Secretary’s authority to carry out Federal respon-
20 sibilities with respect to Medicaid and CHIP.”;

21 (2) in subsection (c)(2)—

22 (A) by striking subparagraphs (A) and (B)
23 and inserting the following:

24 “(A) IN GENERAL.—The membership of
25 MACPAC shall include individuals who have

1 had direct experience as enrollees or parents or
2 caregivers of enrollees in Medicaid or CHIP and
3 individuals with national recognition for their
4 expertise in Federal safety net health programs,
5 health finance and economics, actuarial science,
6 health plans and integrated delivery systems,
7 reimbursement for health care, health informa-
8 tion technology, and other providers of health
9 services, public health, and other related fields,
10 who provide a mix of different professions,
11 broad geographic representation, and a balance
12 between urban and rural representation.

13 “(B) INCLUSION.—The membership of
14 MACPAC shall include (but not be limited to)
15 physicians, dentists, and other health profes-
16 sionals, employers, third-party payers, and indi-
17 viduals with expertise in the delivery of health
18 services. Such membership shall also include
19 representatives of children, pregnant women,
20 the elderly, individuals with disabilities, care-
21 givers, and dual eligible individuals, current or
22 former representatives of State agencies respon-
23 sible for administering Medicaid, and current or
24 former representatives of State agencies respon-
25 sible for administering CHIP.”.

1 (3) in subsection (d)(2), by inserting “and
2 State” after “Federal”;

3 (4) in subsection (e)(1), in the first sentence, by
4 inserting “and, as a condition for receiving payments
5 under sections 1903(a) and 2105(a), from any State
6 agency responsible for administering Medicaid or
7 CHIP,” after “United States”; and

8 (5) in subsection (f)—

9 (A) in the subsection heading, by striking
10 “AUTHORIZATION OF APPROPRIATIONS” and
11 inserting “FUNDING”;

12 (B) in paragraph (1), by inserting “(other
13 than for fiscal year 2010)” before “in the same
14 manner”; and

15 (C) by adding at the end the following:

16 “(3) FUNDING FOR FISCAL YEAR 2010.—

17 “(A) IN GENERAL.—Out of any funds in
18 the Treasury not otherwise appropriated, there
19 is appropriated to MACPAC to carry out the
20 provisions of this section for fiscal year 2010,
21 \$9,000,000.

22 “(B) TRANSFER OF FUNDS.—Notwith-
23 standing section 2104(a)(13), from the
24 amounts appropriated in such section for fiscal
25 year 2010, \$2,000,000 is hereby transferred

1 and made available in such fiscal year to
2 MACPAC to carry out the provisions of this
3 section.

4 “(4) AVAILABILITY.—Amounts made available
5 under paragraphs (2) and (3) to MACPAC to carry
6 out the provisions of this section shall remain avail-
7 able until expended.”.

8 (b) CONFORMING MEDPAC AMENDMENTS.—Section
9 1805(b) of the Social Security Act (42 U.S.C. 1395b-
10 6(b)), is amended—

11 (1) in paragraph (1)(C), by striking “March 1
12 of each year (beginning with 1998)” and inserting
13 “March 15”;

14 (2) in paragraph (1)(D), by inserting “, and
15 (beginning with 2012) containing an examination of
16 the topics described in paragraph (9), to the extent
17 feasible” before the period; and

18 (3) by adding at the end the following:

19 “(9) REVIEW AND ANNUAL REPORT ON MED-
20 ICAID AND COMMERCIAL TRENDS.—The Commission
21 shall review and report on aggregate trends in
22 spending, utilization, and financial performance
23 under the Medicaid program under title XIX and
24 the private market for health care services with re-
25 spect to providers for which, on an aggregate na-

1 tional basis, a significant portion of revenue or serv-
2 ices is associated with the Medicaid program. Where
3 appropriate, the Commission shall conduct such re-
4 view in consultation with the Medicaid and CHIP
5 Payment and Access Commission (MACPAC) estab-
6 lished under section 1900.

7 “(10) COORDINATE AND CONSULT WITH THE
8 FEDERAL COORDINATED HEALTH CARE OFFICE.—
9 The Commission shall coordinate and consult with
10 the Federal Coordinated Health Care Office estab-
11 lished under section 1662 of the America’s Healthy
12 Future Act of 2009 before making any recommenda-
13 tions regarding dual eligible individuals.”.

14 **PART X—AMERICAN INDIANS AND ALASKA**

15 **NATIVES**

16 **SEC. 1691. SPECIAL RULES RELATING TO INDIANS.**

17 (a) NO COST-SHARING FOR INDIANS WITH INCOME
18 AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN
19 COVERAGE THROUGH A STATE EXCHANGE.—For provi-
20 sions prohibiting cost sharing for Indians enrolled in any
21 qualified health benefits plan in the individual market
22 through an exchange, see section 2247(d) of the Social
23 Security Act.

24 (b) PAYER OF LAST RESORT.—Nothing in this Act
25 or the amendments made by this Act shall affect the right

1 of the United States, an Indian tribe, or a tribal organiza-
2 tion to recover reimbursement from third parties for the
3 costs of health services in accordance with section 206 of
4 the Indian Health Care Improvement Act (42 U.S.C.
5 1621e).

6 (c) FACILITATING ENROLLMENT OF INDIANS UNDER
7 THE EXPRESS LANE OPTION.—Section
8 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C.
9 1396a(e)(13)(F)(ii)) is amended—

10 (1) in the clause heading, by inserting “AND IN-
11 DIAN TRIBES AND TRIBAL ORGANIZATIONS” after
12 “AGENCIES”; and

13 (2) by adding at the end the following:

14 “(IV) The Indian Health Service,
15 an Indian Tribe, Tribal Organization,
16 or Urban Indian Organization (as de-
17 fined in section 1139(c)).”.

18 (d) TECHNICAL CORRECTIONS.—Section 1139(c) of
19 the Social Security Act (42 U.S.C. 1320b–9(c)) is amend-
20 ed by striking “In this section” and inserting “For pur-
21 poses of this section, title XIX, and title XXI”.

1 **SEC. 1692. ELIMINATION OF SUNSET FOR REIMBURSEMENT**
2 **FOR ALL MEDICARE PART B SERVICES FUR-**
3 **NISHED BY CERTAIN INDIAN HOSPITALS AND**
4 **CLINICS.**

5 (a) REIMBURSEMENT FOR ALL MEDICARE PART B
6 SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS
7 AND CLINICS.—Section 1880(e)(1)(A) of the Social Secu-
8 rity Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by strik-
9 ing “during the 5-year period beginning on” and inserting
10 “on or after”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to items or services furnished on
13 or after January 1, 2010.

14 **Subtitle H—Addressing Health**
15 **Disparities**

16 **SEC. 1701. STANDARDIZED COLLECTION OF DATA.**

17 (a) UNIFORM CATEGORIES AND COLLECTION RE-
18 QUIREMENTS.—

19 (1) APPLICATION OF OMB STANDARDS FOR
20 DATA COLLECTION AND CLASSIFICATION.—The Sec-
21 retary of Health and Human Services, in consulta-
22 tion with the Director of the Office of Personnel
23 Management, the Secretary of Defense, the Sec-
24 retary of Veterans Affairs, and the head of other ap-
25 propriate Federal agencies, shall establish proce-
26 dures to ensure that, beginning January 1, 2011, all

1 data collected under a Federal health care program
2 (as defined in section 1128B(f) of the Social Security
3 Act (42 U.S.C. 1320a–7b(f)) and under the
4 health insurance program under chapter 89 of title
5 5, United States Code, on race, ethnicity, sex, and
6 primary language, complies with the following:

7 (A) Office of Management and Budget Directive
8 15 (Standards for the Classification of
9 Federal Data on Race and Ethnicity).

10 (B) Guidance for Federal agencies that
11 collect or use aggregate data on race issued by
12 the Office of Management and Budget.

13 (C) Guidance for Federal agencies for the
14 allocation of multiple race responses for use in
15 civil rights monitoring and enforcement issued
16 by the Office of Management and Budget.

17 (2) ACCESS AND TREATMENT FOR INDIVIDUALS
18 WITH DISABILITIES.—Not later than January 1,
19 2012, the Secretary of Health and Human Services,
20 in consultation with the Director of the Office of
21 Personnel Management, the Secretary of Defense,
22 the Secretary of Veterans Affairs, and the head of
23 other appropriate Federal agencies, shall establish
24 procedures for the Administrator of the Centers on
25 Medicare & Medicaid Services to collect data under

1 Federal health care programs (as so defined) and
2 the health insurance program under chapter 89 of
3 title 5, United States Code, in order to assess access
4 to care and treatment for individuals with disabili-
5 ties. Such procedures shall include surveying health
6 care providers to identify—

7 (A) locations where individuals with dis-
8 abilities access primary, acute (including inten-
9 sive), and long-term care;

10 (B) the number of providers with acces-
11 sible facilities and equipment to meet the needs
12 of the individuals with disabilities; and

13 (C) the number of employees of health care
14 providers trained in disability awareness and
15 patient care of individuals with disabilities.

16 (b) MEDICAID CONFORMING AMENDMENTS.—

17 (1) STATE PLAN REQUIREMENT.—Section
18 1902(a) of the Social Security Act (42 U.S.C.
19 1396a(a)), as amended by section 1601(d), is
20 amended—

21 (A) in paragraph (74), by striking “and”
22 at the end;

23 (B) in paragraph (75), by striking the pe-
24 riod at the end and inserting “; and”; and

1 (C) by inserting after paragraph (75) the
2 following new paragraph:

3 “(76) provide that any data collected under the
4 State plan meets the requirements of section
5 1701(a) of the America’s Healthy Future Act of
6 2009.”.

7 (c) CHIP CONFORMING AMENDMENTS.—Section
8 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e))
9 is amended by adding at the end the following new para-
10 graph:

11 “(7) Data collected and reported in accordance
12 with section 1701(a) of the America’s Healthy Fu-
13 ture Act of 2009, with respect to individuals enrolled
14 in the State child health plan (and, in the case of
15 enrollees under 19 years of age, their parents or
16 legal guardians), including data regarding the pri-
17 mary language of such individuals, parents, and
18 legal guardians.”.

19 **SEC. 1702. REQUIRED COLLECTION OF DATA.**

20 (a) POPULATION SURVEYS AND QUALITY REPORT-
21 ING.—Beginning January 1, 2012:

22 (1) FEDERALLY-FUNDED POPULATION SUR-
23 VEYS.—All federally funded population survey, in-
24 cluding Current Population Surveys and American
25 Community Surveys conducted by the Bureau of

1 Labor Statistics and the Bureau of the Census, shall
2 collect sufficient data relating to race, ethnicity, sex,
3 primary language, and types of disability subgroups
4 to generate statistically reliable estimates in studies
5 comparing health disparities populations.

6 (2) QUALITY REPORTING REQUIREMENTS.—
7 Any reporting requirements imposed for purposes of
8 measuring quality under a Federal health care pro-
9 gram (as defined in section 1128B(f) of the such
10 Act (42 U.S.C. 1320a–7b(f)) or under the health in-
11 surance program under chapter 89 of title 5, United
12 States Code, shall include requirements for the col-
13 lection of data on individuals receiving health care
14 items or services under such programs by race, eth-
15 nicity, sex, primary language, and types of disability.

16 (b) EXTENDING MEDICARE REQUIREMENT TO AD-
17 DRESS HEALTH DISPARITIES DATA COLLECTION TO
18 MEDICAID AND CHIP.—Title XIX of the Social Security
19 Act (42 U.S.C. 1396 et seq.), as amended by section 1640
20 is amended by adding at the end the following new section:

21 **“SEC. 1945. ADDRESSING HEALTH CARE DISPARITIES.**

22 “(a) EVALUATING DATA COLLECTION AP-
23 PROACHES.—The Secretary shall evaluate approaches for
24 the collection of data under this title and title XXI, to
25 be performed in conjunction with existing quality report-

1 ing requirements and programs under this title and title
2 XXI, that allow for the ongoing, accurate, and timely col-
3 lection and evaluation of data on disparities in health care
4 services and performance on the basis of race, ethnicity,
5 sex, primary language, and types of disability. In con-
6 ducting such evaluation, the Secretary shall consider the
7 following objectives:

8 “(1) Protecting patient privacy.

9 “(2) Minimizing the administrative burdens of
10 data collection and reporting on States, providers,
11 and health plans participating under this title or
12 title XXI.

13 “(3) Improving program data under this title
14 and title XXI on race, ethnicity, sex, primary lan-
15 guage, and types of disability.

16 “(b) REPORTS TO CONGRESS.—

17 “(1) REPORT ON EVALUATION.—Not later than
18 18 months after the date of the enactment of this
19 section, the Secretary shall submit to Congress a re-
20 port on the evaluation conducted under subsection
21 (a). Such report shall, taking into consideration the
22 results of such evaluation—

23 “(A) identify approaches (including defin-
24 ing methodologies) for identifying and collecting
25 and evaluating data on health care disparities

1 on the basis of race, ethnicity, sex, primary lan-
2 guage, and types of disability for the programs
3 under this title and title XXI; and

4 “(B) include recommendations on the most
5 effective strategies and approaches to reporting
6 HEDIS quality measures as required under sec-
7 tion 1852(e)(3) and other nationally recognized
8 quality performance measures, as appropriate,
9 on such bases.

10 “(2) REPORTS ON DATA ANALYSES.—Not later
11 than 4 years after the date of the enactment of this
12 section, and 4 years thereafter, the Secretary shall
13 submit to Congress a report that includes rec-
14 ommendations for improving the identification of
15 health care disparities for beneficiaries under this
16 title and under title XXI based on analyses of the
17 data collected under subsection (c).

18 “(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
19 later than 24 months after the date of the enactment of
20 this section, the Secretary shall implement the approaches
21 identified in the report submitted under subsection (b)(1)
22 for the ongoing, accurate, and timely collection and eval-
23 uation of data on health care disparities on the basis of
24 race, ethnicity, sex, primary language, and types of dis-
25 ability.”.

1 **SEC. 1703. DATA SHARING AND PROTECTION.**

2 The Secretary of Health and Human Services, in con-
3 sultation with the Director of the Office of Personnel Man-
4 agement, the Secretary of Defense, the Secretary of Vet-
5 erans Affairs, and the head of other appropriate Federal
6 agencies, shall establish procedures —

7 (1) for sharing data collected under a Federal
8 health care program (as defined in section 1128B(f)
9 of the such Act (42 U.S.C. 1320a–7b(f)) or under
10 the health insurance program under chapter 89 of
11 title 5, United States Code, on race, ethnicity, sex
12 primary language, and type of disability, measures
13 relating to such data, and analyses of such data,
14 with other relevant Federal and State agencies in-
15 cluding, within the Department of Health and
16 Human Services, the Office of Minority Health, the
17 Agency for Healthcare Research and Quality, the
18 Centers for Disease Control and Prevention, and the
19 Centers for Medicare & Medicaid Services; and

20 (2) establish procedures to ensure that all ap-
21 propriate privacy and information security safe-
22 guards are used in the collection, analysis, and shar-
23 ing of such data.

1 **SEC. 1704. INCLUSION OF INFORMATION ABOUT THE IM-**
2 **PORTANCE OF HAVING A HEALTH CARE**
3 **POWER OF ATTORNEY IN TRANSITION PLAN-**
4 **NING FOR CHILDREN AGING OUT OF FOSTER**
5 **CARE AND INDEPENDENT LIVING PROGRAMS.**

6 (a) **TRANSITION PLANNING.**—Section 475(5)(H) of
7 the Social Security Act (42 U.S.C. 675(5)(H)) is amended
8 by inserting “includes information about the importance
9 of designating another individual to make health care
10 treatment decisions on behalf of the child if the child be-
11 comes unable to participate in such decisions and the child
12 does not have, or does not want, a relative who would oth-
13 erwise be authorized under State law to make such deci-
14 sions, and provides the child with the option to execute
15 a health care power of attorney, health care proxy, or
16 other similar document recognized under State law,” after
17 “employment services,”.

18 (b) **INDEPENDENT LIVING EDUCATION.**—Section
19 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended
20 by adding at the end the following:

21 “(K) A certification by the chief executive
22 officer of the State that the State will ensure
23 that an adolescent participating in the program
24 under this section are provided with education
25 about the importance of designating another in-
26 dividual to make health care treatment deci-

1 State law, and to provide the child with the
2 option to execute such a document, are
3 met; and”.

4 (d) EFFECTIVE DATE.—The amendments made by
5 this section take effect on October 1, 2010.

6 **Subtitle I—Maternal and Child**
7 **Health Services**

8 **SEC. 1801. MATERNAL, INFANT, AND EARLY CHILDHOOD**
9 **HOME VISITING PROGRAMS.**

10 Title V of the Social Security Act (42 U.S.C. 701
11 et seq.) is amended by adding at the end the following
12 new section:

13 **“SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD**
14 **HOME VISITING PROGRAMS.**

15 “(a) PURPOSES.—The purposes of this section are—

16 “(1) to strengthen and improve the programs
17 and activities carried out under this title;

18 “(2) to improve coordination of services for at
19 risk communities; and

20 “(3) to identify and provide comprehensive
21 services to improve outcomes for families who reside
22 in at risk communities.

23 “(b) REQUIREMENT FOR ALL STATES TO ASSESS
24 STATEWIDE NEEDS AND IDENTIFY AT RISK COMMU-
25 NITIES.—

1 “(1) IN GENERAL.—Not later than 6 months
2 after the date of enactment of this section, each
3 State shall, as a condition of receiving payments
4 from an allotment for the State under section 502
5 for fiscal year 2011, conduct a statewide needs as-
6 sessment (which shall be separate from the statewide
7 needs assessment required under section 505(a))
8 that identifies—

9 “(A) communities with concentrations of—

10 “(i) premature birth, low-birth weight
11 infants, and infant mortality, including in-
12 fant death due to neglect, or other indica-
13 tors of at-risk prenatal, maternal, newborn,
14 or child health;

15 “(ii) poverty;

16 “(iii) crime;

17 “(iv) domestic violence;

18 “(v) high rates of high-school drop-
19 outs;

20 “(vi) substance abuse;

21 “(vii) unemployment; or

22 “(viii) child maltreatment;

23 “(B) the quality and capacity of existing
24 programs or initiatives for early childhood home
25 visitation in the State including—

1 “(i) the number and types of individ-
2 uals and families who are receiving services
3 under such programs or initiatives;

4 “(ii) the gaps in early childhood home
5 visitation in the State; and

6 “(iii) the extent to which such pro-
7 grams or initiatives are meeting the needs
8 of eligible families described in subsection
9 (k)(2); and

10 “(C) the State’s capacity for providing
11 substance abuse treatment and counseling serv-
12 ices to individuals and families in need of such
13 treatment or services.

14 “(2) COORDINATION WITH OTHER ASSESS-
15 MENTS.—In conducting the statewide needs assess-
16 ment required under paragraph (1), the State shall
17 coordinate with, and take into account, other appro-
18 priate needs assessments conducted by the State, as
19 determined by the Secretary, including the needs as-
20 sessment required under section 505(a) (both the
21 most recently completed assessment and any such
22 assessment in progress), the communitywide stra-
23 tegic planning and needs assessments conducted in
24 accordance with section 640(g)(1)(C) of the Head
25 Start Act, and the inventory of current unmet needs

1 and current community-based and prevention-fo-
2 cused programs and activities to prevent child abuse
3 and neglect, and other family resource services oper-
4 ating in the State required under section 205(3) of
5 the Child Abuse Prevention and Treatment Act.

6 “(3) SUBMISSION TO THE SECRETARY.—Each
7 State shall submit to the Secretary, in such form
8 and manner as the Secretary shall require—

9 “(A) the results of the statewide needs as-
10 sessment required under paragraph (1); and

11 “(B) a description of how the State in-
12 tends to address needs identified by the assess-
13 ment, particularly with respect to communities
14 identified under paragraph (1)(A), which may
15 include applying for a grant to conduct an early
16 childhood home visitation program in accord-
17 ance with the requirements of this section.

18 “(c) GRANTS FOR EARLY CHILDHOOD HOME VISITA-
19 TION PROGRAMS.—

20 “(1) AUTHORITY TO MAKE GRANTS.—In addi-
21 tion to any other payments made under this title to
22 a State, the Secretary shall make grants to eligible
23 entities to enable the entities to deliver services
24 under early childhood home visitation programs that
25 satisfy the requirements of subsection (d) to eligible

1 families in order to promote improvements in mater-
2 nal and prenatal health, infant health, child health
3 and development, parenting related to child develop-
4 ment outcomes, school readiness, and the socio-
5 economic status of such families, and reductions in
6 child abuse, neglect, and injuries.

7 “(2) AUTHORITY TO USE INITIAL GRANT FUNDS
8 FOR PLANNING OR IMPLEMENTATION.—An eligible
9 entity that receives a grant under paragraph (1)
10 may use a portion of the funds made available to the
11 entity during the first 6 months of the period for
12 which the grant is made for planning or implementa-
13 tion activities to assist with the establishment of
14 early childhood home visitation programs that sat-
15 isfy the requirements of subsection (d).

16 “(3) GRANT DURATION.—The Secretary shall
17 determine the period of years for which a grant is
18 made to an eligible entity under paragraph (1).

19 “(d) REQUIREMENTS.—The requirements of this sub-
20 section for an early childhood home visitation program
21 conducted with a grant made under this section are as
22 follows:

23 “(1) QUANTIFIABLE, MEASURABLE IMPROVE-
24 MENT IN BENCHMARK AREAS.—

1 “(A) IN GENERAL.—The eligible entity es-
2 tablishes, subject to the approval of the Sec-
3 retary, quantifiable, measurable 3- and 5-year
4 benchmarks for demonstrating that the pro-
5 gram results in improvements for the eligible
6 families participating in the program in each of
7 the following areas:

8 “(i) Improved maternal and newborn
9 health.

10 “(ii) Prevention of child injuries and
11 reduction of emergency department visits.

12 “(iii) Improvement in school readiness
13 and achievement.

14 “(iv) Reduction in crime or domestic
15 violence.

16 “(v) Improvements in family economic
17 self-sufficiency.

18 “(vi) Improvements in the coordina-
19 tion and referrals for other community re-
20 sources and supports.

21 “(B) DEMONSTRATION OF IMPROVEMENTS
22 AFTER 3 YEARS.—

23 “(i) REPORT TO THE SECRETARY.—
24 Not later than 30 days after the end of the
25 3rd year in which the eligible entity con-

1 ducts the program, the entity submits to
2 the Secretary a report demonstrating im-
3 provement in at least 4 of the areas speci-
4 fied in subparagraph (A).

5 “(ii) CORRECTIVE ACTION PLAN.—If
6 the report submitted by the eligible entity
7 under clause (i) fails to demonstrate im-
8 provement in at least 4 of the areas speci-
9 fied in subparagraph (A), the entity shall
10 develop and implement a plan to improve
11 outcomes in each of the areas specified in
12 subparagraph (A), subject to approval by
13 the Secretary. The plan shall include provi-
14 sions for the Secretary to monitor imple-
15 mentation of the plan and conduct contin-
16 ued oversight of the program, including
17 through submission by the entity of reg-
18 ular reports to the Secretary.

19 “(iii) TECHNICAL ASSISTANCE.—

20 “(I) IN GENERAL.—The Sec-
21 retary shall provide an eligible entity
22 required to develop and implement an
23 improvement plan under clause (ii)
24 with technical assistance to develop
25 and implement the plan. The Sec-

1 retary may provide the technical as-
2 sistance directly or through grants,
3 contracts, or cooperative agreements.

4 “(II) ADVISORY PANEL.—The
5 Secretary shall establish an advisory
6 panel for purposes of obtaining rec-
7 ommendations regarding the technical
8 assistance provided to entities in ac-
9 cordance with subclause (I).

10 “(iv) NO IMPROVEMENT OR FAILURE
11 TO SUBMIT REPORT.—If the Secretary de-
12 termines after a period of time specified by
13 the Secretary that an eligible entity imple-
14 menting an improvement plan under clause
15 (ii) has failed to demonstrate any improve-
16 ment in the areas specified in subpara-
17 graph (A), or if the Secretary determines
18 that an eligible entity has failed to submit
19 the report required under clause (i), the
20 Secretary shall terminate the entity’s grant
21 and may include any unexpended grant
22 funds in grants made to nonprofit organi-
23 zations under subsection (h)(2)(B).

24 “(C) FINAL REPORT.—Not later than De-
25 cember 31, 2014, the eligible entity shall sub-

1 mit a report to the Secretary demonstrating im-
2 provements (if any) in each of the areas speci-
3 fied in subparagraph (A).

4 “(2) IMPROVEMENTS IN OUTCOMES FOR INDI-
5 VIDUAL FAMILIES.—

6 “(A) IN GENERAL.—The program is de-
7 signed, with respect to an eligible family partici-
8 pating in the program, to result in the partici-
9 pant outcomes described in subparagraph (B)
10 that the eligible entity identifies on the basis of
11 an individualized assessment of the family, are
12 relevant for that family.

13 “(B) PARTICIPANT OUTCOMES.—The par-
14 ticipant outcomes described in this subpara-
15 graph are the following:

16 “(i) Improvements in prenatal, mater-
17 nal, and newborn health, including im-
18 proved pregnancy outcomes

19 “(ii) Improvements in child health
20 and development, including the prevention
21 of child injuries and maltreatment and im-
22 provements in cognitive, language, social-
23 emotional, and physical developmental indi-
24 cators.

1 “(iii) Improvements in parenting
2 skills.

3 “(iv) Improvements in school readi-
4 ness and child academic achievement.

5 “(v) Reductions in crime or domestic
6 violence.

7 “(vi) Improvements in family eco-
8 nomic self-sufficiency.

9 “(vii) Improvements in the coordina-
10 tion of referrals for, and the provision of,
11 other community resources and supports
12 for eligible families, consistent with State
13 child welfare agency training.

14 “(3) CORE COMPONENTS.—The program in-
15 cludes the following core components:

16 “(A) SERVICE DELIVERY MODEL OR MOD-
17 ELS.—

18 “(i) IN GENERAL.—Subject to clause
19 (ii), the program is conducted using 1 or
20 more of the service delivery models de-
21 scribed in item (aa) or (bb) of subclause
22 (I) or in subclause (II) selected by the eli-
23 gible entity:

24 “(I) The model conforms to a
25 clear consistent home visitation model

1 that has been in existence for at least
2 3 years and is research-based, ground-
3 ed in relevant empirically-based
4 knowledge, linked to program deter-
5 mined outcomes, associated with a na-
6 tional organization or institution of
7 higher education that has comprehen-
8 sive home visitation program stand-
9 ards that ensure high quality service
10 delivery and continuous program qual-
11 ity improvement, and has dem-
12 onstrated significant, (and in the case
13 of the service delivery model described
14 in item (aa), sustained) positive out-
15 comes, as described in the benchmark
16 areas specified in paragraph (1)(A)
17 and the participant outcomes de-
18 scribed in paragraph (2)(B), when
19 evaluated using well-designed and rig-
20 orous—

21 “(aa) randomized controlled
22 research designs, and the evalua-
23 tion results have been published
24 in a peer-reviewed journal; or

1 “(bb) quasi-experimental re-
2 search designs.

3 “(II) The model conforms to a
4 promising and new approach to
5 achieving the benchmark areas speci-
6 fied in paragraph (1)(A) and the par-
7 ticipant outcomes described in para-
8 graph (2)(B), has been developed or
9 identified by a national organization
10 or institution of higher education, and
11 will be evaluated through well-de-
12 signed and rigorous process.

13 “(ii) MAJORITY OF GRANT FUNDS
14 USED FOR EVIDENCE-BASED MODELS.—An
15 eligible entity shall use not more than 25
16 percent of the amount of the grant paid to
17 the entity for a fiscal year for purposes of
18 conducting a program using the service de-
19 livery model described in clause (i)(III).

20 “(iii) CRITERIA FOR EVIDENCE OF EF-
21 FECTIVENESS OF MODELS.—The Secretary
22 shall establish criteria for evidence of effec-
23 tiveness of the service delivery models
24 (which may be tiered) and for assessing
25 such evidence with respect to each such

1 model. The Secretary shall ensure that the
2 process for establishing the criteria is
3 transparent and provides the opportunity
4 for public comment.

5 “(B) ADDITIONAL REQUIREMENTS.—

6 “(i) The program adheres to a clear,
7 consistent model that satisfies the require-
8 ments of being grounded in empirically-
9 based knowledge related to home visiting
10 and linked to the benchmark areas speci-
11 fied in paragraph (1)(A) and the partici-
12 pant outcomes described in paragraph
13 (2)(B).

14 “(ii) The program employs well-
15 trained and competent staff, as dem-
16 onstrated by education or training, such as
17 nurses, social workers, child development
18 specialists, or other well-trained and com-
19 petent staff, and provides ongoing and spe-
20 cific training on the model being delivered.

21 “(iii) The program maintains high
22 quality supervision to establish home vis-
23 itor competencies.

1 “(iv) The program demonstrates
2 strong organizational capacity to imple-
3 ment the activities involved.

4 “(v) The program establishes appro-
5 priate linkages and referral networks to
6 other community resources and supports
7 for eligible families.

8 “(vi) The program monitors the fidel-
9 ity of program implementation to ensure
10 that services are delivered pursuant to the
11 specified model.

12 “(4) PRIORITY FOR SERVING HIGH-RISK POPU-
13 LATIONS.—The eligible entity gives priority to pro-
14 viding services under the program to the following:

15 “(A) Eligible families who reside in com-
16 munities in need of such services, as identified
17 in the statewide needs assessment required
18 under subsection (b)(1)(A).

19 “(B) Low-income eligible families.

20 “(C) Eligible families who are pregnant
21 women who have not attained age 21.

22 “(D) Eligible families that have a history
23 of child abuse or neglect.

24 “(E) Eligible families that have had inter-
25 actions with child welfare services.

1 “(F) Eligible families that have a history
2 of substance abuse or need substance abuse
3 treatment.

4 “(G) Eligible families that have users of
5 tobacco products in the home.

6 “(H) Eligible families that are or have
7 children with low student achievement.

8 “(I) Eligible families with children with de-
9 velopmental delays or disabilities.

10 “(J) Eligible families who, or that include
11 individuals who, are serving or formerly served
12 in the Armed Forces, including such families
13 that have members of the Armed Forces who
14 have had multiple deployments outside of the
15 United States.

16 “(e) APPLICATION REQUIREMENTS.—An eligible en-
17 tity desiring a grant under this section shall submit an
18 application to the Secretary for approval, in such manner
19 as the Secretary may require, that includes the following:

20 “(1) A description of the populations to be
21 served by the entity, including specific information
22 regarding how the entity will serve high risk popu-
23 lations described in subsection (d)(4).

24 “(2) An assurance that the entity will give pri-
25 ority to serving low-income eligible families and eligi-

1 ble families who reside in at risk communities identi-
2 fied in the statewide needs assessment required
3 under subsection (b)(1)(A).

4 “(3) The service delivery model or models de-
5 scribed in subsection (d)(3)(A) that the entity will
6 use under the program and the basis for the selec-
7 tion of the model or models.

8 “(4) A statement identifying how the selection
9 of the populations to be served and the service deliv-
10 ery model or models that the entity will use under
11 the program for such populations is consistent with
12 the results of the statewide needs assessment con-
13 ducted under subsection (b).

14 “(5) The quantifiable, measurable benchmarks
15 established by the State to demonstrate that the
16 program contributes to improvements in the areas
17 specified in subsection (d)(1)(A).

18 “(6) An assurance that the entity will obtain
19 and submit documentation or other appropriate evi-
20 dence from the organization or entity that developed
21 the service delivery model or models used under the
22 program to verify that the program is implemented
23 and services are delivered according to the model
24 specifications.

1 “(7) Assurances that the entity will establish
2 procedures to ensure that—

3 “(A) the participation of each eligible fam-
4 ily in the program is voluntary; and

5 “(B) services are provided to an eligible
6 family in accordance with the individual assess-
7 ment for that family.

8 “(8) Assurances that the entity will—

9 “(A) submit annual reports to the Sec-
10 retary regarding the program and activities car-
11 ried out under the program that include such
12 information and data as the Secretary shall re-
13 quire; and

14 “(B) participate in, and cooperate with,
15 data and information collection necessary for
16 the evaluation required under subsection (g)(2)
17 and other research and evaluation activities car-
18 ried out under subsection (h)(3).

19 “(9) A description of other State programs that
20 include home visitation services, including, if appli-
21 cable to the State, other programs carried out under
22 this title with funds made available from allotments
23 under section 502(c), programs funded under title
24 IV, title II of the Child Abuse Prevention and Treat-
25 ment Act (relating to community-based grants for

1 the prevention of child abuse and neglect), and sec-
2 tion 645A of the Head Start Act (relating to Early
3 Head Start programs).

4 “(10) Other information as required by the Sec-
5 retary.

6 “(f) MAINTENANCE OF EFFORT.—Funds provided to
7 an eligible entity receiving a grant under this section shall
8 supplement, and not supplant, funds from other sources
9 for early childhood home visitation programs or initiatives.

10 “(g) EVALUATION.—

11 “(1) INDEPENDENT, EXPERT ADVISORY
12 PANEL.—The Secretary, in accordance with sub-
13 section (h)(1)(A), shall appoint an independent advi-
14 sory panel consisting of experts in program evalua-
15 tion and research, education, and early childhood
16 programs—

17 “(A) to review, and make recommendations
18 on, the design and plan for the evaluation re-
19 quired under paragraph (2) within 1 year after
20 the date of enactment of this section;

21 “(B) to maintain and advise the Secretary
22 regarding the progress of the evaluation; and

23 “(C) to comment, if the panel so desires,
24 on the report submitted under paragraph (3).

1 “(2) AUTHORITY TO CONDUCT EVALUATION.—

2 On the basis of the recommendations of the advisory
3 panel under paragraph (1), the Secretary shall, by
4 grant, contract, or interagency agreement, conduct
5 an evaluation of the statewide needs assessments
6 submitted under subsection (b) and the grants made
7 under subsections (c) and (h)(3)(B). The evaluation
8 shall include—

9 “(A) an analysis, on a State-by-State
10 basis, of the results of such assessments, in-
11 cluding indicators of maternal and prenatal
12 health and infant health and mortality, and
13 State actions in response to the assessments;
14 and

15 “(B) an assessment of—

16 “(i) the effect of early childhood home
17 visitation programs on child and parent
18 outcomes, including with respect to each of
19 the benchmark areas specified in sub-
20 section (d)(1)(A) and the participant out-
21 comes described in subsection (d)(2)(B);

22 “(ii) the effectiveness of such pro-
23 grams on different populations, including
24 the extent to which the ability of programs

1 to improve participant outcomes varies
2 across programs and populations; and

3 “(iii) the potential for the activities
4 conducted under such programs, if scaled
5 broadly, to improve health care practices,
6 eliminate health disparities, and improve
7 health care system quality, efficiencies, and
8 reduce costs.

9 “(3) REPORT.—Not later than March 31, 2015,
10 the Secretary shall submit a report to Congress on
11 the results of the evaluation conducted under para-
12 graph (2) and shall make the report publicly avail-
13 able.

14 “(h) OTHER PROVISIONS.—

15 “(1) INTRA-AGENCY COLLABORATION.—The
16 Secretary shall ensure that the Maternal and Child
17 Health Bureau and the Administration for Children
18 and Families collaborate with respect to all aspects
19 of carrying out this section, including with respect
20 to—

21 “(A) reviewing and analyzing the statewide
22 needs assessments required under subsection
23 (b), the awarding and oversight of grants
24 awarded under this section, the establishment
25 of the advisory panels required under sub-

1 sections (d)(1)(B)(iii)(II) and (g)(1), and the
2 evaluation and report required under subsection
3 (g); and

4 “(B) consulting with other Federal agen-
5 cies with responsibility for administering or
6 evaluating programs that serve eligible families
7 to coordinate and collaborate with respect to re-
8 search related to such programs and families,
9 including the Office of the Assistant Secretary
10 for Planning and Evaluation of the Department
11 of Health and Human Services, the Centers for
12 Disease Control and Prevention, the National
13 Institute of Child Health and Human Develop-
14 ment of the National Institutes of Health, the
15 Office of Juvenile Justice and Delinquency Pre-
16 vention of the Department of Justice, and the
17 Institute of Education Sciences of the Depart-
18 ment of Education.

19 “(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE
20 NOT STATES.—

21 “(A) INDIAN TRIBES, TRIBAL ORGANIZA-
22 TIONS, OR URBAN INDIAN ORGANIZATIONS.—
23 The Secretary shall specify requirements for eli-
24 gible entities that are Indian Tribes (or a con-
25 sortium of Indian Tribes), Tribal Organiza-

1 tions, or Urban Indian Organizations to apply
2 for and conduct an early childhood home visita-
3 tion program with a grant under this section.
4 Such requirements shall, to the greatest extent
5 practicable, be consistent with the requirements
6 applicable to eligible entities that are States
7 and shall require an Indian Tribe (or consor-
8 tium), Tribal Organization, or Urban Indian
9 Organization to—

10 “(i) conduct a needs assessment simi-
11 lar to the assessment required for all
12 States under subsection (b); and

13 “(ii) establish quantifiable, measur-
14 able 3- and 5-year benchmarks consistent
15 with subsection (d)(1)(A).

16 “(B) NONPROFIT ORGANIZATIONS.—If, as
17 of the beginning of fiscal year 2012, a State
18 has not applied and been approved for a grant
19 under this section, the Secretary may use
20 amounts appropriated under paragraph (1) of
21 subsection (j) that are available for expenditure
22 under paragraph (3) of that subsection to make
23 a grant to an eligible entity that is a nonprofit
24 organization described in subsection (k)(1)(B)
25 to conduct an early childhood home visitation

1 program in the State. The Secretary shall speci-
2 fy the requirements for such an organization to
3 apply for and conduct the program which shall,
4 to the greatest extent practicable, be consistent
5 with the requirements applicable to eligible enti-
6 ties that are States and shall require the orga-
7 nization to—

8 “(i) carry out the program based on
9 the needs assessment conducted by the
10 State under subsection (b); and

11 “(ii) establish quantifiable, measur-
12 able 3- and 5-year benchmarks consistent
13 with subsection (d)(1)(A).

14 “(3) RESEARCH AND OTHER EVALUATION AC-
15 TIVITIES.—

16 “(A) IN GENERAL.—The Secretary shall
17 carry out a continuous program of research and
18 evaluation activities in order to increase knowl-
19 edge about the implementation and effective-
20 ness of home visiting programs, using random
21 assignment designs to the maximum extent fea-
22 sible. The Secretary may carry out such activi-
23 ties directly, or through grants, cooperative
24 agreements, or contracts.

1 “(B) REQUIREMENTS.—The Secretary
2 shall ensure that—

3 “(i) evaluation of a specific program
4 or project is conducted by persons or indi-
5 viduals not directly involved in the oper-
6 ation of such program or project; and

7 “(ii) the conduct of research and eval-
8 uation activities includes consultation with
9 independent researchers, State officials,
10 and developers and providers of home vis-
11 iting programs on topics including research
12 design and administrative data matching.

13 “(4) REPORT AND RECOMMENDATION.—Not
14 later than December 31, 2015, the Secretary shall
15 submit a report to Congress regarding the programs
16 conducted with grants under this section. The report
17 required under this paragraph shall include—

18 “(A) information regarding the extent to
19 which eligible entities receiving grants under
20 this section demonstrated improvements in each
21 of the areas specified in subsection (d)(1)(A);

22 “(B) information regarding any technical
23 assistance provided under subsection
24 (d)(1)(B)(iii)(I), including the type of any such
25 assistance provided; and

1 “(C) recommendations for such legislative
2 or administrative action as the Secretary deter-
3 mines appropriate.

4 “(i) APPLICATION OF OTHER PROVISIONS OF
5 TITLE.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), the other provisions of this title shall not
8 apply to a grant made under this section.

9 “(2) EXCEPTIONS.—The following provisions of
10 this title shall apply to a grant made under this sec-
11 tion to the same extent and in the same manner as
12 such provisions apply to allotments made under sec-
13 tion 502(c):

14 “(A) Section 504(b)(6) (relating to prohi-
15 bition on payments to excluded individuals and
16 entities).

17 “(B) Section 504(c) (relating to the use of
18 funds for the purchase of technical assistance).

19 “(C) Section 504(d) (relating to a limita-
20 tion on administrative expenditures).

21 “(D) Section 506 (relating to reports and
22 audits), but only to the extent determined by
23 the Secretary to be appropriate for grants made
24 under this section.

1 “(E) Section 507 (relating to penalties for
2 false statements).

3 “(F) Section 508 (relating to non-
4 discrimination).

5 “(G) Section 509(a) (relating to the ad-
6 ministration of the grant program).

7 “(j) APPROPRIATIONS.—

8 “(1) IN GENERAL.—Out of any funds in the
9 Treasury not otherwise appropriated, there are ap-
10 propriated to the Secretary to carry out this sec-
11 tion—

12 “(A) \$100,000,000 for fiscal year 2010;

13 “(B) \$250,000,000 for fiscal year 2011;

14 “(C) \$350,000,000 for fiscal year 2012;

15 “(D) \$400,000,000 for fiscal year 2013;

16 and

17 “(E) \$400,000,000 for fiscal year 2014.

18 “(2) RESERVATIONS.—Of the amount appro-
19 priated under this subsection for a fiscal year, the
20 Secretary shall reserve—

21 “(A) 3 percent of such amount for pur-
22 poses of making grants to eligible entities that
23 are Indian Tribes (or a consortium of Indian
24 Tribes), Tribal Organizations, or Urban Indian
25 Organizations; and

1 “(B) 3 percent of such amount for pur-
2 poses of carrying out subsections (d)(1)(B)(iii),
3 (g), and (h)(3).

4 “(3) AVAILABILITY.—Funds made available to
5 an eligible entity under this section for a fiscal year
6 shall remain available for expenditure by the eligible
7 entity through the end of the second succeeding fis-
8 cal year after award. Any funds that are not ex-
9 pended by the eligible entity during the period in
10 which the funds are available under the preceding
11 sentence may be used for grants to nonprofit organi-
12 zations under subsection (h)(2)(B).

13 “(k) DEFINITIONS.—In this section:

14 “(1) ELIGIBLE ENTITY.—

15 “(A) IN GENERAL.—The term ‘eligible en-
16 tity’ means a State, an Indian Tribe, Tribal Or-
17 ganization, or Urban Indian Organization,
18 Puerto Rico, Guam, the Virgin Islands, the
19 Northern Mariana Islands, and American
20 Samoa.

21 “(B) NONPROFIT ORGANIZATIONS.—Only
22 for purposes of awarding grants under sub-
23 section (h)(2)(B), such term shall include a
24 nonprofit organization with an established
25 record of providing early childhood home visita-

1 tion programs or initiatives in a State or sev-
2 eral States.

3 “(2) ELIGIBLE FAMILY.—The term ‘eligible
4 family’ means—

5 “(A) a woman who is pregnant, and the fa-
6 ther of the child if the father is available; or

7 “(B) a parent or primary caregiver of a
8 child, including grandparents or other relatives
9 of the child, and foster parents, who are serving
10 as the child’s primary caregiver from birth until
11 entry into kindergarten, and including a non-
12 custodial parent who has an ongoing relation-
13 ship with, and at times provides physical care
14 for, the child.

15 “(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—
16 The terms ‘Indian Tribe’ and ‘Tribal Organization’,
17 and ‘Urban Indian Organization’ have the meanings
18 given such terms in section 4 of the Indian Health
19 Care Improvement Act.”.

20 **SEC. 1802. SUPPORT, EDUCATION, AND RESEARCH FOR**
21 **POSTPARTUM DEPRESSION.**

22 (a) DEFINITIONS.—In this section:

23 (1) The term “postpartum condition” means
24 postpartum depression or postpartum psychosis.

1 (2) The term “Secretary” means the Secretary
2 of Health and Human Services.

3 (b) RESEARCH ON POSTPARTUM CONDITIONS.—

4 (1) EXPANSION AND INTENSIFICATION OF AC-
5 TIVITIES.—

6 (A) CONTINUATION OF ACTIVITIES.—The
7 Secretary is encouraged to continue activities
8 on postpartum conditions.

9 (B) PROGRAMS FOR POSTPARTUM CONDI-
10 TIONS.—In carrying out subparagraph (A), the
11 Secretary is encouraged to continue research to
12 expand the understanding of the causes of, and
13 treatments for, postpartum conditions. Activi-
14 ties under such subsection shall include con-
15 ducting and supporting the following:

16 (i) Basic research concerning the eti-
17 ology and causes of the conditions.

18 (ii) Epidemiological studies to address
19 the frequency and natural history of the
20 conditions and the differences among racial
21 and ethnic groups with respect to the con-
22 ditions.

23 (iii) The development of improved
24 screening and diagnostic techniques.

1 (iv) Clinical research for the develop-
2 ment and evaluation of new treatments.

3 (v) Information and education pro-
4 grams for health care professionals and the
5 public, which may include a coordinated
6 national campaign to increase the aware-
7 ness and knowledge of postpartum condi-
8 tions. Activities under such a national
9 campaign may—

10 (I) include public service an-
11 nouncements through television, radio,
12 and other means; and

13 (II) focus on—

14 (aa) raising awareness about
15 screening;

16 (bb) educating new mothers
17 and their families about
18 postpartum conditions to pro-
19 mote earlier diagnosis and treat-
20 ment; and

21 (cc) ensuring that such edu-
22 cation includes complete informa-
23 tion concerning postpartum con-
24 ditions, including its symptoms,

1 methods of coping with the ill-
2 ness, and treatment resources.

3 (2) SENSE OF CONGRESS REGARDING LONGITU-
4 DINAL STUDY OF RELATIVE MENTAL HEALTH CON-
5 SEQUENCES FOR WOMEN OF RESOLVING A PREG-
6 NANCY.—

7 (A) SENSE OF CONGRESS.—It is the sense
8 of Congress that the Director of the National
9 Institute of Mental Health may conduct a na-
10 tionally representative longitudinal study (dur-
11 ing the period of fiscal years 2010 through
12 2019) of the relative mental health con-
13 sequences for women of resolving a pregnancy
14 (intended and unintended) in various ways, in-
15 cluding carrying the pregnancy to term and
16 parenting the child, carrying the pregnancy to
17 term and placing the child for adoption, mis-
18 carriage, and having an abortion. This study
19 may assess the incidence, timing, magnitude,
20 and duration of the immediate and long-term
21 mental health consequences (positive or nega-
22 tive) of these pregnancy outcomes.

23 (B) REPORT.—Subject to the completion
24 of the study under subsection (a), beginning not
25 later than 5 years after the date of the enact-

1 ment of this Act, and periodically thereafter for
2 the duration of the study, such Director may
3 prepare and submit to the Congress reports on
4 the findings of the study.

5 (c) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS
6 WITH A POSTPARTUM CONDITION AND THEIR FAMI-
7 LIES.—Title V of the Social Security Act (42 U.S.C. 701
8 et seq.), as amended by section 1801, is amended by add-
9 ing at the end the following new section:

10 **“SEC. 512. SERVICES TO INDIVIDUALS WITH A**
11 **POSTPARTUM CONDITION AND THEIR FAMI-**
12 **LIES.**

13 “(a) IN GENERAL.—In addition to any other pay-
14 ments made under this title to a State, the Secretary may
15 make grants to eligible entities for projects for the estab-
16 lishment, operation, and coordination of effective and cost-
17 efficient systems for the delivery of essential services to
18 individuals with a postpartum condition and their families.

19 “(b) CERTAIN ACTIVITIES.—To the extent prac-
20 ticable and appropriate, the Secretary shall ensure that
21 projects funded under subsection (a) provide education
22 and services with respect to the diagnosis and manage-
23 ment of postpartum conditions. The Secretary may allow
24 such projects to include the following:

1 “(1) Delivering or enhancing outpatient and
2 home-based health and support services, including
3 case management and comprehensive treatment
4 services for individuals with or at risk for
5 postpartum conditions, and delivering or enhancing
6 support services for their families.

7 “(2) Delivering or enhancing inpatient care
8 management services that ensure the well-being of
9 the mother and family and the future development
10 of the infant.

11 “(3) Improving the quality, availability, and or-
12 ganization of health care and support services (in-
13 cluding transportation services, attendant care,
14 homemaker services, day or respite care, and pro-
15 viding counseling on financial assistance and insur-
16 ance) for individuals with a postpartum condition
17 and support services for their families.

18 “(4) Providing education to new mothers and,
19 as appropriate, their families about postpartum con-
20 ditions to promote earlier diagnosis and treatment.
21 Such education may include—

22 “(A) providing complete information on
23 postpartum conditions, symptoms, methods of
24 coping with the illness, and treatment re-
25 sources; and

1 “(B) in the case of a grantee that is a
2 State, hospital, or birthing facility—

3 “(i) providing education to new moth-
4 ers and fathers, and other family members
5 as appropriate, concerning postpartum
6 conditions before new mothers leave the
7 health facility; and

8 “(ii) ensuring that training programs
9 regarding such education are carried out
10 at the health facility.

11 “(c) INTEGRATION WITH OTHER PROGRAMS.—To
12 the extent practicable and appropriate, the Secretary may
13 integrate the grant program under this section with other
14 grant programs carried out by the Secretary, including the
15 program under section 330 of the Public Health Service
16 Act.

17 “(d) CERTAIN REQUIREMENTS.—A grant may be
18 made under this section only if the applicant involved
19 makes the following agreements:

20 “(1) Not more than 5 percent of the grant will
21 be used for administration, accounting, reporting,
22 and program oversight functions.

23 “(2) The grant will be used to supplement and
24 not supplant funds from other sources related to the
25 treatment of postpartum conditions.

1 “(3) The applicant will abide by any limitations
2 deemed appropriate by the Secretary on any charges
3 to individuals receiving services pursuant to the
4 grant. As deemed appropriate by the Secretary, such
5 limitations on charges may vary based on the finan-
6 cial circumstances of the individual receiving serv-
7 ices.

8 “(4) The grant will not be expended to make
9 payment for services authorized under subsection (a)
10 to the extent that payment has been made, or can
11 reasonably be expected to be made, with respect to
12 such services—

13 “(A) under any State compensation pro-
14 gram, under an insurance policy, or under any
15 Federal or State health benefits program; or

16 “(B) by an entity that provides health
17 services on a prepaid basis.

18 “(5) The applicant will, at each site at which
19 the applicant provides services funded under sub-
20 section (a), post a conspicuous notice informing indi-
21 viduals who receive the services of any Federal poli-
22 cies that apply to the applicant with respect to the
23 imposition of charges on such individuals.

1 “(6) For each grant period, the applicant will
2 submit to the Secretary a report that describes how
3 grant funds were used during such period.

4 “(e) TECHNICAL ASSISTANCE.—The Secretary may
5 provide technical assistance to entities seeking a grant
6 under this section in order to assist such entities in com-
7 plying with the requirements of this section.

8 “(f) APPLICATION OF OTHER PROVISIONS OF
9 TITLE.—

10 “(1) IN GENERAL.—Except as provided in para-
11 graph (2), the other provisions of this title shall not
12 apply to a grant made under this section.

13 “(2) EXCEPTIONS.—The following provisions of
14 this title shall apply to a grant made under this sec-
15 tion to the same extent and in the same manner as
16 such provisions apply to allotments made under sec-
17 tion 502(c):

18 “(A) Section 504(b)(6) (relating to prohi-
19 bition on payments to excluded individuals and
20 entities).

21 “(B) Section 504(c) (relating to the use of
22 funds for the purchase of technical assistance).

23 “(C) Section 504(d) (relating to a limita-
24 tion on administrative expenditures).

1 “(D) Section 506 (relating to reports and
2 audits), but only to the extent determined by
3 the Secretary to be appropriate for grants made
4 under this section.

5 “(E) Section 507 (relating to penalties for
6 false statements).

7 “(F) Section 508 (relating to non-
8 discrimination).

9 “(G) Section 509(a) (relating to the ad-
10 ministration of the grant program).

11 “(g) DEFINITIONS.—In this section:

12 “(1) The term ‘eligible entity’—

13 “(A) means a public or nonprofit private
14 entity; and

15 “(B) includes a State or local government,
16 public-private partnership, recipient of a grant
17 under section 330H of the Public Health Serv-
18 ice Act (relating to the Healthy Start Initia-
19 tive), public or nonprofit private hospital, com-
20 munity-based organization, hospice, ambulatory
21 care facility, community health center, migrant
22 health center, public housing primary care cen-
23 ter, or homeless health center.

24 “(2) The term ‘postpartum condition’ means
25 postpartum depression or postpartum psychosis.”.

1 (d) GENERAL PROVISIONS.—

2 (1) AUTHORIZATION OF APPROPRIATIONS.—To
3 carry out this section and the amendment made by
4 subsection (c), there are authorized to be appro-
5 priated, in addition to such other sums as may be
6 available for such purpose—

7 (A) \$3,000,000 for fiscal year 2010; and

8 (B) such sums as may be necessary for fis-
9 cal years 2011 and 2012.

10 (2) REPORT BY THE SECRETARY.—

11 (A) STUDY.—The Secretary shall conduct
12 a study on the benefits of screening for
13 postpartum conditions.

14 (B) REPORT.—Not later than 2 years after
15 the date of the enactment of this Act, the Sec-
16 retary shall complete the study required by sub-
17 paragraph (A) and submit a report to the Con-
18 gress on the results of such study.

19 (3) LIMITATION.—Notwithstanding any other
20 provision of this section or the amendment made by
21 subsection (c), the Secretary may not utilize
22 amounts made available under this section or such
23 amendment to carry out activities or programs that
24 are duplicative of activities or programs that are al-

1 ready being carried out through the Department of
2 Health and Human Services.

3 **SEC. 1803. PERSONAL RESPONSIBILITY EDUCATION FOR**
4 **ADULTHOOD TRAINING.**

5 Title V of the Social Security Act (42 U.S.C. 701
6 et seq.), as amended by sections 1801 and 1802(c), is
7 amended by adding at the end the following:

8 **“SEC. 513. PERSONAL RESPONSIBILITY EDUCATION FOR**
9 **ADULTHOOD (PRE-ADULTHOOD) TRAINING.**

10 “(a) ALLOTMENTS TO STATES.—

11 “(1) AMOUNT.—

12 “(A) IN GENERAL.—For the purpose de-
13 scribed in subsection (b), subject to the suc-
14 ceeding provisions of this section, for each of
15 fiscal years 2010 through 2014, the Secretary
16 shall allot to each State an amount equal to the
17 product of—

18 “(i) the amount appropriated under
19 subsection (f) for the fiscal year and avail-
20 able for allotments to States after the ap-
21 plication of subsection (c); and

22 “(ii) the State youth population per-
23 centage determined under paragraph (2).

24 “(B) MINIMUM ALLOTMENT.—

1 “(i) IN GENERAL.—Each State allot-
2 ment under this paragraph for a fiscal
3 year shall be at least \$250,000.

4 “(ii) PRO RATA ADJUSTMENTS.—The
5 Secretary shall adjust on a pro rata basis
6 the amount of the State allotments deter-
7 mined under this paragraph for a fiscal
8 year to the extent necessary to comply with
9 clause (i).

10 “(C) APPLICATION REQUIRED TO ACCESS
11 ALLOTMENTS.—

12 “(i) IN GENERAL.—A State shall not
13 be paid from its allotment for a fiscal year
14 unless the State submits an application to
15 the Secretary for the fiscal year and the
16 Secretary approves the application (or re-
17 quires changes to the application that the
18 State satisfies) and meets such additional
19 requirements as the Secretary may specify.

20 “(ii) REQUIREMENTS.—The State ap-
21 plication shall contain an assurance that
22 the State has complied with the require-
23 ments of this section in preparing and sub-
24 mitting the application and shall include

1 the following as well as such additional in-
2 formation as the Secretary may require:

3 “(I) Based on data from the
4 Centers for Disease Control and Pre-
5 vention National Center for Health
6 Statistics, the most recent pregnancy
7 rates for the State for youth ages 10
8 to 14 and youth ages 15 to 19 for
9 which data are available, the most re-
10 cent birth rates for such youth popu-
11 lations in the State for which data are
12 available, and trends in those rates
13 for the most recently preceding 5-year
14 period for which such data are avail-
15 able.

16 “(II) State-established goals for
17 reducing the pregnancy rates and
18 birth rates for such youth populations.

19 “(III) A description of the
20 State’s plan for using the State allot-
21 ments provided under this section to
22 achieve such goals, especially among
23 youth populations that are the most
24 high-risk or vulnerable for pregnancies
25 or otherwise have special cir-

1 cumstances, including youth in foster
2 care, homeless youth, youth with HIV/
3 AIDS, pregnant youth who are under
4 21 years of age, mothers who are
5 under 21 years of age, and youth re-
6 siding in areas with high birth rates
7 for youth.

8 “(2) STATE YOUTH POPULATION PERCENT-
9 AGE.—

10 “(A) IN GENERAL.—For purposes of para-
11 graph (1)(A)(ii), the State youth population
12 percentage is, with respect to a State, the pro-
13 portion (expressed as a percentage) of—

14 “(i) the number of individuals who
15 have attained age 10 but not attained age
16 20 in the State; to

17 “(ii) the number of such individuals in
18 all States.

19 “(B) DETERMINATION OF NUMBER OF
20 YOUTH.—The number of individuals described
21 in clauses (i) and (ii) of subparagraph (A) in a
22 State shall be determined on the basis of the
23 most recent Bureau of the Census data.

24 “(3) AVAILABILITY OF STATE ALLOTMENTS.—
25 Subject to paragraph (4)(A), amounts allotted to a

1 State pursuant to this subsection for a fiscal year
2 shall remain available for expenditure by the State
3 through the end of the second succeeding fiscal year.

4 “(4) AUTHORITY TO AWARD GRANTS FROM
5 STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND
6 ENTITIES IN NONPARTICIPATING STATES.—

7 “(A) GRANTS FROM UNEXPENDED ALLOT-
8 MENTS.—If a State does not submit an applica-
9 tion under this section for fiscal year 2010 or
10 2011, the State shall no longer be eligible to
11 submit an application to receive funds from the
12 amounts allotted for the State for each of fiscal
13 years 2010 through 2014 and such amounts
14 shall be used by the Secretary to award grants
15 under this paragraph for each of fiscal years
16 2012 through 2014. The Secretary also shall
17 use any amounts from the allotments of States
18 that submit applications under this section for
19 a fiscal year that remain unexpended as of the
20 end of the period in which the allotments are
21 available for expenditure under paragraph (3)
22 for awarding grants under this paragraph.

23 “(B) 3-YEAR GRANTS.—

24 “(i) IN GENERAL.—The Secretary
25 shall solicit applications to award 3-year

1 grants in each of fiscal years 2012, 2013,
2 and 2014 to local organizations and enti-
3 ties to conduct, consistent with subsection
4 (b), programs and activities in States that
5 do not submit an application for an allot-
6 ment under this section for fiscal year
7 2010 or 2011.

8 “(ii) FAITH-BASED ORGANIZATIONS
9 OR CONSORTIA.—The Secretary may solicit
10 and award grants under this paragraph to
11 faith-based organizations or consortia, con-
12 sistent with the requirements of section
13 1955 of the Public Health Service Act re-
14 lating to a grant award to nongovern-
15 mental entities.

16 “(C) EVALUATION.—An organization or
17 entity awarded a grant under this paragraph
18 shall agree to participate in a rigorous Federal
19 evaluation.

20 “(5) MAINTENANCE OF EFFORT.—No payment
21 shall be made to a State from the allotment deter-
22 mined for the State under this subsection or to a
23 local organization or entity awarded a grant under
24 paragraph (4), if the expenditure of non-federal
25 funds by the State, organization, or entity for activi-

1 ties, programs, or initiatives for which amounts from
2 allotments and grants under this subsection may be
3 expended is less than the amount expended by the
4 State, organization, or entity for such programs or
5 initiatives for fiscal year 2009.

6 “(6) DATA COLLECTION AND REPORTING.—A
7 State or local organization or entity receiving funds
8 under this section shall cooperate with such require-
9 ments relating to the collection of data and informa-
10 tion and reporting on outcomes regarding the pro-
11 grams and activities carried out with such funds, as
12 the Secretary shall specify.

13 “(b) PURPOSE.—

14 “(1) IN GENERAL.—The purpose of an allot-
15 ment under subsection (a)(1) to a State is to enable
16 the State (or, in the case of grants made under sub-
17 section (a)(4)(B), to enable a local organization or
18 entity) to carry out personal responsibility education
19 for adulthood programs consistent with this sub-
20 section.

21 “(2) PERSONAL RESPONSIBILITY EDUCATION
22 FOR ADULTHOOD PROGRAMS.—

23 “(A) IN GENERAL.—In this section, the
24 term ‘personal responsibility education for

1 regarding responsible sexual behavior with
2 respect to both abstinence and the use of
3 contraception.

4 “(iv) The program places substantial
5 emphasis on both abstinence and contra-
6 ception for the prevention of pregnancy
7 among youth and sexually transmitted in-
8 fections.

9 “(v) The program provides age-appro-
10 appropriate information and activities.

11 “(vi) The information and activities
12 carried out under the program are pro-
13 vided in the cultural context that is most
14 appropriate for individuals in the par-
15 ticular population group to which they are
16 directed.

17 “(C) ADULTHOOD PREPARATION SUB-
18 JECTS.—The adulthood preparation subjects
19 described in this subparagraph are the fol-
20 lowing:

21 “(i) Healthy relationships, such as
22 positive self-esteem and relationship dy-
23 namics, friendships, dating, romantic in-
24 volvement, marriage, and family inter-
25 actions.

1 “(ii) Adolescent development, such as
2 the development of healthy attitudes and
3 values about adolescent growth and devel-
4 opment, body image, racial and ethnic di-
5 versity, and other related subjects.

6 “(iii) Financial literacy.

7 “(iv) Parent-child communication.

8 “(v) Educational and career success,
9 such as developing skills for employment
10 preparation, job seeking, independent liv-
11 ing, financial self-sufficiency, and work-
12 place productivity.

13 “(vi) Healthy life skills, such as goal-
14 setting, decision making, negotiation, com-
15 munication and interpersonal skills, and
16 stress management.

17 “(D) FAITH-BASED ORGANIZATIONS.—A
18 faith-based entity carrying out a program fund-
19 ed in whole or in part with funds made avail-
20 able under this section through a State allot-
21 ment or a grant shall agree that information,
22 activities, and services are carried out with
23 funds made available to the entity from the al-
24 lotment consistent with the requirements of sec-
25 tion 1955 of the Public Health Service Act re-

1 lating to a grant award to nongovernmental en-
2 tities.

3 “(c) RESERVATIONS OF FUNDS.—

4 “(1) GRANTS TO IMPLEMENT INNOVATIVE
5 STRATEGIES.—From the amount appropriated under
6 subsection (f) for the fiscal year, the Secretary shall
7 reserve \$10,000,000 of such amount for purposes of
8 awarding grants to entities to implement innovative
9 youth pregnancy prevention strategies and target
10 services to high-risk, vulnerable, and culturally
11 under-represented youth populations, including
12 youth in foster care, homeless youth, youth with
13 HIV/AIDS, pregnant women who are under 21 years
14 of age and their partners, mothers who are under 21
15 years of age and their partners, and youth residing
16 in areas with high birth rates for youth. An entity
17 awarded a grant under this paragraph shall agree to
18 participate in a rigorous Federal evaluation of the
19 activities carried out with grant funds.

20 “(2) OTHER RESERVATIONS.—From the
21 amount appropriated under subsection (f) for the
22 fiscal year that remains after the application of
23 paragraph (1), the Secretary shall reserve the fol-
24 lowing amounts:

1 “(A) GRANTS FOR INDIAN TRIBES OR
2 TRIBAL ORGANIZATIONS.—The Secretary shall
3 reserve 5 percent of such remainder for pur-
4 poses of awarding grants to Indian tribes and
5 tribal organizations in such manner, and sub-
6 ject to such requirements, as the Secretary, in
7 consultation with Indian tribes and tribal orga-
8 nizations, determines appropriate.

9 “(B) SECRETARIAL RESPONSIBILITIES.—
10 The Secretary shall reserve 10 percent of such
11 remainder for expenditures by the Secretary for
12 the following:

13 “(i) To award a grant to establish and
14 operate a national teen pregnancy preven-
15 tion resource center consistent with sub-
16 paragraph (C).

17 “(ii) To conduct research, training,
18 and technical assistance with respect to the
19 programs and activities carried out with
20 funds made available through allotments or
21 grants made under this section.

22 “(iii) To evaluate the programs and
23 activities carried out with funds made
24 available through such allotments and
25 grants.

1 “(C) NATIONAL TEEN PREGNANCY PRE-
2 VENTION RESOURCE CENTER.—

3 “(i) IN GENERAL.—The Secretary
4 shall award a grant to a nationally recog-
5 nized, nonpartisan, nonprofit organization
6 that meets the requirements described in
7 clause (ii) to establish and operate a na-
8 tional teen pregnancy prevention resource
9 center (in this subparagraph referred to as
10 the ‘Resource Center’) to carry out the
11 purpose and activities described in clause
12 (iii).

13 “(ii) REQUIREMENTS.—The require-
14 ments described in this clause are the fol-
15 lowing:

16 “(I) The organization has dem-
17 onstrated experience working with and
18 providing assistance to a broad range
19 of individuals and entities to reduce
20 teen pregnancy.

21 “(II) The organization is re-
22 search-based and has comprehensive
23 knowledge and data about teen preg-
24 nancy prevention strategies.

1 “(iii) PURPOSE AND ACTIVITIES.—

2 The Resource Center shall provide infor-
3 mation and technical assistance to public
4 and private entities seeking to reduce teen
5 pregnancy rates through activities that in-
6 clude the following:

7 “(I) Synthesizing and dissemi-
8 nating research and information re-
9 garding effective and promising prac-
10 tices.

11 “(II) Developing and providing
12 information on how to identify, select,
13 and implement effective programs.

14 “(III) Linking organizations to
15 existing resources, experts, and peers.

16 “(IV) Providing consultation and
17 resources on a broad array of strate-
18 gies and messages, including messages
19 that focus on abstinence, contracep-
20 tion, responsible behavior and choices,
21 family communication, relationships,
22 and values.

23 “(iv) COLLABORATION WITH OTHER
24 ORGANIZATIONS.—The organization oper-
25 ating the Resource Center shall collaborate

1 with other entities that have expertise in
2 the prevention of HIV and sexually trans-
3 mitted infections, healthy relationships, fi-
4 nancial literacy, and other topics addressed
5 through the personal responsibility for
6 adulthood educational programs to develop
7 resources and materials, provide technical
8 assistance to States, Indian tribes, and
9 communities, and undertake other activi-
10 ties as necessary.

11 “(d) ADMINISTRATION.—

12 “(1) IN GENERAL.—The Secretary shall admin-
13 ister this section through the Assistant Secretary for
14 the Administration for Children and Families within
15 the Department of Health and Human Services.

16 “(2) APPLICATION OF OTHER PROVISIONS OF
17 TITLE.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraph (B), the other provisions of this
20 title shall not apply to allotments or grants
21 made under this section.

22 “(B) EXCEPTIONS.—The following provi-
23 sions of this title shall apply to allotments and
24 grants made under this section to the same ex-

1 tent and in the same manner as such provisions
2 apply to allotments made under section 502(c):

3 “(i) Section 504(b)(6) (relating to
4 prohibition on payments to excluded indi-
5 viduals and entities).

6 “(ii) Section 504(c) (relating to the
7 use of funds for the purchase of technical
8 assistance).

9 “(iii) Section 504(d) (relating to a
10 limitation on administrative expenditures).

11 “(iv) Section 506 (relating to reports
12 and audits), but only to the extent deter-
13 mined by the Secretary to be appropriate
14 for grants made under this section.

15 “(v) Section 507 (relating to penalties
16 for false statements).

17 “(vi) Section 508 (relating to non-
18 discrimination).

19 “(e) DEFINITIONS.—In this section:

20 “(1) AGE-APPROPRIATE.—The term ‘age-appro-
21 priate’, with respect to the information in pregnancy
22 prevention, means topics, messages, and teaching
23 methods suitable to particular ages or age groups of
24 children and adolescents, based on developing cog-

1 nitive, emotional, and behavioral capacity typical for
2 the age or age group.

3 “(2) **MEDICALLY ACCURATE AND COMPLETE.**—

4 The term ‘medically accurate and complete’ means
5 verified or supported by the weight of research con-
6 ducted in compliance with accepted scientific meth-
7 ods and—

8 “(A) published in peer-reviewed journals,
9 where applicable; or

10 “(B) comprising information that leading
11 professional organizations and agencies with
12 relevant expertise in the field recognize as accu-
13 rate, objective, and complete.

14 “(3) **INDIAN TRIBES; TRIBAL ORGANIZA-**
15 **TIONS.**—The terms ‘Indian tribe’ and ‘Tribal organi-
16 zation’ have the meanings given such terms in sec-
17 tion 4 of the Indian Health Care Improvement Act
18 (25 U.S.C. 1603)).

19 “(4) **YOUTH.**—The term ‘youth’ means an indi-
20 vidual who has attained age 10 but has not attained
21 age 20.

22 “(f) **APPROPRIATION.**—For the purpose of carrying
23 out this section, there is appropriated, out of any money
24 in the Treasury not otherwise appropriated, \$75,000,000
25 for each of fiscal years 2010 through 2014. Amounts ap-

1 appropriated under this subsection shall remain available
2 until expended.”.

3 **SEC. 1804. RESTORATION OF FUNDING FOR ABSTINENCE**
4 **EDUCATION.**

5 Section 510 of the Social Security Act (42 U.S.C.
6 710) is amended—

7 (1) in subsection (a), by striking “fiscal year
8 1998 and each subsequent fiscal year” and inserting
9 “each of fiscal years 2010 through 2014”; and

10 (2) in subsection (d)—

11 (A) in the first sentence, by striking “1998
12 through 2003” and inserting “2010 through
13 2014”; and

14 (B) in the second sentence, by inserting
15 “(except that such appropriation shall be made
16 on the date of enactment of the America’s
17 Healthy Future Act of 2009 in the case of fis-
18 cal year 2010)” before the period.

19 **Subtitle J—Programs of Health**
20 **Promotion and Disease Prevention**

21 **SEC. 1901. PROGRAMS OF HEALTH PROMOTION AND DIS-**
22 **EASE PREVENTION.**

23 (a) INTERNAL REVENUE CODE OF 1986.—Section
24 9802 of the Internal Revenue Code of 1986 is amended—

1 (1) by redesignating the second subsection (f)
2 as subsection (g); and

3 (2) by adding at the end the following:

4 “(h) PROGRAMS OF HEALTH PROMOTION AND DIS-
5 EASE PREVENTION.—

6 “(1) APPLICABILITY.—The following shall apply
7 with respect to a program of health promotion or
8 disease prevention for purposes of subsection
9 (b)(2)(B). Such programs shall be referred to as
10 ‘wellness programs’.

11 “(2) DEFINITION AND GENERAL RULE.—

12 “(A) DEFINITION.—For purposes of this
13 subsection, a wellness program is any program
14 designed to promote health or prevent disease,
15 including a program designed to encourage in-
16 dividuals to adopt healthy behaviors.

17 “(B) GENERAL RULE.—For purposes of
18 subsections (a)(2) and (b)(2) (which provide ex-
19 ceptions to the general prohibitions against dis-
20 crimination based on a health factor for group
21 health plan provisions that vary benefits (in-
22 cluding cost-sharing mechanisms) or the pre-
23 mium or contribution for similarly situated indi-
24 viduals in connection with a wellness program
25 that satisfies the requirements of this sub-

1 section), if none of the conditions for obtaining
2 a reward under a wellness program are based
3 on an individual satisfying a standard that is
4 related to a health factor, under this subsection,
5 such wellness program does not violate this sec-
6 tion if participation in the program is made
7 available to all similarly situated individuals. If
8 any of the conditions for obtaining a reward
9 under such a wellness program is based on an
10 individual satisfying a standard that is related
11 to a health factor, the wellness program shall
12 not violate this section if the requirements of
13 paragraph (4) of this section are satisfied.

14 “(3) WELLNESS PROGRAMS NOT SUBJECT TO
15 REQUIREMENTS.—If none of the conditions for ob-
16 taining a reward under a wellness program are
17 based on an individual satisfying a standard that is
18 related to a health factor (or if a wellness program
19 does not provide a reward), the wellness program
20 shall not violate this section, if participation in the
21 program is made available to all similarly situated
22 individuals. Such programs need not satisfy the re-
23 quirements of paragraph (4), if participation in the
24 program is made available to all similarly situated

1 individuals. Wellness programs described in this
2 paragraph include the following:

3 “(A) A program that reimburses all or
4 part of the cost for memberships in a fitness
5 center.

6 “(B) A diagnostic testing program that
7 provides a reward for participation and does
8 not base any part of the reward on outcomes.

9 “(C) A program that encourages preven-
10 tive care through the waiver of the copayment
11 or deductible requirement under a group health
12 plan for the costs of, for example, prenatal care
13 or well-baby visits.

14 “(D) A program that reimburses employ-
15 ees for the costs of smoking cessation programs
16 without regard to whether the employee quits
17 smoking.

18 “(E) A program that provides a reward to
19 employees for attending a monthly health edu-
20 cation seminar.

21 “(4) WELLNESS PROGRAMS SUBJECT TO RE-
22 QUIREMENTS.—If any of the conditions for obtaining
23 a reward under a wellness program is based on an
24 individual satisfying a standard that is related to a
25 health factor, the wellness program shall not violate

1 this section if the requirements of this paragraph
2 are satisfied.

3 “(A) The reward for the wellness program,
4 coupled with the reward for other wellness pro-
5 grams with respect to the plan that require sat-
6 isfaction of a standard related to a health fac-
7 tor, shall not exceed 30 percent of the cost of
8 employee-only coverage under the plan. How-
9 ever, if, in addition to employees, any class of
10 dependents (such as spouses or spouses and de-
11 pendent children) may participate in the
12 wellness program, the reward shall not exceed
13 30 percent of the cost of the coverage in which
14 an employee and any dependents are enrolled.
15 For purposes of this paragraph, the cost of cov-
16 erage shall be determined based on the total
17 amount of employer and employee contributions
18 for the benefit package under which the em-
19 ployee is (or the employee and any dependents
20 are) receiving coverage. A reward may be in the
21 form of a discount or rebate of a premium or
22 contribution, a waiver of all or part of a cost-
23 sharing mechanism (such as deductibles, copay-
24 ments, or coinsurance), the absence of a sur-
25 charge, or the value of a benefit that would oth-

1 erwise not be provided under the plan. The Sec-
2 retaries of Labor, Health and Human Services,
3 and the Treasury may increase the reward
4 available under this subparagraph to up to 50
5 percent of the cost of coverage under the plan
6 if such Secretaries determine that such an in-
7 crease is appropriate.

8 “(B) The wellness program shall be rea-
9 sonably designed to promote health or prevent
10 disease. A program satisfies this subparagraph
11 if it has a reasonable chance of improving the
12 health of or preventing disease in participating
13 individuals and it is not overly burdensome, is
14 not a subterfuge for discriminating based on a
15 health factor, and is not highly suspect in the
16 method chosen to promote health or prevent
17 disease. At least once per year, each plan or
18 issuer offering a wellness program shall evalu-
19 ate the reasonableness of such program.

20 “(C) The program shall give individuals el-
21 igible for the program the opportunity to qual-
22 ify for the reward under the program at least
23 once per year.

1 “(D)(i) The reward under the program
2 shall be available to all similarly situated indi-
3 viduals.

4 “(ii) For purposes of clause (i), a reward
5 is not available to all similarly situated individ-
6 uals for a period unless the program allows—

7 “(I) a reasonable alternative standard
8 (or waiver of the otherwise applicable
9 standard) for obtaining the reward for any
10 individual for whom, for that period, it is
11 unreasonably difficult due to a medical
12 condition to satisfy the otherwise applica-
13 ble standard; and

14 “(II) a reasonable alternative stand-
15 ard (or waiver of the otherwise applicable
16 standard) for obtaining the reward for any
17 individual for whom, for that period, it is
18 medically inadvisable to attempt to satisfy
19 the otherwise applicable standard.

20 “(iii) A plan or issuer may seek
21 verification, such as a statement from an indi-
22 vidual’s physician, that a health factor makes it
23 unreasonably difficult or medically inadvisable
24 for the individual to satisfy or attempt to sat-
25 isfy the otherwise applicable standard.

1 “(E)(i) The plan or issuer shall disclose in
2 all plan materials describing the terms of the
3 program the availability of a reasonable alter-
4 native standard (or the possibility of waiver of
5 the otherwise applicable standard) required
6 under subparagraph (D). If plan materials
7 merely mention that a program is available,
8 without describing its terms, such disclosure is
9 not required.

10 “(ii) The following language, or similar
11 language, may be used to satisfy the require-
12 ment of this subparagraph: ‘If it is unreason-
13 ably difficult due to a medical condition for you
14 to achieve the standards for the reward under
15 this program, or if it is medically inadvisable
16 for you to attempt to achieve the standards for
17 the reward under this program, call us at [in-
18 sert telephone number] and we will work with
19 you to develop another way to qualify for the
20 reward.’.

21 “(5) REGULATIONS.—The Secretaries of Labor,
22 Health and Human Services, and the Treasury may pro-
23 mulgate regulations, as appropriate, to carry out this sub-
24 section.

1 “(6) EFFECTIVE DATE.—This subsection shall take
2 effect on the date of enactment of the America’s Healthy
3 Future Act of 2009.

4 “(7) EXISTING WELLNESS PROGRAMS.—During the
5 period of time between the date of enactment of the Amer-
6 ica’s Healthy Future Act of 2009 and the date on which
7 the Secretaries of Labor, Health and Human Services,
8 and the Treasury establish regulations to effectuate this
9 subsection, a wellness program that was established prior
10 to the date of enactment of the America’s Healthy Future
11 Act of 2009 may continue to operate in accordance with
12 the requirements in effect on the day before such date of
13 enactment.”.

14 (b) PHSA GROUP MARKET.—Section 2702(b) of the
15 Public Health Service Act (42 U.S.C. 300gg-1(b)) is
16 amended by adding at the end the following:

17 “(4) PROGRAMS OF HEALTH PROMOTION AND
18 DISEASE PREVENTION.—The provisions of section
19 9802(h) of the Internal Revenue Code of 1986 shall
20 apply to programs of health promotion and disease
21 prevention offered through a group health plan or a
22 health insurance issuer offering group health insur-
23 ance coverage.”.

1 (c) ERISA.—Section 702(b) of the Employee Retirement
2 ment Income Security Act of 1974 (29 U.S.C. 1182(b))
3 is amended by adding at the end the following:

4 “(4) PROGRAMS OF HEALTH PROMOTION AND
5 DISEASE PREVENTION.—The provisions of section
6 9802(h) of the Internal Revenue Code of 1986 shall
7 apply to programs of health promotion and disease
8 prevention offered through a group health plan or a
9 health insurance issuer offering group health insurance
10 coverage.”.

11 (d) APPLICATION OF WELLNESS PROGRAMS PROVIDED
12 TO CARRIERS PROVIDING FEDERAL EMPLOYEE
13 HEALTH BENEFITS PLANS.—

14 (1) IN GENERAL.—Notwithstanding section
15 8906 of title 5, United States Code (including sub-
16 sections (b)(1) and (b)(2) of such section), sub-
17 sections (a), (b), and (c) of this section, including
18 the amendments made by those subsections, (relat-
19 ing to wellness programs) shall apply to carriers enter-
20 ing into contracts under section 8902 of title 5,
21 United States Code.

22 (2) PROPOSALS.—Carriers may submit separate
23 proposals relating to voluntary wellness program offer-
24 ings as part of the annual call for benefit and

1 rate proposals to the Office of Personnel Manage-
2 ment.

3 (3) EFFECTIVE DATE.—This subsection shall
4 take effect on the date of enactment of this Act and
5 shall apply to contracts entered into under section
6 8902 of title 5, United States Code, that take effect
7 with respect to calendar years that begin more than
8 1 year after that date.

9 (e) STATE DEMONSTRATION PROJECT.—Subpart 1
10 of part B of title XXVII of the Public Health Service Act
11 (42 U.S.C. 300gg-41 et seq.) is amended by adding at the
12 end the following:

13 **“SEC. 2746. WELLNESS PROGRAM DEMONSTRATION**
14 **PROJECT.**

15 “(a) IN GENERAL.—Not later than July 1, 2014, the
16 Secretary of Health and Human Services, in consultation
17 with the Secretary of the Treasury, shall establish a 10-
18 State demonstration project under which participating
19 States shall apply the provisions of 9802(h) of the Internal
20 Revenue Code of 1986 to programs of health promotion
21 offered by a health insurance issuer that offers health in-
22 surance coverage in the individual market in such State.

23 “(b) EXPANSION OF DEMONSTRATION PROJECT.—If
24 the Secretary of Health and Human Services, in consulta-
25 tion with the Secretary of the Treasury, determines that

1 the demonstration project described in subsection (a) is
2 effective, such Secretaries may, beginning on July 1, 2017
3 expand such demonstration project to include additional
4 participating States.

5 “(c) REQUIREMENTS.—States that participate in the
6 demonstration project under this section shall—

7 “(1) ensure that requirements of consumer pro-
8 tection are met in programs of health promotion in
9 the individual market;

10 “(2) require verification from health insurance
11 issuers that offer health insurance coverage in the
12 individual market of such State that premium dis-
13 counts—

14 “(A) do not create undue burdens for indi-
15 viduals insured in the individual market;

16 “(B) do not lead to cost shifting; and

17 “(C) are not a subterfuge for discrimina-
18 tion; and

19 “(3) ensure that consumer data is protected in
20 accordance with the requirements of section 264(c)
21 of the Health Insurance Portability and Account-
22 ability Act of 1996 (42 U.S.C. 1320d-2 note).

23 “(d) EXISTING PROGRAMS OF HEALTH PROMOTION
24 OR DISEASE PREVENTION.—Nothing in this section shall
25 preempt any State law related to programs of health pro-

1 motion offered by a health insurance issuer that offers
2 health insurance coverage in the individual market in such
3 State that was established or adopted by State law on or
4 after the date of enactment of this Act.

5 “(e) REGULATIONS.—The Secretaries of Health and
6 Human Services and the Treasury may promulgate regu-
7 lations, as appropriate, to carry out this section.”.

8 (f) REPORT.—

9 (1) IN GENERAL.—Not later than 3 years after
10 the date of enactment of this Act, the Secretary of
11 Health and Human Services, in consultation with
12 the Secretary of the Treasury and the Secretary of
13 Labor, shall submit a report to the appropriate com-
14 mittees of Congress concerning—

15 (A) the effectiveness of wellness programs
16 (as defined in section 9802(h)(2) of the Inter-
17 nal Revenue Code of 1986, as added by sub-
18 section (a)) in promoting health and preventing
19 disease;

20 (B) the impact of such wellness programs
21 on the access to care and affordability of cov-
22 erage for participants and non-participants of
23 such programs;

24 (C) the impact of premium-based and cost-
25 sharing incentives on participant behavior and

1 the role of such programs in changing behavior;
2 and

3 (D) the effectiveness of different types of
4 rewards.

5 (2) DATA COLLECTION.—In preparing the re-
6 port described in paragraph (1), the Secretaries
7 shall gather relevant information from employers
8 who provide employees with access to wellness pro-
9 grams, including State and Federal agencies.

10 **Subtitle K—Elder Justice Act**

11 **SEC. 1911. SHORT TITLE OF SUBTITLE.**

12 This subtitle may be cited as the “Elder Justice Act
13 of 2009”.

14 **SEC. 1912. DEFINITIONS.**

15 Except as otherwise specifically provided, any term
16 that is defined in section 2011 of the Social Security Act
17 (as added by section 1913(a)) and is used in this subtitle
18 has the meaning given such term by such section.

19 **SEC. 1913. ELDER JUSTICE.**

20 (a) ELDER JUSTICE.—

21 (1) IN GENERAL.—Title XX of the Social Secu-
22 rity Act (42 U.S.C. 1397 et seq.) is amended—

23 (A) in the heading, by inserting “**AND**
24 **ELDER JUSTICE**” after “**SOCIAL**
25 **SERVICES**”;

1 (B) by inserting before section 2001 the
2 following:

3 **“Subtitle A—Block Grants to States**
4 **for Social Services”;**

5 and

6 (C) by adding at the end the following:

7 **“Subtitle B—Elder Justice**

8 **“SEC. 2011. DEFINITIONS.**

9 “In this subtitle:

10 “(1) ABUSE.—The term ‘abuse’ means the
11 knowing infliction of physical or psychological harm
12 or the knowing deprivation of goods or services that
13 are necessary to meet essential needs or to avoid
14 physical or psychological harm.

15 “(2) ADULT PROTECTIVE SERVICES.—The term
16 ‘adult protective services’ means such services pro-
17 vided to adults as the Secretary may specify and in-
18 cludes services such as—

19 “(A) receiving reports of adult abuse, ne-
20 glect, or exploitation;

21 “(B) investigating the reports described in
22 subparagraph (A);

23 “(C) case planning, monitoring, evaluation,
24 and other case work and services; and

1 “(D) providing, arranging for, or facili-
2 tating the provision of medical, social service,
3 economic, legal, housing, law enforcement, or
4 other protective, emergency, or support services.

5 “(3) CAREGIVER.—The term ‘caregiver’ means
6 an individual who has the responsibility for the care
7 of an elder, either voluntarily, by contract, by receipt
8 of payment for care, or as a result of the operation
9 of law, and means a family member or other indi-
10 vidual who provides (on behalf of such individual or
11 of a public or private agency, organization, or insti-
12 tution) compensated or uncompensated care to an
13 elder who needs supportive services in any setting.

14 “(4) DIRECT CARE.—The term ‘direct care’
15 means care by an employee or contractor who pro-
16 vides assistance or long-term care services to a re-
17 cipient.

18 “(5) ELDER.—The term ‘elder’ means an indi-
19 vidual age 60 or older.

20 “(6) ELDER JUSTICE.—The term ‘elder justice’
21 means—

22 “(A) from a societal perspective, efforts
23 to—

1 “(i) prevent, detect, treat, intervene
2 in, and prosecute elder abuse, neglect, and
3 exploitation; and

4 “(ii) protect elders with diminished
5 capacity while maximizing their autonomy;
6 and

7 “(B) from an individual perspective, the
8 recognition of an elder’s rights, including the
9 right to be free of abuse, neglect, and exploi-
10 tation.

11 “(7) ELIGIBLE ENTITY.—The term ‘eligible en-
12 tity’ means a State or local government agency, In-
13 dian tribe or tribal organization, or any other public
14 or private entity that is engaged in and has expertise
15 in issues relating to elder justice or in a field nec-
16 essary to promote elder justice efforts.

17 “(8) EXPLOITATION.—The term ‘exploitation’
18 means the fraudulent or otherwise illegal, unauthor-
19 ized, or improper act or process of an individual, in-
20 cluding a caregiver or fiduciary, that uses the re-
21 sources of an elder for monetary or personal benefit,
22 profit, or gain, or that results in depriving an elder
23 of rightful access to, or use of, benefits, resources,
24 belongings, or assets.

25 “(9) FIDUCIARY.—The term ‘fiduciary’—

1 “(C) the manner in which the court exer-
2 cises oversight of the surrogate decisionmaker.

3 “(12) INDIAN TRIBE.—

4 “(A) IN GENERAL.—The term ‘Indian
5 tribe’ has the meaning given such term in sec-
6 tion 4 of the Indian Self-Determination and
7 Education Assistance Act (25 U.S.C. 450b).

8 “(B) INCLUSION OF PUEBLO AND
9 RANCHERIA.—The term ‘Indian tribe’ includes
10 any Pueblo or Rancheria.

11 “(13) LAW ENFORCEMENT.—The term ‘law en-
12 forcement’ means the full range of potential re-
13 sponders to elder abuse, neglect, and exploitation in-
14 cluding—

15 “(A) police, sheriffs, detectives, public safe-
16 ty officers, and corrections personnel;

17 “(B) prosecutors;

18 “(C) medical examiners;

19 “(D) investigators; and

20 “(E) coroners.

21 “(14) LONG-TERM CARE.—

22 “(A) IN GENERAL.—The term ‘long-term
23 care’ means supportive and health services spec-
24 ified by the Secretary for individuals who need
25 assistance because the individuals have a loss of

1 capacity for self-care due to illness, disability,
2 or vulnerability.

3 “(B) LOSS OF CAPACITY FOR SELF-
4 CARE.—For purposes of subparagraph (A), the
5 term ‘loss of capacity for self-care’ means an in-
6 ability to engage in 1 or more activities of daily
7 living, including eating, dressing, bathing, man-
8 agement of one’s financial affairs, and other ac-
9 tivities the Secretary determines appropriate.

10 “(15) LONG-TERM CARE FACILITY.—The term
11 ‘long-term care facility’ means a residential care pro-
12 vider that arranges for, or directly provides, long-
13 term care.

14 “(16) NEGLECT.—The term ‘neglect’ means—

15 “(A) the failure of a caregiver or fiduciary
16 to provide the goods or services that are nec-
17 essary to maintain the health or safety of an
18 elder; or

19 “(B) self-neglect.

20 “(17) NURSING FACILITY.—

21 “(A) IN GENERAL.—The term ‘nursing fa-
22 cility’ has the meaning given such term under
23 section 1919(a).

24 “(B) INCLUSION OF SKILLED NURSING FA-
25 CILITY.—The term ‘nursing facility’ includes a

1 skilled nursing facility (as defined in section
2 1819(a)).

3 “(18) SELF-NEGLECT.—The term ‘self-neglect’
4 means an adult’s inability, due to physical or mental
5 impairment or diminished capacity, to perform es-
6 sential self-care tasks including—

7 “(A) obtaining essential food, clothing,
8 shelter, and medical care;

9 “(B) obtaining goods and services nec-
10 essary to maintain physical health, mental
11 health, or general safety; or

12 “(C) managing one’s own financial affairs.

13 “(19) SERIOUS BODILY INJURY.—

14 “(A) IN GENERAL.—The term ‘serious
15 bodily injury’ means an injury—

16 “(i) involving extreme physical pain;

17 “(ii) involving substantial risk of
18 death;

19 “(iii) involving protracted loss or im-
20 pairment of the function of a bodily mem-
21 ber, organ, or mental faculty; or

22 “(iv) requiring medical intervention
23 such as surgery, hospitalization, or phys-
24 ical rehabilitation.

1 “(B) CRIMINAL SEXUAL ABUSE.—Serious
2 bodily injury shall be considered to have oc-
3 curred if the conduct causing the injury is con-
4 duct described in section 2241 (relating to ag-
5 gravated sexual abuse) or 2242 (relating to sex-
6 ual abuse) of title 18, United States Code, or
7 any similar offense under State law.

8 “(20) SOCIAL.—The term ‘social’, when used
9 with respect to a service, includes adult protective
10 services.

11 “(21) STATE LEGAL ASSISTANCE DEVEL-
12 OPER.—The term ‘State legal assistance developer’
13 means an individual described in section 731 of the
14 Older Americans Act of 1965.

15 “(22) STATE LONG-TERM CARE OMBUDSMAN.—
16 The term ‘State Long-Term Care Ombudsman’
17 means the State Long-Term Care Ombudsman de-
18 scribed in section 712(a)(2) of the Older Americans
19 Act of 1965.

20 **“SEC. 2012. GENERAL PROVISIONS.**

21 “(a) PROTECTION OF PRIVACY.—In pursuing activi-
22 ties under this subtitle, the Secretary shall ensure the pro-
23 tection of individual health privacy consistent with the reg-
24 ulations promulgated under section 264(c) of the Health

1 Insurance Portability and Accountability Act of 1996 and
2 applicable State and local privacy regulations.

3 “(b) RULE OF CONSTRUCTION.—Nothing in this sub-
4 title shall be construed to interfere with or abridge an el-
5 der’s right to practice his or her religion through reliance
6 on prayer alone for healing when this choice—

7 “(1) is contemporaneously expressed, either
8 orally or in writing, with respect to a specific illness
9 or injury which the elder has at the time of the deci-
10 sion by an elder who is competent at the time of the
11 decision;

12 “(2) is previously set forth in a living will,
13 health care proxy, or other advance directive docu-
14 ment that is validly executed and applied under
15 State law; or

16 “(3) may be unambiguously deduced from the
17 elder’s life history.

1 **“PART I—NATIONAL COORDINATION OF ELDER**
2 **JUSTICE ACTIVITIES AND RESEARCH**
3 **“Subpart A—Elder Justice Coordinating Council and**
4 **Advisory Board on Elder Abuse, Neglect, and Ex-**
5 **ploitation**

6 **“SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.**

7 “(a) ESTABLISHMENT.—There is established within
8 the Office of the Secretary an Elder Justice Coordinating
9 Council (in this section referred to as the ‘Council’).

10 “(b) MEMBERSHIP.—

11 “(1) IN GENERAL.—The Council shall be com-
12 posed of the following members:

13 “(A) The Secretary (or the Secretary’s
14 designee).

15 “(B) The Attorney General (or the Attor-
16 ney General’s designee).

17 “(C) The head of each Federal department
18 or agency or other governmental entity identi-
19 fied by the Chair referred to in subsection (d)
20 as having responsibilities, or administering pro-
21 grams, relating to elder abuse, neglect, and ex-
22 ploitation.

23 “(2) REQUIREMENT.—Each member of the
24 Council shall be an officer or employee of the Fed-
25 eral Government.

1 “(c) VACANCIES.—Any vacancy in the Council shall
2 not affect its powers, but shall be filled in the same man-
3 ner as the original appointment was made.

4 “(d) CHAIR.—The member described in subsection
5 (b)(1)(A) shall be Chair of the Council.

6 “(e) MEETINGS.—The Council shall meet at least 2
7 times per year, as determined by the Chair.

8 “(f) DUTIES.—

9 “(1) IN GENERAL.—The Council shall make
10 recommendations to the Secretary for the coordina-
11 tion of activities of the Department of Health and
12 Human Services, the Department of Justice, and
13 other relevant Federal, State, local, and private
14 agencies and entities, relating to elder abuse, ne-
15 glect, and exploitation and other crimes against el-
16 ders.

17 “(2) REPORT.—Not later than the date that is
18 2 years after the date of enactment of the Elder
19 Justice Act of 2009 and every 2 years thereafter,
20 the Council shall submit to the Committee on Fi-
21 nance of the Senate and the Committee on Ways
22 and Means and the Committee on Energy and Com-
23 merce of the House of Representatives a report
24 that—

1 “(A) describes the activities and accom-
2 plishments of, and challenges faced by—

3 “(i) the Council; and

4 “(ii) the entities represented on the
5 Council; and

6 “(B) makes such recommendations for leg-
7 islation, model laws, or other action as the
8 Council determines to be appropriate.

9 “(g) POWERS OF THE COUNCIL.—

10 “(1) INFORMATION FROM FEDERAL AGEN-
11 CIES.—Subject to the requirements of section
12 2012(a), the Council may secure directly from any
13 Federal department or agency such information as
14 the Council considers necessary to carry out this sec-
15 tion. Upon request of the Chair of the Council, the
16 head of such department or agency shall furnish
17 such information to the Council.

18 “(2) POSTAL SERVICES.—The Council may use
19 the United States mails in the same manner and
20 under the same conditions as other departments and
21 agencies of the Federal Government.

22 “(h) TRAVEL EXPENSES.—The members of the
23 Council shall not receive compensation for the perform-
24 ance of services for the Council. The members shall be
25 allowed travel expenses, including per diem in lieu of sub-

1 sistence, at rates authorized for employees of agencies
2 under subchapter I of chapter 57 of title 5, United States
3 Code, while away from their homes or regular places of
4 business in the performance of services for the Council.
5 Notwithstanding section 1342 of title 31, United States
6 Code, the Secretary may accept the voluntary and uncom-
7 pensated services of the members of the Council.

8 “(i) **DETAIL OF GOVERNMENT EMPLOYEES.**—Any
9 Federal Government employee may be detailed to the
10 Council without reimbursement, and such detail shall be
11 without interruption or loss of civil service status or privi-
12 lege.

13 “(j) **STATUS AS PERMANENT COUNCIL.**—Section 14
14 of the Federal Advisory Committee Act (5 U.S.C. App.)
15 shall not apply to the Council.

16 “(k) **AUTHORIZATION OF APPROPRIATIONS.**—There
17 are authorized to be appropriated such sums as are nec-
18 essary to carry out this section.

19 **“SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT,**
20 **AND EXPLOITATION.**

21 “(a) **ESTABLISHMENT.**—There is established a board
22 to be known as the ‘Advisory Board on Elder Abuse, Ne-
23 glect, and Exploitation’ (in this section referred to as the
24 ‘Advisory Board’) to create short- and long-term multi-
25 disciplinary strategic plans for the development of the field

1 of elder justice and to make recommendations to the Elder
2 Justice Coordinating Council established under section
3 2021.

4 “(b) COMPOSITION.—The Advisory Board shall be
5 composed of 27 members appointed by the Secretary from
6 among members of the general public who are individuals
7 with experience and expertise in elder abuse, neglect, and
8 exploitation prevention, detection, treatment, intervention,
9 or prosecution.

10 “(c) SOLICITATION OF NOMINATIONS.—The Sec-
11 retary shall publish a notice in the Federal Register solie-
12 iting nominations for the appointment of members of the
13 Advisory Board under subsection (b).

14 “(d) TERMS.—

15 “(1) IN GENERAL.—Each member of the Advi-
16 sory Board shall be appointed for a term of 3 years,
17 except that, of the members first appointed—

18 “(A) 9 shall be appointed for a term of 3
19 years;

20 “(B) 9 shall be appointed for a term of 2
21 years; and

22 “(C) 9 shall be appointed for a term of 1
23 year.

24 “(2) VACANCIES.—

1 “(A) IN GENERAL.—Any vacancy on the
2 Advisory Board shall not affect its powers, but
3 shall be filled in the same manner as the origi-
4 nal appointment was made.

5 “(B) FILLING UNEXPIRED TERM.—An in-
6 dividual chosen to fill a vacancy shall be ap-
7 pointed for the unexpired term of the member
8 replaced.

9 “(3) EXPIRATION OF TERMS.—The term of any
10 member shall not expire before the date on which
11 the member’s successor takes office.

12 “(e) ELECTION OF OFFICERS.—The Advisory Board
13 shall elect a Chair and Vice Chair from among its mem-
14 bers. The Advisory Board shall elect its initial Chair and
15 Vice Chair at its initial meeting.

16 “(f) DUTIES.—

17 “(1) ENHANCE COMMUNICATION ON PRO-
18 MOTING QUALITY OF, AND PREVENTING ABUSE, NE-
19 GLECT, AND EXPLOITATION IN, LONG-TERM CARE.—
20 The Advisory Board shall develop collaborative and
21 innovative approaches to improve the quality of, in-
22 cluding preventing abuse, neglect, and exploitation
23 in, long-term care.

1 “(2) COLLABORATIVE EFFORTS TO DEVELOP
2 CONSENSUS AROUND THE MANAGEMENT OF CER-
3 TAIN QUALITY-RELATED FACTORS.—

4 “(A) IN GENERAL.—The Advisory Board
5 shall establish multidisciplinary panels to ad-
6 dress, and develop consensus on, subjects relat-
7 ing to improving the quality of long-term care.
8 At least 1 such panel shall address, and develop
9 consensus on, methods for managing resident-
10 to-resident abuse in long-term care.

11 “(B) ACTIVITIES CONDUCTED.—The multi-
12 disciplinary panels established under subpara-
13 graph (A) shall examine relevant research and
14 data, identify best practices with respect to the
15 subject of the panel, determine the best way to
16 carry out those best practices in a practical and
17 feasible manner, and determine an effective
18 manner of distributing information on such
19 subject.

20 “(3) REPORT.—Not later than the date that is
21 18 months after the date of enactment of the Elder
22 Justice Act of 2009, and annually thereafter, the
23 Advisory Board shall prepare and submit to the
24 Elder Justice Coordinating Council, the Committee
25 on Finance of the Senate, and the Committee on

1 Ways and Means and the Committee on Energy and
2 Commerce of the House of Representatives a report
3 containing—

4 “(A) information on the status of Federal,
5 State, and local public and private elder justice
6 activities;

7 “(B) recommendations (including rec-
8 ommended priorities) regarding—

9 “(i) elder justice programs, research,
10 training, services, practice, enforcement,
11 and coordination;

12 “(ii) coordination between entities
13 pursuing elder justice efforts and those in-
14 volved in related areas that may inform or
15 overlap with elder justice efforts, such as
16 activities to combat violence against women
17 and child abuse and neglect; and

18 “(iii) activities relating to adult fidu-
19 ciary systems, including guardianship and
20 other fiduciary arrangements;

21 “(C) recommendations for specific modi-
22 fications needed in Federal and State laws (in-
23 cluding regulations) or for programs, research,
24 and training to enhance prevention, detection,
25 and treatment (including diagnosis) of, inter-

1 vention in (including investigation of), and
2 prosecution of elder abuse, neglect, and exploi-
3 tation;

4 “(D) recommendations on methods for the
5 most effective coordinated national data collec-
6 tion with respect to elder justice, and elder
7 abuse, neglect, and exploitation; and

8 “(E) recommendations for a multidisci-
9 plinary strategic plan to guide the effective and
10 efficient development of the field of elder jus-
11 tice.

12 “(g) POWERS OF THE ADVISORY BOARD.—

13 “(1) INFORMATION FROM FEDERAL AGEN-
14 CIES.—Subject to the requirements of section
15 2012(a), the Advisory Board may secure directly
16 from any Federal department or agency such infor-
17 mation as the Advisory Board considers necessary to
18 carry out this section. Upon request of the Chair of
19 the Advisory Board, the head of such department or
20 agency shall furnish such information to the Advi-
21 sory Board.

22 “(2) SHARING OF DATA AND REPORTS.—The
23 Advisory Board may request from any entity pur-
24 suing elder justice activities under the Elder Justice
25 Act of 2009 or an amendment made by that Act,

1 any data, reports, or recommendations generated in
2 connection with such activities.

3 “(3) POSTAL SERVICES.—The Advisory Board
4 may use the United States mails in the same man-
5 ner and under the same conditions as other depart-
6 ments and agencies of the Federal Government.

7 “(h) TRAVEL EXPENSES.—The members of the Advi-
8 sory Board shall not receive compensation for the perform-
9 ance of services for the Advisory Board. The members
10 shall be allowed travel expenses for up to 4 meetings per
11 year, including per diem in lieu of subsistence, at rates
12 authorized for employees of agencies under subchapter I
13 of chapter 57 of title 5, United States Code, while away
14 from their homes or regular places of business in the per-
15 formance of services for the Advisory Board. Notwith-
16 standing section 1342 of title 31, United States Code, the
17 Secretary may accept the voluntary and uncompensated
18 services of the members of the Advisory Board.

19 “(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any
20 Federal Government employee may be detailed to the Ad-
21 visory Board without reimbursement, and such detail shall
22 be without interruption or loss of civil service status or
23 privilege.

1 “(j) STATUS AS PERMANENT ADVISORY COM-
2 MITTEE.—Section 14 of the Federal Advisory Committee
3 Act (5 U.S.C. App.) shall not apply to the advisory board.

4 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as are nec-
6 essary to carry out this section.

7 **“SEC. 2023. RESEARCH PROTECTIONS.**

8 “(a) GUIDELINES.—The Secretary shall promulgate
9 guidelines to assist researchers working in the area of
10 elder abuse, neglect, and exploitation, with issues relating
11 to human subject protections.

12 “(b) DEFINITION OF LEGALLY AUTHORIZED REP-
13 RESENTATIVE FOR APPLICATION OF REGULATIONS.—For
14 purposes of the application of subpart A of part 46 of title
15 45, Code of Federal Regulations, to research conducted
16 under this subpart, the term ‘legally authorized represent-
17 ative’ means, unless otherwise provided by law, the indi-
18 vidual or judicial or other body authorized under the appli-
19 cable law to consent to medical treatment on behalf of an-
20 other person.

21 **“SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.**

22 ““There are authorized to be appropriated to carry out
23 this subpart—

24 “(1) for fiscal year 2011, \$6,500,000; and

1 “(2) for each of fiscal years 2012 through
2 2014, \$7,000,000.

3 **“Subpart B—Elder Abuse, Neglect, and Exploitation**
4 **Forensic Centers**

5 **“SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER**
6 **ABUSE, NEGLECT, AND EXPLOITATION FO-**
7 **RENSIC CENTERS.**

8 “(a) IN GENERAL.—The Secretary, in consultation
9 with the Attorney General, shall make grants to eligible
10 entities to establish and operate stationary and mobile fo-
11 rensic centers, to develop forensic expertise regarding, and
12 provide services relating to, elder abuse, neglect, and ex-
13 ploitation.

14 “(b) STATIONARY FORENSIC CENTERS.—The Sec-
15 retary shall make 4 of the grants described in subsection
16 (a) to institutions of higher education with demonstrated
17 expertise in forensics or commitment to preventing or
18 treating elder abuse, neglect, or exploitation, to establish
19 and operate stationary forensic centers.

20 “(c) MOBILE CENTERS.—The Secretary shall make
21 6 of the grants described in subsection (a) to appropriate
22 entities to establish and operate mobile forensic centers.

23 “(d) AUTHORIZED ACTIVITIES.—

24 “(1) DEVELOPMENT OF FORENSIC MARKERS
25 AND METHODOLOGIES.—An eligible entity that re-

1 ceives a grant under this section shall use funds
2 made available through the grant to assist in deter-
3 mining whether abuse, neglect, or exploitation oc-
4 curred and whether a crime was committed and to
5 conduct research to describe and disseminate infor-
6 mation on—

7 “(A) forensic markers that indicate a case
8 in which elder abuse, neglect, or exploitation
9 may have occurred; and

10 “(B) methodologies for determining, in
11 such a case, when and how health care, emer-
12 gency service, social and protective services, and
13 legal service providers should intervene and
14 when the providers should report the case to
15 law enforcement authorities.

16 “(2) DEVELOPMENT OF FORENSIC EXPER-
17 TISE.—An eligible entity that receives a grant under
18 this section shall use funds made available through
19 the grant to develop forensic expertise regarding
20 elder abuse, neglect, and exploitation in order to
21 provide medical and forensic evaluation, therapeutic
22 intervention, victim support and advocacy, case re-
23 view, and case tracking.

24 “(3) COLLECTION OF EVIDENCE.—The Sec-
25 retary, in coordination with the Attorney General,

1 shall use data made available by grant recipients
2 under this section to develop the capacity of geriatric
3 health care professionals and law enforcement to col-
4 lect forensic evidence, including collecting forensic
5 evidence relating to a potential determination of
6 elder abuse, neglect, or exploitation.

7 “(e) APPLICATION.—To be eligible to receive a grant
8 under this section, an entity shall submit an application
9 to the Secretary at such time, in such manner, and con-
10 taining such information as the Secretary may require.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this sec-
13 tion—

14 “(1) for fiscal year 2011, \$4,000,000;

15 “(2) for fiscal year 2012, \$6,000,000; and

16 “(3) for each of fiscal years 2013 and 2014,
17 \$8,000,000.

18 **“PART II—PROGRAMS TO PROMOTE ELDER**

19 **JUSTICE**

20 **“SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.**

21 “(a) GRANTS AND INCENTIVES FOR LONG-TERM
22 CARE STAFFING.—

23 “(1) IN GENERAL.—The Secretary shall carry
24 out activities, including activities described in para-
25 graphs (2) and (3), to provide incentives for individ-

1 uals to train for, seek, and maintain employment
2 providing direct care in long-term care.

3 “(2) SPECIFIC PROGRAMS TO ENHANCE TRAIN-
4 ING, RECRUITMENT, AND RETENTION OF STAFF.—

5 “(A) COORDINATION WITH SECRETARY OF
6 LABOR TO RECRUIT AND TRAIN LONG-TERM
7 CARE STAFF.—The Secretary shall coordinate
8 activities under this subsection with the Sec-
9 retary of Labor in order to provide incentives
10 for individuals to train for and seek employ-
11 ment providing direct care in long-term care.

12 “(B) CAREER LADDERS AND WAGE OR
13 BENEFIT INCREASES TO INCREASE STAFFING IN
14 LONG-TERM CARE.—

15 “(i) IN GENERAL.—The Secretary
16 shall make grants to eligible entities to
17 carry out programs through which the en-
18 tities—

19 “(I) offer, to employees who pro-
20 vide direct care to residents of an eli-
21 gible entity or individuals receiving
22 community-based long-term care from
23 an eligible entity, continuing training
24 and varying levels of certification,
25 based on observed clinical care prac-

1 tices and the amount of time the em-
2 ployees spend providing direct care;
3 and

4 “(II) provide, or make arrange-
5 ments to provide, bonuses or other in-
6 creased compensation or benefits to
7 employees who achieve certification
8 under such a program.

9 “(ii) APPLICATION.—To be eligible to
10 receive a grant under this subparagraph,
11 an eligible entity shall submit an applica-
12 tion to the Secretary at such time, in such
13 manner, and containing such information
14 as the Secretary may require (which may
15 include evidence of consultation with the
16 State in which the eligible entity is located
17 with respect to carrying out activities fund-
18 ed under the grant).

19 “(iii) AUTHORITY TO LIMIT NUMBER
20 OF APPLICANTS.—Nothing in this subpara-
21 graph shall be construed as prohibiting the
22 Secretary from limiting the number of ap-
23 plicants for a grant under this subpara-
24 graph.

1 “(3) SPECIFIC PROGRAMS TO IMPROVE MAN-
2 AGEMENT PRACTICES.—

3 “(A) IN GENERAL.—The Secretary shall
4 make grants to eligible entities to enable the en-
5 tities to provide training and technical assist-
6 ance.

7 “(B) AUTHORIZED ACTIVITIES.—An eligi-
8 ble entity that receives a grant under subpara-
9 graph (A) shall use funds made available
10 through the grant to provide training and tech-
11 nical assistance regarding management prac-
12 tices using methods that are demonstrated to
13 promote retention of individuals who provide di-
14 rect care, such as—

15 “(i) the establishment of standard
16 human resource policies that reward high
17 performance, including policies that pro-
18 vide for improved wages and benefits on
19 the basis of job reviews;

20 “(ii) the establishment of motivational
21 and thoughtful work organization prac-
22 tices;

23 “(iii) the creation of a workplace cul-
24 ture that respects and values caregivers
25 and their needs;

1 “(iv) the promotion of a workplace
2 culture that respects the rights of residents
3 of an eligible entity or individuals receiving
4 community-based long-term care from an
5 eligible entity and results in improved care
6 for the residents or the individuals; and

7 “(v) the establishment of other pro-
8 grams that promote the provision of high
9 quality care, such as a continuing edu-
10 cation program that provides additional
11 hours of training, including on-the-job
12 training, for employees who are certified
13 nurse aides.

14 “(C) APPLICATION.—To be eligible to re-
15 ceive a grant under this paragraph, an eligible
16 entity shall submit an application to the Sec-
17 retary at such time, in such manner, and con-
18 taining such information as the Secretary may
19 require (which may include evidence of con-
20 sultation with the State in which the eligible en-
21 tity is located with respect to carrying out ac-
22 tivities funded under the grant).

23 “(D) AUTHORITY TO LIMIT NUMBER OF
24 APPLICANTS.—Nothing in this paragraph shall
25 be construed as prohibiting the Secretary from

1 limiting the number of applicants for a grant
2 under this paragraph.

3 “(4) ACCOUNTABILITY MEASURES.—The Sec-
4 retary shall develop accountability measures to en-
5 sure that the activities conducted using funds made
6 available under this subsection benefit individuals
7 who provide direct care and increase the stability of
8 the long-term care workforce.

9 “(5) DEFINITIONS.—In this subsection:

10 “(A) COMMUNITY-BASED LONG-TERM
11 CARE.—The term ‘community-based long-term
12 care’ has the meaning given such term by the
13 Secretary.

14 “(B) ELIGIBLE ENTITY.—The term ‘eligi-
15 ble entity’ means the following:

16 “(i) A long-term care facility.

17 “(ii) A community-based long-term
18 care entity (as defined by the Secretary).

19 “(b) CERTIFIED EHR TECHNOLOGY GRANT PRO-
20 GRAM.—

21 “(1) GRANTS AUTHORIZED.—The Secretary is
22 authorized to make grants to long-term care facili-
23 ties for the purpose of assisting such entities in off-
24 setting the costs related to purchasing, leasing, de-
25 veloping, and implementing certified EHR tech-

1 nology (as defined in section 1848(o)(4)) designed to
2 improve patient safety and reduce adverse events
3 and health care complications resulting from medica-
4 tion errors.

5 “(2) USE OF GRANT FUNDS.—Funds provided
6 under grants under this subsection may be used for
7 any of the following:

8 “(A) Purchasing, leasing, and installing
9 computer software and hardware, including
10 handheld computer technologies.

11 “(B) Making improvements to existing
12 computer software and hardware.

13 “(C) Making upgrades and other improve-
14 ments to existing computer software and hard-
15 ware to enable e-prescribing.

16 “(D) Providing education and training to
17 eligible long-term care facility staff on the use
18 of such technology to implement the electronic
19 transmission of prescription and patient infor-
20 mation.

21 “(3) APPLICATION.—

22 “(A) IN GENERAL.—To be eligible to re-
23 ceive a grant under this subsection, a long-term
24 care facility shall submit an application to the
25 Secretary at such time, in such manner, and

1 containing such information as the Secretary
2 may require (which may include evidence of
3 consultation with the State in which the long-
4 term care facility is located with respect to car-
5 rying out activities funded under the grant).

6 “(B) AUTHORITY TO LIMIT NUMBER OF
7 APPLICANTS.—Nothing in this subsection shall
8 be construed as prohibiting the Secretary from
9 limiting the number of applicants for a grant
10 under this subsection.

11 “(4) PARTICIPATION IN STATE HEALTH EX-
12 CHANGES.—A long-term care facility that receives a
13 grant under this subsection shall, where available,
14 participate in activities conducted by a State or a
15 qualified State-designated entity (as defined in sec-
16 tion 3013(f) of the Public Health Service Act) under
17 a grant under section 3013 of the Public Health
18 Service Act to coordinate care and for other pur-
19 poses determined appropriate by the Secretary.

20 “(5) ACCOUNTABILITY MEASURES.—The Sec-
21 retary shall develop accountability measures to en-
22 sure that the activities conducted using funds made
23 available under this subsection help improve patient
24 safety and reduce adverse events and health care
25 complications resulting from medication errors.

1 “(c) ADOPTION OF STANDARDS FOR TRANSACTIONS
2 INVOLVING CLINICAL DATA BY LONG-TERM CARE FA-
3 CILITIES.—

4 “(1) STANDARDS AND COMPATIBILITY.—The
5 Secretary shall adopt electronic standards for the ex-
6 change of clinical data by long-term care facilities,
7 including, where available, standards for messaging
8 and nomenclature. Standards adopted by the Sec-
9 retary under the preceding sentence shall be compat-
10 ible with standards established under part C of title
11 XI, standards established under subsections
12 (b)(2)(B)(i) and (e)(4) of section 1860D–4, stand-
13 ards adopted under section 3004 of the Public
14 Health Service Act, and general health information
15 technology standards.

16 “(2) ELECTRONIC SUBMISSION OF DATA TO
17 THE SECRETARY.—

18 “(A) IN GENERAL.—Not later than 10
19 years after the date of enactment of the Elder
20 Justice Act of 2009, the Secretary shall have
21 procedures in place to accept the optional elec-
22 tronic submission of clinical data by long-term
23 care facilities pursuant to the standards adopt-
24 ed under paragraph (1).

1 “(B) RULE OF CONSTRUCTION.—Nothing
2 in this subsection shall be construed to require
3 a long-term care facility to submit clinical data
4 electronically to the Secretary.

5 “(3) REGULATIONS.—The Secretary shall pro-
6 mulgate regulations to carry out this subsection.
7 Such regulations shall require a State, as a condi-
8 tion of the receipt of funds under this part, to con-
9 duct such data collection and reporting as the Sec-
10 retary determines are necessary to satisfy the re-
11 quirements of this subsection.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this sec-
14 tion—

15 “(1) for fiscal year 2011, \$20,000,000;
16 “(2) for fiscal year 2012, \$17,500,000; and
17 “(3) for each of fiscal years 2013 and 2014,
18 \$15,000,000.

19 **“SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND**
20 **GRANT PROGRAMS.**

21 “(a) SECRETARIAL RESPONSIBILITIES.—

22 “(1) IN GENERAL.—The Secretary shall ensure
23 that the Department of Health and Human Serv-
24 ices—

1 “(A) provides funding authorized by this
2 part to State and local adult protective services
3 offices that investigate reports of the abuse, ne-
4 glect, and exploitation of elders;

5 “(B) collects and disseminates data annu-
6 ally relating to the abuse, exploitation, and ne-
7 glect of elders in coordination with the Depart-
8 ment of Justice;

9 “(C) develops and disseminates informa-
10 tion on best practices regarding, and provides
11 training on, carrying out adult protective serv-
12 ices;

13 “(D) conducts research related to the pro-
14 vision of adult protective services; and

15 “(E) provides technical assistance to
16 States and other entities that provide or fund
17 the provision of adult protective services, in-
18 cluding through grants made under subsections
19 (b) and (c).

20 “(2) AUTHORIZATION OF APPROPRIATIONS.—

21 There are authorized to be appropriated to carry out
22 this subsection, \$3,000,000 for fiscal year 2011 and
23 \$4,000,000 for each of fiscal years 2012 through
24 2014.

1 “(b) GRANTS TO ENHANCE THE PROVISION OF
2 ADULT PROTECTIVE SERVICES.—

3 “(1) ESTABLISHMENT.—There is established an
4 adult protective services grant program under which
5 the Secretary shall annually award grants to States
6 in the amounts calculated under paragraph (2) for
7 the purposes of enhancing adult protective services
8 provided by States and local units of government.

9 “(2) AMOUNT OF PAYMENT.—

10 “(A) IN GENERAL.—Subject to the avail-
11 ability of appropriations and subparagraphs (B)
12 and (C), the amount paid to a State for a fiscal
13 year under the program under this subsection
14 shall equal the amount appropriated for that
15 year to carry out this subsection multiplied by
16 the percentage of the total number of elders
17 who reside in the United States who reside in
18 that State.

19 “(B) GUARANTEED MINIMUM PAYMENT
20 AMOUNT.—

21 “(i) 50 STATES.—Subject to clause
22 (ii), if the amount determined under sub-
23 paragraph (A) for a State for a fiscal year
24 is less than 0.75 percent of the amount ap-
25 propriated for such year, the Secretary

1 shall increase such determined amount so
2 that the total amount paid under this sub-
3 section to the State for the year is equal
4 to 0.75 percent of the amount so appro-
5 priated.

6 “(ii) TERRITORIES.—In the case of a
7 State other than 1 of the 50 States, clause
8 (i) shall be applied as if each reference to
9 ‘0.75’ were a reference to ‘0.1’.

10 “(C) PRO RATA REDUCTIONS.—The Sec-
11 retary shall make such pro rata reductions to
12 the amounts described in subparagraph (A) as
13 are necessary to comply with the requirements
14 of subparagraph (B).

15 “(3) AUTHORIZED ACTIVITIES.—

16 “(A) ADULT PROTECTIVE SERVICES.—
17 Funds made available pursuant to this sub-
18 section may only be used by States and local
19 units of government to provide adult protective
20 services and may not be used for any other pur-
21 pose.

22 “(B) USE BY AGENCY.—Each State receiv-
23 ing funds pursuant to this subsection shall pro-
24 vide such funds to the agency or unit of State

1 government having legal responsibility for pro-
2 viding adult protective services within the State.

3 “(C) SUPPLEMENT NOT SUPPLANT.—Each
4 State or local unit of government shall use
5 funds made available pursuant to this sub-
6 section to supplement and not supplant other
7 Federal, State, and local public funds expended
8 to provide adult protective services in the State.

9 “(4) STATE REPORTS.—Each State receiving
10 funds under this subsection shall submit to the Sec-
11 retary, at such time and in such manner as the Sec-
12 retary may require, a report on the number of elders
13 served by the grants awarded under this subsection.

14 “(5) AUTHORIZATION OF APPROPRIATIONS.—
15 There are authorized to be appropriated to carry out
16 this subsection, \$100,000,000 for each of fiscal
17 years 2011 through 2014.

18 “(c) STATE DEMONSTRATION PROGRAMS.—

19 “(1) ESTABLISHMENT.—The Secretary shall
20 award grants to States for the purposes of con-
21 ducting demonstration programs in accordance with
22 paragraph (2).

23 “(2) DEMONSTRATION PROGRAMS.—Funds
24 made available pursuant to this subsection may be

1 used by States and local units of government to con-
2 duct demonstration programs that test—

3 “(A) training modules developed for the
4 purpose of detecting or preventing elder abuse;

5 “(B) methods to detect or prevent financial
6 exploitation of elders;

7 “(C) methods to detect elder abuse;

8 “(D) whether training on elder abuse
9 forensics enhances the detection of elder abuse
10 by employees of the State or local unit of gov-
11 ernment; or

12 “(E) other matters relating to the detec-
13 tion or prevention of elder abuse.

14 “(3) APPLICATION.—To be eligible to receive a
15 grant under this subsection, a State shall submit an
16 application to the Secretary at such time, in such
17 manner, and containing such information as the Sec-
18 retary may require.

19 “(4) STATE REPORTS.—Each State that re-
20 ceives funds under this subsection shall submit to
21 the Secretary a report at such time, in such manner,
22 and containing such information as the Secretary
23 may require on the results of the demonstration pro-
24 gram conducted by the State using funds made
25 available under this subsection.

1 “(5) AUTHORIZATION OF APPROPRIATIONS.—
2 There are authorized to be appropriated to carry out
3 this subsection, \$25,000,000 for each of fiscal years
4 2011 through 2014.

5 **“SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM**
6 **GRANTS AND TRAINING.**

7 “(a) GRANTS TO SUPPORT THE LONG-TERM CARE
8 OMBUDSMAN PROGRAM.—

9 “(1) IN GENERAL.—The Secretary shall make
10 grants to eligible entities with relevant expertise and
11 experience in abuse and neglect in long-term care fa-
12 cilities or long-term care ombudsman programs and
13 responsibilities, for the purpose of—

14 “(A) improving the capacity of State long-
15 term care ombudsman programs to respond to
16 and resolve complaints about abuse and neglect;

17 “(B) conducting pilot programs with State
18 long-term care ombudsman offices or local om-
19 budsman entities; and

20 “(C) providing support for such State
21 long-term care ombudsman programs and such
22 pilot programs (such as through the establish-
23 ment of a national long-term care ombudsman
24 resource center).

1 “(2) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated to carry out
3 this subsection—

4 “(A) for fiscal year 2011, \$5,000,000;

5 “(B) for fiscal year 2012, \$7,500,000; and

6 “(C) for each of fiscal years 2013 and
7 2014, \$10,000,000.

8 “(b) OMBUDSMAN TRAINING PROGRAMS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish programs to provide and improve ombudsman
11 training with respect to elder abuse, neglect, and ex-
12 ploitation for national organizations and State long-
13 term care ombudsman programs.

14 “(2) AUTHORIZATION OF APPROPRIATIONS.—

15 There are authorized to be appropriated to carry out
16 this subsection, for each of fiscal years 2011
17 through 2014, \$10,000,000.

18 **“SEC. 2044. PROVISION OF INFORMATION REGARDING, AND**
19 **EVALUATIONS OF, ELDER JUSTICE PRO-**
20 **GRAMS.**

21 “(a) PROVISION OF INFORMATION.—To be eligible to
22 receive a grant under this part, an applicant shall agree—

23 “(1) except as provided in paragraph (2), to
24 provide the eligible entity conducting an evaluation
25 under subsection (b) of the activities funded through

1 the grant with such information as the eligible entity
2 may require in order to conduct such evaluation; or

3 “(2) in the case of an applicant for a grant
4 under section 2041(b), to provide the Secretary with
5 such information as the Secretary may require to
6 conduct an evaluation or audit under subsection (c).

7 “(b) USE OF ELIGIBLE ENTITIES TO CONDUCT
8 EVALUATIONS.—

9 “(1) EVALUATIONS REQUIRED.—Except as pro-
10 vided in paragraph (2), the Secretary shall—

11 “(A) reserve a portion (not less than 2 per-
12 cent) of the funds appropriated with respect to
13 each program carried out under this part; and

14 “(B) use the funds reserved under sub-
15 paragraph (A) to provide assistance to eligible
16 entities to conduct evaluations of the activities
17 funded under each program carried out under
18 this part.

19 “(2) CERTIFIED EHR TECHNOLOGY GRANT PRO-
20 GRAM NOT INCLUDED.—The provisions of this sub-
21 section shall not apply to the certified EHR tech-
22 nology grant program under section 2041(b).

23 “(3) AUTHORIZED ACTIVITIES.—A recipient of
24 assistance described in paragraph (1)(B) shall use
25 the funds made available through the assistance to

1 conduct a validated evaluation of the effectiveness of
2 the activities funded under a program carried out
3 under this part.

4 “(4) APPLICATIONS.—To be eligible to receive
5 assistance under paragraph (1)(B), an entity shall
6 submit an application to the Secretary at such time,
7 in such manner, and containing such information as
8 the Secretary may require, including a proposal for
9 the evaluation.

10 “(5) REPORTS.—Not later than a date specified
11 by the Secretary, an eligible entity receiving assist-
12 ance under paragraph (1)(B) shall submit to the
13 Secretary, the Committee on Ways and Means and
14 the Committee on Energy and Commerce of the
15 House of Representatives, and the Committee on Fi-
16 nance of the Senate a report containing the results
17 of the evaluation conducted using such assistance to-
18 gether with such recommendations as the entity de-
19 termines to be appropriate.

20 “(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR
21 TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

22 “(1) EVALUATIONS.—The Secretary shall con-
23 duct an evaluation of the activities funded under the
24 certified EHR technology grant program under sec-
25 tion 2041(b). Such evaluation shall include an eval-

1 uation of whether the funding provided under the
2 grant is expended only for the purposes for which it
3 is made.

4 “(2) AUDITS.—The Secretary shall conduct ap-
5 propriate audits of grants made under section
6 2041(b).

7 **“SEC. 2045. REPORT.**

8 “Not later than October 1, 2014, the Secretary shall
9 submit to the Elder Justice Coordinating Council estab-
10 lished under section 2021, the Committee on Ways and
11 Means and the Committee on Energy and Commerce of
12 the House of Representatives, and the Committee on Fi-
13 nance of the Senate a report—

14 “(1) compiling, summarizing, and analyzing the
15 information contained in the State reports submitted
16 under subsections (b)(4) and (c)(4) of section 2042;
17 and

18 “(2) containing such recommendations for legis-
19 lative or administrative action as the Secretary de-
20 termines to be appropriate.”.

21 (2) OPTION FOR STATE PLAN UNDER PROGRAM
22 FOR TEMPORARY ASSISTANCE FOR NEEDY FAMI-
23 LIES.—

24 (A) IN GENERAL.—Section 402(a)(1)(B) of
25 the Social Security Act (42 U.S.C.

1 602(a)(1)(B)) is amended by adding at the end
2 the following new clause:

3 “(v) The document shall indicate
4 whether the State intends to assist individ-
5 uals to train for, seek, and maintain em-
6 ployment—

7 “(I) providing direct care in a
8 long-term care facility (as such terms
9 are defined under section 2011); or

10 “(II) in other occupations related
11 to elder care determined appropriate
12 by the State for which the State iden-
13 tifies an unmet need for service per-
14 sonnel,

15 and, if so, shall include an overview of such
16 assistance.”.

17 (B) EFFECTIVE DATE.—The amendment
18 made by subparagraph (A) shall take effect on
19 January 1, 2011.

20 (b) PROTECTING RESIDENTS OF LONG-TERM CARE
21 FACILITIES.—

22 (1) NATIONAL TRAINING INSTITUTE FOR SUR-
23 VEYORS.—

24 (A) IN GENERAL.—The Secretary of
25 Health and Human Services shall enter into a

1 contract with an entity for the purpose of estab-
2 lishing and operating a National Training Insti-
3 tute for Federal and State surveyors. Such In-
4 stitute shall provide and improve the training of
5 surveyors with respect to investigating allega-
6 tions of abuse, neglect, and misappropriation of
7 property in programs and long-term care facili-
8 ties that receive payments under title XVIII or
9 XIX of the Social Security Act.

10 (B) ACTIVITIES CARRIED OUT BY THE IN-
11 STITUTE.—The contract entered into under
12 subparagraph (A) shall require the Institute es-
13 tablished and operated under such contract to
14 carry out the following activities:

15 (i) Assess the extent to which State
16 agencies use specialized surveyors for the
17 investigation of reported allegations of
18 abuse, neglect, and misappropriation of
19 property in such programs and long-term
20 care facilities.

21 (ii) Evaluate how the competencies of
22 surveyors may be improved to more effec-
23 tively investigate reported allegations of
24 such abuse, neglect, and misappropriation
25 of property, and provide feedback to Fed-

1 eral and State agencies on the evaluations
2 conducted.

3 (iii) Provide a national program of
4 training, tools, and technical assistance to
5 Federal and State surveyors on inves-
6 tigating reports of such abuse, neglect, and
7 misappropriation of property.

8 (iv) Develop and disseminate informa-
9 tion on best practices for the investigation
10 of such abuse, neglect, and misappropria-
11 tion of property.

12 (v) Assess the performance of State
13 complaint intake systems, in order to en-
14 sure that the intake of complaints occurs
15 24 hours per day, 7 days a week (including
16 holidays).

17 (vi) To the extent approved by the
18 Secretary of Health and Human Services,
19 provide a national 24 hours per day, 7
20 days a week (including holidays), back-up
21 system to State complaint intake systems
22 in order to ensure optimum national re-
23 sponsiveness to complaints of such abuse,
24 neglect, and misappropriation of property.

1 (vii) Analyze and report annually on
2 the following:

3 (I) The total number and sources
4 of complaints of such abuse, neglect,
5 and misappropriation of property.

6 (II) The extent to which such
7 complaints are referred to law en-
8 forcement agencies.

9 (III) General results of Federal
10 and State investigations of such com-
11 plaints.

12 (viii) Conduct a national study of the
13 cost to State agencies of conducting com-
14 plaint investigations of skilled nursing fa-
15 cilities and nursing facilities under sections
16 1819 and 1919, respectively, of the Social
17 Security Act (42 U.S.C. 1395i-3; 1396r),
18 and making recommendations to the Sec-
19 retary of Health and Human Services with
20 respect to options to increase the efficiency
21 and cost-effectiveness of such investiga-
22 tions.

23 (C) AUTHORIZATION.—There are author-
24 ized to be appropriated to carry out this para-

1 graph, for the period of fiscal years 2011
2 through 2014, \$12,000,000.

3 (2) GRANTS TO STATE SURVEY AGENCIES.—

4 (A) IN GENERAL.—The Secretary of
5 Health and Human Services shall make grants
6 to State agencies that perform surveys of
7 skilled nursing facilities or nursing facilities
8 under sections 1819 or 1919, respectively, of
9 the Social Security Act (42 U.S.C. 1395i–3;
10 1395r).

11 (B) USE OF FUNDS.—A grant awarded
12 under subparagraph (A) shall be used for the
13 purpose of designing and implementing com-
14 plaint investigations systems that—

15 (i) promptly prioritize complaints in
16 order to ensure a rapid response to the
17 most serious and urgent complaints;

18 (ii) respond to complaints with opti-
19 mum effectiveness and timeliness; and

20 (iii) optimize the collaboration be-
21 tween local authorities, consumers, and
22 providers, including—

23 (I) such State agency;

24 (II) the State Long-Term Care
25 Ombudsman;

- 1 (III) local law enforcement agen-
2 cies;
3 (IV) advocacy and consumer or-
4 ganizations;
5 (V) State aging units;
6 (VI) Area Agencies on Aging;
7 and
8 (VII) other appropriate entities.

9 (C) AUTHORIZATION.—There are author-
10 ized to be appropriated to carry out this para-
11 graph, for each of fiscal years 2011 through
12 2014, \$5,000,000.

13 (3) REPORTING OF CRIMES IN FEDERALLY
14 FUNDED LONG-TERM CARE FACILITIES.—Part A of
15 title XI of the Social Security Act (42 U.S.C. 1301
16 et seq.), as amended by sections 1611(c), is amend-
17 ed by inserting after section 1150A the following
18 new section:

19 “REPORTING TO LAW ENFORCEMENT OF CRIMES OCCUR-
20 RING IN FEDERALLY FUNDED LONG-TERM CARE FA-
21 CILITIES

22 “SEC. 1150B. (a) DETERMINATION AND NOTIFICA-
23 TION.—

24 “(1) DETERMINATION.—The owner or operator
25 of each long-term care facility that receives Federal
26 funds under this Act shall annually determine

1 whether the facility received at least \$10,000 in such
2 Federal funds during the preceding year.

3 “(2) NOTIFICATION.—If the owner or operator
4 determines under paragraph (1) that the facility re-
5 ceived at least \$10,000 in such Federal funds during
6 the preceding year, such owner or operator shall an-
7 nually notify each covered individual (as defined in
8 paragraph (3)) of that individual’s obligation to
9 comply with the reporting requirements described in
10 subsection (b).

11 “(3) COVERED INDIVIDUAL DEFINED.—In this
12 section, the term ‘covered individual’ means each in-
13 dividual who is an owner, operator, employee, man-
14 ager, agent, or contractor of a long-term care facility
15 that is the subject of a determination described in
16 paragraph (1).

17 “(b) REPORTING REQUIREMENTS.—

18 “(1) IN GENERAL.—Each covered individual
19 shall report to the Secretary and 1 or more law en-
20 forcement entities for the political subdivision in
21 which the facility is located any reasonable suspicion
22 of a crime (as defined by the law of the applicable
23 political subdivision) against any individual who is a
24 resident of, or is receiving care from, the facility.

1 “(2) TIMING.—If the events that cause the sus-
2 picion—

3 “(A) result in serious bodily injury, the in-
4 dividual shall report the suspicion immediately,
5 but not later than 2 hours after forming the
6 suspicion; and

7 “(B) do not result in serious bodily injury,
8 the individual shall report the suspicion not
9 later than 24 hours after forming the suspicion.

10 “(c) PENALTIES.—

11 “(1) IN GENERAL.—If a covered individual vio-
12 lates subsection (b)—

13 “(A) the covered individual shall be subject
14 to a civil money penalty of not more than
15 \$200,000; and

16 “(B) the Secretary may make a determina-
17 tion in the same proceeding to exclude the cov-
18 ered individual from participation in any Fed-
19 eral health care program (as defined in section
20 1128B(f)).

21 “(2) INCREASED HARM.—If a covered indi-
22 vidual violates subsection (b) and the violation exac-
23 erbates the harm to the victim of the crime or re-
24 sults in harm to another individual—

1 “(A) the covered individual shall be subject
2 to a civil money penalty of not more than
3 \$300,000; and

4 “(B) the Secretary may make a determina-
5 tion in the same proceeding to exclude the cov-
6 ered individual from participation in any Fed-
7 eral health care program (as defined in section
8 1128B(f)).

9 “(3) EXCLUDED INDIVIDUAL.—During any pe-
10 riod for which a covered individual is classified as an
11 excluded individual under paragraph (1)(B) or
12 (2)(B), a long-term care facility that employs such
13 individual shall be ineligible to receive Federal funds
14 under this Act.

15 “(4) EXTENUATING CIRCUMSTANCES.—

16 “(A) IN GENERAL.—The Secretary may
17 take into account the financial burden on pro-
18 viders with underserved populations in deter-
19 mining any penalty to be imposed under this
20 subsection.

21 “(B) UNDERSERVED POPULATION DE-
22 FINED.—In this paragraph, the term ‘under-
23 served population’ means the population of an
24 area designated by the Secretary as an area
25 with a shortage of elder justice programs or a

1 population group designated by the Secretary
2 as having a shortage of such programs. Such
3 areas or groups designated by the Secretary
4 may include—

5 “(i) areas or groups that are geo-
6 graphically isolated (such as isolated in a
7 rural area);

8 “(ii) racial and ethnic minority popu-
9 lations; and

10 “(iii) populations underserved because
11 of special needs (such as language barriers,
12 disabilities, alien status, or age).

13 “(d) ADDITIONAL PENALTIES FOR RETALIATION.—

14 “(1) IN GENERAL.—A long-term care facility
15 may not—

16 “(A) discharge, demote, suspend, threaten,
17 harass, or deny a promotion or other employ-
18 ment-related benefit to an employee, or in any
19 other manner discriminate against an employee
20 in the terms and conditions of employment be-
21 cause of lawful acts done by the employee; or

22 “(B) file a complaint or a report against a
23 nurse or other employee with the appropriate
24 State professional disciplinary agency because
25 of lawful acts done by the nurse or employee,

1 for making a report, causing a report to be made,
2 or for taking steps in furtherance of making a report
3 pursuant to subsection (b)(1).

4 “(2) PENALTIES FOR RETALIATION.—If a long-
5 term care facility violates subparagraph (A) or (B)
6 of paragraph (1) the facility shall be subject to a
7 civil money penalty of not more than \$200,000 or
8 the Secretary may classify the entity as an excluded
9 entity for a period of 2 years pursuant to section
10 1128(b), or both.

11 “(3) REQUIREMENT TO POST NOTICE.—Each
12 long-term care facility shall post conspicuously in an
13 appropriate location a sign (in a form specified by
14 the Secretary) specifying the rights of employees
15 under this section. Such sign shall include a state-
16 ment that an employee may file a complaint with the
17 Secretary against a long-term care facility that vio-
18 lates the provisions of this subsection and informa-
19 tion with respect to the manner of filing such a com-
20 plaint.

21 “(e) PROCEDURE.—The provisions of section 1128A
22 (other than subsections (a) and (b) and the second sen-
23 tence of subsection (f)) shall apply to a civil money penalty
24 or exclusion under this section in the same manner as such

1 provisions apply to a penalty or proceeding under section
2 1128A(a).

3 “(f) DEFINITIONS.—In this section, the terms ‘elder
4 justice’, ‘long-term care facility’, and ‘law enforcement’
5 have the meanings given those terms in section 2011.”.

6 (c) NATIONAL NURSE AIDE REGISTRY.—

7 (1) DEFINITION OF NURSE AIDE.—In this sub-
8 section, the term “nurse aide” has the meaning
9 given that term in sections 1819(b)(5)(F) and
10 1919(b)(5)(F) of the Social Security Act (42 U.S.C.
11 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

12 (2) STUDY AND REPORT.—

13 (A) IN GENERAL.—The Secretary, in con-
14 sultation with appropriate government agencies
15 and private sector organizations, shall conduct
16 a study on establishing a national nurse aide
17 registry.

18 (B) AREAS EVALUATED.—The study con-
19 ducted under this subsection shall include an
20 evaluation of—

21 (i) who should be included in the reg-
22 istry;

23 (ii) how such a registry would comply
24 with Federal and State privacy laws and
25 regulations;

1 (iii) how data would be collected for
2 the registry;

3 (iv) what entities and individuals
4 would have access to the data collected;

5 (v) how the registry would provide ap-
6 propriate information regarding violations
7 of Federal and State law by individuals in-
8 cluded in the registry;

9 (vi) how the functions of a national
10 nurse aide registry would be coordinated
11 with the nationwide program for national
12 and State background checks on direct pa-
13 tient access employees of long-term care
14 facilities and providers under section 4301;
15 and

16 (vii) how the information included in
17 State nurse aide registries developed and
18 maintained under sections 1819(e)(2) and
19 1919(e)(2) of the Social Security Act (42
20 U.S.C. 1395i-3(e)(2); 1396r(e)(2)(2))
21 would be provided as part of a national
22 nurse aide registry.

23 (C) CONSIDERATIONS.—In conducting the
24 study and preparing the report required under
25 this subsection, the Secretary shall take into

1 Data Needs (2004) (in particular with re-
2 spect to chapter 7 and appendix F).

3 (v) The 2001 Report to CMS from
4 the School of Rural Public Health, Texas
5 A&M University, Preventing Abuse and
6 Neglect in Nursing Homes: The Role of
7 Nurse Aide Registries.

8 (vi) Information included in State
9 nurse aide registries developed and main-
10 tained under sections 1819(e)(2) and
11 1919(e)(2) of the Social Security Act (42
12 U.S.C. 1395i-3(e)(2); 1396r(e)(2)(2)).

13 (D) REPORT.—Not later than 18 months
14 after the date of enactment of this Act, the Sec-
15 retary shall submit to the Elder Justice Coordi-
16 nating Council established under section 2021
17 of the Social Security Act, as added by section
18 1805(a), the Committee on Finance of the Sen-
19 ate, and the Committee on Ways and Means
20 and the Committee on Energy and Commerce
21 of the House of Representatives a report con-
22 taining the findings and recommendations of
23 the study conducted under this paragraph.

1 (E) FUNDING LIMITATION.—Funding for
2 the study conducted under this subsection shall
3 not exceed \$500,000.

4 (3) CONGRESSIONAL ACTION.—After receiving
5 the report submitted by the Secretary under para-
6 graph (2)(D), the Committee on Finance of the Sen-
7 ate and the Committee on Ways and Means and the
8 Committee on Energy and Commerce of the House
9 of Representatives shall, as they deem appropriate,
10 take action based on the recommendations contained
11 in the report.

12 (4) AUTHORIZATION OF APPROPRIATIONS.—
13 There are authorized to be appropriated such sums
14 as are necessary for the purpose of carrying out this
15 subsection.

16 (d) CONFORMING AMENDMENTS.—

17 (1) TITLE XX.—Title XX of the Social Security
18 Act (42 U.S.C. 1397 et seq.), as amended by section
19 1913(a), is amended—

20 (A) in the heading of section 2001, by
21 striking “TITLE” and inserting “SUBTITLE”;
22 and

23 (B) in subtitle 1, by striking “this title”
24 each place it appears and inserting “this sub-
25 title”.

1 (2) TITLE IV.—Title IV of the Social Security
2 Act (42 U.S.C. 601 et seq.) is amended—

3 (A) in section 404(d)—

4 (i) in paragraphs (1)(A), (2)(A), and
5 (3)(B), by inserting “subtitle 1 of” before
6 “title XX” each place it appears;

7 (ii) in the heading of paragraph (2),
8 by inserting “SUBTITLE 1 OF” before
9 “TITLE XX”; and

10 (iii) in the heading of paragraph
11 (3)(B), by inserting “SUBTITLE 1 OF” be-
12 fore “TITLE XX”; and

13 (B) in sections 422(b), 471(a)(4),
14 472(h)(1), and 473(b)(2), by inserting “subtitle
15 1 of” before “title XX” each place it appears.

16 (3) TITLE XI.—Title XI of the Social Security
17 Act (42 U.S.C. 1301 et seq.) is amended—

18 (A) in section 1128(h)(3)—

19 (i) by inserting “subtitle 1 of” before
20 “title XX”; and

21 (ii) by striking “such title” and in-
22 serting “such subtitle”; and

23 (B) in section 1128A(i)(1), by inserting
24 “subtitle 1 of” before “title XX”.

1 **Subtitle L—Provisions of General**
2 **Application**

3 **SEC. 1921. PROTECTING AMERICANS AND ENSURING TAX-**
4 **PAYER FUNDS IN GOVERNMENT HEALTH**
5 **CARE PLANS DO NOT SUPPORT OR FUND**
6 **PHYSICIAN-ASSISTED SUICIDE; PROHIBITION**
7 **AGAINST DISCRIMINATION ON ASSISTED SUI-**
8 **CIDE.**

9 (a) PROTECTING AMERICANS AND ENSURING TAX-
10 PAYER FUNDS IN GOVERNMENT HEALTH CARE PLANS
11 DO NOT SUPPORT OR FUND PHYSICIAN-ASSISTED SUI-
12 CIDE.—The Federal Government, and any State or local
13 government or health care provider that receives Federal
14 financial assistance under this Act (or under an amend-
15 ment made by this Act) or any health plan created under
16 this Act (or under an amendment made by this Act), shall
17 not pay for or reimburse any health care entity to provide
18 for any health care item or service furnished for the pur-
19 pose of causing, or for the purpose of assisting in causing,
20 the death of any individual, such as by assisted suicide,
21 euthanasia, or mercy killing.

22 (b) PROHIBITION AGAINST DISCRIMINATION ON AS-
23 SISTED SUICIDE.—

24 (1) IN GENERAL.—The Federal Government,
25 and any State or local government or health care

1 provider that receives Federal financial assistance
2 under this Act (or under an amendment made by
3 this Act) or any health plan created under this Act
4 (or under an amendment made by this Act), may
5 not subject an individual or institutional health care
6 entity to discrimination on the basis that the entity
7 does not provide any health care item or service fur-
8 nished for the purpose of causing, or for the purpose
9 of assisting in causing, the death of any individual,
10 such as by assisted suicide, euthanasia, or mercy
11 killing.

12 (2) ADMINISTRATION.—The Office for Civil
13 Rights of the Department of Health and Human
14 Services is designated to receive complaints of dis-
15 crimination based on this subsection.

16 (c) CONSTRUCTION AND TREATMENT OF CERTAIN
17 SERVICES.—Nothing in subsection (a) or (b) shall be con-
18 strued to apply to or to affect any limitation relating to—

19 (1) the withholding or withdrawing of medical
20 treatment or medical care;

21 (2) the withholding or withdrawing of nutrition
22 or hydration;

23 (3) abortion; or

24 (4) the use of an item, good, benefit, or service
25 furnished for the purpose of alleviating pain or dis-

1 comfort, even if such use may increase the risk of
2 death, so long as such item, good, benefit, or service
3 is not also furnished for the purpose of causing, or
4 the purpose of assisting in causing, death, for any
5 reason.

6 (d) DEFINITION.—In this section, the term “health
7 care entity” includes an individual physician or other
8 health care professional, a hospital, a provider-sponsored
9 organization, a health maintenance organization, a health
10 insurance plan, or any other kind of health care facility,
11 organization, or plan.

12 **SEC. 1922. PROTECTION OF ACCESS TO QUALITY HEALTH**
13 **CARE THROUGH THE DEPARTMENT OF VET-**
14 **ERANS AFFAIRS AND THE DEPARTMENT OF**
15 **DEFENSE.**

16 (a) HEALTH CARE THROUGH DEPARTMENT OF VET-
17 ERANS AFFAIRS.—Nothing is in this Act shall be con-
18 strued to prohibit, limit, or otherwise penalize veterans
19 and dependents eligible for health care through the De-
20 partment of Veterans Affairs under the laws administered
21 by the Secretary of Veterans Affairs from receiving timely
22 access to quality health care in any facility of the Depart-
23 ment or from any non-Department health care provider
24 through which the Secretary provides health care.

1 (b) HEALTH CARE THROUGH DEPARTMENT OF DE-
2 FENSE.—

3 (1) IN GENERAL.—Nothing is in this Act shall
4 be construed to prohibit, limit, or otherwise penalize
5 eligible beneficiaries from receiving timely access to
6 quality health care in any military medical treatment
7 facility or under the TRICARE program.

8 (2) DEFINITIONS.—In this subsection:

9 (A) The term “eligible beneficiaries”
10 means covered beneficiaries (as defined in sec-
11 tion 1072(5) of title 10, United States Code)
12 for purposes of eligible for mental and dental
13 care under chapter 55 of title 10, United States
14 Code.

15 (B) The term “TRICARE program” has
16 the meaning given that term in section 1072(7)
17 of title 10, United States Code.

18 **SEC. 1923. CONTINUED APPLICATION OF ANTITRUST LAWS.**

19 Nothing in this Act shall be construed to modify, im-
20 pair, or supersede the operation of any of the antitrust
21 laws. For the purposes of this Act, the term “antitrust
22 laws” has the meaning given such term in subsection (a)
23 of the first section of the Clayton Act (15 U.S.C. 12(a)).
24 Such term also includes section 5 of the Federal Trade

1 Commission Act (15 U.S.C. 45) to the extent that such
2 section 5 applies to unfair methods of competition.

3 **TITLE II—PROMOTING DISEASE**
4 **PREVENTION AND WELLNESS**
5 **Subtitle A—Medicare**

6 **SEC. 2001. COVERAGE OF ANNUAL WELLNESS VISIT PRO-**
7 **VIDING A PERSONALIZED PREVENTION PLAN.**

8 (a) COVERAGE OF PERSONALIZED PREVENTION
9 PLAN SERVICES.—

10 (1) IN GENERAL.—Section 1861(s)(2) of the
11 Social Security Act (42 U.S.C. 1395x(s)(2)) is
12 amended—

13 (A) in subparagraph (DD), by striking
14 “and” at the end;

15 (B) in subparagraph (EE), by adding
16 “and” at the end; and

17 (C) by adding at the end the following new
18 subparagraph:

19 “(FF) personalized prevention plan services (as
20 defined in subsection (hhh));”.

21 (2) CONFORMING AMENDMENTS.—Clauses (i)
22 and (ii) of section 1861(s)(2)(K) of the Social Secu-
23 rity Act (42 U.S.C. 1395x(s)(2)(K)) are each
24 amended by striking “subsection (ww)(1)” and in-
25 serting “subsections (ww)(1) and (hhh)”.

1 (b) PERSONALIZED PREVENTION PLAN SERVICES
2 DEFINED.—Section 1861 of the Social Security Act (42
3 U.S.C. 1395x) is amended by adding at the end the fol-
4 lowing new subsection:

5 “Annual Wellness Visit

6 “(hhh)(1) The term ‘personalized prevention plan
7 services’ means the creation of a plan for an individual—

8 “(A) that includes a health risk assessment
9 (that meets the guidelines established by the Sec-
10 retary under paragraph (5)(A)) of the individual
11 that is completed prior to or as part of the same
12 visit with a health professional described in para-
13 graph (4); and

14 “(B) that—

15 “(i) takes into account the results of the
16 health risk assessment;

17 “(ii) contains the elements described in
18 paragraph (2); and

19 “(iii) may contain the elements described
20 in paragraph (3).

21 “(2) Subject to paragraph (5)(H), the elements de-
22 scribed in this paragraph are the following:

23 “(A) The establishment of, or an update to, the
24 individual’s medical and family history.

1 “(B) The establishment of, or an update to, the
2 following:

3 “(i) A screening schedule for the next 5 to
4 10 years, as appropriate, based on rec-
5 ommendations of the United States Preventive
6 Services Task Force and the individual’s health
7 status, screening history, and age-appropriate
8 preventive services covered under this title.

9 “(ii) A list of risk factors and conditions
10 that are of concern with respect to the indi-
11 vidual, development of a strategy to improve
12 health status through lifestyle or other interven-
13 tions that emphasize primary prevention, and
14 recommendations for appropriate programs and
15 informational resources for reducing or elimi-
16 nating such risk factors and conditions.

17 “(iii) A list of risk factors and conditions
18 for which secondary or tertiary prevention
19 interventions are recommended or are under-
20 way, and a list of treatment options and their
21 associated risks and benefits.

22 “(iv) A list of all medications currently
23 prescribed for the individual.

1 “(v) A list of all providers of services and
2 suppliers regularly involved in providing care to
3 the individual.

4 “(C) The furnishing of personalized health ad-
5 vice and a referral, as appropriate, to health edu-
6 cation or preventive counseling services aimed at re-
7 ducing identified risk factors, or community-based
8 lifestyle interventions to reduce health risks and pro-
9 mote wellness, including weight loss, physical activ-
10 ity, smoking cessation, and nutrition.

11 “(D) A measurement of height, weight, body
12 mass index (or waist circumference, if appropriate),
13 and blood pressure.

14 “(E) Any other element determined appropriate
15 by the Secretary.

16 “(3) Subject to paragraph (5)(H), the elements de-
17 scribed in this paragraph are the following:

18 “(A) Referral for additional testing related to a
19 diagnosis of a possible chronic condition.

20 “(B) In the case of an individual with a diag-
21 nosed chronic condition, referral for or review of the
22 available treatment options.

23 “(C) The furnishing of or referral for any pre-
24 ventive services described in subparagraphs (A) and
25 (B) of subsection (ddd)(3).

1 “(D) Cognitive impairment assessment.

2 “(E) Any other element determined appropriate
3 by the Secretary.

4 “(4) A health professional described in this para-
5 graph is—

6 “(A) a physician;

7 “(B) a practitioner described in clause (i) of
8 section 1842(b)(18)(C); or

9 “(C) a medical professional (including a health
10 educator, registered dietitian, or nutrition profes-
11 sional) or a team of medical professionals, as deter-
12 mined appropriate by the Secretary, under the su-
13 pervision of a physician.

14 “(5)(A) For purposes of paragraph (1)(A), the Sec-
15 retary, not later than 1 year after the date of enactment
16 of the America’s Healthy Future Act of 2009, shall estab-
17 lish publicly available guidelines for health risk assess-
18 ments. Such guidelines shall be developed in consultation
19 with relevant groups and entities and shall provide that
20 a health risk assessment—

21 “(i) identify chronic diseases, modifiable risk
22 factors, and urgent health needs of the individual;
23 and

24 “(ii) may be furnished—

1 “(I) through an interactive telephonic or
2 web-based program that meets the standards
3 established under subparagraph (D);

4 “(II) during an encounter with a health
5 care professional; or

6 “(III) through any other means the Sec-
7 retary determines appropriate to maximize ac-
8 cessibility and ease of use by beneficiaries, while
9 ensuring the privacy of such beneficiaries.

10 “(B) The Secretary may coordinate with community-
11 based entities (including State Health Insurance Pro-
12 grams, Area Agencies on Aging, Aging and Disability Re-
13 source Centers, and the Administration on Aging) to—

14 “(i) ensure that health risk assessments are ac-
15 cessible to beneficiaries; and

16 “(ii) provide appropriate support for the com-
17 pletion of health risk assessments by beneficiaries.

18 “(C) The Secretary shall establish procedures to
19 make beneficiaries and providers aware of the requirement
20 that a beneficiary complete a health risk assessment prior
21 to or at the same time as receiving personalized prevention
22 plan services.

23 “(D) Not later than 1 year after the date of enact-
24 ment of the America’s Healthy Future Act of 2009, the
25 Secretary shall establish standards for interactive tele-

1 phonic or web-based programs used to furnish health risk
2 assessments under subparagraph (A)(ii)(I).

3 “(E) To the extent practicable, the Secretary shall
4 encourage the use of, integration with, and coordination
5 of health information technology (including use of tech-
6 nology that is compatible with electronic medical records
7 and personal health records) and may experiment with the
8 use of personalized technology to aid in the management
9 of and adherence to provider recommendations in order
10 to improve the health status of beneficiaries.

11 “(F) A beneficiary shall be eligible to receive person-
12 alized prevention plan services under this subsection pro-
13 vided that the beneficiary has not received such services
14 within the preceding 12-month period. During the period
15 of 12 months after the date that the beneficiary’s first
16 coverage begins under part B, payment shall be made
17 under such part for only one of the following services:

18 “(i) An initial preventive physical examination
19 (as defined under subsection (ww)(1)).

20 “(ii) Personalized prevention plan services pro-
21 vided under this subsection.

22 “(G)(i) Not later than 1 year after the date of enact-
23 ment of the America’s Healthy Future Act of 2009, the
24 Secretary shall develop and make available to the public
25 a health risk assessment model. Such model shall meet

1 the guidelines under subparagraph (A) and may be used
2 to meet the requirement under paragraph (1)(A).

3 “(ii) Any health risk assessment that meets the
4 guidelines under subparagraph (A) and is approved by the
5 Secretary may be used to meet the requirement under
6 paragraph (1)(A).

7 “(H)(i) Subject to clause (ii), the Secretary shall
8 issue guidance that—

9 “(I) identifies elements under paragraphs (2)
10 and (3) that are not required to be provided to a
11 beneficiary during each annual visit; and

12 “(II) establishes a yearly schedule for appro-
13 priate provision of such elements.

14 “(ii) Personalized prevention plan services that are
15 provided to a beneficiary within the period of 12 months
16 after the date that such beneficiary’s first coverage period
17 begins under part B shall be required to include any ele-
18 ments included under paragraphs (2) and (3).”.

19 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
20 ING.—

21 (1) PAYMENT AND ELIMINATION OF COINSUR-
22 ANCE.—Section 1833(a)(1) of the Social Security
23 Act (42 U.S.C. 1395l(a)(1)) is amended—

24 (A) in subparagraph (N), by inserting
25 “other than personalized prevention plan serv-

1 ices (as defined in section 1861(hhh)(1))” after
2 “(as defined in section 1848(j)(3))”;

3 (B) by striking “and” before “(W)”;

4 (C) by inserting before the semicolon at
5 the end the following: “, and (X) with respect
6 to personalized prevention plan services (as de-
7 fined in section 1861(hhh)(1)), the amount paid
8 shall be 100 percent of the lesser of the actual
9 charge for the services or the amount deter-
10 mined under the payment basis determined
11 under section 1848”.

12 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-
13 ULE.—Section 1848(j)(3) of the Social Security Act
14 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
15 “(2)(FF) (including administration of the health
16 risk assessment) ,” after “(2)(EE),”.

17 (3) ELIMINATION OF COINSURANCE IN OUT-
18 PATIENT HOSPITAL SETTINGS.—

19 (A) EXCLUSION FROM OPD FEE SCHED-
20 ULE.—Section 1833(t)(1)(B)(iv) of the Social
21 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
22 amended by striking “and diagnostic mammog-
23 raphy” and inserting “, diagnostic mammog-
24 raphy, or personalized prevention plan services
25 (as defined in section 1861(hhh)(1))”.

1 (B) CONFORMING AMENDMENTS.—Section
2 1833(a)(2) of the Social Security Act (42
3 U.S.C. 1395l(a)(2)) is amended—

4 (i) in subparagraph (F), by striking
5 “and” at the end;

6 (ii) in subparagraph (G)(ii), by strik-
7 ing the comma at the end and inserting “;
8 and”; and

9 (iii) by inserting after subparagraph
10 (G)(ii) the following new subparagraph:

11 “(H) with respect to personalized preven-
12 tion plan services (as defined in section
13 1861(hhh)(1)) furnished by an outpatient de-
14 partment of a hospital, the amount determined
15 under paragraph (1)(X),”.

16 (4) WAIVER OF APPLICATION OF DEDUCT-
17 IBLE.—The first sentence of section 1833(b) of the
18 Social Security Act (42 U.S.C. 1395l(b)) is amend-
19 ed—

20 (A) by striking “and” before “(9)”; and

21 (B) by inserting before the period the fol-
22 lowing: “, and (10) such deductible shall not
23 apply with respect to personalized prevention
24 plan services (as defined in section
25 1861(hhh)(1))”.

1 (d) FREQUENCY LIMITATION.—Section 1862(a) of
2 the Social Security Act (42 U.S.C. 1395y(a)) is amend-
3 ed—

4 (1) in paragraph (1)—

5 (A) in subparagraph (N), by striking
6 “and” at the end;

7 (B) in subparagraph (O), by striking the
8 semicolon at the end and inserting “, and”; and

9 (C) by adding at the end the following new
10 subparagraph:

11 “(P) in the case of personalized prevention plan
12 services (as defined in section 1861(hhh)(1)), which
13 are performed more frequently than is covered under
14 such section;”; and

15 (2) in paragraph (7), by striking “or (K)” and
16 inserting “(K), or (P)”.

17 (e) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to services furnished on or after
19 January 1, 2011.

20 **SEC. 2002. REMOVAL OF BARRIERS TO PREVENTIVE SERV-**
21 **ICES.**

22 (a) DEFINITION OF PREVENTIVE SERVICES.—Sec-
23 tion 1861(ddd) of the Social Security Act (42 U.S.C.
24 1395x(ddd)) is amended—

1 (1) in the heading, by inserting “; Preventive
2 Services” after “Services”;

3 (2) in paragraph (1), by striking “not otherwise
4 described in this title” and inserting “not described
5 in subparagraph (A) or (C) of paragraph (3)”; and

6 (3) by adding at the end the following new
7 paragraph:

8 “(3) The term ‘preventive services’ means the fol-
9 lowing:

10 “(A) The screening and preventive services de-
11 scribed in subsection (ww)(2) (other than the service
12 described in subparagraph (M) of such subsection).

13 “(B) An initial preventive physical examination
14 (as defined in subsection (ww)).

15 “(C) Personalized prevention plan services (as
16 defined in subsection (hhh)(1)).”.

17 (b) COINSURANCE.—

18 (1) GENERAL APPLICATION.—

19 (A) IN GENERAL.—Section 1833(a)(1) of
20 the Social Security Act (42 U.S.C.
21 1395l(a)(1)), as amended by section 2001(c)(1),
22 is amended—

23 (i) in subparagraph (T), by inserting
24 “(or 100 percent if such services are rec-
25 ommended with a grade of A or B by the

1 United States Preventive Services Task
2 Force for any indication or population and
3 are appropriate for the individual)” after
4 “80 percent”;

5 (ii) in subparagraph (W)—

6 (I) in clause (i), by inserting “(if
7 such subparagraph were applied, by
8 substituting ‘100 percent’ for ‘80 per-
9 cent’)” after “subparagraph (D)”;
10 and

11 (II) in clause (ii), by striking “80
12 percent” and inserting “100 percent”;

13 (iii) by striking “and” before “(X)”;
14 and

15 (iv) by inserting before the semicolon
16 at the end the following: “, and (Y) with
17 respect to preventive services described in
18 subparagraphs (A) and (B) of section
19 1861(ddd)(3) that are appropriate for the
20 individual and, in the case of such services
21 described in subparagraph (A), are rec-
22 ommended with a grade of A or B by the
23 United States Preventive Services Task
24 Force for any indication or population, the
25 amount paid shall be 100 percent of the

1 lesser of the actual charge for the services
2 or the amount determined under the fee
3 schedule that applies to such services
4 under this part”.

5 (2) ELIMINATION OF COINSURANCE IN OUT-
6 PATIENT HOSPITAL SETTINGS.—

7 (A) EXCLUSION FROM OPD FEE SCHED-
8 ULE.—Section 1833(t)(1)(B)(iv) of the Social
9 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as
10 amended by section 2001(c)(3)(A), is amend-
11 ed—

12 (i) by striking “or” before “personal-
13 ized prevention plan services”; and

14 (ii) by inserting before the period the
15 following: “, or preventive services de-
16 scribed in subparagraphs (A) and (B) of
17 section 1861(ddd)(3) that are appropriate
18 for the individual and, in the case of such
19 services described in subparagraph (A), are
20 recommended with a grade of A or B by
21 the United States Preventive Services Task
22 Force for any indication or population”.

23 (B) CONFORMING AMENDMENTS.—Section
24 1833(a)(2) of the Social Security Act (42

1 U.S.C. 1395l(a)(2)), as amended by section
2 2001(c)(3)(B), is amended—

3 (i) in subparagraph (G)(ii), by strik-
4 ing “and” after the semicolon at the end;

5 (ii) in subparagraph (H), by striking
6 the comma at the end and inserting “;
7 and”; and

8 (iii) by inserting after subparagraph
9 (H) the following new subparagraph:

10 “(I) with respect to preventive services de-
11 scribed in subparagraphs (A) and (B) of section
12 1861(ddd)(3) that are appropriate for the indi-
13 vidual and are furnished by an outpatient de-
14 partment of a hospital and, in the case of such
15 services described in subparagraph (A), are rec-
16 ommended with a grade of A or B by the
17 United States Preventive Services Task Force
18 for any indication or population, the amount
19 determined under paragraph (1)(W) or
20 (1)(Y).”.

21 (c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR
22 PREVENTIVE SERVICES AND COLORECTAL CANCER
23 SCREENING TESTS.—Section 1833(b) of the Social Secu-
24 rity Act (42 U.S.C. 1395l(b)), as amended by section
25 2001(c)(4) is amended—

1 (1) in paragraph (1), by striking “items and
2 services described in section 1861(s)(10)(A)” and in-
3 serting “preventive services described in subpara-
4 graph (A) of section 1861(ddd)(3) that are rec-
5 ommended with a grade of A or B by the United
6 States Preventive Services Task Force for any indi-
7 cation or population and are appropriate for the in-
8 dividual.”; and

9 (2) by adding at the end the following new sen-
10 tence: “Paragraph (1) of the first sentence of this
11 subsection shall apply with respect to a colorectal
12 cancer screening test regardless of the code that is
13 billed for the establishment of a diagnosis as a result
14 of the test, or for the removal of tissue or other mat-
15 ter or other procedure that is furnished in connec-
16 tion with, as a result of, and in the same clinical en-
17 counter as the screening test.”.

18 (d) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to items and services furnished on
20 or after January 1, 2011.

21 **SEC. 2003. EVIDENCE-BASED COVERAGE OF PREVENTIVE**
22 **SERVICES.**

23 (a) AUTHORITY TO MODIFY OR ELIMINATE COV-
24 ERAGE OF CERTAIN PREVENTIVE SERVICES.—

1 (1) IN GENERAL.—Section 1834 of the Social
2 Security Act (42 U.S.C. 1395m) is amended by add-
3 ing at the end the following new subsection:

4 “(n) AUTHORITY TO MODIFY OR ELIMINATE COV-
5 ERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwith-
6 standing any other provision of this title, effective begin-
7 ning on January 1, 2010, if the Secretary determines ap-
8 propriate, the Secretary may—

9 “(1) modify—

10 “(A) the coverage of any preventive service
11 described in subparagraph (A) of section
12 1861(ddd)(3) to the extent that such modifica-
13 tion is consistent with the recommendations of
14 the United States Preventive Services Task
15 Force; and

16 “(B) the services included in the initial
17 preventive physical examination described in
18 subparagraph (B) of such section; and

19 “(2) provide that no payment shall be made
20 under this title for a preventive service described in
21 subparagraph (A) of such section that is not rec-
22 ommended with a grade of A, B, C, or I by such
23 Task Force.”.

24 (2) CONSTRUCTION.—Nothing in the amend-
25 ment made by paragraph (1) shall be construed to

1 affect the coverage of diagnostic or treatment serv-
2 ices under title XVIII of the Social Security Act.

3 (b) SUPPORT FOR OUTREACH AND EDUCATION RE-
4 GARDING PREVENTIVE SERVICES.—

5 (1) FUNDING.—

6 (A) IN GENERAL.—Out of any funds in the
7 Treasury not otherwise appropriated, there are
8 appropriated for fiscal year 2010, \$15,000,000
9 to the Centers for Medicare & Medicaid Serv-
10 ices Program Management Account for the pur-
11 poses described in subparagraph (B). Amounts
12 appropriated under this subparagraph shall—

13 (i) be disbursed to such Account on
14 January 1, 2010; and

15 (ii) remain available until expended.

16 (B) PURPOSES DESCRIBED.—The purposes
17 described in this subparagraph are as follows:

18 (i) To conduct education and outreach
19 activities to Medicare beneficiaries and
20 health care providers regarding the cov-
21 erage of preventive services (as defined in
22 section 1861(ddd)(3) of the Social Security
23 Act, as added by section 2002(a)) under
24 the Medicare program under title XVIII of

1 such Act in order to encourage optimal uti-
2 lization of such services.

3 (ii) To coordinate such education and
4 outreach activities with community-based
5 entities, including State Health Insurance
6 Programs, Area Agencies on Aging, and
7 Aging and Disability Resource Centers,
8 that are carrying out the activities de-
9 scribed in section 1861(hhh)(5)(B) of the
10 Social Security Act, as added by section
11 2001(b).

12 (C) ACTIVITY SUPPORT.—Out of the
13 amounts appropriated under subparagraph (A),
14 the Secretary may provide support and assist-
15 ance for activities conducted by community-
16 based entities as described under subparagraph
17 (B)(ii).

18 (2) HHS STUDY AND REPORT TO CONGRESS.—

19 (A) STUDY.—The Secretary of Health and
20 Human Services shall conduct a study on pre-
21 ventive services under the Medicare program.
22 Such study shall include an analysis of—

23 (i) the implementation of the amend-
24 ments made by section 101(a) of the Medi-
25 care Improvements for Patients and Pro-

1 viders Act of 2008 (Public Law 110–275;
2 122 Stat. 2496), including a description of
3 plans to add coverage of additional preven-
4 tive services pursuant to such amend-
5 ments; and

6 (ii) the implementation of the edu-
7 cation and outreach activities under para-
8 graph (1)(B).

9 (B) REPORT.—Not later than 1 year after
10 the date of the enactment of this Act, the Sec-
11 retary of Health and Human Services shall sub-
12 mit to Congress a report on the study con-
13 ducted under subparagraph (A), together with
14 recommendations for such legislation and ad-
15 ministrative action as the Secretary determines
16 appropriate.

17 (C) FUNDING.—Out of the amounts appro-
18 priated under paragraph (1)(A), an amount not
19 greater than \$1,000,000 shall be made available
20 to carry out this paragraph.

21 (3) GAO STUDY AND REPORT TO CONGRESS.—

22 (A) STUDY.—The Comptroller General of
23 the United States shall conduct a study on ex-
24 isting efforts by the Secretary of Health and
25 Human Services to improve utilization of pre-

1 ventive services under the Medicare program,
2 including primary, secondary, and tertiary serv-
3 ices and the use of health information tech-
4 nology to coordinate such services. Such study
5 shall include an analysis of—

6 (i) the utilization of and payment for
7 preventive services under the Medicare pro-
8 gram; and

9 (ii) whether barriers to optimal utili-
10 zation of and access to such services exist
11 and if so, what are those barriers.

12 (B) REPORT.—Not later than 2 years after
13 the date of the enactment of this Act, the
14 Comptroller General of the United States shall
15 submit to Congress a report on the study con-
16 ducted under subparagraph (A), together with
17 recommendations for—

18 (i) improving access to, and utilization
19 and coordination of, primary, secondary,
20 and tertiary preventive services under the
21 Medicare program, with an emphasis on
22 the most costly chronic conditions affecting
23 Medicare population; and

1 (ii) such legislation and administrative
2 action as the Comptroller General deter-
3 mines appropriate.

4 (C) FUNDING.—Out of any funds in the
5 Treasury not otherwise appropriated, there are
6 appropriated \$2,000,000 to carry out this para-
7 graph. Amounts appropriated under this sub-
8 paragraph shall remain available until ex-
9 pended.

10 **SEC. 2004. GAO STUDY AND REPORT ON MEDICARE BENE-**
11 **FICIARY ACCESS TO VACCINES.**

12 (a) STUDY.—The Comptroller General of the United
13 States (in this section referred to as the “Comptroller
14 General”) shall conduct a study on the ability of Medicare
15 beneficiaries who were 65 years of age or older to access
16 routinely recommended vaccines covered under the pre-
17 scription drug program under part D of title XVIII of the
18 Social Security Act over the period since the establishment
19 of such program. Such study shall include the following:

20 (1) An analysis and determination of—

21 (A) the number of Medicare beneficiaries
22 who were 65 years of age or older and were eli-
23 gible for a routinely recommended vaccination
24 that was covered under part D;

1 (B) the number of such beneficiaries who
2 actually received a routinely recommended vac-
3 cination that was covered under part D; and

4 (C) any barriers to access by such bene-
5 ficiaries to routinely recommended vaccinations
6 that were covered under part D.

7 (2) A summary of the findings and rec-
8 ommendations by government agencies, departments,
9 and advisory bodies (as well as relevant professional
10 organizations) on the impact of coverage under part
11 D of routinely recommended adult immunizations
12 for access to such immunizations by Medicare bene-
13 ficiaries.

14 (b) REPORT.—Not later than June 1, 2010, the
15 Comptroller General shall submit to the appropriate com-
16 mittees of jurisdiction of the House of Representatives and
17 the Senate a report containing the results of the study
18 conducted under subsection (a), together with rec-
19 ommendations for such legislation and administrative ac-
20 tion as the Comptroller General determines appropriate.

21 (c) FUNDING.—Out of any funds in the Treasury not
22 otherwise appropriated, there are appropriated
23 \$1,000,000 for fiscal year 2010 to carry out this section.

24 **SEC. 2005. INCENTIVES FOR HEALTHY LIFESTYLES.**

25 (a) MEDICARE DEMONSTRATION PROJECT.—

1 (1) ESTABLISHMENT.—

2 (A) IN GENERAL.—The Secretary shall es-
3 tablish and implement a demonstration project
4 under title XVIII of the Social Security Act to
5 test programs that provide incentives to Medi-
6 care beneficiaries to reduce their risk of avoid-
7 able health outcomes that are associated with
8 lifestyle choices, including smoking, exercise,
9 and diet.

10 (B) EVIDENCE REVIEW.—Prior to the es-
11 tablishment of the demonstration project, the
12 Secretary shall review the available evidence, lit-
13 erature, best practices, and resources relevant
14 to the Medicare population that are related
15 to—

16 (i) programs that promote a healthy
17 lifestyle and reduce health risk factors; and

18 (ii) providing individuals with incen-
19 tives for participating in such programs.

20 (2) DURATION AND SCOPE.—

21 (A) DURATION.—The Secretary shall con-
22 duct the demonstration project for an initial pe-
23 riod of 3 years, beginning not later than July
24 1, 2010, with authority to continue for an addi-
25 tional 2 years any program or program compo-

1 ment that is determined to be effective under
2 the interim evaluation and report described
3 under subsection (b).

4 (B) SCOPE.—

5 (i) IN GENERAL.—The Secretary shall
6 select not more than 10 sites to conduct
7 the programs described in paragraph (3),
8 and may select such sites in coordination
9 with other community-based programs that
10 are oriented towards promoting healthy
11 lifestyles, reducing risk factors, and reduc-
12 ing the impact of chronic diseases (includ-
13 ing programs conducted by the Adminis-
14 tration on Aging, the Centers for Disease
15 Control and Prevention, and the Agency
16 for Healthcare Research and Quality).

17 (ii) SELECTION.—In selecting sites to
18 participate in the demonstration project,
19 the Secretary shall select—

20 (I) not less than 2 sites that are
21 located in rural areas; and

22 (II) not less than 2 sites that
23 serve a minority community (including
24 Native American communities).

1 (iii) PREFERENCE.—In selecting sites
2 to participate in the demonstration project,
3 the Secretary may give preference to orga-
4 nizations that have demonstrated experi-
5 ence in designing and implementing pro-
6 grams that provide incentives to adults to
7 make healthy lifestyle choices.

8 (3) PROGRAM DESCRIBED.—The Secretary shall
9 select programs that are evidence-based and de-
10 signed to help Medicare beneficiaries make healthy
11 lifestyle choices to reduce their health risks, includ-
12 ing—

13 (A) ceasing use of tobacco products;

14 (B) controlling or reducing their weight;

15 (C) controlling or lowering their choles-
16 terol;

17 (D) lowering their blood pressure;

18 (E) learning strategies to avoid the onset
19 of diabetes or, in the case of a diabetic, improv-
20 ing the management of such condition;

21 (F) reducing the risks of falls; and

22 (G) other approaches as determined by the
23 Secretary.

1 (4) MONITORING PARTICIPATION AND MEAS-
2 URING OUTCOMES.—Each participating site shall es-
3 tablish a system to—

4 (A) monitor participation by Medicare
5 beneficiaries in programs described in para-
6 graph (3); and

7 (B) validate changes in health risks and
8 outcomes, including adoption and maintenance
9 of healthy behaviors by Medicare beneficiaries
10 participating in such programs; and

11 (C) establish standards and health status
12 targets for Medicare beneficiaries participating
13 in such programs and measure the degree to
14 which such standards and targets are met.

15 (b) EVALUATIONS AND REPORTS.—

16 (1) IN GENERAL.—

17 (A) INDEPENDENT EVALUATIONS.—The
18 Secretary shall provide for an interim and final
19 independent evaluation of the demonstration
20 project that shall assess—

21 (i) the extent to which participating
22 Medicare beneficiaries achieved the pro-
23 gram goals described in subsection (a)(3);
24 and

1 (ii) any impact on utilization of health
2 services and costs to the Medicare program
3 as compared to the cost of the programs
4 conducted under the demonstration
5 project.

6 (B) INTERIM DETERMINATION.—Not later
7 than July 1, 2013, the Secretary shall make a
8 determination, pursuant to subsection
9 (a)(2)(A), as to any programs or program com-
10 ponents that should be extended through July
11 1, 2015.

12 (2) INTERIM REPORT.—Not later than January
13 1, 2014, the Secretary shall submit to Congress an
14 interim report on the demonstration project. The in-
15 terim report shall include—

16 (A) a preliminary evaluation of the effec-
17 tiveness of the programs or program compo-
18 nents conducted through the demonstration
19 project; and

20 (B) a description of any programs or pro-
21 gram components that have been extended
22 under paragraph (1)(B).

23 (3) FINAL REPORT.—Not later than January 1,
24 2016, the Secretary shall submit to Congress a final
25 report on the demonstration project that includes

1 the results of the independent evaluation required
2 under paragraph (1), together with recommenda-
3 tions for such legislation and administrative action
4 as the Secretary determines appropriate, including a
5 recommendation as to any programs conducted
6 under the demonstration project that should be ex-
7 tended or expanded.

8 (c) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT
9 OF, OTHER BENEFITS.—Any incentives provided to a
10 Medicare beneficiary participating in the demonstration
11 project shall not be taken into account for purposes of de-
12 termining the beneficiary's eligibility for, or amount of,
13 benefits under the Medicare program or any other pro-
14 gram funded in whole or in part with Federal funds.

15 (d) FUNDING.—

16 (1) IN GENERAL.—Out of any funds in the
17 Treasury not otherwise appropriated, there are ap-
18 propriated \$15,000,000 for each of fiscal years 2010
19 through 2015 to the Centers for Medicare & Med-
20 icaid Services Program Management Account to
21 carry out the demonstration project. Amounts appro-
22 priated under this paragraph shall remain available
23 until expended.

24 (2) USE OF CERTAIN FUNDS.—Out of the
25 amounts appropriated under paragraph (1), an

1 amount not greater than \$5,000,000 shall be made
2 available to design, implement, and evaluate pro-
3 grams conducted under the demonstration project,
4 with such amount to remain available until ex-
5 pended.

6 (e) ADMINISTRATION.—Chapter 35 of title 44,
7 United States Code shall not apply to the selection, test-
8 ing, and evaluation of programs, or the expansion of such
9 programs, under this section.

10 (f) DEFINITIONS.—In this section:

11 (1) DEMONSTRATION PROJECT.—The term
12 “demonstration project” means the demonstration
13 project conducted under this section.

14 (2) MEDICARE BENEFICIARY.—The term
15 “Medicare beneficiary” means an individual who is
16 entitled to benefits under part A of title XVIII of
17 the Social Security Act and enrolled under part B
18 of such title.

19 (3) SECRETARY.—The term “Secretary” means
20 the Secretary of Health and Human Services.

Subtitle B—Medicaid

2 SEC. 2101. IMPROVING ACCESS TO PREVENTIVE SERVICES 3 FOR ELIGIBLE ADULTS.

4 (a) CLARIFICATION OF INCLUSION OF SERVICES.—
5 Section 1905(a)(13) of the Social Security Act (42 U.S.C.
6 1396d(a)(13)) is amended to read as follows:

7 “(13) other diagnostic, screening, preventive,
8 and rehabilitative services, including—

9 “(A) any clinical preventive services that
10 are assigned a grade of A or B by the United
11 States Preventive Services Task Force;

12 “(B) with respect to an adult individual,
13 approved vaccines recommended by the Advi-
14 sory Committee on Immunization Practices (an
15 advisory committee established by the Sec-
16 retary, acting through the Director of the Cen-
17 ters for Disease Control and Prevention) and
18 their administration; and

19 “(C) any medical or remedial services (pro-
20 vided in a facility, a home, or other setting) rec-
21 ommended by a physician or other licensed
22 practitioner of the healing arts within the scope
23 of their practice under State law, for the max-
24 imum reduction of physical or mental disability

1 and restoration of an individual to the best pos-
2 sible functional level;”.

3 (b) INCREASED FMAP.—Section 1905(b) of the So-
4 cial Security Act (42 U.S.C. 1396d(b)), as amended by
5 sections 1601(a)(3)(A) and 1604(c)(1), is amended in the
6 first sentence—

7 (1) by striking “, and (4)” and inserting “,
8 (4)”;

9 (2) by inserting before the period the following:
10 “, and (5) in the case of a State that provides med-
11 ical assistance for services and vaccines described in
12 subparagraphs (A) and (B) of subsection (a)(13),
13 and prohibits cost-sharing for such services and vac-
14 cines, the Federal medical assistance percentage, as
15 determined under this subsection and subsection (y)
16 (without regard to paragraph (1)(C) of such sub-
17 section), shall be increased by 1 percentage point
18 with respect to medical assistance for such services
19 and vaccines and for items and services described in
20 subsection (a)(4)(D)”.

21 (c) EFFECTIVE DATE.—The amendments made
22 under this section shall take effect on January 1, 2013.

1 **SEC. 2102. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
2 **SATION SERVICES FOR PREGNANT WOMEN.**

3 (a) REQUIRING COVERAGE OF COUNSELING AND
4 PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE
5 BY PREGNANT WOMEN.—Section 1905 of the Social Secu-
6 rity Act (42 U.S.C. 1396d), as amended by sections
7 1601(a)(3)(B), 1636, and 1642, is further amended—

8 (1) in subsection (a)(4)—

9 (A) by striking “and” before “(C)”; and

10 (B) by inserting before the semicolon at
11 the end the following new subparagraph: “; and
12 (D) counseling and pharmacotherapy for ces-
13 sation of tobacco use by pregnant women (as
14 defined in subsection (bb))”; and

15 (2) by adding at the end the following:

16 “(bb)(1) For purposes of this title, the term ‘coun-
17 seling and pharmacotherapy for cessation of tobacco use
18 by pregnant women’ means diagnostic, therapy, and coun-
19 seling services and pharmacotherapy (including the cov-
20 erage of prescription and nonprescription tobacco ces-
21 sation agents approved by the Food and Drug Administra-
22 tion) for cessation of tobacco use by pregnant women who
23 use tobacco products or who are being treated for tobacco
24 use that is furnished—

25 “(A) by or under the supervision of a physician;

26 or

1 “(B) by any other health care professional
2 who—

3 “(i) is legally authorized to furnish such
4 services under State law (or the State regu-
5 latory mechanism provided by State law) of the
6 State in which the services are furnished; and

7 “(ii) is authorized to receive payment for
8 other services under this title or is designated
9 by the Secretary for this purpose.

10 “(2) Subject to paragraph (3), such term is limited
11 to—

12 “(A) services recommended with respect to
13 pregnant women in ‘Treating Tobacco Use and De-
14 pendence: 2008 Update: A Clinical Practice Guide-
15 line’, published by the Public Health Service in May
16 2008, or any subsequent modification of such Guide-
17 line; and

18 “(B) such other services that the Secretary rec-
19 ognizes to be effective for cessation of tobacco use
20 by pregnant women.

21 “(3) Such term shall not include coverage for drugs
22 or biologicals that are not otherwise covered under this
23 title.”.

24 (b) EXCEPTION FROM OPTIONAL RESTRICTION
25 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—

1 Section 1927(d)(2)(F) of the Social Security Act (42
2 U.S.C. 1396r-8(d)(2)(F)), as redesignated by section
3 1652(a), is amended by inserting before the period at the
4 end the following: “, except, in the case of pregnant
5 women when recommended in accordance with the Guide-
6 line referred to in section 1905(bb)(2)(A), agents ap-
7 proved by the Food and Drug Administration under the
8 over-the-counter monograph process for purposes of pro-
9 moting, and when used to promote, tobacco cessation”.

10 (c) REMOVAL OF COST-SHARING FOR COUNSELING
11 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
12 USE BY PREGNANT WOMEN.—

13 (1) GENERAL COST-SHARING LIMITATIONS.—
14 Section 1916 of the Social Security Act (42 U.S.C.
15 1396o) is amended in each of subsections (a)(2)(B)
16 and (b)(2)(B) by inserting “, and counseling and
17 pharmacotherapy for cessation of tobacco use by
18 pregnant women (as defined in section 1905(bb))
19 and covered outpatient drugs (as defined in sub-
20 section (k)(2) of section 1927 and including non-
21 prescription drugs described in subsection (d)(2) of
22 such section) that are prescribed for purposes of
23 promoting, and when used to promote, tobacco ces-
24 sation by pregnant women in accordance with the

1 Guideline referred to in section 1905(bb)(2)(A)”
2 after “complicate the pregnancy”.

3 (2) APPLICATION TO ALTERNATIVE COST-SHAR-
4 ING.—Section 1916A(b)(3)(B)(iii) of such Act (42
5 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by insert-
6 ing “, and counseling and pharmacotherapy for ces-
7 sation of tobacco use by pregnant women (as defined
8 in section 1905(bb))” after “complicate the preg-
9 nancy”.

10 (d) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on October 1, 2010.

12 **SEC. 2103. INCENTIVES FOR HEALTHY LIFESTYLES.**

13 (a) INITIATIVES.—

14 (1) ESTABLISHMENT.—

15 (A) IN GENERAL.—The Secretary shall
16 award grants to States to carry out initiatives
17 to provide incentives to Medicaid beneficiaries
18 who—

19 (i) successfully participate in a pro-
20 gram described in paragraph (3); and

21 (ii) upon completion of such participa-
22 tion, demonstrate changes in health risk
23 and outcomes, including the adoption and
24 maintenance of healthy behaviors by meet-

1 ing specific targets (as described in sub-
2 section (c)(2)).

3 (B) PURPOSE.—The purpose of the initia-
4 tives under this section is to test approaches
5 that may encourage behavior modification and
6 determine scalable solutions.

7 (2) DURATION.—

8 (A) INITIATION OF PROGRAM; RE-
9 SOURCES.—The Secretary shall awards grants
10 to States beginning on January 1, 2011, or be-
11 ginning on the date on which the Secretary de-
12 velops program criteria, whichever is earlier.
13 The Secretary shall develop program criteria for
14 initiatives under this section using relevant evi-
15 dence-based research and resources, including
16 the Guide to Community Preventive Services,
17 the Guide to Clinical Preventive Services, and
18 the National Registry of Evidence-Based Pro-
19 grams and Practices.

20 (B) DURATION OF PROGRAM.—A State
21 awarded a grant to carry out initiatives under
22 this section shall carry out such initiatives with-
23 in the 5-year period beginning on January 1,
24 2011, or beginning on the date on which the
25 Secretary develops program criteria, whichever

1 is earlier. Initiatives under this section shall be
2 carried out by a State for a period of not less
3 than 3 years.

4 (3) PROGRAM DESCRIBED.—

5 (A) IN GENERAL.—A program described in
6 this paragraph is a comprehensive, evidence-
7 based, widely available, and easily accessible
8 program, proposed by the State and approved
9 by the Secretary, that is designed and uniquely
10 suited to address the needs of Medicaid bene-
11 ficiaries and has demonstrated success in help-
12 ing individuals achieve one or more of the fol-
13 lowing:

- 14 (i) Ceasing use of tobacco products.
15 (ii) Controlling or reducing their
16 weight.
17 (iii) Lowering their cholesterol.
18 (iv) Lowering their blood pressure.
19 (v) Avoiding the onset of diabetes or,
20 in the case of a diabetic, improving the
21 management of that condition.

22 (B) CO-MORBIDITIES.—A program under
23 this section may also address co-morbidities (in-
24 cluding depression) that are related to any of
25 the conditions described in subparagraph (A).

1 (C) WAIVER AUTHORITY.—The Secretary
2 may waive the requirements of sections
3 1902(a)(1) (relating to statewideness) and
4 1902(a)(10)(B) (relating to comparability) of
5 the Social Security Act for a State awarded a
6 grant to conduct an initiative under this section
7 and shall ensure that a State makes any pro-
8 gram described in subparagraph (A) widely
9 available and accessible to Medicaid bene-
10 ficiaries in the State.

11 (D) FLEXIBILITY IN IMPLEMENTATION.—
12 A State may enter into arrangements with pro-
13 viders participating in Medicaid, community-
14 based organizations, faith-based organizations,
15 public-private partnerships, Indian tribes, or
16 similar entities or organizations to carry out
17 programs described in subparagraph (A).

18 (4) APPLICATION.—Following the development
19 of program criteria by the Secretary, a State may
20 submit an application, in such manner and con-
21 taining such information as the Secretary may re-
22 quire, that shall include a proposal for programs de-
23 scribed in paragraph (3)(A) and a plan to make
24 Medicaid beneficiaries and providers participating in

1 Medicaid who reside in the State aware and in-
2 formed about such programs.

3 (b) EDUCATION AND OUTREACH CAMPAIGN.—

4 (1) STATE AWARENESS.—The Secretary shall
5 conduct an outreach and education campaign to
6 make States aware of the grants under this section.

7 (2) PROVIDER AND BENEFICIARY EDU-
8 CATION.—A State awarded a grant to conduct an
9 initiative under this section shall conduct an out-
10 reach and education campaign to make Medicaid
11 beneficiaries and providers participating in Medicaid
12 who reside in the State aware of the programs de-
13 scribed in subsection (a)(3) that are to be carried
14 out by the State under the grant.

15 (c) MONITORING.—A State awarded a grant to con-
16 duct an initiative under this section shall develop and im-
17 plement a system to—

18 (1) monitor Medicaid beneficiary participation
19 in the program and validate changes in health risk
20 and outcomes with clinical data, including the adop-
21 tion and maintenance of health behaviors by such
22 beneficiaries;

23 (2) to the extent practicable, establish stand-
24 ards and health status targets for Medicaid bene-
25 ficiaries participating in the program and measure

1 the degree to which such standards and targets are
2 met;

3 (3) evaluate the effectiveness of the program
4 and provide the Secretary with such evaluations;

5 (4) report to the Secretary on processes that
6 have been developed and lessons learned from the
7 program; and

8 (5) report on preventive services as part of re-
9 porting on quality measures for Medicaid managed
10 care programs.

11 (d) INDEPENDENT ASSESSMENTS.—

12 (1) IN GENERAL.—The Secretary shall provide
13 for an independent assessment of the initiatives car-
14 ried out under this section.

15 (2) STATE REPORTING.—A State awarded a
16 grant to carry out initiatives under this section shall
17 submit reports to the Secretary, on a semi-annual
18 basis, regarding the programs that are supported by
19 the grant funds. Such report shall include informa-
20 tion, as specified by the Secretary, regarding—

21 (A) the specific uses of the grant funds;

22 (B) an assessment of program implementa-
23 tion and lessons learned from the programs;

24 (C) an assessment of quality improvements
25 and clinical outcomes under such programs; and

1 (D) estimates of cost savings resulting
2 from such programs.

3 (3) INITIAL REPORT.—Not later than January
4 1, 2014, the Secretary shall submit to Congress an
5 initial report on such initiatives based on informa-
6 tion provided by States through reports required
7 under paragraph (2). The initial report shall include
8 an interim evaluation of the effectiveness of the ini-
9 tiatives carried out with grants awarded under this
10 section and a recommendation regarding whether
11 funding for expanding or extending the initiatives
12 should be extended beyond January 1, 2016.

13 (4) FINAL REPORT.—Not later than July 1,
14 2016, the Secretary shall submit to Congress a final
15 report on the program that includes the results of
16 the independent assessment required under para-
17 graph (1), together with recommendations for such
18 legislation and administrative action as the Sec-
19 retary determines appropriate.

20 (e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT
21 OF, OTHER BENEFITS.—Any incentives provided to a
22 Medicaid beneficiary participating in a program described
23 in subsection (a)(3) shall not be taken into account for
24 purposes of determining the beneficiary's eligibility for, or

1 amount of, benefits under any program funded in whole
2 or in part with Federal funds.

3 (f) FUNDING.—Out of any funds in the Treasury not
4 otherwise appropriated, there are appropriated for the 5-
5 year period beginning on January 1, 2011, \$100,000,000
6 to the Secretary to carry out this section. Amounts appro-
7 priated under this subsection shall remain available until
8 expended.

9 (g) DEFINITIONS.—In this section:

10 (1) MEDICAID BENEFICIARY.—The term “Med-
11 icaid beneficiary” means an individual who is eligible
12 for medical assistance under a State plan or waiver
13 under title XIX of the Social Security Act (42
14 U.S.C. 1396 et seq.) and is enrolled in such plan or
15 waiver.

16 (2) SECRETARY.—The term “Secretary” means
17 the Secretary of Health and Human Services.

18 (3) STATE.—The term “State” has the mean-
19 ing given that term for purposes of title XIX of the
20 Social Security Act (42 U.S.C. 1396 et seq.).

21 **SEC. 2104. STATE OPTION TO PROVIDE HEALTH HOMES**
22 **FOR ENROLLEES WITH CHRONIC CONDI-**
23 **TIONS.**

24 (a) STATE PLAN AMENDMENT.—Title XIX of the So-
25 cial Security Act (42 U.S.C. 1396a et seq.), as amended

1 by sections 1621, 1640, and 1702(b), is amended by add-
2 ing at the end the following new section:

3 “SEC. 1946. STATE OPTION TO PROVIDE COORDI-
4 NATED CARE THROUGH A HEALTH HOME FOR INDIVID-
5 UALS WITH CHRONIC CONDITIONS.—

6 “(a) IN GENERAL.—Notwithstanding section
7 1902(a)(1) (relating to statewideness), section
8 1902(a)(10)(B) (relating to comparability), and any other
9 provision of this title for which the Secretary determines
10 it is necessary to waive in order to implement this section,
11 beginning January 1, 2011, a State, at its option as a
12 State plan amendment, may provide for medical assistance
13 under this title to eligible individuals with chronic condi-
14 tions who select a designated provider as the individual’s
15 health home for purposes of providing the individual with
16 health home services.

17 “(b) HEALTH HOME QUALIFICATION STANDARDS.—
18 The Secretary shall establish standards for qualification
19 as a designated provider (as described under subsection
20 (h)(3)) for the purpose of being eligible to be a health
21 home for purposes of this section.

22 “(c) PAYMENTS.—

23 “(1) IN GENERAL.—A State shall provide a des-
24 igned provider, or a team of health care profes-
25 sionals operating with such a provider, with pay-

1 ments for the provision of health home services to
2 each eligible individual with chronic conditions that
3 selects the provider as the individual's health home.
4 Payments made to a designated provider or a team
5 for such services shall be treated as medical assist-
6 ance for purposes of section 1903(a), except that,
7 during the first 8 fiscal year quarters that the State
8 plan amendment is in effect, the Federal medical as-
9 sistance percentage applicable to such payments
10 shall be equal to 90 percent.

11 “(2) METHODOLOGY.—

12 “(A) IN GENERAL.—The State shall speci-
13 fy in the State plan amendment the method-
14 ology the State will use for determining pay-
15 ment for the provision of health home services.
16 Such methodology for determining payment—

17 “(i) may be tiered to reflect, with re-
18 spect to each eligible individual with chron-
19 ic conditions provided such services by a
20 designated provider or a team of health
21 care professionals operating with such a
22 provider, the severity or number of each
23 such individual's chronic conditions or the
24 specific capabilities of the provider or
25 team; and

1 “(ii) shall be established consistent
2 with section 1902(a)(30)(A).

3 “(B) ALTERNATE MODELS OF PAYMENT.—

4 The methodology for determining payment for
5 provision of health home services under this
6 section shall not be limited to a per-member
7 per-month basis and may provide (as proposed
8 by the State and subject to approval by the
9 Secretary) for alternate models of payment.

10 “(3) PLANNING GRANTS.—The Secretary may
11 award planning grants to States for purposes of de-
12 veloping a State plan amendment under this section.
13 A State awarded a planning grant shall contribute
14 an amount equal to the State percentage determined
15 under section 1905(b) (without regard to section
16 5001 of Public Law 111–5) for each fiscal year for
17 which the grant is awarded. The total amount of
18 payments made to States under this paragraph shall
19 not exceed \$25,000,000.

20 “(d) HOSPITAL REFERRALS.—A State shall include
21 in the State plan amendment a requirement for hospitals
22 that are participating providers under the State plan or
23 a waiver of such plan to establish procedures for referring
24 any eligible individuals with chronic conditions who seek

1 or need treatment in a hospital emergency department to
2 designated providers.

3 “(e) COORDINATION.—A State shall consult and co-
4 ordinate, as appropriate, with the Substance Abuse and
5 Mental Health Services Administration in addressing
6 issues regarding the prevention and treatment of mental
7 illness and substance abuse among eligible individuals with
8 chronic conditions.

9 “(f) MONITORING.—A State shall include in the State
10 plan amendment—

11 “(1) a methodology for tracking avoidable hos-
12 pital readmissions and calculating savings that re-
13 sult from improved chronic care coordination and
14 management under this section; and

15 “(2) a proposal for use of health information
16 technology in providing health home services under
17 this section and improving service delivery and co-
18 ordination across the care continuum (including the
19 use of wireless patient technology to improve coordi-
20 nation and management of care and patient adher-
21 ence to recommendations made by their provider).

22 “(g) REPORT ON QUALITY MEASURES.—As a condi-
23 tion for receiving payment for health home services pro-
24 vided to an eligible individual with chronic conditions, a
25 designated provider shall report to the State, in accord-

1 ance with such requirements as the Secretary shall specify,
2 on all applicable measures for determining the quality of
3 such services. When appropriate and feasible, a designated
4 provider shall use health information technology in pro-
5 viding the State with such information.

6 “(h) DEFINITIONS.—In this section:

7 “(1) ELIGIBLE INDIVIDUAL WITH CHRONIC
8 CONDITIONS.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (B), the term ‘eligible individual with
11 chronic conditions’ means an individual who—

12 “(i) is eligible for medical assistance
13 under the State plan or under a waiver of
14 such plan; and

15 “(ii) has at least—

16 “(I) 2 chronic conditions;

17 “(II) 1 chronic condition and is
18 at risk of having a second chronic
19 condition; or

20 “(III) 1 serious and persistent
21 mental health condition.

22 “(B) RULE OF CONSTRUCTION.—Nothing
23 in this paragraph shall prevent the Secretary
24 from establishing higher levels as to the number
25 or severity of chronic or mental health condi-

1 tions for purposes of determining eligibility for
2 receipt of health home services under this sec-
3 tion.

4 “(2) CHRONIC CONDITION.—The term ‘chronic
5 condition’ has the meaning given that term by the
6 Secretary and shall include, but is not limited to, the
7 following:

8 “(A) A mental health condition.

9 “(B) Substance abuse.

10 “(C) Asthma.

11 “(D) Diabetes.

12 “(E) Heart disease.

13 “(F) Being overweight, as evidenced by
14 having a Body Mass Index (BMI) over 25.

15 “(3) DESIGNATED PROVIDER.—The term ‘des-
16 ignated provider’ means a physician, clinical practice
17 or clinical group practice, rural clinic, community
18 health center, community mental health center,
19 home health agency, or any other entity or provider
20 (including pediatricians and obstetricians) that is de-
21 termined by the State and approved by the Sec-
22 retary to be qualified to be a health home for eligible
23 individuals with chronic conditions on the basis of
24 documentation evidencing that the physician, prac-
25 tice, or clinic—

1 “(A) has the systems and infrastructure in
2 place to provide health home services; and

3 “(B) satisfies the qualification standards
4 established by the Secretary under subsection
5 (b).

6 “(4) HEALTH HOME.—The term ‘health home’
7 means a designated provider (including a provider
8 that operates in coordination with a team of health
9 care professionals) selected by an eligible individual
10 with chronic conditions to provide health home serv-
11 ices.

12 “(5) HEALTH HOME SERVICES.—

13 “(A) IN GENERAL.—The term ‘health
14 home services’ means comprehensive and timely
15 high-quality services described in subparagraph
16 (B) that are provided by a designated provider
17 or a team of health care professionals (as de-
18 scribed in subparagraph (C)) operating with
19 such a provider.

20 “(B) SERVICES DESCRIBED.—The services
21 described in this subparagraph are—

22 “(i) comprehensive care management;

23 “(ii) care coordination and health pro-
24 motion;

1 entity deemed appropriate by the State
2 and approved by the Secretary.”.

3 (b) EVALUATION.—

4 (1) INDEPENDENT EVALUATION.—

5 (A) IN GENERAL.—Not later than January
6 1, 2013, the Secretary shall enter into a con-
7 tract with an independent entity or organization
8 to conduct an evaluation and assessment of the
9 States that have elected the option to provide
10 coordinated care through a health home for
11 Medicaid beneficiaries with chronic conditions
12 under section 1946 of the Social Security Act
13 (as added by subsection (a)) for the purpose of
14 determining the effect of such option on reduc-
15 ing hospital admissions, emergency room visits,
16 and admissions to skilled nursing facilities.

17 (B) EVALUATION REPORT.—Not later than
18 January 1, 2017, the Secretary shall report to
19 Congress on the evaluation and assessment con-
20 ducted under subparagraph (A).

21 (2) SURVEY AND INTERIM REPORT.—

22 (A) IN GENERAL.—Not later than January
23 1, 2014, the Secretary of Health and Human
24 Services shall survey States that have elected
25 the option under section 1946 of the Social Se-

1 curity Act (as added by subsection (a)) and re-
2 port to Congress on the nature, extent, and use
3 of such option, particularly as it pertains to—

4 (i) hospital admission rates;

5 (ii) chronic disease management;

6 (iii) coordination of care for individ-
7 uals with chronic conditions;

8 (iv) assessment of program implemen-
9 tation;

10 (v) processes and lessons learned (as
11 described in subparagraph (B));

12 (vi) assessment of quality improve-
13 ments and clinical outcomes under such
14 option; and

15 (vii) estimates of cost savings.

16 (B) IMPLEMENTATION REPORTING.—A

17 State that has elected the option under section
18 1946 of the Social Security Act (as added by
19 subsection (a)) shall report to the Secretary, as
20 necessary, on processes that have been devel-
21 oped and lessons learned regarding provision of
22 coordinated care through a health home for
23 Medicaid beneficiaries with chronic conditions
24 under such option.

1 **SEC. 2105. FUNDING FOR CHILDHOOD OBESITY DEM-**
2 **ONSTRATION PROJECT.**

3 Section 1139A(e)(8) of the Social Security Act (42
4 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

5 “(8) APPROPRIATION.—Out of any funds in the
6 Treasury not otherwise appropriated, there is appro-
7 priated to carry out this subsection, \$25,000,000 for
8 the period of fiscal years 2010 through 2014.”.

9 **SEC. 2106. PUBLIC AWARENESS OF PREVENTIVE AND OBE-**
10 **SITY-RELATED SERVICES.**

11 (a) INFORMATION TO STATES.—The Secretary of
12 Health and Human Services shall provide guidance and
13 relevant information to States and health care providers
14 regarding preventive and obesity-related services that are
15 available to Medicaid enrollees, including obesity screening
16 and counseling for children and adults.

17 (b) INFORMATION TO ENROLLEES.—Each State shall
18 design a public awareness campaign to educate Medicaid
19 enrollees regarding availability and coverage of such serv-
20 ices, with the goal of reducing incidences of obesity.

21 (c) REPORT.—Not later than January 1, 2011, and
22 every 3 years thereafter through January 1, 2017, the
23 Secretary of Health and Human Services shall report to
24 Congress on the status and effectiveness of efforts under
25 subsections (a) and (b), including summaries of the

1 States' efforts to increase awareness of coverage of obe-
2 sity-related services.

3 **TITLE III—IMPROVING THE**
4 **QUALITY AND EFFICIENCY OF**
5 **HEALTH CARE**

6 **Subtitle A—Transforming the**
7 **Health Care Delivery System**

8 **PART I—LINKING PAYMENT TO QUALITY**
9 **OUTCOMES UNDER THE MEDICARE PROGRAM**

10 **SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PRO-**
11 **GRAM.**

12 (a) PROGRAM.—

13 (1) IN GENERAL.—Section 1886 of the Social
14 Security Act (42 U.S.C. 1395ww), as amended by
15 section 4102(a) of the HITECH Act (Public Law
16 111–5), is amended by adding at the end the fol-
17 lowing new subsection:

18 “(o) HOSPITAL VALUE-BASED PURCHASING PRO-
19 GRAM.—

20 “(1) ESTABLISHMENT.—

21 “(A) IN GENERAL.—Subject to the suc-
22 ceeding provisions of this subsection, the Sec-
23 retary shall establish a hospital value-based
24 purchasing program (in this subsection referred
25 to as the ‘Program’) under which value-based

1 incentive payments are made in a fiscal year to
2 hospitals that meet the performance standards
3 under paragraph (3) for the performance period
4 for such fiscal year (as established under para-
5 graph (4)).

6 “(B) PROGRAM TO BEGIN IN FISCAL YEAR
7 2013.—The Program shall apply to payments
8 for discharges occurring on or after October 1,
9 2012.

10 “(C) APPLICABILITY OF PROGRAM TO HOS-
11 PITALS.—

12 “(i) IN GENERAL.—For purposes of
13 this subsection, subject to clause (ii), the
14 term ‘hospital’ means a subsection (d) hos-
15 pital (as defined in subsection (d)(1)(B)).

16 “(ii) EXCLUSIONS.—The term ‘hos-
17 pital’ shall not include, with respect to a
18 fiscal year, a hospital—

19 “(I) that is subject to the pay-
20 ment reduction under subsection
21 (b)(3)(B)(viii)(I) for such fiscal year;

22 “(II) for which, during the per-
23 formance period for such fiscal year,
24 the Secretary has cited deficiencies

1 that pose immediate jeopardy to the
2 health or safety of patients;

3 “(III) for which there are not a
4 minimum number (as determined by
5 the Secretary) of measures that apply
6 to the hospital for the performance
7 period for such fiscal year; or

8 “(IV) for which there are not a
9 minimum number (as determined by
10 the Secretary) of cases for the meas-
11 ures that apply to the hospital for the
12 performance period for such fiscal
13 year.

14 “(iii) INDEPENDENT ANALYSIS.—For
15 purposes of determining the minimum
16 numbers under subclauses (III) and (IV)
17 of clause (ii), the Secretary shall have con-
18 ducted an independent analysis of what
19 numbers are appropriate.

20 “(2) MEASURES.—

21 “(A) IN GENERAL.—The Secretary shall
22 select measures for purposes of the Program.
23 Such measures shall be selected from the meas-
24 ures specified under subsection (b)(3)(B)(viii).

25 “(B) REQUIREMENTS.—

1 “(i) FOR FISCAL YEAR 2013.—For
2 value-based incentive payments made with
3 respect to discharges occurring during fis-
4 cal year 2013, the Secretary shall ensure
5 the following:

6 “(I) CONDITIONS OR PROCE-
7 DURES.—Measures are selected under
8 subparagraph (A) that cover at least
9 the following 5 specific conditions or
10 procedures:

11 “(aa) Acute myocardial in-
12 farction (AMI).

13 “(bb) Heart failure.

14 “(cc) Pneumonia.

15 “(dd) Surgeries, as meas-
16 ured by the Surgical Care Im-
17 provement Project (formerly re-
18 ferred to as ‘Surgical Infection
19 Prevention’ for discharges occur-
20 ring before July 2006).

21 “(ee) Healthcare-associated
22 infections, as measured by the
23 prevention metrics and targets
24 established in the HHS Action
25 Plan to Prevent Healthcare-Asso-

1 respect to a performance period for a fiscal
2 year (as established under paragraph (4))
3 unless such measure has been specified
4 under subsection (b)(3)(B)(viii) and in-
5 cluded on the Hospital Compare Internet
6 website for at least 1 year prior to the be-
7 ginning of such performance period.

8 “(ii) MEASURE NOT APPLICABLE UN-
9 LESS HOSPITAL FURNISHES SERVICES AP-
10 PROPRIATE TO THE MEASURE.—A measure
11 selected under subparagraph (A) shall not
12 apply to a hospital if such hospital does
13 not furnish services appropriate to such
14 measure.

15 “(D) REPLACING MEASURES.—Subclause
16 (VI) of subsection (b)(3)(B)(viii) shall apply to
17 measures selected under subparagraph (A) in
18 the same manner as such subclause applies to
19 measures selected under such subsection.

20 “(3) PERFORMANCE STANDARDS.—

21 “(A) ESTABLISHMENT.—The Secretary
22 shall establish performance standards with re-
23 spect to measures selected under paragraph (2)
24 for a performance period for a fiscal year (as
25 established under paragraph (4)).

1 “(B) ACHIEVEMENT AND IMPROVE-
2 MENT.—The performance standards established
3 under subparagraph (A) shall include levels of
4 achievement and improvement.

5 “(C) TIMING.—The Secretary shall estab-
6 lish and announce the performance standards
7 under subparagraph (A) not later than 60 days
8 prior to the beginning of the performance pe-
9 riod for the fiscal year involved.

10 “(D) CONSIDERATIONS IN ESTABLISHING
11 STANDARDS.—In establishing performance
12 standards with respect to measures under this
13 paragraph, the Secretary shall take into ac-
14 count appropriate factors, such as—

15 “(i) practical experience with the
16 measures involved, including whether a sig-
17 nificant proportion of hospitals failed to
18 meet the performance standard during pre-
19 vious performance periods;

20 “(ii) historical performance standards;

21 “(iii) improvement rates; and

22 “(iv) the opportunity for continued
23 improvement.

24 “(4) PERFORMANCE PERIOD.—For purposes of
25 the Program, the Secretary shall establish the per-

1 performance period for a fiscal year. Such performance
2 period shall begin and end prior to the beginning of
3 such fiscal year.

4 “(5) HOSPITAL PERFORMANCE SCORE.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), the Secretary shall develop a meth-
7 odology for assessing the total performance of
8 each hospital based on performance standards
9 with respect to the measures selected under
10 paragraph (2) for a performance period (as es-
11 tablished under paragraph (4)). Using such
12 methodology, the Secretary shall provide for an
13 assessment (in this subsection referred to as the
14 ‘hospital performance score’) for each hospital
15 for each performance period.

16 “(B) APPLICATION.—

17 “(i) APPROPRIATE DISTRIBUTION.—

18 The Secretary shall ensure that the appli-
19 cation of the methodology developed under
20 subparagraph (A) results in an appropriate
21 distribution of value-based incentive pay-
22 ments under paragraph (6) among hos-
23 pitals achieving different levels of hospital
24 performance scores, with hospitals achiev-
25 ing the highest hospital performance scores

1 receiving the largest value-based incentive
2 payments.

3 “(ii) HIGHER OF ACHIEVEMENT OR
4 IMPROVEMENT.—The methodology devel-
5 oped under subparagraph (A) shall provide
6 that the hospital performance score is de-
7 termined using the higher of its achieve-
8 ment or improvement score for each meas-
9 ure.

10 “(iii) WEIGHTS.—The methodology
11 developed under subparagraph (A) shall
12 provide for the assignment of weights for
13 categories of measures as the Secretary de-
14 termines appropriate.

15 “(iv) NO MINIMUM PERFORMANCE
16 STANDARD.—The Secretary shall not set a
17 minimum performance standard in deter-
18 mining the hospital performance score for
19 any hospital.

20 “(v) REFLECTION OF MEASURES AP-
21 PPLICABLE TO THE HOSPITAL.—The hos-
22 pital performance score for a hospital shall
23 reflect the measures that apply to the hos-
24 pital.

1 “(6) CALCULATION OF VALUE-BASED INCEN-
2 TIVE PAYMENTS.—

3 “(A) IN GENERAL.—In the case of a hos-
4 pital that the Secretary determines meets (or
5 exceeds) the performance standards under para-
6 graph (3) for the performance period for a fis-
7 cal year (as established under paragraph (4)),
8 the Secretary shall increase the base operating
9 DRG payment amount (as defined in paragraph
10 (7)(D)), as determined after application of
11 paragraph (7)(B)(i), for a hospital for each dis-
12 charge occurring in such fiscal year by the
13 value-based incentive payment amount.

14 “(B) VALUE-BASED INCENTIVE PAYMENT
15 AMOUNT.—The value-based incentive payment
16 amount for each discharge of a hospital in a fis-
17 cal year shall be equal to the product of—

18 “(i) the base operating DRG payment
19 amount (as defined in paragraph (7)(D))
20 for the discharge for the hospital for such
21 fiscal year; and

22 “(ii) the value-based incentive pay-
23 ment percentage specified under subpara-
24 graph (C) for the hospital for such fiscal
25 year.

1 “(C) VALUE-BASED INCENTIVE PAYMENT
2 PERCENTAGE.—

3 “(i) IN GENERAL.—The Secretary
4 shall specify a value-based incentive pay-
5 ment percentage for a hospital for a fiscal
6 year.

7 “(ii) REQUIREMENTS.—In specifying
8 the value-based incentive payment percent-
9 age for each hospital for a fiscal year
10 under clause (i), the Secretary shall ensure
11 that—

12 “(I) such percentage is based on
13 the hospital performance score of the
14 hospital under paragraph (5); and

15 “(II) the total amount of value-
16 based incentive payments under this
17 paragraph to all hospitals in such fis-
18 cal year is equal to the total amount
19 available for value-based incentive
20 payments for such fiscal year under
21 paragraph (7)(A), as estimated by the
22 Secretary.

23 “(7) FUNDING FOR VALUE-BASED INCENTIVE
24 PAYMENTS.—

1 “(A) AMOUNT.—The total amount avail-
2 able for value-based incentive payments under
3 paragraph (6) for all hospitals for a fiscal year
4 shall be equal to the total amount of reduced
5 payments for all hospitals under subparagraph
6 (B) for such fiscal year, as estimated by the
7 Secretary.

8 “(B) ADJUSTMENT TO PAYMENTS.—

9 “(i) IN GENERAL.—The Secretary
10 shall reduce the base operating DRG pay-
11 ment amount (as defined in subparagraph
12 (D)) for a hospital for each discharge in a
13 fiscal year (beginning with fiscal year
14 2013) by an amount equal to the applica-
15 ble percent (as defined in subparagraph
16 (C)) of the base operating DRG payment
17 amount for the discharge for the hospital
18 for such fiscal year. The Secretary shall
19 make such reductions for all hospitals in
20 the fiscal year involved, regardless of
21 whether or not the hospital has been deter-
22 mined by the Secretary to have earned a
23 value-based incentive payment under para-
24 graph (6) for such fiscal year.

1 “(ii) NO EFFECT ON OTHER PAY-
2 MENTS.—Payments described in items (aa)
3 and (bb) of subparagraph (D)(i)(II) for a
4 hospital shall be determined as if this sub-
5 section had not been enacted.

6 “(C) APPLICABLE PERCENT DEFINED.—
7 For purposes of subparagraph (B), the term
8 ‘applicable percent’ means—

9 “(i) with respect to fiscal year 2013,
10 1.0 percent;

11 “(ii) with respect to fiscal year 2014,
12 1.25 percent;

13 “(iii) with respect to fiscal year 2015,
14 1.5 percent;

15 “(iv) with respect to fiscal year 2016,
16 1.75 percent; and

17 “(v) with respect to fiscal year 2017
18 and succeeding fiscal years, 2 percent.

19 “(D) BASE OPERATING DRG PAYMENT
20 AMOUNT DEFINED.—

21 “(i) IN GENERAL.—Except as pro-
22 vided in clause (ii), in this subsection, the
23 term ‘base operating DRG payment
24 amount’ means, with respect to a hospital
25 for a fiscal year—

1 “(I) the payment amount that
2 would otherwise be made under sub-
3 section (d) for a discharge if this sub-
4 section did not apply; reduced by

5 “(II) any portion of such pay-
6 ment amount that is attributable to—

7 “(aa) payments under para-
8 graphs (5)(A), (5)(B), (5)(F),
9 and (12) of subsection (d); and

10 “(bb) such other payments
11 under subsection (d) determined
12 appropriate by the Secretary.

13 “(ii) SPECIAL RULES FOR CERTAIN
14 HOSPITALS.—

15 “(I) SOLE COMMUNITY HOS-
16 PITALS AND MEDICARE-DEPENDENT,
17 SMALL RURAL HOSPITALS.—In the
18 case of a medicare-dependent, small
19 rural hospital (with respect to dis-
20 charges occurring during fiscal year
21 2012 and 2013) or a sole community
22 hospital, in applying subparagraph
23 (A)(i), the payment amount that
24 would otherwise be made under sub-
25 section (d) shall be determined with-

1 out regard to subparagraphs (I) and
2 (L) of subsection (b)(3) and subpara-
3 graphs (D) and (G) of subsection
4 (d)(5).

5 “(II) HOSPITALS PAID UNDER
6 SECTION 1814.—In the case of a hos-
7 pital that is paid under section
8 1814(b)(3), the term ‘base operating
9 DRG payment amount’ means the
10 payment amount under such section.

11 “(8) ANNOUNCEMENT OF NET RESULT OF AD-
12 JUSTMENTS.—Under the Program, the Secretary
13 shall, not later than 60 days prior to the fiscal year
14 involved, inform each hospital of the adjustments to
15 payments to the hospital for discharges occurring in
16 such fiscal year under paragraphs (6) and (7)(B)(i).

17 “(9) NO EFFECT IN SUBSEQUENT FISCAL
18 YEARS.—The value-based incentive payment under
19 paragraph (6) and the payment reduction under
20 paragraph (7)(B)(i) shall each apply only with re-
21 spect to the fiscal year involved, and the Secretary
22 shall not take into account such value-based incen-
23 tive payment or payment reduction in making pay-
24 ments to a hospital under this section in a subse-
25 quent fiscal year.

1 “(10) PUBLIC REPORTING.—

2 “(A) HOSPITAL SPECIFIC INFORMATION.—

3 “(i) IN GENERAL.—The Secretary
4 shall make information available to the
5 public regarding the performance of indi-
6 vidual hospitals under the Program, in-
7 cluding—

8 “(I) the performance of the hos-
9 pital with respect to each measure
10 that applies to the hospital;

11 “(II) the performance of the hos-
12 pital with respect to each condition or
13 procedure; and

14 “(III) the hospital performance
15 score assessing the total performance
16 of the hospital.

17 “(ii) OPPORTUNITY TO REVIEW AND
18 SUBMIT CORRECTIONS.—The Secretary
19 shall ensure that a hospital has the oppor-
20 tunity to review, and submit corrections
21 for, the information to be made public with
22 respect to the hospital under clause (i)
23 prior to such information being made pub-
24 lic.

1 “(iii) WEBSITE.—Such information
2 shall be posted on the Hospital Compare
3 Internet website in an easily understand-
4 able format.

5 “(B) AGGREGATE INFORMATION.—The
6 Secretary shall periodically post on the Hospital
7 Compare Internet website aggregate informa-
8 tion on the Program, including—

9 “(i) the number of hospitals receiving
10 value-based incentive payments under
11 paragraph (6) and the range and total
12 amount of such value-based incentive pay-
13 ments; and

14 “(ii) the number of hospitals receiving
15 less than the maximum value-based incen-
16 tive payment available to the hospital for
17 the fiscal year involved and the range and
18 amount of such payments.

19 “(11) IMPLEMENTATION.—

20 “(A) APPEALS.—The Secretary shall es-
21 tablish a process by which hospitals may appeal
22 the calculation of a hospital’s performance as-
23 sessment with respect to the performance
24 standards established under paragraph (3)(A)
25 and the hospital performance score under para-

1 graph (5). The Secretary shall ensure that such
2 process provides for resolution of such appeals
3 in a timely manner.

4 “(B) LIMITATION ON REVIEW.—Except as
5 provided in subparagraph (A), there shall be no
6 administrative or judicial review under section
7 1869, section 1878, or otherwise of the fol-
8 lowing:

9 “(i) The methodology used to deter-
10 mine the amount of the value-based incen-
11 tive payment under paragraph (6) and the
12 determination of such amount.

13 “(ii) The determination of the amount
14 of funding available for such value-based
15 incentive payments under paragraph
16 (7)(A) and the payment reduction under
17 paragraph (7)(B)(i).

18 “(iii) The establishment of the per-
19 formance standards under paragraph (3)
20 and the performance period under para-
21 graph (4).

22 “(iv) The measures specified under
23 subsection (b)(3)(B)(viii) and the measures
24 selected under paragraph (2).

1 “(v) The methodology developed under
2 paragraph (5) that is used to calculate
3 hospital performance scores and the cal-
4 culation of such scores.

5 “(vi) The validation methodology
6 specified in subsection (b)(3)(B)(viii)(XI).

7 “(C) CONSULTATION WITH SMALL HOS-
8 PITALS.—The Secretary shall consult with small
9 rural and urban hospitals on the application of
10 the Program to such hospitals.

11 “(12) PROMULGATION OF REGULATIONS.—The
12 Secretary shall promulgate regulations to carry out
13 the Program, including the selection of measures
14 under paragraph (2), the methodology developed
15 under paragraph (5) that is used to calculate hos-
16 pital performance scores, and the methodology used
17 to determine the amount of value-based incentive
18 payments under paragraph (6).”.

19 (2) AMENDMENTS FOR REPORTING OF HOS-
20 PITAL QUALITY INFORMATION.—Section
21 1886(b)(3)(B)(viii) of the Social Security Act (42
22 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

23 (A) in subclause (II), by adding at the end
24 the following sentence: “The Secretary may re-
25 quire hospitals to submit data on measures that

1 are not used for the determination of value-
2 based incentive payments under subsection
3 (o).”;

4 (B) in subclause (V), by striking “begin-
5 ning with fiscal year 2008” and inserting “for
6 fiscal years 2008 through 2012”;

7 (C) in subclause (VII), in the first sen-
8 tence, by striking “data submitted” and insert-
9 ing “information regarding measures sub-
10 mitted”; and

11 (D) by adding at the end the following new
12 subclauses:

13 “(VIII) Effective for payments beginning with fiscal
14 year 2013, with respect to quality measures for outcomes
15 of care, the Secretary shall provide for such risk adjust-
16 ment as the Secretary determines to be appropriate to
17 maintain incentives for hospitals to treat patients with se-
18 vere illnesses or conditions.

19 “(IX) Effective for payments beginning with fiscal
20 year 2013, each measure specified by the Secretary under
21 this clause shall be endorsed under paragraph (1) of sec-
22 tion 1890C(f) or used as a result of a determination under
23 paragraph (2) of such section.

24 “(X) To the extent practicable, the Secretary shall,
25 with input from consensus organizations and other stake-

1 holders, take steps to ensure that the measures specified
2 by the Secretary under this clause are coordinated and
3 aligned with quality measures applicable to—

4 “(aa) physicians under section 1848(k); and

5 “(bb) other providers of services and suppliers
6 under this title.

7 “(XI) The Secretary shall establish a process to vali-
8 date measures specified under this clause as appropriate.
9 Such process shall include the auditing of a number of
10 randomly selected hospitals sufficient to ensure validity of
11 the reporting program under this clause as a whole and
12 shall provide a hospital with an opportunity to appeal the
13 validation of measures reported by such hospital.”.

14 (3) WEBSITE IMPROVEMENTS.—Section
15 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
16 1395ww(b)(3)(B)), as amended by section 4102(b)
17 of the HITECH Act (Public Law 111–5), is amend-
18 ed by adding at the end the following new clause:

19 “(ix)(I) The Secretary shall develop standard Inter-
20 net website reports tailored to meet the needs of various
21 stakeholders such as hospitals, patients, researchers, and
22 policymakers. The Secretary shall seek input from such
23 stakeholders in determining the type of information that
24 is useful and the formats that best facilitate the use of
25 the information.

1 “(II) The Secretary shall modify the Hospital Com-
2 pare Internet website to make the use and navigation of
3 that website readily available to individuals accessing it.”.

4 (4) GAO STUDY AND REPORT.—

5 (A) STUDY.—The Comptroller General of
6 the United States shall conduct a study on the
7 performance of the hospital value-based pur-
8 chasing program established under section
9 1886(o) of the Social Security Act, as added by
10 paragraph (1). Such study shall include an
11 analysis of the impact of such program on—

12 (i) the quality of care furnished to
13 Medicare beneficiaries, including diverse
14 Medicare beneficiary populations (such as
15 diverse in terms of race, ethnicity, and so-
16 cioeconomic status);

17 (ii) expenditures under the Medicare
18 program, including any reduced expendi-
19 tures under Part A of title XVIII of such
20 Act that are attributable to the improve-
21 ment in the delivery of inpatient hospital
22 services by reason of such hospital value-
23 based purchasing program;

24 (iii) the quality performance among
25 safety net hospitals and any barriers such

1 hospitals face in meeting the performance
2 standards applicable under such hospital
3 value-based purchasing program; and

4 (iv) the quality performance among
5 small rural and small urban hospitals and
6 any barriers such hospitals face in meeting
7 the performance standards applicable
8 under such hospital value-based purchasing
9 program.

10 (B) REPORTS.—

11 (i) INTERIM REPORT.—Not later than
12 October 1, 2015, the Comptroller General
13 of the United States shall submit to Con-
14 gress an interim report containing the re-
15 sults of the study conducted under sub-
16 paragraph (A), together with recommenda-
17 tions for such legislation and administra-
18 tive action as the Comptroller General de-
19 termines appropriate.

20 (ii) FINAL REPORT.—Not later than
21 July 1, 2017, the Comptroller General of
22 the United States shall submit to Congress
23 a report containing the results of the study
24 conducted under subparagraph (A), to-
25 gether with recommendations for such leg-

1 islation and administrative action as the
2 Comptroller General determines appro-
3 priate.

4 (5) HHS STUDY AND REPORT.—

5 (A) STUDY.—The Secretary of Health and
6 Human Services shall conduct a study on the
7 performance of the hospital value-based pur-
8 chasing program established under section
9 1886(o) of the Social Security Act, as added by
10 paragraph (1). Such study shall include an
11 analysis—

12 (i) of ways to improve the hospital
13 value-based purchasing program and ways
14 to address any unintended consequences
15 that may occur as a result of such pro-
16 gram;

17 (ii) of whether the hospital value-
18 based purchasing program resulted in
19 lower spending under the Medicare pro-
20 gram under title XVIII of such Act or
21 other financial savings to hospitals;

22 (iii) the appropriateness of the Medi-
23 care program sharing in any savings gen-
24 erated through the hospital value-based
25 purchasing program; and

1 (iv) any other area determined appro-
2 priate by the Secretary.

3 (B) REPORT.—Not later than January 1,
4 2016, the Secretary of Health and Human
5 Services shall submit to Congress a report con-
6 taining the results of the study conducted under
7 subparagraph (A), together with recommenda-
8 tions for such legislation and administrative ac-
9 tion as the Secretary determines appropriate.

10 (b) VALUE-BASED PURCHASING DEMONSTRATION
11 PROGRAMS.—

12 (1) VALUE-BASED PURCHASING DEMONSTRA-
13 TION PROGRAM FOR INPATIENT CRITICAL ACCESS
14 HOSPITALS.—

15 (A) ESTABLISHMENT.—

16 (i) IN GENERAL.—Not later than 2
17 years after the date of enactment of this
18 Act, the Secretary of Health and Human
19 Services (in this subsection referred to as
20 the “Secretary”) shall establish a dem-
21 onstration program under which the Sec-
22 retary establishes a value-based purchasing
23 program under the Medicare program
24 under title XVIII of the Social Security
25 Act for critical access hospitals (as defined

1 in paragraph (1) of section 1861(mm) of
2 such Act (42 U.S.C. 1395x(mm))) with re-
3 spect to inpatient critical access hospital
4 services (as defined in paragraph (2) of
5 such section) in order to test innovative
6 methods of measuring and rewarding qual-
7 ity health care furnished by such hospitals.

8 (ii) DURATION.—The demonstration
9 program under this paragraph shall be
10 conducted for a 3-year period.

11 (iii) SITES.—The Secretary shall con-
12 duct the demonstration program under this
13 paragraph at an appropriate number (as
14 determined by the Secretary) of critical ac-
15 cess hospitals. The Secretary shall ensure
16 that such hospitals are representative of
17 the spectrum of such hospitals that partici-
18 pate in the Medicare program.

19 (B) WAIVER AUTHORITY.—The Secretary
20 may waive such requirements of titles XI and
21 XVIII of the Social Security Act as may be nec-
22 essary to carry out the demonstration program
23 under this paragraph.

24 (C) REPORT.—Not later than 18 months
25 after the completion of the demonstration pro-

1 Act for applicable hospitals (as defined in
2 clause (ii)) with respect to inpatient hos-
3 pital services (as defined in section
4 1861(b) of the Social Security Act (42
5 U.S.C. 1395x(b))) in order to test innova-
6 tive methods of measuring and rewarding
7 quality health care furnished by such hos-
8 pitals.

9 (ii) APPLICABLE HOSPITAL DE-
10 FINED.—For purposes of this paragraph,
11 the term “applicable hospital” means a
12 hospital described in subclause (III) or
13 (IV) of section 1886(o)(1)(C)(ii) of the So-
14 cial Security Act, as added by subsection
15 (a)(1).

16 (iii) DURATION.—The demonstration
17 program under this paragraph shall be
18 conducted for a 3-year period.

19 (iv) SITES.—The Secretary shall con-
20 duct the demonstration program under this
21 paragraph at an appropriate number (as
22 determined by the Secretary) of applicable
23 hospitals. The Secretary shall ensure that
24 such hospitals are representative of the

1 spectrum of such hospitals that participate
2 in the Medicare program.

3 (B) WAIVER AUTHORITY.—The Secretary
4 may waive such requirements of titles XI and
5 XVIII of the Social Security Act as may be nec-
6 essary to carry out the demonstration program
7 under this paragraph.

8 (C) REPORT.—Not later than 18 months
9 after the completion of the demonstration pro-
10 gram under this paragraph, the Secretary shall
11 submit to Congress a report on the demonstra-
12 tion program together with—

13 (i) recommendations on the establish-
14 ment of a permanent value-based pur-
15 chasing program under the Medicare pro-
16 gram for applicable hospitals with respect
17 to inpatient hospital services; and

18 (ii) recommendations for such other
19 legislation and administrative action as the
20 Secretary determines appropriate.

21 **SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY**
22 **REPORTING SYSTEM.**

23 (a) EXTENSION.—Section 1848(m) of the Social Se-
24 curity Act (42 U.S.C. 1395w-4(m)) is amended—

25 (1) in paragraph (1)—

1 (A) in subparagraph (A), in the matter
2 preceding clause (i), by striking “2010” and in-
3 serting “2012”; and

4 (B) in subparagraph (B)—

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

7 (ii) in clause (ii), by striking the pe-
8 riod at the end and inserting a semicolon;
9 and

10 (iii) by adding at the end the fol-
11 lowing new clauses:

12 “(iii) for 2011, 1.0 percent; and

13 “(iv) for 2012, 0.5 percent.”;

14 (2) in paragraph (3)—

15 (A) in subparagraph (A), in the matter
16 preceding clause (i), by inserting “(or, for pur-
17 poses of subsection (a)(8), for the quality re-
18 porting period for the year)” after “reporting
19 period”; and

20 (B) in subparagraph (C)(i), by inserting “,
21 or, for purposes of subsection (a)(8), for a qual-
22 ity reporting period for the year” after “(a)(5),
23 for a reporting period for a year”;

1 (3) in paragraph (5)(E)(iv), by striking “sub-
2 section (a)(5)(A)” and inserting “paragraphs (5)(A)
3 and (8)(A) of subsection (a)”;

4 (4) in paragraph (6)(C)—

5 (A) in clause (i)(II), by striking “, 2009,
6 2010, and 2011” and inserting “and subse-
7 quent years”;

8 (B) in clause (iii)—

9 (i) by inserting “(a)(8)” after
10 “(a)(5)”;

11 (ii) by striking “under subparagraph
12 (D)(iii) of such subsection” and inserting
13 “under subsection (a)(5)(D)(iii) or the
14 quality reporting period under subsection
15 (a)(8)(D)(iii), respectively”.

16 (b) INCENTIVE PAYMENT ADJUSTMENT FOR QUAL-
17 ITY REPORTING.—Section 1848(a) of the Social Security
18 Act (42 U.S.C. 1395w-4(a)) is amended by adding at the
19 end the following new paragraph:

20 “(8) INCENTIVES FOR QUALITY REPORTING.—

21 “(A) ADJUSTMENT.—

22 “(i) IN GENERAL.—With respect to
23 covered professional services furnished by
24 an eligible professional during 2013 or any
25 subsequent year, if the eligible professional

1 does not satisfactorily submit data on qual-
2 ity measures for covered professional serv-
3 ices for the quality reporting period for the
4 year (as determined under subsection
5 (m)(3)(A)), the fee schedule amount for
6 such services furnished by such profes-
7 sional during the year (including the fee
8 schedule amount for purposes of deter-
9 mining a payment based on such amount)
10 shall be equal to the applicable percent of
11 the fee schedule amount that would other-
12 wise apply to such services under this sub-
13 section (determined after application of
14 paragraphs (3), (5), and (7), but without
15 regard to this paragraph).

16 “(ii) APPLICABLE PERCENT.—For
17 purposes of clause (i), the term ‘applicable
18 percent’ means—

19 “(I) for 2013, 98.5 percent; and

20 “(II) for 2014 and each subse-
21 quent year, 98 percent.

22 “(B) APPLICATION.—

23 “(i) PHYSICIAN REPORTING SYSTEM
24 RULES.—Paragraphs (5), (6), and (8) of
25 subsection (k) shall apply for purposes of

1 this paragraph in the same manner as they
2 apply for purposes of such subsection.

3 “(ii) INCENTIVE PAYMENT VALIDA-
4 TION RULES.—Clauses (ii) and (iii) of sub-
5 section (m)(5)(D) shall apply for purposes
6 of this paragraph in a similar manner as
7 they apply for purposes of such subsection.

8 “(C) DEFINITIONS.—For purposes of this
9 paragraph:

10 “(i) ELIGIBLE PROFESSIONAL; COV-
11 ERED PROFESSIONAL SERVICES.—The
12 terms ‘eligible professional’ and ‘covered
13 professional services’ have the meanings
14 given such terms in subsection (k)(3).

15 “(ii) PHYSICIAN REPORTING SYS-
16 TEM.—The term ‘physician reporting sys-
17 tem’ means the system established under
18 subsection (k).

19 “(iii) QUALITY REPORTING PERIOD.—
20 The term ‘quality reporting period’ means,
21 with respect to a year, a period specified
22 by the Secretary.”.

23 (c) ADDITIONAL MECHANISM FOR DETERMINING
24 SATISFACTORY AND SUCCESSFUL REPORTING.—Section
25 1848(m)(3) of the Social Security Act (42 U.S.C. 1395w-

1 4(m)(3)) is amended by adding at the end the following
2 new subparagraph:

3 “(E) ADDITIONAL MECHANISM FOR SATIS-
4 FACTORY AND SUCCESSFUL REPORTING OF
5 MEASURES.—

6 “(i) IN GENERAL.—Not later than
7 January 1, 2011, the Secretary shall es-
8 tablish and have in place a process under
9 which an eligible professional shall be
10 treated as satisfactorily submitting data on
11 quality measures under subparagraph (A)
12 and as meeting the requirement described
13 in subparagraph (B)(ii) for covered profes-
14 sional services for reporting periods for 2
15 consecutive years (or, for purposes of sub-
16 section (a)(5), for reporting periods for 2
17 consecutive years, or, for purposes of sub-
18 section (a)(8), for quality reporting periods
19 for 2 consecutive years) if, during the re-
20 porting period of the first of such years,
21 the eligible professional—

22 “(I) participates in a program
23 described in clause (ii); and

24 “(II) completes a qualified MOC
25 practice assessment.

1 “(ii) PROGRAM DESCRIBED.—A pro-
2 gram described in this clause is a qualified
3 American Board of Medical Specialties
4 Maintenance of Certification program
5 (commonly referred to as a ‘Maintenance
6 of Certification program’ or ‘MOC’) or an
7 equivalent program (as determined by the
8 Secretary) that—

9 “(I) satisfactorily submits data
10 through the mechanism described in
11 subsection (k)(4) on quality measures
12 under subparagraph (A) with respect
13 to the eligible professional for the re-
14 porting period for the first year of
15 such 2 consecutive years (as deter-
16 mined as determined by the Sec-
17 retary); and

18 “(II) submits to the Secretary (in
19 accordance with procedures estab-
20 lished by the Secretary under clause
21 (iv)(II)) the information described in
22 clause (iv)(I).

23 “(iii) QUALIFIED MOC PRACTICE AS-
24 SESSMENT.—For purposes of clauses
25 (i)(II), the term ‘qualified MOC practice

1 assessment' means an assessment of a phy-
2 sician's practice that includes an initial as-
3 sessment of an eligible professional's prac-
4 tice, is designed to demonstrate the eligible
5 professional's use of evidence-based medi-
6 cine, and would seek to improve quality of
7 care through follow-up assessments.

8 “(iv) INFORMATION DESCRIBED AND
9 ESTABLISHMENT OF PROCEDURES.—

10 “(I) INFORMATION DE-
11 SCRIBED.—The information described
12 in this subclause is the methods,
13 measures, and data used under a pro-
14 gram described in clause (ii) or a
15 qualified MOC practice assessment
16 under clause (iii).

17 “(II) PROCEDURES.—The Sec-
18 retary, in consultation with programs
19 described in clause (ii), shall establish
20 procedures for the submission of in-
21 formation under clause (ii). Such pro-
22 cedures shall ensure that the informa-
23 tion described in subclause (I) allows
24 for innovation and appropriateness

1 with respect to the specialty of the eli-
2 gible professional.”.

3 (d) INTEGRATION OF PHYSICIAN QUALITY REPORT-
4 ING AND EHR REPORTING.—Section 1848(m) of the So-
5 cial Security Act (42 U.S.C. 1395w-4(m)) is amended by
6 adding at the end the following new paragraph:

7 “(7) INTEGRATION OF PHYSICIAN QUALITY RE-
8 PORTING AND EHR REPORTING.—Not later than
9 January 1, 2012, the Secretary shall develop a plan
10 to integrate reporting on quality measures under
11 this subsection with reporting requirements under
12 subsection (o) relating to the meaningful use of elec-
13 tronic health records. Such integration shall consist
14 of the following:

15 “(A) The selection of measures, the report-
16 ing of which would both demonstrate—

17 “(i) meaningful use of an electronic
18 health record for purposes of subsection
19 (o); and

20 “(ii) quality of care furnished to an
21 individual.

22 “(B) Such other activities as specified by
23 the Secretary.”.

1 (e) FEEDBACK.—Section 1848(m)(5) of the Social
2 Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by
3 adding at the end the following new subparagraph:

4 “(H) FEEDBACK.—The Secretary shall
5 provide timely feedback to eligible professionals
6 on the performance of the eligible professional
7 with respect to satisfactorily submitting data on
8 quality measures under this subsection.”.

9 (f) APPEALS.—Such section is further amended—

10 (1) in subparagraph (E), by striking “There
11 shall” and inserting “Except as provided in subpara-
12 graph (I), there shall”; and

13 (2) by adding at the end the following new sub-
14 paragraph:

15 “(I) INFORMAL APPEALS PROCESS.—The
16 Secretary shall, by not later than January 1,
17 2011, establish and have in place an informal
18 process for eligible professionals to seek a re-
19 view of the determination that an eligible pro-
20 fessional did not satisfactorily submit data on
21 quality measures under this subsection.”.

22 **SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK**
23 **PROGRAM.**

24 (a) IMPROVEMENTS.—

1 (1) IN GENERAL.—Section 1848(n) of the So-
2 cial Security Act (42 U.S.C. 1395w-4(n)) is amend-
3 ed—

4 (A) in paragraph (1)—

5 (i) in subparagraph (A)—

6 (I) by striking “GENERAL.—The
7 Secretary” and inserting “GEN-
8 ERAL.—

9 “(i) ESTABLISHMENT.—The Sec-
10 retary”;

11 (II) in clause (i), as added by
12 clause (i), by striking “the ‘Pro-
13 gram’)” and all that follows through
14 the period at the end of the second
15 sentence and inserting “the ‘Pro-
16 gram’).”;

17 (III) by adding at the end the
18 following new clauses:

19 “(ii) REPORTS ON RESOURCES.—The
20 Secretary shall use claims data under this
21 title (and may use other data) to provide
22 confidential reports to physicians (and, as
23 determined appropriate by the Secretary,
24 to groups of physicians) that measure the

1 resources involved in furnishing care to in-
2 dividuals under this title.

3 “(iii) INCLUSION OF CERTAIN INFOR-
4 MATION.—If determined appropriate by
5 the Secretary, the Secretary may include
6 information on the quality of care fur-
7 nished to individuals under this title by the
8 physician (or group of physicians) in such
9 reports.”; and

10 (ii) in subparagraph (B), by striking
11 “subparagraph (A)” and inserting “sub-
12 paragraph (A)(ii)”;

13 (B) in paragraph (4)—

14 (i) in the heading, by inserting “INI-
15 TIAL” after “FOCUS”; and

16 (ii) in the matter preceding subpara-
17 graph (A), by inserting “initial” after
18 “focus the”;

19 (C) in paragraph (6), by adding at the end
20 the following new sentence: “For adjustments
21 for reports on utilization under paragraph (9),
22 see subparagraph (D) of such paragraph.”; and

23 (D) by adding at the end the following new
24 paragraphs:

25 “(9) REPORTS ON UTILIZATION.—

1 “(A) DEVELOPMENT OF EPISODE GROUP-
2 ER.—

3 “(i) IN GENERAL.—The Secretary
4 shall develop an episode grouper that com-
5 bines separate but clinically related items
6 and services into an episode of care for an
7 individual, as appropriate.

8 “(ii) TIMELINE FOR DEVELOP-
9 MENT.—The episode grouper described in
10 subparagraph (A) shall be developed by not
11 later than January 1, 2012.

12 “(iii) PUBLIC AVAILABILITY.—The
13 Secretary shall make the details of the epi-
14 sode grouper described in subparagraph
15 (A) available to the public.

16 “(iv) ENDORSEMENT.—The Secretary
17 shall seek endorsement of the episode
18 grouper described in subparagraph (A) by
19 the entity with a contract under section
20 1890(a).

21 “(B) REPORTS ON UTILIZATION.—Effec-
22 tive beginning with 2012, the Secretary shall
23 provide reports to physicians that compare, as
24 determined appropriate by the Secretary, pat-

1 terns of resource use of the individual physician
2 to such patterns of other physicians.

3 “(C) ANALYSIS OF DATA.—The Secretary
4 shall, for purposes of preparing reports under
5 this paragraph, establish methodologies as ap-
6 propriate, such as to—

7 “(i) attribute episodes of care, in
8 whole or in part, to physicians;

9 “(ii) identify appropriate physicians
10 for purposes of comparison under subpara-
11 graph (B); and

12 “(iii) aggregate episodes of care at-
13 tributed to a physician under clause (i)
14 into a composite measure per individual.

15 “(D) DATA ADJUSTMENT.—In preparing
16 reports under this paragraph, the Secretary
17 shall make appropriate adjustments, including
18 adjustments—

19 “(i) to account for differences in
20 socio-economic and demographic character-
21 istics, ethnicity, and health status of indi-
22 viduals (such as to recognize that less
23 healthy individuals may require more in-
24 tensive interventions); and

1 “(ii) to eliminate the effect of geo-
2 graphic adjustments in payment rates (as
3 described in subsection (e)).

4 “(E) PUBLIC AVAILABILITY OF METHODOD-
5 OLOGY.—The Secretary shall make available to
6 the public—

7 “(i) the methodologies established
8 under subparagraph (C);

9 “(ii) information regarding any ad-
10 justments made to data under subpara-
11 graph (D); and

12 “(iii) aggregate reports with respect
13 to physicians.

14 “(F) DEFINITION OF PHYSICIAN.—In this
15 paragraph:

16 “(i) IN GENERAL.—The term ‘physi-
17 cian’ has the meaning given that term in
18 section 1861(r)(1).

19 “(ii) TREATMENT OF GROUPS.—Such
20 term includes, as the Secretary determines
21 appropriate, a group of physicians.

22 “(G) LIMITATIONS ON REVIEW.—There
23 shall be no administrative or judicial review
24 under section 1869, section 1878, or otherwise
25 or otherwise of the establishment of the meth-

1 odology under subparagraph (C), including the
2 determination of an episode of care under such
3 methodology.

4 “(10) COORDINATION WITH OTHER VALUE-
5 BASED PURCHASING REFORMS.—The Secretary shall
6 coordinate the Program with the value-based pay-
7 ment modifier established under subsection (p) and,
8 as the Secretary determines appropriate, other simi-
9 lar provisions of this title.”.

10 (2) CONFORMING AMENDMENT.—Section
11 1890(b) of the Social Security Act (42 U.S.C.
12 1395aaa(b)) is amended by adding at the end the
13 following new paragraph:

14 “(6) REVIEW AND ENDORSEMENT OF EPISODE
15 GROUPER UNDER THE PHYSICIAN FEEDBACK PRO-
16 GRAM.—The entity shall provide for the review and,
17 as appropriate, the endorsement of the episode
18 grouper developed by the Secretary under section
19 1848(n)(9)(A). Such review shall be conducted on an
20 expedited basis.”.

21 (b) INCENTIVES FOR AVOIDING EXCESS UTILIZA-
22 TION.—Section 1848(a) of the Social Security Act (42
23 U.S.C. 1395w-4(a)), as amended by section 3002(b), is
24 amended by adding at the end the following new para-
25 graph:

1 “(9) INCENTIVE FOR AVOIDING EXCESS UTILI-
2 ZATION.—

3 “(A) IN GENERAL.—With respect to physi-
4 cians’ services furnished by an applicable physi-
5 cian on or after January 1, 2014, the fee sched-
6 ule amount for such services furnished by the
7 applicable physician during the year (including
8 the fee schedule amount for purposes of deter-
9 mining a payment based on such amount) shall
10 be 95 percent of the fee schedule amount that
11 would otherwise apply to such services under
12 this subsection (determined after application of
13 paragraphs (3), (5), (7), and (8), but without
14 regard to this paragraph).

15 “(B) APPLICABLE PHYSICIAN.—In this
16 paragraph:

17 “(i) IN GENERAL.—The term ‘applica-
18 ble physician’ means a physician which the
19 Secretary determines is at or above the
20 90th percentile of resource use (or, if ap-
21 plicable, the standard measure of utiliza-
22 tion specified under subparagraph (C))
23 with respect to a composite measure per
24 individual, such as the composite measure

1 under the methodology established under
2 subsection (n)(9)(C)(iii).

3 “(ii) DEFINITION OF PHYSICIAN.—In
4 this paragraph:

5 “(I) IN GENERAL.—The term
6 ‘physician’ has the meaning given that
7 term in section 1861(r)(1).

8 “(II) TREATMENT OF GROUPS.—
9 Such term includes, as the Secretary
10 determines appropriate, a group of
11 physicians.

12 “(C) AUTHORITY TO REVISE STANDARD
13 MEASURE OF RESOURCE USE FOR DETER-
14 MINING APPLICABLE PHYSICIANS.—With re-
15 spect to physicians’ services furnished by an ap-
16 plicable physician on or after January 1, 2020,
17 the Secretary may substitute a standard meas-
18 ure of resource use, such as deviation from the
19 national mean, (as specified by the Secretary)
20 for the percentile of resource use described in
21 subparagraph (B)(i).

22 “(D) REPORTING PERIOD.—In this para-
23 graph, the term ‘reporting period’ means a pe-
24 riod specified by the Secretary.

1 “(E) LIMITATIONS ON REVIEW.—There
2 shall be no administrative or judicial review
3 under section 1869, section 1878, or otherwise
4 or otherwise of—

5 “(i) the determination of any incentive
6 payment under subparagraph (A);

7 “(ii) the determination of who is an
8 applicable physician under subparagraph
9 (B)(i), including the specification and ap-
10 plication of the standard measure of utili-
11 zation under subparagraph (C); and

12 “(iii) the specification of the reporting
13 period under subparagraph (D).”.

14 **SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE**
15 **HOSPITALS, INPATIENT REHABILITATION**
16 **HOSPITALS, AND HOSPICE PROGRAMS.**

17 (a) LONG-TERM CARE HOSPITALS.—Section
18 1886(m) of the Social Security Act (42 U. S.C.
19 1395ww(m)), as amended by section 3401(c), is amended
20 by adding at the end the following new paragraph:

21 “(5) QUALITY REPORTING.—

22 “(A) REDUCTION IN UPDATE FOR FAILURE
23 TO REPORT.—Under the system described in
24 paragraph (1), for rate year 2014 and each
25 subsequent rate year, in the case of a long-term

1 care hospital that does not submit data to the
2 Secretary in accordance with subparagraph (C)
3 with respect to such a rate year, the update for
4 payments for discharges occurring during such
5 rate year shall be reduced by 2 percentage
6 points.

7 “(B) NONCUMULATIVE APPLICATION.—
8 Any reduction under subparagraph (A) shall
9 apply only with respect to the rate year involved
10 and the Secretary shall not take into account
11 such reduction in computing the payment
12 amount under the system described in para-
13 graph (1) for a subsequent rate year.

14 “(C) SUBMISSION OF QUALITY DATA.—For
15 rate year 2014 and each subsequent rate year,
16 each long-term care hospital shall submit to the
17 Secretary data on quality measures specified
18 under subparagraph (D). Such data shall be
19 submitted in a form and manner, and at a time,
20 specified by the Secretary for purposes of this
21 subparagraph.

22 “(D) QUALITY MEASURES.—

23 “(i) IN GENERAL.—The quality meas-
24 ures specified under this subparagraph
25 shall be such measures selected by the Sec-

1 retary from measures that have been en-
2 dorsed under paragraph (1) of section
3 1890C(f) or used as a result of a deter-
4 mination under paragraph (2) of such sec-
5 tion.

6 “(ii) TIME FRAME.—Not later than
7 October 1, 2012, the Secretary shall pub-
8 lish the measures selected under this sub-
9 paragraph that will be applicable with re-
10 spect to rate year 2014.

11 “(E) PUBLIC AVAILABILITY OF DATA SUB-
12 MITTED.—The Secretary shall establish proce-
13 dures for making data submitted under sub-
14 paragraph (C) available to the public. Such pro-
15 cedures shall ensure that a long-term care hos-
16 pital has the opportunity to review the data
17 that is to be made public with respect to the
18 hospital prior to such data being made public.
19 The Secretary shall report quality measures
20 that relate to services furnished in inpatient
21 settings in long-term care hospitals on the
22 Internet website of the Centers for Medicare &
23 Medicaid Services.”.

1 (b) INPATIENT REHABILITATION HOSPITALS.—Sec-
2 tion 1886(j) of the Social Security Act (42 U.S.C.
3 1395ww(j)) is amended—

4 (1) by redesignating paragraph (7) as para-
5 graph (8); and

6 (2) by inserting after paragraph (6) the fol-
7 lowing new paragraph:

8 “(7) QUALITY REPORTING.—

9 “(A) REDUCTION IN UPDATE FOR FAILURE
10 TO REPORT.—For purposes of fiscal year 2014
11 and each subsequent fiscal year, in the case of
12 a rehabilitation facility that does not submit
13 data to the Secretary in accordance with sub-
14 paragraph (C) with respect to such a fiscal
15 year, the increase factor to be applied under
16 paragraph (3)(C) for payments for discharges
17 occurring during such fiscal year shall be re-
18 duced by 2 percentage points.

19 “(B) NONCUMULATIVE APPLICATION.—
20 Any reduction under subparagraph (A) shall
21 apply only with respect to the fiscal year in-
22 volved and the Secretary shall not take into ac-
23 count such reduction in computing the payment
24 amount under this subsection for a subsequent
25 fiscal year.

1 “(C) SUBMISSION OF QUALITY DATA.—For
2 fiscal year 2014 and each subsequent rate year,
3 each rehabilitation facility shall submit to the
4 Secretary data on quality measures specified
5 under subparagraph (D). Such data shall be
6 submitted in a form and manner, and at a time,
7 specified by the Secretary for purposes of this
8 subparagraph.

9 “(D) QUALITY MEASURES.—

10 “(i) IN GENERAL.—The quality meas-
11 ures specified under this subparagraph
12 shall be such measures selected by the Sec-
13 retary from measures that have been en-
14 dorsed under paragraph (1) of section
15 1890C(f) or used as a result of a deter-
16 mination under paragraph (2) of such sec-
17 tion.

18 “(ii) TIME FRAME.—Not later than
19 October 1, 2012, the Secretary shall pub-
20 lish the measures selected under this sub-
21 paragraph that will be applicable with re-
22 spect to fiscal year 2014.

23 “(E) PUBLIC AVAILABILITY OF DATA SUB-
24 MITTED.—The Secretary shall establish proce-
25 dures for making data submitted under sub-

1 paragraph (C) available to the public. Such pro-
2 cedures shall ensure that a rehabilitation facil-
3 ity has the opportunity to review the data that
4 is to be made public with respect to the facility
5 prior to such data being made public. The Sec-
6 retary shall report quality measures that relate
7 to services furnished in inpatient settings in re-
8 habilitation facilities on the Internet website of
9 the Centers for Medicare & Medicaid Services.”.

10 (c) HOSPICE PROGRAMS.—Section 1814(i) of the So-
11 cial Security Act (42 U.S.C. 1395f(i)) is amended—

12 (1) by redesignating paragraph (5) as para-
13 graph (6); and

14 (2) by inserting after paragraph (4) the fol-
15 lowing new paragraph:

16 “(5) QUALITY REPORTING.—

17 “(A) REDUCTION IN UPDATE FOR FAILURE
18 TO REPORT.—For purposes of fiscal year 2014
19 and each subsequent fiscal year, in the case of
20 a hospice program that does not submit data to
21 the Secretary in accordance with subparagraph
22 (C) with respect to such a fiscal year, the mar-
23 ket basket percentage increase to be applied
24 under clause (ii) or (iii) of paragraph (1)(C), as
25 applicable, for payments for routine home care

1 and other services included in hospice care fur-
2 nished during such fiscal year shall be reduced
3 by 2 percentage points.

4 “(B) NONCUMULATIVE APPLICATION.—
5 Any reduction under subparagraph (A) shall
6 apply only with respect to the fiscal year in-
7 volved and the Secretary shall not take into ac-
8 count such reduction in computing the payment
9 amount under this subsection for a subsequent
10 fiscal year.

11 “(C) SUBMISSION OF QUALITY DATA.—For
12 fiscal year 2014 and each subsequent fiscal
13 year, each hospice program shall submit to the
14 Secretary data on quality measures specified
15 under subparagraph (D). Such data shall be
16 submitted in a form and manner, and at a time,
17 specified by the Secretary for purposes of this
18 subparagraph.

19 “(D) QUALITY MEASURES.—

20 “(i) IN GENERAL.—The quality meas-
21 ures specified under this subparagraph
22 shall be such measures selected by the Sec-
23 retary from measures that have been en-
24 dorsed under paragraph (1) of section
25 1890C(f) or used as a result of a deter-

1 mination under paragraph (2) of such sec-
2 tion.

3 “(ii) TIME FRAME.—Not later than
4 October 1, 2012, the Secretary shall pub-
5 lish the measures selected under this sub-
6 paragraph that will be applicable with re-
7 spect to fiscal year 2014.

8 “(E) PUBLIC AVAILABILITY OF DATA SUB-
9 MITTED.—The Secretary shall establish proce-
10 dures for making data submitted under sub-
11 paragraph (C) available to the public. Such pro-
12 cedures shall ensure that a hospice program has
13 the opportunity to review the data that is to be
14 made public with respect to the hospice pro-
15 gram prior to such data being made public. The
16 Secretary shall report quality measures that re-
17 late to hospice care provided by hospice pro-
18 grams on the Internet website of the Centers
19 for Medicare & Medicaid Services.”.

20 **SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER**
21 **HOSPITALS.**

22 Section 1866 of the Social Security Act (42 U.S.C.
23 1395cc) is amended—

24 (1) in subsection (a)(1)—

1 (A) in subparagraph (U), by striking
2 “and” at the end;

3 (B) in subparagraph (V), 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 “(W) in the case of a hospital described in
8 section 1886(d)(1)(B)(v), to report quality data
9 to the Secretary in accordance with subsection
10 (k).”; and

11 (2) by adding at the end the following new sub-
12 section:

13 “(k) QUALITY REPORTING BY CANCER HOS-
14 PITALS.—

15 “(1) IN GENERAL.—For purposes of fiscal year
16 2014 and each subsequent fiscal year, a hospital de-
17 scribed in section 1886(d)(1)(B)(v) shall submit
18 data to the Secretary in accordance with paragraph
19 (2) with respect to such a fiscal year.

20 “(2) SUBMISSION OF QUALITY DATA.—For fis-
21 cal year 2014 and each subsequent fiscal year, each
22 hospital described in such section shall submit to the
23 Secretary data on quality measures specified under
24 paragraph (3). Such data shall be submitted in a

1 form and manner, and at a time, specified by the
2 Secretary for purposes of this subparagraph.

3 “(3) QUALITY MEASURES.—

4 “(A) IN GENERAL.—The quality measures
5 specified under this subparagraph shall be such
6 measures selected by the Secretary from meas-
7 ures that have been endorsed under paragraph
8 (1) of section 1890C(f) or used as a result of
9 a determination under paragraph (2) of such
10 section.

11 “(C) TIME FRAME.—Not later than Octo-
12 ber 1, 2012, the Secretary shall publish the
13 measures selected under this paragraph that
14 will be applicable with respect to fiscal year
15 2014.

16 “(4) PUBLIC AVAILABILITY OF DATA SUB-
17 MITTED.—The Secretary shall establish procedures
18 for making data submitted under paragraph (4)
19 available to the public. Such procedures shall ensure
20 that a hospital described in section 1886(d)(1)(B)(v)
21 has the opportunity to review the data that is to be
22 made public with respect to the hospital prior to
23 such data being made public. The Secretary shall re-
24 port quality measures of process, structure, outcome,
25 patients’ perspective on care, efficiency, and costs of

1 care that relate to services furnished in such hos-
2 pitals on the Internet website of the Centers for
3 Medicare & Medicaid Services.”.

4 **SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PRO-**
5 **GRAM FOR SKILLED NURSING FACILITIES**
6 **AND HOME HEALTH AGENCIES.**

7 (a) SKILLED NURSING FACILITIES.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services (in this section referred to as the
10 “Secretary”) shall develop a plan to implement a
11 value-based purchasing program for payments under
12 the Medicare program under title XVIII of the So-
13 cial Security Act for skilled nursing facilities (as de-
14 fined in section 1819(a) of such Act (42 U.S.C.
15 1395i–3(a))).

16 (2) DETAILS.—In developing the plan under
17 paragraph (1), the Secretary shall consider the fol-
18 lowing issues:

19 (A) The ongoing development, selection,
20 and modification process for measures (as se-
21 lected from measures that are endorsed under
22 paragraph (1) of section 1890C(f) or used as a
23 result of a determination under paragraph (2)
24 of such section), to the extent feasible and prac-

1 ticable, of all dimensions of quality and effi-
2 ciency in skilled nursing facilities.

3 (B) The reporting, collection, and valida-
4 tion of quality data.

5 (C) The structure of value-based payment
6 adjustments, including the determination of
7 thresholds or improvements in quality that
8 would substantiate a payment adjustment, the
9 size of such payments, and the sources of fund-
10 ing for the value-based bonus payments.

11 (D) Methods for the public disclosure of
12 information on the performance of skilled nurs-
13 ing facilities.

14 (E) Any other issues determined appro-
15 priate by the Secretary.

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

18 (A) consult with relevant affected parties;
19 and

20 (B) consider experience with such dem-
21 onstrations that the Secretary determines are
22 relevant to the value-based purchasing program
23 described in paragraph (1).

24 (4) REPORT TO CONGRESS.—Not later than Oc-
25 tober 1, 2011, the Secretary shall submit to Con-

1 gress a report containing the plan developed under
2 paragraph (1).

3 (b) HOME HEALTH AGENCIES.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the
6 “Secretary”) shall develop a plan to implement a
7 value-based purchasing program for payments under
8 the Medicare program under title XVIII of the So-
9 cial Security Act for home health agencies (as de-
10 fined in section 1861(o) of such Act (42 U.S.C.
11 1395x(o))).

12 (2) DETAILS.—In developing the plan under
13 paragraph (1), the Secretary shall consider the fol-
14 lowing issues:

15 (A) The ongoing development, selection,
16 and modification process for measures (as se-
17 lected from measures that are endorsed under
18 paragraph (1) of section 1890C(f) or used as a
19 result of a determination under paragraph (2)
20 of such section), to the extent feasible and prac-
21 ticable, of all dimensions of quality and effi-
22 ciency in home health agencies.

23 (B) The reporting, collection, and valida-
24 tion of quality data.

1 (C) The structure of value-based payment
2 adjustments, including the determination of
3 thresholds or improvements in quality that
4 would substantiate a payment adjustment, the
5 size of such payments, and the sources of fund-
6 ing for the value-based bonus payments.

7 (D) Methods for the public disclosure of
8 information on the performance of home health
9 agencies.

10 (E) Any other issues determined appro-
11 priate by the Secretary.

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

14 (A) consult with relevant affected parties;
15 and

16 (B) consider experience with such dem-
17 onstrations that the Secretary determines are
18 relevant to the value-based purchasing program
19 described in paragraph (1).

20 (4) REPORT TO CONGRESS.—Not later than Oc-
21 tober 1, 2010, the Secretary shall submit to Con-
22 gress a report containing the plan developed under
23 paragraph (1).

1 **SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE**
2 **PHYSICIAN FEE SCHEDULE.**

3 Section 1848 of the Social Security Act (42 U.S.C.
4 1395w-4) is amended—

5 (1) in subsection (b)(1), by inserting “subject
6 to subsection (p),” after “1998,”.

7 (2) by adding at the end the following new sub-
8 section:

9 “(p) ESTABLISHMENT OF VALUE-BASED PAYMENT
10 MODIFIER.—

11 “(1) IN GENERAL.—The Secretary shall estab-
12 lish a payment modifier that provides for differential
13 payment to a physician or a group of physicians
14 under the fee schedule established under subsection
15 (b) based upon the quality of care furnished com-
16 pared to cost (as determined under paragraphs (2)
17 and (3), respectively) during a performance period.
18 Such payment modifier shall be separate from the
19 geographic adjustment factors established under
20 subsection (e).

21 “(2) QUALITY.—

22 “(A) IN GENERAL.—For purposes of para-
23 graph (1), quality of care shall be evaluated, to
24 the extent practicable, based on a composite of
25 measures of the quality of care furnished (as

1 established by the Secretary under subpara-
2 graph (B)).

3 “(B) MEASURES.—

4 “(i) The Secretary shall establish ap-
5 propriate measures of the quality of care
6 furnished by a physician or group of physi-
7 cians to individuals enrolled under this
8 part, such as measures that reflect health
9 outcomes. Such measures shall be risk ad-
10 justed as determined appropriate by the
11 Secretary.

12 “(ii) The Secretary shall seek endorse-
13 ment of the measures established under
14 this subparagraph by the entity with a
15 contract under section 1890(a).

16 “(3) COSTS.—For purposes of paragraph (1),
17 costs shall be evaluated, to the extent practicable,
18 based on a composite of appropriate measures of
19 costs established by the Secretary (such as the com-
20 posite measure under the methodology established
21 under subsection (n)(9)(C)(iii)) that eliminate the
22 effect of geographic adjustments in payment rates
23 (as described in subsection (e)), and take into ac-
24 count risk factors (such as socio-economic and demo-
25 graphic characteristics, ethnicity, and health status

1 of individuals (such as to recognize that less healthy
2 individuals may require more intensive interventions)
3 and other factors determined appropriate by the
4 Secretary.

5 “(4) IMPLEMENTATION.—

6 “(A) PUBLICATION OF MEASURES, DATES
7 OF IMPLEMENTATION, PERFORMANCE PE-
8 RIOD.—Not later than January 1, 2012, the
9 Secretary shall publish the following:

10 “(i) The measures of quality of care
11 and costs established under paragraphs (2)
12 and (3), respectively.

13 “(ii) The dates for implementation of
14 the payment modifier (as determined under
15 subparagraph (B)).

16 “(iii) The initial performance period
17 (as specified under subparagraph (B)(ii)).

18 “(B) DEADLINES FOR IMPLEMENTA-
19 TION.—

20 “(i) INITIAL IMPLEMENTATION.—Sub-
21 ject to the preceding provisions of this sub-
22 paragraph, the Secretary shall begin imple-
23 menting the payment modifier established
24 under this subsection through the rule-
25 making process during 2013 for the physi-

1 cian fee schedule established under sub-
2 section (b).

3 “(ii) INITIAL PERFORMANCE PE-
4 RIOD.—

5 “(I) IN GENERAL.—The Sec-
6 retary shall specify an initial perform-
7 ance period for application of the pay-
8 ment modifier established under this
9 subsection with respect to 2015.

10 “(II) PROVISION OF INFORMA-
11 TION DURING INITIAL PERFORMANCE
12 PERIOD.—During the initial perform-
13 ance period, the Secretary shall, to
14 the extent practicable, provide infor-
15 mation to physicians and groups of
16 physicians about the quality of care
17 furnished by the physician or group of
18 physicians to individuals enrolled
19 under this part compared to cost (as
20 determined under paragraphs (2) and
21 (3), respectively) with respect to the
22 performance period.

23 “(iii) APPLICATION.—The Secretary
24 shall apply the payment modifier estab-

1 lished under this subsection for items and
2 services furnished—

3 “(I) beginning on January 1,
4 2015, with respect to specific physi-
5 cians and groups of physicians the
6 Secretary determines appropriate; and

7 “(II) beginning not later than
8 January 1, 2017, with respect to all
9 physicians and groups of physicians.

10 “(C) BUDGET NEUTRALITY.—The pay-
11 ment modifier established under this subsection
12 shall be implemented in a budget neutral man-
13 ner.

14 “(5) SYSTEMS-BASED CARE.—The Secretary
15 shall, as appropriate, apply the payment modifier es-
16 tablished under this subsection in a manner that
17 promotes systems-based care.

18 “(6) CONSIDERATION OF SPECIAL CIR-
19 CUMSTANCES OF CERTAIN PROVIDERS.—In applying
20 the payment modifier under this subsection, the Sec-
21 retary shall, as appropriate, take into account the
22 special circumstances of physicians or groups of phy-
23 sicians in rural areas and other underserved commu-
24 nities.

1 “(7) APPLICATION.—For purposes of the initial
2 application of the payment modifier established
3 under this subsection during the period beginning on
4 January 1, 2015, and ending on December 31,
5 2016, the term ‘physician’ has the meaning given
6 such term in section 1861(r). On or after January
7 1, 2017, the Secretary may apply this subsection to
8 eligible professionals (as defined in subsection
9 (k)(3)(B)) as the Secretary determines appropriate.

10 “(8) DEFINITIONS.—For purposes of this sub-
11 section:

12 “(A) COSTS.—The term ‘costs’ means ex-
13 penditures per individual as determined appro-
14 priate by the Secretary. In making the deter-
15 mination under the preceding sentence, the Sec-
16 retary may take into account the amount of
17 growth in expenditures per individual for a phy-
18 sician compared to the amount of such growth
19 for other physicians.

20 “(B) PERFORMANCE PERIOD.—The term
21 ‘performance period’ means a period specified
22 by the Secretary.

23 “(9) COORDINATION WITH OTHER VALUE-
24 BASED PURCHASING REFORMS.—The Secretary shall
25 coordinate the value-based payment modifier estab-

1 lished under this subsection with the Physician
2 Feedback Program under subsection (n) and, as the
3 Secretary determines appropriate, other similar pro-
4 visions of this title.

5 “(10) LIMITATIONS ON REVIEW.—There shall
6 be no administrative or judicial review under section
7 1869, section 1878, or otherwise or otherwise of—

8 “(A) the establishment of the value-based
9 payment modifier under this subsection;

10 “(B) the evaluation of quality of care
11 under paragraph (2), including the establish-
12 ment of appropriate measures of the quality of
13 care under paragraph (2)(B);

14 “(C) the evaluation of costs under para-
15 graph (3), including the establishment of appro-
16 priate measures of costs under such paragraph;

17 “(D) the dates for implementation of the
18 value-based payment modifier;

19 “(E) the specification of the initial per-
20 formance period and any other performance pe-
21 riod under paragraphs (4)(B)(ii) and (8)(B),
22 respectively;

23 “(F) the application of the value-based
24 payment modifier under paragraph (7); and

1 “(G) the determination of costs under
2 paragraph (8)(A).”.

3 **SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS AC-**
4 **QUIRED IN HOSPITALS.**

5 Section 1886 of the Social Security Act (42 U.S.C.
6 1395ww), as amended by section 3001, is amended by
7 adding at the end the following new subsection:

8 “(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR
9 HOSPITAL ACQUIRED CONDITIONS.—

10 “(1) IN GENERAL.—In order to provide an in-
11 centive for applicable hospitals to reduce hospital ac-
12 quired conditions under this title, with respect to
13 discharges from an applicable hospital occurring
14 during fiscal year 2015 or a subsequent fiscal year,
15 the amount of payment under this section or section
16 1814(b)(3), as applicable, for such discharges during
17 the fiscal year shall be equal to 99 percent of the
18 amount of payment that would otherwise apply to
19 such discharges under this section or section
20 1814(b)(3) (determined after the application of sub-
21 sections (n), (o), and (q) and section 1814(l)(3) but
22 without regard to this subsection).

23 “(2) APPLICABLE HOSPITALS.—

24 “(A) IN GENERAL.—For purposes of this
25 subsection, the term ‘applicable hospital’ means

1 a subsection (d) hospital that meets the criteria
2 described in subparagraph (B).

3 “(B) CRITERIA DESCRIBED.—

4 “(i) IN GENERAL.—The criteria de-
5 scribed in this subparagraph, with respect
6 to a subsection (d) hospital, is that the
7 subsection (d) hospital is in the top quar-
8 tile of all subsection (d) hospitals, relative
9 to the national average, of hospital ac-
10 quired conditions during the applicable pe-
11 riod, as determined by the Secretary.

12 “(ii) RISK ADJUSTMENT.—In carrying
13 out clause (i), the Secretary shall establish
14 and apply an appropriate risk adjustment
15 methodology.

16 “(3) HOSPITAL ACQUIRED CONDITIONS.—For
17 purposes of this subsection, the term ‘hospital ac-
18 quired condition’ means a condition identified for
19 purposes of subsection (d)(4)(D)(iv) that an indi-
20 vidual acquires during a stay in an applicable hos-
21 pital, as determined by the Secretary.

22 “(4) APPLICABLE PERIOD.—In this subsection,
23 the term ‘applicable period’ means, with respect to
24 a fiscal year, a period specified by the Secretary.

1 “(5) REPORTING TO HOSPITALS.—Prior to fis-
2 cal year 2015 and each subsequent fiscal year, the
3 Secretary shall provide confidential reports to appli-
4 cable hospitals with respect to hospital acquired con-
5 ditions of the applicable hospital during the applica-
6 ble period.

7 “(6) REPORTING HOSPITAL SPECIFIC INFORMA-
8 TION.—

9 “(A) IN GENERAL.—The Secretary shall
10 make information available to the public re-
11 garding hospital acquired conditions of each ap-
12 plicable hospital.

13 “(B) OPPORTUNITY TO REVIEW AND SUB-
14 MIT CORRECTIONS.—The Secretary shall ensure
15 that an applicable hospital has the opportunity
16 to review, and submit corrections for, the infor-
17 mation to be made public with respect to the
18 hospital under subparagraph (A) prior to such
19 information being made public.

20 “(C) WEBSITE.—Such information shall be
21 posted on the Hospital Compare Internet
22 website in an easily understandable format.

23 “(7) LIMITATIONS ON REVIEW.—There shall be
24 no administrative or judicial review under section
25 1869, section 1878, or otherwise of the following:

1 “(A) The criteria described in paragraph
2 (2)(A).

3 “(B) The specification of hospital acquired
4 conditions under paragraph (3).

5 “(C) The specification of the applicable pe-
6 riod under paragraph (4).

7 “(D) The provision of reports to applicable
8 hospitals under paragraph (5) and the informa-
9 tion made available to the public under para-
10 graph (6)”.

11 **PART II—STRENGTHENING THE QUALITY**
12 **INFRASTRUCTURE**

13 **SEC. 3011. NATIONAL STRATEGY.**

14 Title XVIII of the Social Security Act (42 U.S.C.
15 1395 et seq.) is amended by inserting after section 1890
16 the following new section:

17 “NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN
18 HEALTH CARE

19 “SEC. 1890A. (a) ESTABLISHMENT OF NATIONAL
20 STRATEGY AND PRIORITIES.—

21 “(1) NATIONAL STRATEGY.—The Secretary,
22 through a transparent collaborative process, shall es-
23 tablish a national strategy to improve the delivery of
24 health care services, patient health outcomes, and
25 population health.

26 “(2) IDENTIFICATION OF PRIORITIES.—

1 “(A) IN GENERAL.—The Secretary shall
2 identify national priorities for improvement in
3 developing the strategy under paragraph (1).

4 “(B) REQUIREMENTS.—The Secretary
5 shall ensure that priorities identified under sub-
6 paragraph (A) will—

7 “(i) have the greatest potential for im-
8 proving the health outcomes, efficiency,
9 and patient-centeredness of health care;

10 “(ii) identify areas in the delivery of
11 health care services that have the potential
12 for rapid improvement in the quality and
13 efficiency of patient care;

14 “(iii) address gaps in quality , effi-
15 ciency, and health outcomes measures and
16 data aggregation techniques;

17 “(iv) improve Federal payment policy
18 to emphasize quality and efficiency;

19 “(v) enhance the use of health care
20 data to improve quality, efficiency, trans-
21 parency, and outcomes;

22 “(vi) address the health care provided
23 to patients with high-cost chronic diseases;

24 “(vii) improve strategies and best
25 practices to improve patient safety and re-

1 duce medical errors, preventable admis-
2 sions and readmissions, and health care-as-
3 sociated infections;

4 “(viii) reduce health disparities across
5 health disparity populations (as defined by
6 section 485E of the Public Health Service
7 Act) and geographic areas; and

8 “(ix) address other areas as deter-
9 mined appropriate by the Secretary.

10 “(C) CONSIDERATIONS.—In identifying
11 priorities under subparagraph (A), the Sec-
12 retary shall take into consideration—

13 “(i) the recommendations submitted
14 by qualified consensus-based entities as re-
15 quired under section 1890C; and

16 “(ii) the recommendations of the
17 Interagency Working Group on Health
18 Care Quality established under section
19 3012 of the America’s Healthy Future Act
20 of 2009.

21 “(b) STRATEGIC PLAN.—

22 “(1) IN GENERAL.—The national strategy shall
23 include a comprehensive strategic plan to achieve the
24 priorities described in subsection (a).

1 “(2) REQUIREMENTS.—The strategic plan shall
2 include provisions for addressing, at a minimum, the
3 following:

4 “(A) Coordination among agencies within
5 the Department, which shall include steps to
6 minimize duplication of efforts and utilization
7 of common quality measures, where available.
8 Such common quality measures shall be meas-
9 ures endorsed under section 1890C.

10 “(B) Agency-specific strategic plans to
11 achieve national priorities.

12 “(C) Establishment of annual benchmarks
13 for each relevant agency to achieve national pri-
14 orities.

15 “(D) A process for regular reporting by
16 the agencies to the Secretary on the implemen-
17 tation of the strategic plan.

18 “(E) Strategies to align incentives among
19 public and private payers with regard to quality
20 and patient safety efforts.

21 “(F) Incorporating quality improvement
22 and measurement in the strategic plan for
23 health information technology required by the
24 American Recovery and Reinvestment Act of
25 2009 (Public Law 111–5).

1 “(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—

2 The Secretary shall update the national strategy not less
3 than triennially. Any such update shall include a review
4 of short- and long-term goals.

5 “(d) SUBMISSION AND AVAILABILITY OF NATIONAL
6 STRATEGY AND UPDATES.—

7 “(1) DEADLINE FOR INITIAL SUBMISSION OF
8 NATIONAL STRATEGY.—Not later than December 31,
9 2010, the Secretary shall submit to the relevant
10 Committees of Congress the national strategy.

11 “(2) UPDATES.—

12 “(A) IN GENERAL.—The Secretary shall
13 submit to the relevant Committees of Congress
14 any updates to such strategy.

15 “(B) INFORMATION SUBMITTED.—Any up-
16 date submitted under subparagraph (A) shall
17 include—

18 “(i) a review of the short and long-
19 term goals of the national strategy; and

20 “(ii) an analysis of the progress made
21 in meeting those goals.

22 “(e) HEALTH CARE QUALITY WEBSITE.—The Sec-
23 retary shall create an Internet website to make public in-
24 formation regarding—

1 “(1) the national priorities for health care qual-
2 ity improvement established under subsection (a)(2);

3 “(2) the agency-specific strategic plans for
4 health care quality described in subsection (b)(2)(B);
5 and

6 “(3) other information, as the Secretary deter-
7 mines to be appropriate.”.

8 **SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH**
9 **CARE QUALITY.**

10 (a) **IN GENERAL.**—The President shall convene a
11 working group to be known as the Interagency Working
12 Group on Health Care Quality (referred to in this section
13 as the “Working Group”).

14 (b) **GOALS.**—The goals of the Working Group shall
15 be to achieve the following:

16 (1) Collaboration, cooperation, and consultation
17 between Federal departments and agencies with re-
18 spect to developing and disseminating strategies,
19 goals, models, and timetables that are consistent
20 with the national priorities identified under section
21 1890A of the Social Security Act (as added by sec-
22 tion 3011).

23 (2) Avoidance of inefficient duplication of qual-
24 ity improvement efforts and resources, where prac-

1 ticable, and a streamlined process for quality report-
2 ing and compliance requirements.

3 (c) COMPOSITION.—

4 (1) IN GENERAL.—The Working Group shall be
5 composed of senior level representatives of—

6 (A) the Department of Health and Human
7 Services;

8 (B) the Centers for Medicare & Medicaid
9 Services;

10 (C) the National Institutes of Health;

11 (D) the Centers for Disease Control and
12 Prevention;

13 (E) the Food and Drug Administration;

14 (F) the Health Resources and Services Ad-
15 ministration;

16 (G) the Agency for Healthcare Research
17 and Quality;

18 (H) the Administration for Children and
19 Families;

20 (I) the Department of Commerce;

21 (J) the Office of Management and Budget;

22 (K) the United States Coast Guard;

23 (L) the Federal Bureau of Prisons;

24 (M) the National Highway Traffic Safety
25 Administration;

1 (N) the Federal Trade Commission;
2 (O) the Social Security Administration;
3 (P) the Department of Labor;
4 (Q) the United States Office of Personnel
5 Management;
6 (R) the Department of Defense;
7 (S) the Department of Education;
8 (T) the Department of Veterans Affairs;
9 (U) the Veterans Health Administration;
10 and
11 (V) any other Federal agencies and depart-
12 ments with activities relating to improving
13 health care quality and safety, as determined by
14 the President.

15 (2) CHAIR AND VICE CHAIR.—

16 (A) CHAIR.—The Working Group shall be
17 chaired by the Secretary of Health and Human
18 Services.

19 (B) VICE CHAIR.—Members of the Work-
20 ing Group, other than the Secretary of Health
21 and Human Services, shall serve as Vice Chair
22 of the Group on a rotating basis, as determined
23 by the Group.

24 (d) REPORT TO CONGRESS.—Not later than a date
25 determined appropriate by the Secretary, and annually

1 thereafter, the Working Group shall submit to the relevant
2 Committees of Congress, and make public on an Internet
3 website, a report describing the progress and recommenda-
4 tions of the Working Group in meeting the goals described
5 in subsection (b).

6 **SEC. 3013. QUALITY MEASURE DEVELOPMENT.**

7 Title XVIII of the Social Security Act (42 U.S.C.
8 1395 et seq.), as amended by section 3011, is further
9 amended by inserting after section 1890A the following
10 new section:

11 “QUALITY MEASURE DEVELOPMENT

12 “SEC. 1890B. (a) QUALITY MEASURE.—In this sec-
13 tion, the term ‘quality measure’ means a standard for
14 measuring the performance and improvement of popu-
15 lation health or of health plans, providers of services, and
16 other clinicians in the delivery of health care services.

17 “(b) IDENTIFICATION OF QUALITY MEASURES.—

18 “(1) IDENTIFICATION.—The Secretary shall
19 identify, not less often than triennially, gaps where
20 no quality measures exist, or where existing quality
21 measures need improvement, updating, or expansion,
22 consistent with the national strategy under section
23 1890A, for use in programs authorized under this
24 Act. In identifying such gaps, the Secretary shall
25 take into consideration the gaps identified by a

1 qualified consensus-based entity under section
2 1890C.

3 “(2) PUBLICATION.—The Secretary shall make
4 available to the public on an Internet website a re-
5 port on any gaps identified under paragraph (1) and
6 the process used to make such identification.

7 “(c) GRANTS OR CONTRACTS FOR QUALITY MEAS-
8 URE DEVELOPMENT.—

9 “(1) IN GENERAL.—The Secretary shall award
10 grants, contracts, or intergovernmental agreements
11 to eligible entities for purposes of developing, im-
12 proving, updating, or expanding quality measures
13 identified under subsection (b).

14 “(2) PRIORITIZATION IN THE DEVELOPMENT
15 OF QUALITY MEASURES.—In awarding grants, con-
16 tracts, or agreements under this subsection, the Sec-
17 retary shall give priority to the development of qual-
18 ity measures that allow the assessment of—

19 “(A) health outcomes and functional status
20 of patients;

21 “(B) the coordination of health care across
22 episodes of care and care transitions;

23 “(C) the meaningful use of health informa-
24 tion technology;

1 “(D) safety, effectiveness, patient-
2 centeredness, appropriateness, and timeliness of
3 care;

4 “(E) efficiency of care;

5 “(F) equity of health services and health
6 disparities across health disparity populations
7 (as defined in section 485E of the Public
8 Health Service Act) and geographic areas;

9 “(G) patient experience and satisfaction;
10 and

11 “(H) other areas determined appropriate
12 by the Secretary.

13 “(3) ELIGIBLE ENTITIES.—To be eligible for a
14 grant or contract under this subsection, an entity
15 shall—

16 “(A) have demonstrated expertise and ca-
17 pacity in the development and evaluation of
18 quality measures;

19 “(B) have adopted procedures to include in
20 the quality measure development process—

21 “(i) the views of those providers or
22 payers whose performance will be assessed
23 by the measure; and

24 “(ii) the views of other parties who
25 also will use the quality measures (such as

1 patients, consumers, and health care pur-
2 chasers);

3 “(C) collaborate with a qualified con-
4 sensus-based entity (as defined in section
5 1890C), as practicable, and the Secretary so
6 that quality measures developed by the eligible
7 entity will meet the requirements to be consid-
8 ered for endorsement by such qualified con-
9 sensus-based entity;

10 “(D) have transparent policies regarding
11 governance and conflicts of interest; and

12 “(E) submit an application to the Sec-
13 retary at such time and in such manner, as the
14 Secretary may require.

15 “(4) USE OF FUNDS.—An entity that receives
16 a grant, contract, or agreement under this sub-
17 section shall use such award to develop quality
18 measures that meet the following requirements:

19 “(A) Such measures build upon measures
20 required to be reported pursuant to this title,
21 where applicable.

22 “(B) To the extent practicable, data on
23 such quality measures is able to be collected
24 using health information technologies.

1 “(C) Each quality measure is free of
2 charge to users of such measure.

3 “(D) Each quality measure is publicly
4 available on an Internet website.

5 “(d) OTHER ACTIVITIES BY THE SECRETARY.—The
6 Secretary may use amounts available under this section
7 to update and test, where applicable, quality measures en-
8 dorsed by a qualified consensus-based entity (as defined
9 in section 1890C) or adopted by the Secretary.

10 “(e) FUNDING.—There are authorized to be appro-
11 priated to carry out this section, \$75,000,000 for each of
12 fiscal years 2010 through 2014.”.

13 **SEC. 3014. QUALITY MEASURE ENDORSEMENT.**

14 Title XVIII of the Social Security Act (42 U.S.C.
15 1395 et seq.), as amended by sections 3011 and 3013,
16 is further amended by inserting after section 1890B the
17 following new section:

18 “QUALITY MEASURE ENDORSEMENT

19 “SEC. 1890C. (a) DEFINITION.—In this section:

20 “(1) QUALIFIED CONSENSUS-BASED ENTITY.—
21 The term ‘qualified consensus-based entity’ means
22 an entity with a contract with the Secretary under
23 section 1890.

24 “(2) QUALITY MEASURE.—The term ‘quality
25 measure’ means a standard for measuring the per-
26 formance and improvement of population health or

1 of health plans, providers of services, and other clini-
2 cians in the delivery of health care services.

3 “(3) MULTI-STAKEHOLDER GROUP.—The term
4 ‘multi-stakeholder group’ means, with respect to a
5 quality measure, a voluntary collaborative of organi-
6 zations representing a broad group of stakeholders
7 interested in or affected by the use of such quality
8 measure. Stakeholders would include representatives
9 of hospitals, physicians, post-acute providers, quality
10 alliances, nurses and other health care practitioners,
11 health plans, consumer representatives, life sciences
12 industry, employers and public purchasers, labor or-
13 ganizations, licensing, credentialing and accrediting
14 bodies, relevant government agency representatives;
15 and others deemed appropriate by the Secretary.
16 Such a multi-stakeholder group would operate in an
17 open and transparent process.

18 “(b) GRANTS AND CONTRACTS.—A qualified con-
19 sensus-based entity may receive a grant or contract under
20 this section to—

21 “(1) make recommendations to the Secretary
22 for national priorities for performance improvement
23 in population health and in the delivery of health
24 care services;

1 “(2) identify gaps in endorsed quality measures,
2 which shall include measures that are within priority
3 areas identified by the Secretary under the national
4 strategy established under section 1890A;

5 “(3) identify and endorse quality measures;

6 “(4) update endorsed quality measures at least
7 every 3 years;

8 “(5) make endorsed quality measures publicly
9 available and have a plan for broad-based dissemina-
10 tion of endorsed measures; and

11 “(6) transmit endorsed quality measures to the
12 Secretary.

13 “(c) ANNUAL REPORTS.—

14 “(1) IN GENERAL.—A qualified consensus-
15 based entity that receives a grant or contract under
16 this section shall provide a report to the Secretary
17 not less than annually—

18 “(A) of where gaps (as described in sub-
19 section (b)(2)) exist and where quality measures
20 are unavailable or inadequate to identify or ad-
21 dress such gaps; and

22 “(B) regarding areas in which evidence is
23 insufficient to support endorsement of quality
24 measures in priority areas identified by the Sec-
25 retary under the national strategy established

1 under section 1890A and where targeted re-
2 search may address such gaps.

3 “(2) IMPACT OF QUALITY MEASURES.—A quali-
4 fied consensus-based entity that receives a grant or
5 contract under this section shall provide a report to
6 the Secretary not less than annually regarding the
7 economic and quality impact of the use of endorsed
8 measures.

9 “(d) PRIORITIES FOR PERFORMANCE IMPROVE-
10 MENT.—

11 “(1) RECOMMENDATION FOR NATIONAL PRIOR-
12 ITIES.—A qualified consensus-based entity that re-
13 ceives a grant or contract under this section shall
14 evaluate evidence and convene multi-stakeholder
15 groups to make recommendations to the Secretary
16 for national priorities (as identified in section
17 1890A(a)(2)) for improvement in population health
18 and in the delivery of health care services for consid-
19 eration under the national strategy established
20 under section 1890A. The qualified consensus-based
21 entity shall make such recommendations not less fre-
22 quently than triennially.

23 “(2) REQUIREMENTS FOR TRANSPARENCY IN
24 PROCESS.—

1 “(A) IN GENERAL.—In convening multi-
2 stakeholder groups under paragraph (1) with
3 respect to recommendations for national prior-
4 ities, the qualified consensus-based entity shall
5 provide for an open and transparent process for
6 the activities conducted pursuant to such con-
7 vening.

8 “(B) SELECTION OF ORGANIZATIONS PAR-
9 TICIPATING IN MULTI-STAKEHOLDER
10 GROUPS.—The process under subparagraph (A)
11 shall ensure that the selection of representatives
12 comprising such groups provides for public
13 nominations for, and the opportunity for public
14 comment on, such selection.

15 “(e) PROCESS FOR CONSULTATION OF STAKE-
16 HOLDER GROUPS.—

17 “(1) CONSULTATION OF SELECTION OF EN-
18 DORSED QUALITY MEASURES.—A qualified con-
19 sensus-based entity that receives a grant or contract
20 under this section shall convene multi-stakeholder
21 groups to provide guidance on the selection of indi-
22 vidual or composite quality measures, for use in re-
23 porting performance information to the public or for
24 use in Federal health programs, from among—

1 “(A) such measures that have been en-
2 dorsed by the qualified consensus-based entity
3 (under section 1890(b) or otherwise); and

4 “(B) such measures that have not been
5 considered for endorsement by the qualified
6 consensus-based entity but are used or proposed
7 to be used by the Secretary under subsection
8 (f)(2) under laws under the jurisdiction of the
9 Secretary that require the collection or report-
10 ing of quality measures.

11 “(2) ESTABLISHMENT OF PRE-RULEMAKING
12 PROCESS.—

13 “(A) IN GENERAL.—The Secretary shall
14 establish a pre-rulemaking process under which
15 a qualified consensus-based entity that receives
16 a grant or contract under this section and
17 multi-stakeholder groups convened under para-
18 graph (1) provide guidance to the Secretary on
19 the selection of individual or composite quality
20 measures (as described in such paragraph).

21 “(B) PUBLIC AVAILABILITY OF MEASURES
22 CONSIDERED FOR SELECTION.—Not later than
23 December 1 or each year (beginning with
24 2011), the Secretary shall make available to the
25 public a list of such measures that the Sec-

1 retary is considering for selection with respect
2 to quality reporting and payment systems under
3 this title.

4 “(C) INCLUSION OF MEASURES.—The list
5 made available under subparagraph (B) may in-
6 clude such measures that are described in sub-
7 paragraphs (A) or (B) of paragraph (1) as the
8 Secretary determines appropriate.

9 “(D) TRANSMISSION OF MULTI-STAKE-
10 HOLDER GUIDANCE.—Not later than February
11 1 of each year (beginning with 2012), the quali-
12 fied consensus-based entity shall transmit to
13 the Secretary the guidance of multi-stakeholder
14 groups provided under paragraph (1).

15 “(3) REQUIREMENT FOR TRANSPARENCY IN
16 PROCESS.—

17 “(A) IN GENERAL.—In convening multi-
18 stakeholder groups under paragraph (1) with
19 respect to the selection of quality measures, the
20 qualified consensus-based entity shall provide
21 for an open and transparent process for the ac-
22 tivities conducted pursuant to such convening.

23 “(B) SELECTION OF ORGANIZATIONS PAR-
24 TICIPATING IN MULTI-STAKEHOLDER
25 GROUPS.—The process under subparagraph (A)

1 shall ensure that the selection of representatives
2 comprising such groups provides for public
3 nominations for, and the opportunity for public
4 comment on, such selection.

5 “(f) COORDINATION OF USE OF QUALITY MEAS-
6 URES.—

7 “(1) ENDORSED QUALITY MEASURES.—The
8 Secretary may make a determination under regula-
9 tion or otherwise to use a quality measure described
10 in subsection (e)(1)(A) only after taking into ac-
11 count the guidance of multi-stakeholder groups
12 under subsection (e)(2).

13 “(2) USE OF NON-ENDORSED MEASURES.—

14 “(A) IN GENERAL.—The Secretary may
15 make a determination, by regulation or other-
16 wise, to use a quality measure that has not
17 been endorsed as described in subsection
18 (e)(1)(A), provided that the Secretary—

19 “(i) in a timely manner, transmits the
20 measure to the qualified consensus-based
21 entity for consideration for endorsement
22 and for the multi-stakeholder consultation
23 process under subsection (e)(1);

1 “(ii) publishes in the Federal Register
2 the rationale for the use of the measure;
3 and

4 “(iii) phases out use of the measure
5 upon a decision of the qualified consensus-
6 based entity not to endorse the measure,
7 contingent on availability of an adequate
8 alternative endorsed measure (as deter-
9 mined by the Secretary), taking into ac-
10 count guidance from multi-stakeholder con-
11 sultation process under subsection (e)(1).

12 “(B) NO ADEQUATE ALTERNATIVE.—If an
13 adequate alternative endorsed measure is not
14 available, the Secretary shall support the devel-
15 opment of such an alternative endorsed meas-
16 ure, as described in section 1890B.

17 “(3) EFFECTIVE DATE.—This subsection shall
18 apply with respect to determinations or requirements
19 by the Secretary for the use of quality measures
20 made on or after the date of enactment of the Amer-
21 ica’s Health Future Act of 2009.

22 “(g) REVIEW OF QUALITY MEASURES USED BY THE
23 SECRETARY.—

24 “(1) IN GENERAL.—Not less than once every 3
25 years, the Secretary shall review quality measures

1 used by the Secretary and, with respect to each such
2 measure, shall determine whether to—

3 “(A) maintain the use of such measure; or

4 “(B) phase out such measure.

5 “(2) CONSIDERATIONS.—In conducting the re-
6 view under paragraph (1), the Secretary shall—

7 “(A) seek to avoid duplication of measures
8 used; and

9 “(B) take into consideration current inno-
10 vative methodologies and strategies for quality
11 improvement practices in the delivery of health
12 care services that represent best practices for
13 such quality improvement and measures en-
14 dored by a qualified consensus-based entity
15 since the previous review by the Secretary.

16 “(h) PROCESS FOR DISSEMINATION OF MEASURES
17 USED BY THE SECRETARY.—

18 “(1) IN GENERAL.—The Secretary shall estab-
19 lish a process for disseminating quality measures
20 used by the Secretary. Such process shall include the
21 incorporation of such measures, where applicable, in
22 workforce programs, training curricula, payment
23 programs, and any other means of dissemination de-
24 termined by the Secretary. The Secretary shall es-
25 tablish a process to disseminate such quality meas-

1 ures to the Interagency Working Group established
2 in section 3012 of the America’s Health Future Act
3 of 2009.

4 “(2) AUTHORITY TO CONTRACT WITH CERTAIN
5 ORGANIZATIONS FOR DISSEMINATION.—

6 “(A) IN GENERAL.—The Secretary may
7 contract with 1 or more entities that meet the
8 requirements described in subparagraph (B) to
9 carry out this subsection.

10 “(B) ENTITIES DESCRIBED.—The require-
11 ments described in this subparagraph are the
12 following:

13 “(i) The entity is a nonprofit entity.

14 “(ii) The entity has at least 5 years of
15 experience in developing and implementing
16 quality improvement strategies.

17 “(iii) The entity has operated pro-
18 grams described in paragraph (1) on a
19 statewide or multi-State basis to improve
20 patient safety and the quality of health
21 care delivered in hospitals, including at a
22 minimum such programs in hospital inten-
23 sive care units, hospital-associated infec-
24 tions, hospital perioperative patient safety,
25 and hospital emergency rooms.

1 “(iv) The entity has worked with a va-
2 riety of institutional health care providers,
3 physicians, and other providers of services
4 and suppliers.

5 “(i) TECHNICAL ASSISTANCE.—The Secretary shall
6 provide technical assistance to providers of services and
7 suppliers required to report on measures under this title.
8 In providing such assistance, the Secretary shall give pri-
9 ority to—

10 “(1) rural and urban providers of services and
11 suppliers with limited infrastructure and financial
12 resources to implement and support quality improve-
13 ment activities;

14 “(2) providers of services and suppliers with
15 poor performance scores; and

16 “(3) providers of services and suppliers with
17 disparities in care among subgroups of patients.

18 “(j) FUNDING.—For purposes of carrying out this
19 section, the Secretary of Health and Human Services shall
20 provide for the transfer, from the Federal Hospital Insur-
21 ance Trust Fund under section 1817 and the Federal Sup-
22 plementary Medical Insurance Trust Fund under section
23 1841, in such proportion as the Secretary determines ap-
24 propriate, of \$50,000,000, to the Centers for Medicare &
25 Medicaid Services Program Management Account for each

1 of fiscal years 2010 through 2014. Amounts transferred
2 under the preceding sentence shall remain available until
3 expended.”.

4 **PART III—ENCOURAGING DEVELOPMENT OF**
5 **NEW PATIENT CARE MODELS**

6 **SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE**
7 **AND MEDICAID INNOVATION WITHIN CMS.**

8 (a) IN GENERAL.—Title XI of the Social Security Act
9 is amended by inserting after section 1115 the following
10 new section:

11 “CENTER FOR MEDICARE AND MEDICAID INNOVATION

12 “SEC. 1115A. (a) CENTER FOR MEDICARE AND
13 MEDICAID INNOVATION ESTABLISHED.—

14 “(1) IN GENERAL.—There is created within the
15 Centers for Medicare & Medicaid Services a Center
16 for Medicare and Medicaid Innovation (in this sec-
17 tion referred to as the ‘CMI’) to carry out the duties
18 described in this section. The purpose of the CMI is
19 to test innovative payment and service delivery mod-
20 els to reduce program expenditures under the appli-
21 cable titles while preserving or enhancing the quality
22 of care furnished to individuals under such titles. In
23 selecting such models, the Secretary shall give pref-
24 erence to models that also improve the coordination,
25 quality, and efficiency of health care services fur-

1 nished to applicable individuals defined in paragraph
2 (4)(A).

3 “(2) DEADLINE.—The Secretary shall ensure
4 that the CMI is carrying out the duties described in
5 this section by not later than January 1, 2011.

6 “(3) CONSULTATION.—In carrying out the du-
7 ties under this section, the CMI shall consult rep-
8 resentatives of relevant Federal agencies, and clin-
9 ical and analytical experts with expertise in medicine
10 and health care management. The CMI shall use
11 open door forums or other mechanisms to seek input
12 from interested parties.

13 “(4) DEFINITIONS.—In this section:

14 “(A) APPLICABLE INDIVIDUAL.—The term
15 ‘applicable individual’ means—

16 “(i) an individual who is entitled to,
17 or enrolled for, benefits under part A of
18 title XVIII or enrolled for benefits under
19 part B of such title;

20 “(ii) an individual who is eligible for
21 medical assistance under title XIX, under
22 a State plan or waiver; or

23 “(iii) an individual who meets the cri-
24 teria of both clauses (i) and (ii).

1 “(B) APPLICABLE TITLE.—The term ‘ap-
2 plicable title’ means title XVIII, title XIX, or
3 both.

4 “(b) TESTING OF MODELS (PHASE I).—

5 “(1) IN GENERAL.—The CMI shall test pay-
6 ment and service delivery models in accordance with
7 selection criteria under paragraph (2) to determine
8 the effect of applying such models under the applica-
9 ble title (as defined in subsection (a)(4)(B)) on pro-
10 gram expenditures under such titles and the quality
11 of care received by individuals receiving benefits
12 under such title.

13 “(2) SELECTION OF MODELS TO BE TESTED.—

14 “(A) IN GENERAL.—The Secretary shall
15 select models to be tested from models where
16 the Secretary determines that there is evidence
17 that the model addresses a defined population
18 for which there are deficits in care leading to
19 poor clinical outcomes or potentially avoidable
20 expenditures. The models selected under the
21 preceding sentence may include the models de-
22 scribed in subparagraph (B).

23 “(B) OPPORTUNITIES.—The models de-
24 scribed in this subparagraph are the following
25 models:

1 “(i) Promoting broad payment and
2 practice reform in primary care, including
3 patient-centered medical home models for
4 high-need Medicare beneficiaries, medical
5 homes that address women’s unique health
6 care needs, and models that transition pri-
7 mary care practices away from fee-for-serv-
8 ice based reimbursement and toward com-
9 prehensive payment or salary-based pay-
10 ment under title XVIII

11 “(ii) Contracting directly with groups
12 of providers of services and suppliers to
13 promote innovative care delivery models,
14 such as through risk-based comprehensive
15 payment or salary-based payment.

16 “(iii) Promote care coordination be-
17 tween providers of services and suppliers
18 that transition health care providers away
19 from fee-for-service based reimbursement
20 and toward salary-based payment.

21 “(iv) Supporting care coordination for
22 chronically-ill Medicare beneficiaries at
23 high risk of hospitalization, such as indi-
24 viduals with cognitive impairment (includ-
25 ing dementia) through a health informa-

1 tion technology-enabled network that in-
2 cludes a chronic disease registry, home
3 tele-health technology, and care oversight
4 by the Medicare beneficiary’s treating phy-
5 sician.

6 “(v) Varying payment to physicians
7 who order advanced diagnostic imaging
8 services (as defined in section
9 1834(e)(1)(B)) according to the physi-
10 cian’s adherence to appropriateness criteria
11 for the ordering of such services, as deter-
12 mined in consultation with physician spe-
13 cialty groups and other relevant stake-
14 holders.

15 “(vi) Utilizing medication therapy
16 management services.

17 “(vii) Establishing community-based
18 health teams to support small-practice
19 medical homes by assisting the primary
20 care practitioner in chronic care manage-
21 ment activities.

22 “(viii) Funding physician, nurse prac-
23 titioner, or physician assistant-led home-
24 based primary care programs with dem-
25 onstrated experience in serving high-cost

1 Medicare beneficiaries with multiple chron-
2 ic illnesses and functional disabilities.

3 “(ix) Assisting Medicare beneficiaries
4 in making informed health care choices by
5 paying providers of services and suppliers
6 for using patient decision-support tools
7 that improve Medicare beneficiary and
8 caregiver understanding of medical treat-
9 ment options.

10 “(x) Allowing States to test and
11 evaluate fully integrating care for dual eli-
12 gible individuals in the State, including the
13 management and oversight of all funds
14 under the applicable titles with respect to
15 such individuals.

16 “(xi) Allowing States to test and
17 evaluate systems of all-payer payment re-
18 form for the medical care of residents of
19 the State, including dual eligible individ-
20 uals.

21 “(xii) Aligning nationally-recognized,
22 evidence-based guidelines of cancer care
23 with payment incentives under title XVIII
24 in the areas of treatment planning and fol-
25 low-up care planning for Medicare bene-

1 ficiaries with cancer, including the identi-
2 fication of gaps in applicable quality meas-
3 ures.

4 “(xiii) Improving post-acute care
5 through continuing care hospitals that
6 offer inpatient rehabilitation, long-term
7 care hospitals, and home health or skilled
8 nursing care during an inpatient stay and
9 the 30 days immediately following dis-
10 charge.

11 “(xiv) Funding home health providers
12 who offer chronic care management serv-
13 ices to Medicare beneficiaries in coopera-
14 tion with interdisciplinary teams.

15 “(xv) Promoting improved quality and
16 reduced cost by developing a collaborative
17 of high-quality, low-cost health care insti-
18 tutions that is responsible for—

19 “(I) developing, documenting,
20 and disseminating best practices and
21 proven care methods;

22 “(II) implementing such best
23 practices and proven care methods
24 within such institutions to dem-

1 onstrate further improvements in
2 quality and efficiency; and

3 “(III) providing assistance to
4 other health care institutions on how
5 best to employ such best practices and
6 proven care methods to improve
7 health care quality and lower costs.

8 “(xvi) Promoting greater efficiencies
9 and timely access to outpatient services
10 (such as outpatient physical therapy serv-
11 ices) through models that do not require a
12 physician or other health professional to
13 refer the service or be involved in estab-
14 lishing the plan of care for the service,
15 when such service is furnished by a health
16 professional who has the authority to fur-
17 nish the service under existing State law.

18 “(C) ADDITIONAL FACTORS FOR CONSID-
19 ERATION.—In selecting models for testing
20 under subparagraph (A), the CMI may consider
21 the following additional factors:

22 “(i) Whether the model includes a
23 regular process for monitoring and updat-
24 ing patient care plans in a manner that is

1 consistent with the needs and preferences
2 of Medicare beneficiaries.

3 “(ii) Whether the model places the
4 Medicare beneficiary, including family
5 members and other informal caregivers of
6 the beneficiary, at the center of the care
7 team of the beneficiary.

8 “(iii) Whether the model provides for
9 in-person contact with Medicare bene-
10 ficiaries.

11 “(iv) Whether the model utilizes tech-
12 nology, such as electronic health records
13 and patient-based remote monitoring sys-
14 tems, to coordinate care over time and
15 across settings.

16 “(v) Whether the model provides for
17 the maintenance of a close relationship be-
18 tween care coordinators, primary care
19 practitioners, specialist physicians, and
20 other providers of services and suppliers.

21 “(vi) Whether the model relies on a
22 team-based approach to interventions, such
23 as comprehensive care assessments, care
24 planning, and self-management coaching.

1 “(vii) Whether, under the model, pro-
2 viders of services and suppliers are able to
3 share information with other providers of
4 services and suppliers on a real time basis.

5 “(3) BUDGET NEUTRALITY.—

6 “(A) INITIAL PERIOD.—The Secretary
7 shall not require, as a condition for testing a
8 model under paragraph (1), that the design of
9 such model ensure that such model is budget
10 neutral initially with respect to expenditures
11 under the applicable title.

12 “(B) TERMINATION OR MODIFICATION.—
13 The Secretary shall terminate or modify the de-
14 sign and implementation of a model unless the
15 Secretary determines (and the Chief Actuary of
16 the Centers for Medicare & Medicaid Services,
17 with respect to program spending under the ap-
18 plicable title, certifies), after testing has begun,
19 that the model is expected to—

20 “(i) improve the quality of care (as
21 determined by the Administrator of the
22 Centers for Medicare & Medicaid Services)
23 without increasing spending under the ap-
24 plicable title;

1 “(ii) reduce spending under the appli-
2 cable title without reducing the quality of
3 care; or

4 “(iii) improve the quality of care and
5 reduce spending.

6 Such termination may occur at any time after
7 such testing has begun and before completion of
8 the testing.

9 “(4) EVALUATION.—

10 “(A) IN GENERAL.—The Secretary shall
11 conduct an evaluation of each model tested
12 under this subsection. Such evaluation shall in-
13 clude an analysis of—

14 “(i) the quality of care furnished
15 under the model, including the measure-
16 ment of patient-level outcomes; and

17 “(ii) the changes in spending under
18 the applicable titles by reason of the
19 model.

20 “(B) INFORMATION.—The Secretary shall
21 make the results of each evaluation under this
22 paragraph available to the public in a timely
23 fashion and may establish requirements for
24 States and other entities participating in the
25 testing of models under this section to collect

1 and report information that the Secretary de-
2 termines is necessary to monitor and evaluate
3 such models.

4 “(c) EXPANSION OF MODELS (PHASE II).—Taking
5 into account the evaluation under subsection (b)(4), the
6 Secretary may, through rulemaking, expand (including im-
7 plementation on a nationwide basis) the duration and the
8 scope of a model that is being tested under subsection (b)
9 or a demonstration project under section 1866C, to the
10 extent determined appropriate by the Secretary, if—

11 “(1) the Secretary determines that such expan-
12 sion is expected to—

13 “(A) reduce spending under applicable title
14 without reducing the quality of care; or

15 “(B) improve the quality of care and re-
16 duce spending; and

17 “(2) the Chief Actuary of the Centers for Medi-
18 care & Medicaid Services certifies that such expan-
19 sion would reduce net program spending under ap-
20 plicable titles.

21 “(d) IMPLEMENTATION.—

22 “(1) WAIVER AUTHORITY.—The Secretary may
23 waive such requirements of titles XI and XVIII and
24 of sections 1902(a)(1), 1902(a)(13), and
25 1903(m)(2)(A)(iii) as may be necessary solely for

1 purposes of carrying out this section with respect to
2 testing models described in subsection (b).

3 “(2) LIMITATIONS ON REVIEW.—There shall be
4 no administrative or judicial review under section
5 1869, section 1878, or otherwise of—

6 “(A) the selection of models for testing or
7 expansion under this section;

8 “(B) the selection of organizations, sites,
9 or participants to test those models selected;

10 “(C) the elements, parameters, scope, and
11 duration of such models for testing or dissemi-
12 nation;

13 “(D) determinations regarding budget neu-
14 trality under subsection (b)(3);

15 “(E) the termination or modification of the
16 design and implementation of a model under
17 subsection (b)(3)(B); and

18 “(F) determinations about expansion of
19 the duration and scope of a model under sub-
20 section (c), including the determination that a
21 model is not expected to meet criteria described
22 in paragraph (1) or (2) of such subsection.

23 “(3) ADMINISTRATION.—Chapter 35 of title 44,
24 United States Code, shall not apply to the testing

1 and evaluation of models or expansion of such mod-
2 els under this section.

3 “(e) APPLICATION TO CHIP.—The Center may carry
4 out activities under this section with respect to title XXI
5 in the same manner as provided under this section with
6 respect to the program under the applicable titles.

7 “(f) FUNDING.—

8 “(1) IN GENERAL.—There are appropriated,
9 from amounts in the Treasury not otherwise appro-
10 priated—

11 “(A) \$10,000,000,000 for the activities ini-
12 tiated under this section for the period of fiscal
13 years 2011 through 2019; and

14 “(B) the amount described in subpara-
15 graph (A) for the activities initiated under this
16 section for each subsequent 10-year fiscal pe-
17 riod (beginning with the 10-year fiscal period
18 beginning with fiscal year 2020).

19 Amounts appropriated under the preceding sentence
20 shall remain available until expended.

21 “(2) USE OF CERTAIN FUNDS.—Out of
22 amounts appropriated under paragraph (1), not less
23 than \$25,000,000 shall be made available each such
24 fiscal year to design, implement, and evaluate mod-
25 els under subsection (b).

1 “(g) REPORT TO CONGRESS.—Beginning in 2012,
2 and not less than once every other year thereafter, the
3 Secretary shall submit to Congress a report on activities
4 under this section. Each such report shall describe the
5 models tested under subsection (b), including the number
6 of individuals described in subsection (a)(4)(A)(i) and of
7 individuals described in subsection (a)(4)(A)(ii) partici-
8 pating in such models and payments made under applica-
9 ble titles for services on behalf of such individuals, any
10 models chosen for expansion under subsection (c), and the
11 results from evaluations under subsection (b)(4). In addi-
12 tion, each such report shall provide such recommendations
13 as the Secretary determines are appropriate for legislative
14 action to facilitate the development and expansion of suc-
15 cessful payment models.”.

16 (b) MEDICAID CONFORMING AMENDMENT.—Section
17 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
18 as amended by sections 5103 and 5105, is amended—

19 (1) in paragraph (77), by striking “and” at the
20 end;

21 (2) in paragraph (78), by striking the period at
22 the end and inserting “; and”; and

23 (3) by inserting after paragraph (78) the fol-
24 lowing new paragraph:

1 “(A) groups of providers of services and
2 suppliers meeting criteria specified by the Sec-
3 retary may work together to manage and co-
4 ordinate care for Medicare fee-for-service bene-
5 ficiaries through an accountable care organiza-
6 tion (referred to in this section as an ‘ACO’);
7 and

8 “(B) ACOs that meet quality performance
9 standards established by the Secretary are eligi-
10 ble to receive payments for shared savings
11 under subsection (d)(2).

12 “(b) ELIGIBLE ACOS.—

13 “(1) IN GENERAL.—Subject to the succeeding
14 provisions of this subsection, as determined appro-
15 priate by the Secretary, the following groups of pro-
16 viders of services and suppliers which have estab-
17 lished a mechanism for shared governance are eligi-
18 ble to participate as ACOs under the program under
19 this section:

20 “(A) ACO professionals in group practice
21 arrangements.

22 “(B) Networks of individual practices of
23 ACO professionals.

1 “(C) Partnerships or joint venture ar-
2 rangements between hospitals and ACO profes-
3 sionals.

4 “(D) Hospitals employing ACO profes-
5 sionals.

6 “(E) Such other groups of providers of
7 services and suppliers as the Secretary deter-
8 mines appropriate.

9 “(2) REQUIREMENTS.—An ACO shall meet the
10 following requirements:

11 “(A) The ACO shall be willing to become
12 accountable for the quality, cost, and overall
13 care of the Medicare fee-for-service beneficiaries
14 assigned to it.

15 “(B) The ACO shall enter into an agree-
16 ment with the Secretary to participate in the
17 program for not less than a 3-year period (re-
18 ferred to in this section as the ‘agreement pe-
19 riod’).

20 “(C) The ACO shall have a formal legal
21 structure that would allow the organization to
22 receive and distribute payments for shared sav-
23 ings under subsection (d)(2) to participating
24 providers of services and suppliers.

1 “(D) The ACO shall include the primary
2 care ACO professionals described in subsection
3 (h)(1)(A) of at least 5,000 Medicare fee-for-
4 service beneficiaries assigned to the ACO under
5 subsection (c).

6 “(E) The ACO shall provide the Secretary
7 with such information regarding ACO profes-
8 sionals participating in the ACO as the Sec-
9 retary determines necessary to support the as-
10 signment of Medicare fee-for-service bene-
11 ficiaries to an ACO, the implementation of
12 quality and other reporting requirements under
13 paragraph (3), and the determination of pay-
14 ments for shared savings under subsection
15 (d)(2).

16 “(F) The ACO shall have in place a leader-
17 ship and management structure that includes
18 clinical and administrative systems.

19 “(G) The ACO shall define processes to
20 promote evidence-based medicine, report on
21 quality and cost measures, and coordinate care,
22 such as through the use of telehealth, remote
23 patient monitoring, and other such enabling
24 technologies.

1 “(H) The ACO shall demonstrate to the
2 Secretary that it meets patient-centeredness cri-
3 teria specified by the Secretary, such as the use
4 of patient and caregiver assessments or the use
5 of individualized care plans.

6 “(3) QUALITY AND OTHER REPORTING RE-
7 QUIREMENTS.—

8 “(A) IN GENERAL.—The Secretary shall
9 determine appropriate measures to assess the
10 quality of care furnished by the ACO, such as
11 measures of—

12 “(i) clinical processes and outcomes;

13 “(ii) patient perspectives on care; and

14 “(iii) utilization (such as rates of hos-
15 pital admissions for ambulatory care sen-
16 sitive conditions).

17 “(B) REPORTING REQUIREMENTS.—An
18 ACO shall submit data in a form and manner
19 specified by the Secretary on measures the Sec-
20 retary determines necessary for the ACO to re-
21 port in order to evaluate the quality of care fur-
22 nished by the ACO. Such data may include care
23 transitions across health care settings, including
24 hospital discharge planning and post hospital

1 discharge follow-up by ACO professionals, as
2 the Secretary determines appropriate.

3 “(C) QUALITY PERFORMANCE STAND-
4 ARDS.—The Secretary shall establish quality
5 performance standards to assess the quality of
6 care furnished by ACOs. The Secretary shall
7 seek to improve the quality of care furnished by
8 ACOs over time by specifying higher standards,
9 new measures, or both for purposes of assessing
10 such quality of care.

11 “(D) OTHER REPORTING REQUIRE-
12 MENTS.—The Secretary may, as the Secretary
13 determines appropriate, incorporate reporting
14 requirements and incentive payments related to
15 the physician quality reporting initiative
16 (PQRI) under section 1848, including such re-
17 quirements and such payments related to elec-
18 tronic prescribing, electronic health records,
19 and other similar initiatives under section 1848,
20 and may use alternative criteria than would
21 otherwise apply under such section for deter-
22 mining whether to make such payments. The
23 incentive payments described in the preceding
24 sentence shall not be taken into consideration

1 when calculating any payments otherwise made
2 under subsection (d).

3 “(4) NO DUPLICATION IN PARTICIPATION IN
4 SHARED SAVINGS PROGRAMS.—A provider of services
5 or supplier that participates in any of the following
6 shall not be eligible to participate in an ACO under
7 this section:

8 “(A) A model tested or expanded under
9 section 1115A that involves shared savings
10 under this title, or any other program or dem-
11 onstration project that involves such shared
12 savings.

13 “(B) The independence at home medical
14 practice pilot program under section 1866E.

15 “(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE
16 BENEFICIARIES TO ACOS.—The Secretary shall deter-
17 mine an appropriate method to assign Medicare fee-for-
18 service beneficiaries to an ACO based on their utilization
19 of primary care services under this title.

20 “(d) PAYMENTS AND TREATMENT OF SAVINGS.—

21 “(1) PAYMENTS.—

22 “(A) IN GENERAL.—Under the program,
23 subject to paragraph (3), payments shall con-
24 tinue to be made to providers of services and
25 suppliers participating in an ACO under the

1 original Medicare fee-for-service program under
2 parts A and B in the same manner as they
3 would otherwise be made except that a partici-
4 pating ACO is eligible to receive payment for
5 shared savings under paragraph (2) if—

6 “(i) the ACO meets quality perform-
7 ance standards established by the Sec-
8 retary under subsection (b)(3); and

9 “(ii) the ACO meets the requirement
10 under subparagraph (B)(i).

11 “(B) SAVINGS REQUIREMENT AND BENCH-
12 MARK.—

13 “(i) DETERMINING SAVINGS.—In each
14 year of the agreement period, an ACO
15 shall be eligible to receive payment for
16 shared savings under paragraph (2) only if
17 the estimated average per capita Medicare
18 expenditures under the ACO for Medicare
19 fee-for-service beneficiaries for parts A and
20 B services, adjusted for beneficiary charac-
21 teristics, is at least the percent specified by
22 the Secretary below the applicable bench-
23 mark under clause (ii). The Secretary shall
24 determine the appropriate percent de-
25 scribed in the preceding sentence to ac-

1 count for normal variation in expenditures
2 under this title, based upon the number of
3 Medicare fee-for-service beneficiaries as-
4 signed to an ACO.

5 “(ii) ESTABLISH AND UPDATE
6 BENCHMARK.—The Secretary shall esti-
7 mate a benchmark for each agreement pe-
8 riod for each ACO using the most recent
9 available 3 years of per-beneficiary expend-
10 itures for parts A and B services for Medi-
11 care fee-for-service beneficiaries assigned
12 to the ACO. Such benchmark shall be ad-
13 justed for beneficiary characteristics and
14 such other factors as the Secretary deter-
15 mines appropriate and updated by the pro-
16 jected absolute amount of growth in na-
17 tional per capita expenditures for parts A
18 and B services under the original Medicare
19 fee-for-service program, as estimated by
20 the Secretary. Such benchmark shall be
21 reset at the start of each agreement pe-
22 riod.

23 “(2) PAYMENTS FOR SHARED SAVINGS.—Sub-
24 ject to performance with respect to the quality per-
25 formance standards established by the Secretary

1 under subsection (b)(3), if an ACO meets the re-
2 quirements under paragraph (1), a percent (as de-
3 termined appropriate by the Secretary) of the dif-
4 ference between such estimated average per capita
5 Medicare expenditures in a year, adjusted for bene-
6 ficiary characteristics, under the ACO and such
7 benchmark for the ACO may be paid to the ACO as
8 shared savings and the remainder of such difference
9 shall be retained by the program under this title.
10 The Secretary shall establish limits on the total
11 amount of shared savings that may be paid to an
12 ACO under this paragraph.

13 “(3) MONITORING AVOIDANCE OF AT-RISK PA-
14 TIENTS.—If the Secretary determines that an ACO
15 has taken steps to avoid patients at risk in order to
16 reduce the likelihood of increasing costs to the ACO
17 the Secretary may impose an appropriate sanction
18 on the ACO, including termination from the pro-
19 gram.

20 “(4) TERMINATION.—The Secretary may termi-
21 nate an agreement with an ACO if it does not meet
22 the quality performance standards established by the
23 Secretary under subsection (b)(3).

24 “(e) ADMINISTRATION.—Chapter 35 of title 44,
25 United States Code, shall not apply to the program.

1 “(f) WAIVER AUTHORITY.—The Secretary may waive
2 such requirements of sections 1128A and 1128B and title
3 XVIII of this Act as may be necessary to carry out the
4 provisions of this section.

5 “(g) LIMITATIONS ON REVIEW.—There shall be no
6 administrative or judicial review under section 1869, sec-
7 tion 1878, or otherwise of—

8 “(1) the specification of criteria under sub-
9 section (a)(1)(B);

10 “(2) the assessment of the quality of care fur-
11 nished by an ACO and the establishment of perform-
12 ance standards under subsection (b)(3);

13 “(3) the assignment of Medicare fee-for-service
14 beneficiaries to an ACO under subsection (c);

15 “(4) the determination of whether an ACO is
16 eligible for shared savings under subsection (d)(2)
17 and the amount of such shared savings, including
18 the determination of the estimated average per cap-
19 ita Medicare expenditures under the ACO for Medi-
20 care fee-for-service beneficiaries assigned to the ACO
21 and the average benchmark for the ACO under sub-
22 section (d)(1)(B);

23 “(5) the percent of shared savings specified by
24 the Secretary under subsection (d)(2) and any limit

1 on the total amount of shared savings established by
2 the Secretary under such subsection; and

3 “(6) the termination of an ACO under sub-
4 section (d)(4).

5 “(h) DEFINITIONS.—In this section:

6 “(1) ACO PROFESSIONAL.—The term ‘ACO
7 professional’ means—

8 “(A) a physician (as defined in section
9 1861(r)(1)); and

10 “(B) a practitioner described in section
11 1842(b)(18)(C)(i).

12 “(2) HOSPITAL.—The term ‘hospital’ means a
13 subsection (d) hospital (as defined in section
14 1886(d)(1)(B)).

15 “(3) MEDICARE FEE-FOR-SERVICE BENE-
16 FICIARY.—The term ‘Medicare fee-for-service bene-
17 ficiary’ means an individual who is enrolled in the
18 original Medicare fee-for-service program under
19 parts A and B and is not enrolled in an MA plan
20 under part C, an eligible organization under section
21 1876, or a PACE program under section 1894.”.

1 **SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUN-**
2 **DLING.**

3 Title XVIII of the Social Security Act, as amended
4 by section 3021, is amended by inserting after section
5 1886C the following new section:

6 “NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

7 “SEC. 1866D. (a) IMPLEMENTATION.—

8 “(1) IN GENERAL.—The Secretary shall estab-
9 lish a pilot program for integrated care during an
10 episode of care provided to an applicable beneficiary
11 around a hospitalization.

12 “(2) DEFINITIONS.—In this section:

13 “(A) APPLICABLE BENEFICIARY.—The
14 term ‘applicable beneficiary’ means an indi-
15 vidual who—

16 “(i) is entitled to, or enrolled for, ben-
17 efits under part A and enrolled for benefits
18 under part B of such title, but not enrolled
19 under part C; and

20 “(ii) is admitted to a hospital for an
21 applicable condition.

22 “(B) APPLICABLE CONDITION.—The term
23 ‘applicable condition’ means 1 or more of 8 con-
24 ditions selected by the Secretary. In selecting
25 conditions under the preceding sentence, the

1 Secretary shall take into consideration the fol-
2 lowing factors:

3 “(i) Whether the conditions selected
4 include a mix of chronic and acute condi-
5 tions.

6 “(ii) Whether the conditions selected
7 include a mix of surgical and medical con-
8 ditions.

9 “(iii) Whether a condition is one for
10 which there is evidence of an opportunity
11 for providers of services and suppliers to
12 improve the quality of care furnished while
13 reducing total expenditures under this
14 title.

15 “(iv) Whether a condition has signifi-
16 cant variation in—

17 “(I) the number of readmissions;
18 and

19 “(II) the amount of expenditures
20 for post-acute care spending under
21 this title.

22 “(v) Whether a condition has high-vol-
23 ume and high post-acute care expenditures
24 under this title.

1 “(vi) Which conditions the Secretary
2 determines are most amenable to bundling
3 across the spectrum of care given practice
4 patterns under this title.

5 “(C) APPLICABLE SERVICES.—The term
6 ‘applicable services’ means the following:

7 “(i) Acute care inpatient services.

8 “(ii) Physicians’ services delivered in
9 and outside of an acute care hospital set-
10 ting.

11 “(iii) Outpatient hospital services, in-
12 cluding emergency department services.

13 “(iv) Services associated with acute
14 care hospital readmissions.

15 “(v) Post-acute care services, includ-
16 ing home health services, skilled nursing
17 services, inpatient rehabilitation services,
18 and inpatient hospital services furnished by
19 a long-term care hospital.

20 “(vi) Other services the Secretary de-
21 termines appropriate.

22 “(D) EPISODE OF CARE.—

23 “(i) IN GENERAL.—Subject to clause
24 (ii), the term ‘episode of care’ means, with

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1 respect to an applicable beneficiary, the pe-
2 riod that includes—

3 “(I) the 3 days prior to the ad-
4 mission of the applicable beneficiary
5 to a hospital for an applicable condi-
6 tion;

7 “(II) the length of stay of the ap-
8 plicable beneficiary in such hospital;
9 and

10 “(III) the 30 days following the
11 discharge of the applicable beneficiary
12 from such hospital.

13 “(ii) ESTABLISHMENT OF PERIOD BY
14 THE SECRETARY.—The Secretary, as ap-
15 propriate, may establish a period (other
16 than the period described in clause (i)) for
17 an episode of care under the pilot program.

18 “(E) PHYSICIANS’ SERVICES.—The term
19 ‘physicians’ services’ has the meaning given
20 such term in section 1861(q).

21 “(F) PILOT PROGRAM.—The term ‘pilot
22 program’ means the pilot program under this
23 section.

1 “(G) PROVIDER OF SERVICES.—The term
2 ‘provider of services’ has the meaning given
3 such term in section 1861(u).

4 “(H) READMISSION.—The term ‘readmis-
5 sion’ has the meaning given such term in sec-
6 tion 1886(q)(3)(B).

7 “(I) SUPPLIER.—The term ‘supplier’ has
8 the meaning given such term in section
9 1861(d).

10 “(3) DEADLINE FOR IMPLEMENTATION.—The
11 Secretary shall establish the pilot program not later
12 than January 1, 2013.

13 “(b) DEVELOPMENTAL PHASE.—

14 “(1) DETERMINATION OF PATIENT ASSESS-
15 MENT INSTRUMENT.—The Secretary shall determine
16 which patient assessment instrument (such as the
17 Continuity Assessment Record and Evaluation
18 (CARE) tool) shall be used under the pilot program
19 to evaluate the applicable condition of an applicable
20 beneficiary for purposes of determining the most
21 clinically-appropriate site for the provision of post-
22 acute care to the applicable beneficiary.

23 “(2) DEVELOPMENT OF QUALITY MEASURES
24 FOR AN EPISODE OF CARE AND FOR POST-ACUTE
25 CARE.—

1 “(A) IN GENERAL.—The Secretary, in con-
2 sultation with the Agency for Healthcare Re-
3 search and Quality and a qualified consensus-
4 based entity under section 1890C, shall develop
5 quality measures for use in the pilot program—

6 “(i) for episodes of care; and

7 “(ii) for post-acute care.

8 “(B) SITE-NEUTRAL POST-ACUTE CARE
9 QUALITY MEASURES.—Any quality measures
10 developed under subparagraph (A)(ii) shall be
11 site-neutral.

12 “(C) COORDINATION WITH QUALITY MEAS-
13 SURE DEVELOPMENT AND ENDORSEMENT PRO-
14 CEDURES.—The Secretary shall ensure that the
15 development of quality measures under sub-
16 paragraph (A) is done in a manner that is con-
17 sistent with the measures developed and en-
18 dorsed under sections 1890B and 1890C that
19 are applicable to all post-acute care settings.

20 “(3) DETERMINATION OF APPLICATION OF
21 WAIVER AUTHORITY.—The Secretary shall determine
22 which requirements of this title and title XI to waive
23 under subsection (d) to carry out the pilot program

24 .

25 “(c) DETAILS.—

1 “(1) DURATION.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), the pilot program shall be conducted
4 for a period of 5 years.

5 “(B) EXTENSION.—The Secretary may ex-
6 tend the duration of the pilot program for pro-
7 viders of services and suppliers participating in
8 the pilot program as of the day before the end
9 of the 5-year period described in subparagraph
10 (A), for a period determined appropriate by the
11 Secretary, if the Secretary determines that such
12 extension will result in any of the following con-
13 ditions being met:

14 “(i) The extension of the pilot pro-
15 gram is expected to improve the quality of
16 patient care without increasing expendi-
17 tures under this title.

18 “(ii) The extension of the pilot pro-
19 gram is expected to reduce expenditures
20 under this title without reducing the qual-
21 ity of patient care.

22 “(2) PARTICIPATING PROVIDERS OF SERVICES
23 AND SUPPLIERS.—

24 “(A) IN GENERAL.—Subject to subpara-
25 graph (C), any provider of services or supplier,

1 including a hospital, a physician group, or an
2 entity composed of 2 or more providers of serv-
3 ices or suppliers may submit an application to
4 the Secretary to participate in the pilot pro-
5 gram.

6 “(B) REQUIREMENTS.—The Secretary
7 shall develop requirements for providers of serv-
8 ices, suppliers, and entities composed of 2 or
9 more providers of services or suppliers to par-
10 ticipate in the pilot program. Such require-
11 ments shall ensure that applicable beneficiaries
12 have an adequate choice of providers of services
13 and suppliers under the pilot program.

14 “(C) REQUIREMENTS FOR POST-ACUTE
15 ENTITIES.—An entity composed of 2 or more
16 providers of services or suppliers may only par-
17 ticipate in the pilot program if the entity owns,
18 operates, or contracts with an acute care hos-
19 pital for the furnishing of services for which a
20 bundled payment is made under paragraph
21 (3)(D).

22 “(3) PAYMENT METHODOLOGY.—

23 “(A) IN GENERAL.—

24 “(i) ESTABLISHMENT OF PAYMENT
25 RATES.—The Secretary shall establish pay-

1 ment rates under the pilot program for
2 providers of services, suppliers, and entities
3 participating in the pilot program at an
4 amount that is equal to the average ex-
5 pected reimbursement under this title of
6 providers of services, suppliers, and entities
7 not participating in the pilot program for
8 applicable services over an episode of care.

9 “(ii) TESTING OF ALTERNATIVE PAY-
10 MENT METHODOLOGIES.—The Secretary
11 shall test alternative payment methodolo-
12 gies under the pilot program, including
13 bundled payments or arrangements in
14 which providers of services, suppliers, and
15 entities continue to receive reimbursement
16 under payment systems that would other-
17 wise apply under this title, in accordance
18 with this paragraph.

19 “(B) ADJUSTMENT OF PAYMENTS.—Pay-
20 ments to participating providers of services,
21 suppliers, and entities under the pilot program
22 shall be adjusted for—

23 “(i) severity of illness and other char-
24 acteristics of applicable beneficiaries, in-

1 cluding having a major diagnosis of sub-
2 stance abuse or mental illness; and

3 “(ii) resources needed to provide care,
4 including an adjustment for differences in
5 hospital average hourly wages, physician
6 work, practice expense, malpractice ex-
7 pense, and geographic adjustment factors.

8 “(C) INCLUSION OF CERTAIN SERVICES.—

9 A payment methodology tested under the pilot
10 program shall include payment for the fur-
11 nishing of applicable services and other appro-
12 priate services, such as care coordination, medi-
13 cation reconciliation, discharge planning, transi-
14 tional care services, and other patient-centered
15 activities as determined appropriate by the Sec-
16 retary.

17 “(D) BUNDLED PAYMENTS.—

18 “(i) IN GENERAL.—A bundled pay-
19 ment under the pilot program shall—

20 “(I) be comprehensive, covering
21 the costs of applicable services and
22 other appropriate services furnished to
23 an individual during an episode of
24 care (as determined by the Secretary),
25 including the costs of any readmission

1 which would otherwise be subject to a
2 payment adjustment under section
3 1886(q)(5); and

4 “(II) be made to a provider of
5 services or supplier (or an entity com-
6 posed of 2 or more providers of serv-
7 ices or suppliers) participating in the
8 pilot program.

9 “(ii) REQUIREMENT FOR PROVISION
10 OF APPLICABLE SERVICES AND OTHER AP-
11 PROPRIATE SERVICES.—Applicable services
12 and other appropriate services for which
13 payment is made under this subparagraph
14 shall be furnished or directed by a provider
15 of services, supplier, or entity which is par-
16 ticipating under this title.

17 “(iii) BUNDLED PAYMENT FOR APPLI-
18 CABLE CONDITIONS.—A bundled payment
19 under the pilot program with respect to an
20 applicable condition shall be based on the
21 average of the amount of payment other-
22 wise made under this title to a hospital, a
23 physician, other providers of services, and
24 other suppliers for such services furnished
25 to an applicable beneficiary with respect to

1 the applicable condition during an episode
2 of care.

3 “(iv) PAYMENT FOR EACH APPLICA-
4 BLE BENEFICIARY FURNISHED APPLICA-
5 BLE SERVICES DURING AN EPISODE OF
6 CARE.—A bundled payment under the pilot
7 program shall be made to a provider of
8 services, supplier, or entity with respect to
9 each applicable beneficiary who is fur-
10 nished applicable services during an epi-
11 sode of care by the provider of services,
12 supplier, or entity, regardless of whether
13 the applicable beneficiary receives a certain
14 level of physicians’ services or post-acute
15 care services.

16 “(E) EXEMPTION FROM PAYMENT ADJUST-
17 MENT FOR READMISSIONS.—In the case where
18 the Secretary determines there is overlap be-
19 tween an applicable condition under the pilot
20 program and a condition selected under para-
21 graph (2) of section 1886(q) for which there
22 would otherwise be a payment adjustment
23 under paragraph (5) of such section, the appli-
24 cable condition shall be exempt from such pay-
25 ment adjustment.

1 “(F) READMISSIONS TO A HOSPITAL
2 OTHER THAN THE HOSPITAL OF THE INITIAL
3 ADMISSION.—

4 “(i) IN GENERAL.—Under the pilot
5 program, in the case of the readmission of
6 an applicable beneficiary to a hospital
7 other than the hospital of the initial admis-
8 sion, the Secretary shall reimburse the hos-
9 pital of the readmission the amount of pay-
10 ment that would otherwise be made under
11 this title for the readmission.

12 “(ii) ADJUSTMENT OF BUNDLED PAY-
13 MENT.—In the case described in clause (i),
14 the Secretary shall reduce the amount of
15 the bundled payment under subparagraph
16 (D) for the hospital of the initial admission
17 by an amount equal to the amount paid to
18 the hospital of the readmission under such
19 clause.

20 “(G) PAYMENT FOR POST-ACUTE CARE
21 SERVICES AFTER THE EPISODE OF CARE.—The
22 Secretary shall establish procedures, in the case
23 where an applicable beneficiary requires contin-
24 ued post-acute care services after the last day
25 of the episode of care, under which the original

1 Medicare fee-for-service program under parts A
2 and B covers post-acute care services furnished
3 to the applicable beneficiary in an appropriate
4 setting (as determined using the patient assess-
5 ment instrument under subsection (b)(1)).

6 “(4) QUALITY MEASURES.—

7 “(A) IN GENERAL.—The Secretary shall
8 establish quality measures (including quality
9 measures of process, outcome, and structure)
10 related to care provided across all providers of
11 services, suppliers, and entities participating in
12 the pilot program. Quality measures established
13 under the preceding sentence shall include
14 measures of the following:

15 “(i) An episode of care.

16 “(ii) Functional status improvement.

17 “(iii) Rates of readmission.

18 “(iv) Rates of readmissions described
19 in section 1861(q)(3)(B)(ii).

20 “(v) Rates of return to the commu-
21 nity.

22 “(vi) Rates of admission to an emer-
23 gency room after a hospitalization (as dis-
24 tinctly separate from rates described in
25 clauses (iii) and (iv)).

1 “(vii) Efficiency measures.

2 “(viii) Measures of patient-
3 centeredness of care.

4 “(ix) Measures of patient perception
5 of care.

6 “(x) Measures to monitor and detect
7 the under provision of necessary care.

8 “(xi) Other measures, including meas-
9 ures of patient outcomes, determined ap-
10 propriate by the Secretary.

11 “(B) RISK ADJUSTMENT.—Quality meas-
12 ures established under subparagraph (A) shall
13 be risk-adjusted.

14 “(C) REVISION OF QUALITY MEASURES.—
15 The Secretary may revise quality measures so
16 established (including adding new quality meas-
17 ures and retiring quality measures that are ob-
18 solete) as the Secretary determines appropriate
19 with respect to applicable services and other ap-
20 propriate services provided to applicable bene-
21 ficiaries under the pilot program.

22 “(D) REPORTING ON QUALITY MEAS-
23 URES.—

24 “(i) IN GENERAL.—A provider of
25 services, supplier, or entity described in

1 clause (ii) shall submit data to the Sec-
2 retary on quality measures established
3 under subparagraph (A) during each year
4 of the pilot program (in a form and man-
5 ner, subject to clause (iii), specified by the
6 Secretary).

7 “(ii) PROVIDER OF SERVICES, SUP-
8 PLIER, OR ENTITY DESCRIBED.—A pro-
9 vider of services, supplier, or entity de-
10 scribed in this clause is a provider of serv-
11 ices, supplier, or entity—

12 “(I) participating in the pilot
13 program; and

14 “(II) who receives a bundled pay-
15 ment under paragraph (3)(D).

16 “(iii) SUBMISSION OF DATA THROUGH
17 ELECTRONIC HEALTH RECORD.—To the
18 extent practicable, the Secretary shall
19 specify that data on measures be sub-
20 mitted under clause (i) through the use of
21 an qualified electronic health record (as de-
22 fined in section 3000(13) of the Public
23 Health Service Act (42 U.S.C. 300jj-
24 11(13)) in a manner specified by the Sec-
25 retary.

1 “(d) WAIVER.—The Secretary may waive such provi-
2 sions of this title and title XI as may be necessary to carry
3 out the pilot program.

4 “(e) INDEPENDENT EVALUATION AND REPORTS ON
5 PILOT PROGRAM.—

6 “(1) INDEPENDENT EVALUATION.—

7 “(A) IN GENERAL.—The Secretary shall
8 enter into a contract with an entity for the con-
9 duct of an independent evaluation of the pilot
10 program, including an evaluation of whether
11 and if so, the extent to which, the performance
12 of providers of services, suppliers, and entities
13 composed of 2 or more providers of services or
14 suppliers participating in the pilot program has
15 improved with respect to—

16 “(i) quality measures established
17 under subsection (c)(4)(A);

18 “(ii) health outcomes;

19 “(iii) applicable beneficiary access to
20 care; and

21 “(iv) financial outcomes.

22 “(B) SUBMISSION OF REPORTS.—Such
23 contract shall provide for the submission to the
24 Secretary and Congress of the reports described
25 in paragraph (2).

1 “(2) REPORTS BY ENTITY CONDUCTING INDE-
2 PENDENT EVALUATION.—

3 “(A) INTERIM REPORT.—Not later than 2
4 years after the implementation of the pilot pro-
5 gram, the entity with a contract under para-
6 graph (1) shall submit to the Secretary and to
7 Congress a report on the initial results of the
8 independent evaluation conducted under such
9 paragraph.

10 “(B) FINAL REPORT.—Not later than 3
11 years after the implementation of the pilot pro-
12 gram, the entity described in subparagraph (A)
13 shall submit to the Secretary and to Congress
14 a report on the final results of such inde-
15 pendent evaluation.

16 “(C) CONTENTS OF REPORT.—Each report
17 submitted under this paragraph shall include an
18 evaluation of—

19 “(i) whether the performance of pro-
20 viders of services, suppliers, and entities
21 participating in the pilot program has im-
22 proved with respect to—

23 “(I) quality measures established
24 under subsection (c)(4)(A);

25 “(II) health outcomes;

1 “(III) applicable beneficiary ac-
2 cess to care; and

3 “(IV) financial outcomes; and

4 “(ii) if the evaluation under clause (i)
5 determines such performance has im-
6 proved, the extent of such improvement.

7 “(f) STUDY AND REPORT ON APPLICATION OF PILOT
8 PROGRAM TO SMALL RURAL HOSPITALS.—

9 “(1) STUDY.—The Secretary, in consultation
10 with representatives of small rural hospitals, includ-
11 ing critical access hospitals, shall conduct a study to
12 determine appropriate and effective methods for
13 such hospitals to participate in the pilot program or
14 in a pilot program conducted in a similar manner
15 under this title. Such study shall include consider-
16 ation of innovative methods of implementing bundled
17 payments in hospitals described in the preceding
18 sentence, taking into consideration any difficulties in
19 doing so as a result of the low volume of services
20 provided by such hospitals.

21 “(2) REPORT.—Not later than 2 years after the
22 date of enactment of this section, the Secretary shall
23 submit to Congress a report containing the results
24 of the study conducted under paragraph (1), to-
25 gether with recommendations for such legislation

1 and administrative action as the Secretary deter-
2 mines appropriate.

3 “(3) DEFINITION OF SMALL RURAL HOS-
4 PITAL.—In this subsection, the term ‘small rural
5 hospital’ means a hospital located in a rural area (as
6 defined in section 1886(d)(2)(D)(ii)) with fewer than
7 250 acute care inpatient beds.

8 “(g) IMPLEMENTATION PLAN.—

9 “(1) IN GENERAL.—Not later than January 1,
10 2016, subject to paragraph (2), the Secretary shall
11 submit a plan for the implementation of an expan-
12 sion of the pilot program by not later than January
13 1, 2018, to an extent determined appropriate by the
14 Secretary, if the Secretary determines that such ex-
15 pansion will result in any of the following conditions
16 being met:

17 “(A) The expansion of the pilot program is
18 expected to improve the quality of patient care
19 without increasing expenditures under this title.

20 “(B) The expansion of the pilot program is
21 expected to reduce expenditures under this title
22 without reducing the quality of patient care.”.

1 **SEC. 3024. INDEPENDENCE AT HOME PILOT PROGRAM.**

2 Title XVIII of the Social Security Act, as amended
3 by section 3023, is amended by inserting after section
4 1866D the following new section:

5 “INDEPENDENCE AT HOME MEDICAL PRACTICE PILOT
6 PROGRAM

7 “SEC. 1866E. (a) ESTABLISHMENT.—

8 “(1) IN GENERAL.—The Secretary shall con-
9 duct a pilot program (in this section referred to as
10 the ‘pilot program’) to test a payment incentive and
11 service delivery model that utilizes physician and
12 nurse practitioner directed home-based primary care
13 teams designed to reduce expenditures and improve
14 health outcomes in the provision of items and serv-
15 ices under this title to applicable beneficiaries (as
16 defined in subsection (d)).

17 “(2) REQUIREMENT.—The pilot program shall
18 test whether a model described in paragraph (1),
19 which is accountable for providing comprehensive,
20 coordinated, continuous, and accessible care to high-
21 need populations at home and coordinating health
22 care across all treatment settings, results in—

23 “(A) reducing preventable hospitalizations;

24 “(B) preventing hospital readmissions;

25 “(C) reducing emergency room visits;

1 “(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;

2 “(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

3 “(F) reducing the cost of health care services covered under this title; and

4 “(G) achieving beneficiary and family caregiver satisfaction.

5 “(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

6 “(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

7 “(A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal entity that—

8 “(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based pri-

1 mary care to applicable beneficiaries, make
2 in-home visits, and are available 24 hours
3 per day, 7 days per week to carry out
4 plans of care that are tailored to the indi-
5 vidual beneficiary's chronic conditions and
6 designed to achieve the results in sub-
7 section (a) and—

8 “(ii) is organized at least in part for
9 the purpose of providing physicians' serv-
10 ices and has the medical training or experi-
11 ence to fulfill the physician's role in clause
12 (i);

13 “(iii) has documented experience in
14 providing home-based primary care serv-
15 ices to high cost chronically ill bene-
16 ficiaries, as determined appropriate by the
17 Secretary;

18 “(iv) has the capacity to provide serv-
19 ices covered by this section to at least 200
20 applicable beneficiaries as defined in sub-
21 section (d);

22 “(v) has entered into an agreement
23 with the Secretary;

1 “(vi) uses electronic health informa-
2 tion systems, remote monitoring, and mo-
3 bile diagnostic technology; and

4 “(vii) meets such other criteria as the
5 Secretary determines to be appropriate to
6 participate in the pilot program.

7 An agreement described in clause (iv) shall re-
8 quire the entity to report on quality measures
9 (in such form, manner, and frequency as speci-
10 fied by the Secretary, which may be for the
11 group, for providers of services and suppliers,
12 or both) and report to the Secretary (in a form,
13 manner, and frequency as specified by the Sec-
14 retary) such data as the Secretary determines
15 appropriate to monitor and evaluate the pilot
16 program .

17 “(B) PHYSICIAN.—The term ‘physician’ in-
18 cludes, except as the Secretary may otherwise
19 provide, any individual who—

20 “(i) furnishes services for which pay-
21 ment may be made as physicians’ services;
22 and

23 “(ii) has the medical training or expe-
24 rience to fulfill the physician’s role in
25 (1)(A)(i).

1 “(2) PARTICIPATION OF NURSE PRACTITIONERS
2 AND PHYSICIAN ASSISTANTS.—Nothing in this sec-
3 tion shall be construed to prevent a nurse practi-
4 tioner or physician assistant from participating in,
5 or leading, a home-based primary care team as part
6 of an independence at home medical practice if—

7 “(A) all the requirements of this section
8 are met;

9 “(B) the nurse practitioner or physician
10 assistant, as the case may be, is acting con-
11 sistent with State law; and

12 “(C) the nurse practitioner or physician
13 assistant has the medical training or experience
14 to fulfill the nurse practitioner or physician as-
15 sistant role in paragraph (1)(A)(i).

16 “(3) INCLUSION OF PROVIDERS AND PRACTI-
17 TIONERS.—Nothing in this subsection shall be con-
18 strued as preventing an independence at home med-
19 ical practice from including a provider of services or
20 a participating practitioner described in section
21 1842(b)(18)(C) that is affiliated with the practice
22 under an arrangement structured so that such pro-
23 vider of services or practitioner participates in the
24 pilot program and shares in any savings under the
25 pilot program.

1 “(4) QUALITY AND PERFORMANCE STAND-
2 ARDS.—The Secretary shall develop quality perform-
3 ance standards for independence at home medical
4 practices participating in the pilot program.

5 “(c) PAYMENT.—

6 “(1) SHARED SAVINGS PAYMENT METHOD-
7 OLOGY.—

8 “(A) ESTABLISHMENT OF TARGET SPEND-
9 ING LEVELS AND SHARED SAVINGS AMOUNTS.—

10 “(i) TARGETS.—The Secretary shall
11 establish annual target spending levels in
12 such a manner as to account for normal
13 variation in expenditures for items and
14 services covered under parts A and B for
15 each participating independence at home
16 medical practices based upon the size of
17 the practice, characteristics of the enrolled
18 individuals, and such other factors as the
19 Secretary determines appropriate.

20 “(ii) DESIGNATION OF SAVINGS.—The
21 Secretary shall designate annually the ag-
22 gregate amount of savings achieved for
23 beneficiaries enrolled in independence at
24 home medical practices.

1 “(iii) APPORTIONMENT OF SAVINGS.—

2 The Secretary shall designate how, and to
3 what extent, savings beyond the first 5
4 percent are to be apportioned among par-
5 ticipating independence at home medical
6 practices, taking into account the number
7 of beneficiaries served by each practice, the
8 characteristics of the individuals enrolled
9 in each practice, the independence at home
10 medical practices’ performance on quality
11 performance measures, and such other fac-
12 tors as the Secretary determines appro-
13 priate.

14 “(B) MINIMUM 5 PERCENT SAVINGS TO
15 THE MEDICARE PROGRAM.—The Secretary shall
16 limit shared savings payments to each an inde-
17 pendence at home medical practice under this
18 paragraph as necessary to ensure that the ag-
19 gregate expenditures for part A and B services
20 with respect to applicable beneficiaries for such
21 independence at home medical practice (inclu-
22 sive of shared savings payments) do not exceed
23 the amount that the Secretary estimates, less 5
24 percent, would be expended for such services for
25 such beneficiaries enrolled in an independence

1 at home medical practice if the pilot program
2 under this section were not implemented.

3 “(d) APPLICABLE BENEFICIARIES.—

4 “(1) DEFINITION.—In this section, the term
5 ‘applicable beneficiary’ means, with respect to a
6 qualifying independence at home medical practice,
7 an individual who the practice has determined—

8 “(A) is entitled to, or enrolled for, benefits
9 under part A and enrolled for benefits under
10 part B;

11 “(B) is not enrolled in a Medicare Advan-
12 tage plan under part C, a PACE program
13 under section 1894, or an ACO under section
14 1899 or any other shared savings program
15 under this title;

16 “(C) has 2 or more chronic illnesses, such
17 as congestive heart failure, diabetes, other de-
18 mentias designated by the Secretary, chronic
19 obstructive pulmonary disease, ischemic heart
20 disease, stroke, Alzheimer’s Disease and
21 neurodegenerative diseases, and other diseases
22 and conditions designated by the Secretary
23 which result in high costs under this title;

24 “(D) within the past 12 months has had a
25 nonelective hospital admission and received

1 acute or subacute rehabilitation services or
2 skilled home care services;

3 “(E) has 2 or more functional depend-
4 encies requiring the assistance of another per-
5 son (such as bathing, dressing, toileting, walk-
6 ing, or feeding); and

7 “(F) meets such other criteria as the Sec-
8 retary determines appropriate.

9 “(2) PATIENT ELECTION TO PARTICIPATE.—

10 The Secretary shall determine an appropriate meth-
11 od of ensuring that applicable beneficiaries have
12 agreed to enroll in an independence at home medical
13 practice. Enrollment in the pilot program shall be
14 voluntary.

15 “(3) BENEFICIARY ACCESS TO SERVICES.—

16 Nothing in this section shall be construed as encour-
17 aging physicians or nurse practitioners to limit ap-
18 plicable beneficiary access to services covered under
19 this title and applicable beneficiaries shall not be re-
20 quired to relinquish access to any benefit under this
21 title as a condition of receiving services from an
22 independence at home medical practice.

23 “(e) IMPLEMENTATION.—

24 “(1) STARTING DATE.—The pilot program shall
25 begin not later than January 1, 2012. An agreement

1 with an independence at home medical practice
2 under the pilot program may cover a 3-year period.

3 “(2) NO PHYSICIAN DUPLICATION IN PILOT
4 PARTICIPATION.—The Secretary shall not pay an
5 independence at home medical practice under this
6 section that participates in section 1115A or section
7 1866D.

8 “(3) PREFERENCE.—In approving an independ-
9 ence at home medical practice, the Secretary shall
10 give preference to practices that are—

11 “(A) located in high-cost areas of the
12 country;

13 “(B) have experience in furnishing health
14 care services to applicable beneficiaries in the
15 home; and

16 “(C) use electronic medical records, health
17 information technology, and individualized plans
18 of care.

19 “(4) NUMBER OF PRACTICES.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), the Secretary shall enter into agree-
22 ments with as many qualified independence at
23 home medial practices as practicable and con-
24 sistent with this subsection to test the potential
25 of the independence at home medical practice

1 model under this section in order to achieve the
2 results described in subsection (a)(2) across
3 practices serving varying numbers of applicable
4 beneficiaries.

5 “(B) LIMITATION.—In selecting qualified
6 independence at home medical practices to par-
7 ticipate under the pilot program, the Secretary
8 shall limit the number of applicable bene-
9 ficiaries that may participate in the pilot pro-
10 gram to 10,000.

11 “(5) WAIVER.—The Secretary may waive such
12 provisions of this title and title XI as the Secretary
13 determines necessary in order to implement the pilot
14 program.

15 “(6) ADMINISTRATION.—Chapter 35 of title 44,
16 United States Code, shall not apply to this section.

17 “(f) EVALUATION AND MONITORING.—The Secretary
18 shall evaluate each independence at home medical practice
19 under the pilot program to assess whether the practice
20 achieved the results described in subsection (a)(2).

21 “(g) REPORTS TO CONGRESS.—The Secretary shall
22 conduct an independent evaluation of the pilot program
23 and submit to Congress an interim and a final report..
24 Each report shall include an analysis of—

1 “(1) best practices under the pilot program;
2 and

3 “(2) the impact of the pilot program on—

4 “(A) coordination of care;

5 “(B) expenditures under this title;

6 “(C) access to services; and

7 “(D) the quality of health care services
8 provided to applicable beneficiaries; and

9 “(E) Such other areas determined appro-
10 priate by the Secretary.

11 “(h) EXPANSION TO PROGRAM; IMPLEMENTATION.—

12 “(1) TESTING AND REFINEMENT OF PAYMENT
13 INCENTIVE AND SERVICE DELIVERY MODELS.—Sub-
14 ject to the evaluation described in subsection (g), the
15 Secretary may enter into agreements under the pilot
16 program with additional qualifying independence at
17 home medical practices to further test and refine
18 models with respect to qualifying independence at
19 home medical practices.

20 “(2) EXPANDING USE OF SUCCESSFUL MODELS
21 TO PROGRAM IMPLEMENTATION.—Taking into ac-
22 count the results of the evaluations under sub-
23 sections (f) and (g), the Secretary may issue regula-
24 tions to implement, on a permanent (and if appro-
25 priate, on a nationwide) basis, the independence at

1 home medical practice model if, and to the extent
2 that—

3 “(A) such models are beneficial to the pro-
4 gram under this title, as determined by the Sec-
5 retary; and

6 “(B) the Chief Actuary of the Centers for
7 Medicare & Medicaid Services certifies that
8 such model would result in estimated expendi-
9 tures for part A and B items and services are
10 at least 5 percent less than the expenditures
11 that would be otherwise be made for such items
12 and services in the absence of such expansion,
13 as estimated by Chief Actuary.

14 “(i) FUNDING.—For purposes of administering and
15 carrying out the pilot program, other than for payments
16 for items and services furnished under this title and
17 shared savings under subsection (c), in addition to funds
18 otherwise appropriated, the Secretary shall provide for the
19 transfer, from the Federal Hospital Insurance Trust Fund
20 under section 1817 and the Federal Supplementary Med-
21 ical Insurance Trust Fund under section 1841, in such
22 proportion as the Secretary determines appropriate, of
23 \$5,000,000 to the Centers for Medicare & Medicaid Serv-
24 ices Program Management Account for each of fiscal years

1 2010 through 2015. Amounts appropriated under the pre-
2 ceding sentence shall remain available until expended.”.

3 **SEC. 3025. HOSPITAL READMISSIONS REDUCTION PRO-**
4 **GRAM.**

5 Section 1886 of the Social Security Act (42 U.S.C.
6 1395ww), as amended by section 3001 and 3008, is
7 amended by adding at the end the following new sub-
8 section:

9 “(q) HOSPITAL READMISSIONS REDUCTION PRO-
10 GRAM.—

11 “(1) ESTABLISHMENT.—

12 “(A) IN GENERAL.—Subject to the suc-
13 ceeding provisions of this subsection, the Sec-
14 retary shall establish a hospital readmissions re-
15 duction program (in this subsection referred to
16 as the ‘Program’) under which payments to
17 subsection (d) hospitals are reduced under
18 paragraph (5) for certain readmissions.

19 “(B) PROGRAM TO BEGIN IN FISCAL YEAR
20 2013.—The Program shall apply to payments
21 for discharges occurring on or after October 1,
22 2012.

23 “(C) DEFINITION OF SUBSECTION (D) HOS-
24 PITAL.—For purposes of this subsection, the

1 term ‘subsection (d) hospital’ has the meaning
2 given such term in subsection (d)(1)(B)).

3 “(2) SELECTION OF CONDITIONS ASSOCIATED
4 WITH READMISSIONS.—

5 “(A) INITIAL SET.—Beginning during fis-
6 cal year 2012, the Secretary shall select 8 con-
7 ditions that have a high volume or high rate, or
8 both, of potentially preventable inpatient hos-
9 pital readmissions, as determined by the Sec-
10 retary.

11 “(B) EXPANSION.—For fiscal year 2016
12 and subsequent fiscal years, the Secretary may
13 expand the list of conditions selected under sub-
14 paragraph (A). In selecting conditions under
15 the preceding sentence, the Secretary shall take
16 into account whether—

17 “(i) the condition has a high volume
18 or high rate, or both, of potentially pre-
19 ventable inpatient hospital readmissions;
20 and

21 “(ii) the condition has high expendi-
22 tures under this title.

23 “(3) DETERMINATION OF RISK-ADJUSTED NA-
24 TIONAL AVERAGE AND HOSPITAL-SPECIFIC READMIS-
25 SION RATES FOR EACH SELECTED CONDITION.—

1 “(A) IN GENERAL.—Before the beginning
2 of the fiscal year involved under the Program,
3 the Secretary shall calculate the following:

4 “(i) A national average readmission
5 rate related to each condition selected
6 under paragraph (2). Such rate shall be a
7 weighted average of all diagnosis-related
8 groups related to the condition. Such rate
9 shall be risk-adjusted for patient severity
10 of illness and other patient characteristics
11 as the Secretary determines appropriate.

12 “(ii) A hospital-specific hospital read-
13 mission rate related to each condition se-
14 lected under paragraph (2). Such rate shall
15 be risk-adjusted in the same manner as the
16 rate under clause (i) is risk-adjusted.

17 “(B) READMISSION DEFINED.—

18 “(i) IN GENERAL.—Subject to clause
19 (ii), for purposes of this subsection, the
20 term ‘readmission’ means, in the case of
21 an individual who is discharged from a
22 subsection (d) hospital, the admission of
23 the individual to the same or another hos-
24 pital or a critical access hospital within 30
25 days from the date of such discharge.

1 “(ii) EXCLUSIONS.—The term ‘read-
2 mission’ does not include—

3 “(I) a planned readmission;

4 “(II) a readmission related to
5 major or metastatic malignancies,
6 burn care, or trauma care;

7 “(III) a readmission where the
8 original admission was with a dis-
9 charge status of ‘left against medical
10 advice’; and

11 “(IV) a transfer from another
12 hospital.

13 “(4) ASSIGNMENT OF HOSPITALS.—With re-
14 spect to each fiscal year the Secretary shall—

15 “(A) rank all subsection (d) hospitals
16 based on the national average and hospital-spe-
17 cific readmission rate calculated under para-
18 graph (3) for a period specified by the Sec-
19 retary for each condition selected under para-
20 graph (2); and

21 “(B) identify the quartile of such hospitals
22 with the highest readmission rates for each
23 such condition.

24 “(5) PAYMENT ADJUSTMENT.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graphs (B) and (C), for discharges occurring in
3 a fiscal year beginning on or after October 1,
4 2013, if an individual is readmitted (as defined
5 in paragraph (3)(B)) and the prior discharge
6 from the subsection (d) hospital is related to a
7 condition selected under paragraph (2) for the
8 fiscal year, the Secretary shall reduce the pay-
9 ment amount for the prior discharge under sub-
10 section (d) by an amount equal to the applica-
11 ble percent (as defined in subparagraph (C)) of
12 the payment amount for the discharge under
13 subsection (d) (determined without regard to
14 the application of this paragraph).

15 “(B) EXCEPTION.—The payment adjust-
16 ment under this paragraph for a discharge in a
17 fiscal year shall only apply to a subsection (d)
18 hospital that is identified under paragraph
19 (4)(B) for the fiscal year with respect to the
20 condition that is related to such discharge.

21 “(C) NO EFFECT IN SUBSEQUENT FISCAL
22 YEARS.—The payment reductions under sub-
23 paragraph (A) shall apply only with respect to
24 the fiscal year involved, and the Secretary shall
25 not take into account such payment reductions

1 in making payments to a subsection (d) hospital
2 under this section in a subsequent fiscal year.

3 “(D) APPLICABLE PERCENT.—In this
4 paragraph, the term ‘applicable percent’
5 means—

6 “(i) in the case of a readmission that
7 occurs within 7 days of the prior dis-
8 charge, 20 percent; and

9 “(ii) in the case of a readmission that
10 occurs within 15 days of the prior dis-
11 charge, 10 percent.

12 “(6) REPORTING TO HOSPITALS.—Prior to each
13 fiscal year under the Program (and prior to the fis-
14 cal year preceding the first fiscal year under the
15 Program), the Secretary shall provide confidential
16 reports to subsection (d) hospitals with respect to
17 the national average and hospital-specific readmis-
18 sion rates for each condition selected under para-
19 graph (2).

20 “(7) REPORTING HOSPITAL SPECIFIC INFORMA-
21 TION.—

22 “(A) IN GENERAL.—The Secretary shall
23 make information available to the public re-
24 garding readmission rates of each subsection
25 (d) hospital under the Program.

1 “(B) OPPORTUNITY TO REVIEW AND SUB-
2 MIT CORRECTIONS.—The Secretary shall ensure
3 that a subsection (d) hospital has the oppor-
4 tunity to review, and submit corrections for, the
5 information to be made public with respect to
6 the hospital under subparagraph (A) prior to
7 such information being made public.

8 “(C) WEBSITE.—Such information shall be
9 posted on the Hospital Compare Internet
10 website in an easily understandable format.

11 “(8) LIMITATIONS ON REVIEW.—There shall be
12 no administrative or judicial review under section
13 1869, section 1878, or otherwise of the following:

14 “(A) The determination of the payment
15 amount for the prior discharge under sub-
16 section (d) under paragraph (5)(A).

17 “(B) The methodology for selecting condi-
18 tions under paragraph (2), determining rates
19 under paragraph (4), and making adjustments
20 under paragraph (5).

21 “(C) The provision of reports to subsection
22 (d) hospitals under paragraph (6) and the in-
23 formation made available to the public under
24 paragraph (7).”.

1 **SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PRO-**
2 **GRAM.**

3 (a) **IN GENERAL.**—The Secretary shall establish a
4 Community-Based Care Transitions Program under which
5 the Secretary provides funding to eligible entities that fur-
6 nish improved care transition services to high-risk Medi-
7 care beneficiaries.

8 (b) **DEFINITIONS.**—In this section:

9 (1) **ELIGIBLE ENTITY.**—The term “eligible enti-
10 ty” means the following:

11 (A) A subsection (d) hospital (as defined in
12 section 1886(d)(1)(B) of the Social Security
13 Act (42 U.S.C. 1395ww(d)(1)(B))) identified by
14 the Secretary as having a high readmission
15 rate, such as a hospital-specific hospital read-
16 mission rate above the 75th percentile (as cal-
17 culated under paragraph (3)(A)(ii) of section
18 1886(q) of the Social Security Act, as added by
19 section 3025) for conditions selected under
20 paragraph (2) of such section 1886(q).

21 (B) An appropriate community-based orga-
22 nization that is capable of providing care transi-
23 tion services under this section, including the
24 ability to have arrangements with subsection
25 (d) hospitals (as so defined) to furnish the serv-
26 ices described in subsection (c)(2)(B)(i).

1 (2) HIGH-RISK MEDICARE BENEFICIARY.—The
2 term “high-risk Medicare beneficiary” means a
3 Medicare beneficiary who has attained a minimum
4 hierarchical condition category score, as determined
5 by the Secretary, based on a diagnosis of multiple
6 chronic conditions or other risk factors associated
7 with a hospital readmission or substandard transi-
8 tion into post-hospitalization care, which may in-
9 clude 1 or more of the following:

10 (A) Cognitive impairment.

11 (B) Depression.

12 (C) A history of multiple readmissions.

13 (D) Any other chronic disease or risk fac-
14 tor as determined by the Secretary.

15 (3) MEDICARE BENEFICIARY.—The term
16 “Medicare beneficiary” means an individual who is
17 entitled to benefits under part A of title XVIII of
18 the Social Security Act (42 U.S.C. 1395 et seq.) and
19 enrolled under part B of such title, but not enrolled
20 under part C of such title.

21 (4) PROGRAM.—The term “program” means
22 the program conducted under this section.

23 (5) READMISSION.—The term “readmission”
24 has the meaning given such term in section

1 1886(q)(3)(B) of the Social Security Act, as added
2 by section 3025.

3 (6) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services.

5 (c) REQUIREMENTS.—

6 (1) DURATION.—

7 (A) IN GENERAL.—The program shall be
8 conducted for a 5-year period, beginning not
9 later than January 1, 2011.

10 (B) EXPANSION.—The Secretary may ex-
11 pand the duration and the scope of the pro-
12 gram, to the extent determined appropriate by
13 the Secretary, if the Secretary determines (and
14 the Chief Actuary of the Centers for Medicare
15 & Medicaid Services, with respect to spending
16 under this title, certifies) that such expansion
17 would reduce spending under this title without
18 reducing quality.

19 (2) APPLICATION; PARTICIPATION.—

20 (A) IN GENERAL.—

21 (i) APPLICATION.—An eligible entity
22 seeking to participate in the program shall
23 submit an application to the Secretary at
24 such time, in such manner, and containing

1 such information as the Secretary may re-
2 quire.

3 (ii) PARTNERSHIP.—If an eligible en-
4 tity is a hospital, such hospital shall enter
5 into a partnership with a community-based
6 organization to participate in the program.

7 (B) INTERVENTION PROPOSAL.—Subject
8 to subparagraph (C), an application submitted
9 under subparagraph (A)(i) shall include a de-
10 tailed proposal for at least 1 care transition
11 intervention, which may include the following:

12 (i) Initiating care transition services
13 for a high-risk Medicare beneficiary not
14 later than 24 hours prior to the discharge
15 of the beneficiary from the eligible entity.

16 (ii) Arranging timely post-discharge
17 follow-up services to the high-risk Medicare
18 beneficiary to provide the beneficiary (and,
19 as appropriate, the primary caregiver of
20 the beneficiary) with information regarding
21 responding to symptoms that may indicate
22 additional health problems or a deterio-
23 rating condition.

24 (iii) Providing the high-risk Medicare
25 beneficiary (and, as appropriate, the pri-

1 mary caregiver of the beneficiary) with as-
2 sistance to ensure productive and timely
3 interactions with post-acute and outpatient
4 providers.

5 (iv) Assessing and actively engaging
6 with a high-risk Medicare beneficiary (and,
7 as appropriate, the primary caregiver of
8 the beneficiary) through the provision of
9 self-management support and relevant in-
10 formation that is specific to the bene-
11 ficiary's condition.

12 (v) Conducting comprehensive medica-
13 tion review and management (including, if
14 appropriate, self-management support).

15 (C) LIMITATION.—A care transition inter-
16 vention proposed under subparagraph (B) may
17 not include services required under the dis-
18 charge planning process described in section
19 1861(ee) of the Social Security Act (42 U.S.C.
20 1395x(ee)).

21 (3) SELECTION.—In selecting eligible entities to
22 participate in the program, the Secretary shall give
23 priority to eligible entities that provide services to
24 medically underserved populations, small commu-
25 nities, and rural areas.

1 (d) IMPLEMENTATION.—Notwithstanding any other
2 provision of law, the Secretary may implement the provi-
3 sions of this section by program instruction or otherwise.

4 (e) WAIVER AUTHORITY.—The Secretary may waive
5 such requirements of titles XI and XVIII of the Social
6 Security Act as may be necessary to carry out the pro-
7 gram.

8 (f) FUNDING.—For purposes of carrying out this sec-
9 tion, the Secretary of Health and Human Services shall
10 provide for the transfer, from the Federal Hospital Insur-
11 ance Trust Fund under section 1817 of the Social Secu-
12 rity Act (42 U.S.C. 1395i) and the Federal Supple-
13 mentary Medical Insurance Trust Fund under section
14 1841 of such Act (42 U.S.C. 1395t), in such proportion
15 as the Secretary determines appropriate, of \$500,000,000,
16 to the Centers for Medicare & Medicaid Services Program
17 Management Account for the period of fiscal years 2011
18 through 2015. Amounts transferred under the preceding
19 sentence shall remain available until expended.

20 **SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.**

21 (a) IN GENERAL.—Subsection (d)(3) of section 5007
22 of the Deficit Reduction Act of 2005 (Public Law 109–
23 171) is amended by inserting “(or September 30, 2011,
24 in the case of a demonstration project in operation as of
25 October 1, 2008)” after “December 31, 2009”.

1 (b) FUNDING.—

2 (1) IN GENERAL.—Subsection (f)(1) of such
3 section is amended by inserting “and for fiscal year
4 2010, \$1,600,000,” after “\$6,000,000,”.

5 (2) AVAILABILITY.—Subsection (f)(2) of such
6 section is amended by striking “2010” and inserting
7 “2014 or until expended”.

8 (c) REPORTS.—

9 (1) QUALITY IMPROVEMENT AND SAVINGS.—
10 Subsection (e)(3) of such section is amended by
11 striking “December 1, 2008” and inserting “March
12 31, 2011”.

13 (2) FINAL REPORT.—Subsection (e)(4) of such
14 section is amended by striking “May 1, 2010” and
15 inserting “March 31, 2013”.

16 **PART IV—STRENGTHENING PRIMARY CARE AND**
17 **OTHER WORKFORCE IMPROVEMENTS**

18 **SEC. 3031. EXPANDING ACCESS TO PRIMARY CARE SERV-**
19 **ICES AND GENERAL SURGERY SERVICES.**

20 (a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY
21 CARE SERVICES.—

22 (1) IN GENERAL.—Section 1833 of the Social
23 Security Act (42 U.S.C. 1395l) is amended by add-
24 ing at the end the following new subsection:

1 “(x) INCENTIVE PAYMENTS FOR PRIMARY CARE
2 SERVICES.—

3 “(1) IN GENERAL.—In the case of primary care
4 services furnished on or after January 1, 2011, and
5 before January 1, 2016, by a primary care practi-
6 tioner, in addition to the amount of payment that
7 would otherwise be made for such services under this
8 part, there also shall be paid (on a monthly or quar-
9 terly basis) an amount equal to 10 percent of the
10 payment amount for the service under this part.

11 “(2) DEFINITIONS.—In this subsection:

12 “(A) PRIMARY CARE PRACTITIONER.—The
13 term ‘primary care practitioner’ means an indi-
14 vidual—

15 “(i) who—

16 “(I) is a physician (as described
17 in section 1861(r)(1)) who has a pri-
18 mary specialty designation of family
19 medicine, internal medicine, geriatric
20 medicine, or pediatric medicine; or

21 “(II) is a nurse practitioner, clin-
22 ical nurse specialist, or physician as-
23 sistant (as those terms are defined in
24 section 1861(aa)(5)); and

1 “(ii) for whom primary care services
2 accounted for at least 60 percent of the al-
3 lowed charges under this part for such
4 physician or practitioner in a prior period
5 as determined appropriate by the Sec-
6 retary.

7 “(B) PRIMARY CARE SERVICES.—The term
8 ‘primary care services’ means services identi-
9 fied, as of January 1, 2009, by the following
10 HCPCS codes (and as subsequently modified by
11 the Secretary):

12 “(i) 99201 through 99215.

13 “(ii) 99304 through 99340.

14 “(iii) 99341 through 99350.

15 “(3) COORDINATION WITH OTHER PAY-
16 MENTS.—The amount of the additional payment for
17 a service under this subsection and subsection (m)
18 shall be determined without regard to any additional
19 payment for the service under subsection (m) and
20 this subsection, respectively.

21 “(4) LIMITATION ON REVIEW.—There shall be
22 no administrative or judicial review under section
23 1869, 1878, or otherwise, respecting the identifica-
24 tion of primary care practitioners under this sub-
25 section.”.

1 (2) CONFORMING AMENDMENT.—Section
2 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
3 1395m(g)(2)(B)) is amended by adding at the end
4 the following sentence: “Section 1833(x) shall not be
5 taken into account in determining the amounts that
6 would otherwise be paid pursuant to the preceding
7 sentence.”.

8 (b) INCENTIVE PAYMENT PROGRAM FOR MAJOR
9 SURGICAL PROCEDURES FURNISHED IN HEALTH PRO-
10 FESSIONAL SHORTAGE AREAS.—

11 (1) IN GENERAL.—Section 1833 of the Social
12 Security Act (42 U.S.C. 1395l), as amended by sub-
13 section (a)(1), is amended by adding at the end the
14 following new subsection:

15 “(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL
16 PROCEDURES FURNISHED IN HEALTH PROFESSIONAL
17 SHORTAGE AREAS.—

18 “(1) IN GENERAL.—In the case of major sur-
19 gical procedures furnished on or after January 1,
20 2011, and before January 1, 2016, by a general sur-
21 geon in an area that is designated (under section
22 332(a)(1)(A) of the Public Health Service Act) as a
23 health professional shortage area as identified by the
24 Secretary prior to the beginning of the year involved,
25 in addition to the amount of payment that would

1 otherwise be made for such services under this part,
2 there also shall be paid (on a monthly or quarterly
3 basis) an amount equal to 10 percent of the pay-
4 ment amount for the service under this part.

5 “(2) DEFINITIONS.—In this subsection:

6 “(A) GENERAL SURGEON.—In this sub-
7 section, the term ‘general surgeon’ means a
8 physician (as described in section 1861(r)(1))
9 who has designated CMS specialty code 02–
10 General Surgery as their primary specialty code
11 in the physician’s application granted by the
12 Secretary for a supplier number for the submis-
13 sion of claims for reimbursement under this
14 title.

15 “(B) MAJOR SURGICAL PROCEDURES.—
16 The term ‘major surgical procedures’ means
17 physicians’ services which are surgical proce-
18 dures for which a 10-day or 90-day global pe-
19 riod is used for payment under the fee schedule
20 under section 1848(b).

21 “(3) COORDINATION WITH OTHER PAY-
22 MENTS.—The amount of the additional payment for
23 a service under this subsection and subsection (m)
24 shall be determined without regard to any additional

1 payment for the service under subsection (m) and
2 this subsection, respectively.

3 “(4) APPLICATION.—The provisions of para-
4 graph (2) and (4) of subsection (m) shall apply to
5 the determination of additional payments under this
6 subsection in the same manner as such provisions
7 apply to the determination of additional payments
8 under subsection (m).”.

9 (2) CONFORMING AMENDMENT.—Section
10 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
11 1395m(g)(2)(B)), as amended by subsection (a)(2),
12 is amended by striking “Section 1833(x)” and in-
13 sserting “Subsections (x) and (y) of section 1833” in
14 the last sentence.

15 (c) BUDGET-NEUTRALITY ADJUSTMENT.—Section
16 1848(c)(2)(B) of the Social Security Act (42 U.S.C.
17 1395w-4(c)(2)(B)) is amended by adding at the end the
18 following new clause:

19 “(vii) ADJUSTMENT FOR CERTAIN
20 PHYSICIAN INCENTIVE PAYMENTS.—Fifty
21 percent of the additional expenditures
22 under this part attributable to subsections
23 (x) and (y) of section 1833 for a year (as
24 estimated by the Secretary) shall be taken
25 into account in applying clause (ii)(II) for

1 2011 and subsequent years. In lieu of ap-
2 plying the budget-neutrality adjustments
3 required under clause (ii)(II) to relative
4 value units to account for such costs for
5 the year, the Secretary shall apply such
6 budget-neutrality adjustments to the con-
7 version factor otherwise determined for the
8 year. For 2011 and subsequent years, the
9 Secretary shall increase the incentive pay-
10 ment otherwise applicable under section
11 1833(m) by a percent estimated to be
12 equal to the additional expenditures esti-
13 mated under the first sentence of this
14 clause for such year that is applicable to
15 physicians who primarily furnish services
16 in areas designated (under section
17 332(a)(1)(A) of the Public Health Service
18 Act) as health professional shortage
19 areas.”.

20 **SEC. 3031A. MEDICARE FEDERALLY QUALIFIED HEALTH**
21 **CENTER IMPROVEMENTS.**

22 (a) EXPANSION OF MEDICARE-COVERED PREVEN-
23 TIVE SERVICES AT FEDERALLY QUALIFIED HEALTH
24 CENTERS.—

1 (1) IN GENERAL.—Section 1861(aa)(3)(A) of
2 the Social Security Act (42 U.S.C. 1395w
3 (aa)(3)(A)) is amended to read as follows:

4 “(A) services of the type described sub-
5 paragraphs (A) through (C) of paragraph (1)
6 and preventive services (as defined in section
7 1861(ddd)(3)); and”.

8 (2) EFFECTIVE DATE.—The amendment made
9 by paragraph (1) shall apply to services furnished on
10 or after January 1, 2011.

11 (b) ESTABLISHMENT OF A MEDICARE PROSPECTIVE
12 PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH
13 CENTER SERVICES.—

14 (1) IN GENERAL.—Paragraph (3) section
15 1833(a) of the Social Security Act (42 U.S.C.
16 1395l(a)) is amended to read as follows:

17 “(3)(A) in the case of services described in sec-
18 tion 1832(a)(2)(D)(i), the costs which are reason-
19 able and related to the furnishing of such services or
20 which are based on such other tests of reasonable-
21 ness as the Secretary may prescribe in regulations
22 including those authorized under section
23 1861(v)(1)(A), less the amount a provider may
24 charge as described in clause (ii) of section

1 1866(a)(2)(A), but in no case may the payment for
2 such services (other than for items and services de-
3 scribed in section 1861(s)(10)(A)) exceed 80 percent
4 of such costs; and

5 “(B) in the case of services described in section
6 1832(a)(2)(D)(ii) furnished by a Federally qualified
7 health center—

8 “(i) subject to clauses (iii) and (iv), for
9 services furnished on and after January 1,
10 2012, during the center’s fiscal year that ends
11 in 2012, an amount (calculated on a per visit
12 basis) that is equal to 100 percent of the aver-
13 age of the costs of the center of furnishing such
14 services during such center’s fiscal years ending
15 during 2010 and 2011 which are reasonable
16 and related to the cost of furnishing such serv-
17 ices, or which are based on such other tests of
18 reasonableness as the Secretary prescribes in
19 regulations including those authorized under
20 section 1861(v)(1)(A) (except that in calcu-
21 lating such cost in a center’s fiscal years ending
22 during 2010 and 2011 and applying the aver-
23 age of such cost for a center’s fiscal year end-
24 ing during fiscal year 2012, the Secretary shall
25 not apply a per visit payment limit or produc-

1 tivity screen), less the amount a provider may
2 charge as described in clause (ii) of section
3 1866(a)(2)(A), but in no case may the payment
4 for such services (other than for items or serv-
5 ices described in section 1861(s)(10)(A)) exceed
6 80 percent of such average of such costs;

7 “(ii) subject to clauses (iii) and (iv), for
8 services furnished during the center’s fiscal
9 year ending during 2013 or a succeeding fiscal
10 year, an amount (calculated on a per visit basis
11 and without the application of a per visit limit
12 or productivity screen) that is equal to the
13 amount determined under this subparagraph
14 for the center’s preceding fiscal year (without
15 regard to any copayment)—

16 “(I) increased for a center’s fiscal
17 year ending during 2013 by the percentage
18 increase in the MEI (as defined in section
19 1842(i)(3)) applicable to primary care
20 services (as defined in section 1842(i)(4))
21 for 2013 and increased for a center’s fiscal
22 year ending during 2014 or any succeeding
23 fiscal year by the percentage increase for
24 such year of a market basket of Federally
25 qualified health center costs as developed

1 and promulgated through regulations by
2 the Secretary; and

3 “(II) adjusted to take into account
4 any increase or decrease in the scope of
5 services, including a change in the type, in-
6 tensity, duration, or amount of services,
7 furnished by the center during the center’s
8 fiscal year,

9 less the amount a provider may charge as described
10 in clause (ii) of section 1866(a)(2)(A), but in no
11 case may the payment for such services (other than
12 for items or services described in section
13 1861(s)(10)(A)) exceed 80 percent of the amount
14 determined under this clause (without regard to any
15 copayment);

16 “(iii) subject to clause (iv), in the case of
17 an entity that first qualifies as a Federally
18 qualified health center in a center’s fiscal year
19 ending after 2011—

20 “(I) for the first such center’s fiscal
21 year, an amount (calculated on a per visit
22 basis and without the application of a per
23 visit payment limit or productivity screen)
24 that is equal to 100 percent of the costs of
25 furnishing such services during such cen-

1 ter’s fiscal year based on the per visit pay-
2 ment rates established under clause (i) or
3 (ii) for a comparable period for other such
4 centers located in the same or adjacent
5 areas with a similar caseload or, in the ab-
6 sence of such a center, in accordance with
7 the regulations and methodology referred
8 to in clause (i) or based on such other
9 tests of reasonableness (without the appli-
10 cation of a per visit payment limit or pro-
11 ductivity screen) as the Secretary may
12 specify, less the amount a provider may
13 charge as described in clause (ii) of section
14 1866(a)(2)(A), but in no case may the
15 payment for such services (other than for
16 items and services described in section
17 1861(s)(10)(A)) exceed 80 percent of such
18 costs; and

19 “(II) for each succeeding center’s fis-
20 cal year, the amount calculated in accord-
21 ance with clause (ii); and

22 “(iv) with respect to Federally qualified
23 health center services that are furnished to an
24 individual enrolled with a Medicare Advantage
25 plan under part C pursuant to a written agree-

1 ment described in section 1853(a)(4) (or, in the
2 case of a Medicare Advantage private fee-for-
3 service plan, without such written agreement)
4 the amount (if any) by which—

5 “(I) the amount of payment that
6 would have otherwise been provided under
7 clause (i), (ii), or (iii) (calculated as if ‘100
8 percent’ were substituted for ‘80 percent’
9 in such clauses) for such services if the in-
10 dividual had not been enrolled; exceeds

11 “(II) the amount of the payments re-
12 ceived under such written agreement (or,
13 in the case of Medicare Advantage private
14 fee-for-service plans, without such written
15 agreement) for such services (not including
16 any financial incentives provided for in
17 such agreement such as risk pool pay-
18 ments, bonuses, or withholds) less the
19 amount the Federally qualified health cen-
20 ter may charge as described in section
21 1857(e)(3)(B);”.

22 (2) EFFECTIVE DATE.—The amendment made
23 by paragraph (1) shall apply to services furnished on
24 or after January 1, 2012.

1 **SEC. 3032. DISTRIBUTION OF ADDITIONAL RESIDENCY PO-**
2 **SITIONS.**

3 (a) IN GENERAL.—Section 1886(h) of the Social Se-
4 curity Act (42 U.S.C. 1395ww(h)) is amended—

5 (1) in paragraph (4)(F)(i), by striking “para-
6 graph (7)” and inserting “paragraphs (7) and (8)”;

7 (2) in paragraph (4)(H)(i), by striking “para-
8 graph (7)” and inserting “paragraphs (7) and (8)”;
9 and

10 (3) by adding at the end the following new
11 paragraph:

12 “(8) DISTRIBUTION OF ADDITIONAL RESIDENCY
13 POSITIONS.—

14 “(A) REDUCTIONS IN LIMIT BASED ON UN-
15 USED POSITIONS.—

16 “(i) IN GENERAL.—Except as pro-
17 vided in clause (ii), if a hospital’s reference
18 resident level (as defined in subparagraph
19 (I)(i)) is less than the otherwise applicable
20 resident limit (as defined in subparagraph
21 (I)(iii)), effective for portions of cost re-
22 porting periods occurring on or after July
23 1, 2011, the otherwise applicable resident
24 limit shall be reduced by 65 percent of the
25 difference between such otherwise applica-

1 ble resident limit and such reference resi-
2 dent level.

3 “(ii) EXCEPTIONS.—This subpara-
4 graph shall not apply to—

5 “(I) a hospital located in a rural
6 area (as defined in subsection
7 (d)(2)(D)(ii)) with fewer than 250
8 acute care inpatient beds; or

9 “(II) a hospital that was part of
10 a qualifying entity which had a vol-
11 untary residency reduction plan ap-
12 proved under paragraph (6)(B), if the
13 hospital demonstrates to the Secretary
14 that it has a specified plan in place
15 for filling the unused positions by not
16 later than 2 years after the date of
17 enactment of this paragraph.

18 “(B) DISTRIBUTION.—

19 “(i) IN GENERAL.—The Secretary
20 shall increase the otherwise applicable resi-
21 dent limit for each qualifying hospital that
22 submits an application under this subpara-
23 graph by such number as the Secretary
24 may approve for portions of cost reporting
25 periods occurring on or after July 1, 2011.

1 The aggregate number of increases in the
2 otherwise applicable resident limit under
3 this subparagraph shall be equal to the ag-
4 gregate reduction in such limits attrib-
5 utable to subparagraph (A) (as estimated
6 by the Secretary).

7 “(ii) REQUIREMENTS.—Subject to
8 clause (iii), a hospital that receives an in-
9 crease in the otherwise applicable resident
10 limit under this subparagraph shall ensure,
11 during the 5-year period beginning on the
12 date of such increase, that—

13 “(I) the number of full-time
14 equivalent primary care residents (as
15 determined by the Secretary) is not
16 less than the average number of full-
17 time equivalent primary care residents
18 (as so determined) during the 3 most
19 recent cost reporting periods ending
20 prior to the date of enactment of this
21 paragraph; and

22 “(II) not less than 75 percent of
23 the positions attributable to such in-
24 crease are in a primary care or gen-

1 eral surgery residency (as determined
2 by the Secretary).

3 The Secretary may determine whether a
4 hospital has met the requirements under
5 this clause during such 5-year period in
6 such manner and at such time as the Sec-
7 retary determines appropriate, including at
8 the end of such 5-year period.

9 “(iii) REDISTRIBUTION OF POSITIONS
10 IF HOSPITAL NO LONGER MEETS CERTAIN
11 REQUIREMENTS.—In the case where the
12 Secretary determines that a hospital de-
13 scribed in clause (ii) does not meet either
14 of the requirements under subclause (I) or
15 (II) of such clause, the Secretary shall—

16 “(I) reduce the otherwise applica-
17 ble resident limit of the hospital by
18 the amount by which such limit was
19 increased under this paragraph; and

20 “(II) provide for the distribution
21 of positions attributable to such re-
22 duction in accordance with the re-
23 quirements of this paragraph.

24 “(C) CONSIDERATIONS IN REDISTRIBU-
25 TION.—In determining for which hospitals the

1 increase in the otherwise applicable resident
2 limit is provided under subparagraph (B), the
3 Secretary shall take into account—

4 “(i) the demonstration likelihood of
5 the hospital filling the positions made
6 available under this paragraph within the
7 first 3 cost reporting periods beginning on
8 or after July 1, 2011, as determined by
9 the Secretary;

10 “(ii) whether the hospital is taking
11 part in an innovative delivery model that
12 promotes quality and care coordination;
13 and

14 “(iii) whether the hospital has an ac-
15 credited rural training track (as described
16 in paragraph (4)(H)(iv)).

17 “(D) PRIORITY FOR CERTAIN AREAS.—In
18 determining for which hospitals the increase in
19 the otherwise applicable resident limit is pro-
20 vided under subparagraph (B), subject to sub-
21 paragraph (E), the Secretary shall distribute
22 the increase to hospitals based on the following
23 factors:

24 “(i) Whether the hospital is located in
25 a State with a resident-to-population ratio

1 in the lowest quartile (as determined by
2 the Secretary).

3 “(ii) Whether the hospital is located
4 in a State that is among the top 10 States
5 in terms of the ratio of—

6 “(I) the total population of the
7 State living in an area designated
8 (under such section 332(a)(1)(A)) as
9 a health professional shortage area
10 (as of the date of enactment of this
11 paragraph); to

12 “(II) the total population of the
13 State (as determined by the Secretary
14 based on the most recent available
15 population data published by the Bu-
16 reau of the Census).

17 “(iii) Whether the hospital is located
18 in a rural area (as defined in subsection
19 (d)(2)(D)(ii)).

20 “(E) RESERVATION OF POSITIONS FOR
21 CERTAIN HOSPITALS.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), the Secretary shall reserve the posi-
24 tions available for distribution under this
25 paragraph as follows:

1 “(I) 70 percent of such positions
2 for distribution to hospitals described
3 in clause (i) of subparagraph (D).

4 “(II) 30 percent of such positions
5 for distribution to hospitals described
6 in clause (ii) and (iii) of such sub-
7 paragraph.

8 “(ii) EXCEPTION IF POSITIONS NOT
9 REDISTRIBUTED WITHIN ONE YEAR.—In
10 the case where the Secretary does not dis-
11 tribute positions to hospitals in accordance
12 with clause (i) by not later than 1 year
13 after the date of enactment of this para-
14 graph, the Secretary shall distribute such
15 positions to other hospitals in accordance
16 with the considerations described in sub-
17 paragraph (C) and the priority described
18 in subparagraph (D).

19 “(F) LIMITATION.—A hospital may not re-
20 ceive more than 75 full-time equivalent addi-
21 tional residency positions under this paragraph.

22 “(G) APPLICATION OF PER RESIDENT
23 AMOUNTS FOR PRIMARY CARE AND NONPRI-
24 MARY CARE.—With respect to additional resi-
25 dency positions in a hospital attributable to the

1 increase provided under this paragraph, the ap-
2 proved FTE resident amounts are deemed to be
3 equal to the hospital per resident amounts for
4 primary care and nonprimary care computed
5 under paragraph (2)(D) for that hospital.

6 “(H) DISTRIBUTION.—The Secretary shall
7 distribute the increase to hospitals under this
8 paragraph not later than 3 years after the date
9 of enactment of this paragraph.

10 “(I) DEFINITIONS.—In this paragraph:

11 “(i) REFERENCE RESIDENT LEVEL.—
12 The term ‘reference resident level’ has the
13 meaning given such term by the Secretary.

14 “(ii) RESIDENT LEVEL.—The term
15 ‘resident level’ has the meaning given such
16 term in paragraph (7)(C)(i).

17 “(iii) OTHERWISE APPLICABLE RESI-
18 DENT LIMIT.—The term ‘otherwise appli-
19 cable resident limit’ means, with respect to
20 a hospital, the limit otherwise applicable
21 under subparagraphs (F)(i) and (H) of
22 paragraph (4) on the resident level for the
23 hospital determined without regard to this
24 paragraph but taking into account para-
25 graph (7)(A).

1 “(J) ADMINISTRATION.—Chapter 35 of
2 title 44, United States Code, shall not apply to
3 the implementation of this paragraph.”.

4 (b) IME.—

5 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
6 the Social Security Act (42 U.S.C.
7 1395ww(d)(5)(B)(v)), in the second sentence, is
8 amended—

9 (A) by striking “subsection (h)(7)” and in-
10 serting “subsections (h)(7) and (h)(8)”; and

11 (B) by striking “it applies” and inserting
12 “they apply”.

13 (2) CONFORMING AMENDMENT.—Section
14 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
15 1395ww(d)(5)(B)) is amended by adding at the end
16 the following clause:

17 “(x) For discharges occurring on or after the
18 date of enactment of this clause, insofar as an addi-
19 tional payment amount under this subparagraph is
20 attributable to resident positions distributed to a
21 hospital under subsection (h)(8)(B), the indirect
22 teaching adjustment factor shall be computed in the
23 same manner as provided under clause (ii) with re-
24 spect to such resident positions.”.

1 **SEC. 3033. COUNTING RESIDENT TIME IN OUTPATIENT SET-**
2 **TINGS AND ALLOWING FLEXIBILITY FOR**
3 **JOINTLY OPERATED RESIDENCY TRAINING**
4 **PROGRAMS.**

5 (a) GME.—Section 1886(h)(4) of the Social Security
6 Act (42 U.S.C. 1395ww(h)(4)) is amended—

7 (1) in subparagraph (E)—

8 (A) by striking “shall be counted and that
9 all the time” and inserting “shall be counted
10 and that—

11 “(i) effective for cost reporting peri-
12 ods beginning before July 1, 2010, all the
13 time”;

14 (B) in clause (i), as inserted by paragraph
15 (1), by striking the period at the end and in-
16 serting “; and”; and

17 (C) by inserting after clause (i), as so in-
18 serted, the following new clause:

19 “(ii) effective for cost reporting peri-
20 ods beginning on or after July 1, 2010, all
21 the time so spent by a resident shall be
22 counted towards the determination of full-
23 time equivalency, without regard to the
24 setting in which the activities are per-
25 formed, if the hospital incurs, or, in the
26 case of a jointly operated residency train-

1 1 or more eligible training sites under
2 a written agreement which specifies a
3 method for the equitable distribution
4 of time spent by the resident in activi-
5 ties relating to patient care for pur-
6 poses of determining the number of
7 full-time equivalent residents of the
8 hospitals or of the hospitals and the
9 eligible training sites, as applicable.

10 “(ii) REQUIRED SUBMISSION OF WRIT-
11 TEN AGREEMENT.—Each hospital or eligi-
12 ble training site participating in the oper-
13 ation of a jointly operated residency train-
14 ing program shall submit to the Secretary
15 the written agreement described in clause
16 (i)(II) upon request.

17 “(iii) LIMITATION.—The Secretary
18 shall ensure that, in the case of a jointly
19 operated residency training program, the
20 aggregate direct graduate medical edu-
21 cation payments to the hospitals or to the
22 hospitals and eligible training sites with re-
23 spect to full-time equivalent residents in
24 such jointly operated residency training
25 program do not exceed the aggregate direct

1 graduate medical education payments
2 which would have been made to the hos-
3 pitals or to the hospitals and eligible train-
4 ing sites if the hospitals or the hospitals
5 and eligible training sites independently
6 operated an approved medical residency
7 training program for such residents.”.

8 (b) IME.—Section 1886(d)(5) of the Social Security
9 Act (42 U.S.C. 1395ww(d)(5)) is amended—

10 (1) in subparagraph (B)(iv)—

11 (A) by striking “(iv) Effective for dis-
12 charges occurring on or after October 1, 1997”
13 and inserting “(iv)(A) Effective for discharges
14 occurring on or after October 1, 1997, and be-
15 fore July 1, 2010”; and

16 (B) by inserting after subparagraph (A),
17 as inserted by paragraph (1), the following new
18 subparagraph:

19 “(B) Effective for discharges occur-
20 ring on or after July 1, 2010, all the time
21 spent by an intern or resident in patient
22 care activities in a nonhospital setting shall
23 be counted towards the determination of
24 full-time equivalency if the hospital incurs,
25 or, in the case of a jointly operated resi-

1 dency training program (as defined in sub-
2 paragraph (M)(i)), 1 or more hospitals or
3 1 or more hospitals and 1 or more eligible
4 training sites (as defined in subparagraph
5 (M)(i)) continue to incur the costs of the
6 stipends and fringe benefits of the intern
7 or resident during the time the intern or
8 resident spends in that setting.”; and
9 (C) by adding at the end the following new

10 subparagraph:

11 “(M)(i) In this subparagraph:

12 “(I) The term ‘eligible training site’ means an
13 ambulatory or non-hospital training site at which the
14 training occurs.

15 “(II) The term ‘jointly operated residency train-
16 ing program’ means an approved medical residency
17 training program that is jointly operated by 1 or
18 more hospitals or by 1 or more hospitals and 1 or
19 more eligible training sites under a written agree-
20 ment which specifies a method for the equitable dis-
21 tribution of time spent by the resident in activities
22 relating to patient care for purposes of determining
23 the number of full-time equivalent residents of the
24 hospitals or of the hospitals and the eligible training
25 sites, as applicable.

1 “(ii) Each hospital or eligible training site partici-
2 pating in the operation of a jointly operated residency
3 training program shall submit to the Secretary the written
4 agreement described in clause (i)(II) upon request.

5 “(iii) The Secretary shall ensure that, in the case of
6 a jointly operated residency training program, the aggre-
7 gate indirect costs of medical education payments to the
8 hospitals or to the hospitals and eligible training sites with
9 respect to full-time equivalent residents in such jointly op-
10 erated residency training program do not exceed the ag-
11 gregate indirect costs of medical education payments
12 which would have been made to the hospitals or to the
13 hospitals and eligible training sites if the hospitals or the
14 hospitals and eligible training sites independently operated
15 an approved medical residency training program for such
16 residents.”.

17 (c) APPLICATION.—The amendments made by this
18 section shall not be applied in a manner that requires re-
19 opening of any settled hospital cost reports as to which
20 there is not a jurisdictionally proper appeal pending as
21 of the date of the enactment of this Act on the issue of
22 payment for indirect costs of medical education under sec-
23 tion 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
24 1395ww(d)(5)(B)) or for direct graduate medical edu-

1 cation costs under section 1886(h) of such Act (42 U.S.C.
2 1395ww(h)).

3 **SEC. 3034. RULES FOR COUNTING RESIDENT TIME FOR DI-**
4 **DACTIC AND SCHOLARLY ACTIVITIES AND**
5 **OTHER ACTIVITIES.**

6 (a) GME.—Section 1886(h) of the Social Security
7 Act (42 U.S.C. 1395ww(h)), as amended by section 3033,
8 is amended—

9 (1) in paragraph (4)—

10 (A) in subparagraph (E), by striking
11 “Such rules” and inserting “Subject to sub-
12 paragraphs (J) and (K), such rules”; and

13 (B) by adding at the end the following new
14 subparagraphs:

15 “(J) TREATMENT OF CERTAIN NONHOS-
16 PITAL AND DIDACTIC ACTIVITIES.—Such rules
17 shall provide that all time spent by an intern or
18 resident in an approved medical residency train-
19 ing program in a nonhospital setting that is pri-
20 marily engaged in furnishing patient care (as
21 defined in paragraph (5)(K)) in non-patient
22 care activities, such as didactic conferences and
23 seminars, but not including research not associ-
24 ated with the treatment or diagnosis of a par-
25 ticular patient, as such time and activities are

1 defined by the Secretary, shall be counted to-
2 ward the determination of full-time equivalency.

3 “(K) TREATMENT OF CERTAIN OTHER AC-
4 TIVITIES.—In determining the hospital’s num-
5 ber of full-time equivalent residents for pur-
6 poses of this subsection, all the time that is
7 spent by an intern or resident in an approved
8 medical residency training program on vacation,
9 sick leave, or other approved leave, as such time
10 is defined by the Secretary, and that does not
11 prolong the total time the resident is partici-
12 pating in the approved program beyond the nor-
13 mal duration of the program shall be counted
14 toward the determination of full-time equiva-
15 lency.”; and

16 (2) in paragraph (5), by adding at the end the
17 following new subparagraph:

18 “(K) NONHOSPITAL SETTING THAT IS PRI-
19 MARILY ENGAGED IN FURNISHING PATIENT
20 CARE.—The term ‘nonhospital setting that is
21 primarily engaged in furnishing patient care’
22 means a nonhospital setting in which the pri-
23 mary activity is the care and treatment of pa-
24 tients, as defined by the Secretary.”.

1 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
2 of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by
3 adding at the end the following new clause:

4 “(x)(I) The provisions of subpara-
5 graph (K) of subsection (h)(4) shall apply
6 under this subparagraph in the same man-
7 ner as they apply under such subsection.

8 “(II) In determining the hospital’s
9 number of full-time equivalent residents
10 for purposes of this subparagraph, all the
11 time spent by an intern or resident in an
12 approved medical residency training pro-
13 gram in non-patient care activities, such as
14 didactic conferences and seminars, as such
15 time and activities are defined by the Sec-
16 retary, that occurs in the hospital shall be
17 counted toward the determination of full-
18 time equivalency if the hospital—

19 “(aa) is recognized as a sub-
20 section (d) hospital;

21 “(bb) is recognized as a sub-
22 section (d) Puerto Rico hospital;

23 “(cc) is reimbursed under a reim-
24 bursement system authorized under
25 section 1814(b)(3); or

1 “(dd) is a provider-based hospital
2 outpatient department.

3 “(III) In determining the hospital’s
4 number of full-time equivalent residents
5 for purposes of this subparagraph, all the
6 time spent by an intern or resident in an
7 approved medical residency training pro-
8 gram in research activities that are not as-
9 sociated with the treatment or diagnosis of
10 a particular patient, as such time and ac-
11 tivities are defined by the Secretary, shall
12 not be counted toward the determination of
13 full-time equivalency.”.

14 (c) EFFECTIVE DATES; APPLICATION.—

15 (1) IN GENERAL.—Subject to paragraph (2),
16 the amendments made by this section apply to cost
17 reporting periods determined appropriate by the Sec-
18 retary.

19 (2) APPLICATION.—The amendments made by
20 this section shall not be applied in a manner that re-
21 quires reopening of any settled hospital cost reports
22 as to which there is not a jurisdictionally proper ap-
23 peal pending as of the date of the enactment of this
24 Act on the issue of payment for indirect costs of
25 medical education under section 1886(d)(5)(B) of

1 the Social Security Act or for direct graduate med-
2 ical education costs under section 1886(h) of such
3 Act.

4 **SEC. 3035. PRESERVATION OF RESIDENT CAP POSITIONS**
5 **FROM CLOSED AND ACQUIRED HOSPITALS.**

6 (a) GME.—Section 1886(h)(4)(H) of the Social Se-
7 curity Act (42 U.S.C. Section 1395ww(h)(4)(H)) is
8 amended by adding at the end the following new clauses:

9 “(vi) REDISTRIBUTION OF RESIDENCY
10 SLOTS AFTER A HOSPITAL CLOSES.—

11 “(I) IN GENERAL.—Subject to
12 the succeeding provisions of this
13 clause, the Secretary shall, by regula-
14 tion, establish a process under which,
15 in the case where a hospital with an
16 approved medical residency program
17 closes on or after the date of enact-
18 ment of the Balanced Budget Act of
19 1997, the Secretary shall increase the
20 otherwise applicable resident limit
21 under this paragraph for other hos-
22 pitals in accordance with this clause.

23 “(II) PRIORITY FOR HOSPITALS
24 IN CERTAIN AREAS.—Subject to the
25 succeeding provisions of this clause, in

1 determining for which hospitals the
2 increase in the otherwise applicable
3 resident limit is provided under such
4 process, the Secretary shall distribute
5 the increase to hospitals in the fol-
6 lowing priority order (with preference
7 given within each category to hos-
8 pitals that are members of the same
9 affiliated group (as defined by the
10 Secretary under clause (ii)) as the
11 closed hospital):

12 “(aa) First, to hospitals lo-
13 cated in the same core-based sta-
14 tistical area as, or a core-based
15 statistical area contiguous to, the
16 hospital that closed.

17 “(bb) Second, to hospitals
18 located in the same State as the
19 hospital that closed.

20 “(cc) Third, to hospitals lo-
21 cated in the same region of the
22 country as the hospital that
23 closed.

24 “(dd) Fourth, only if the
25 Secretary is not able to distribute

1 the increase to hospitals de-
2 scribed in item (cc), to qualifying
3 hospitals in accordance with the
4 provisions of paragraph (8).

5 “(III) REQUIREMENT HOSPITAL
6 LIKELY TO FILL POSITION WITHIN
7 CERTAIN TIME PERIOD.—The Sec-
8 retary may only increase the otherwise
9 applicable resident limit of a hospital
10 under such process if the Secretary
11 determines the hospital has dem-
12 onstrated a likelihood of filling the po-
13 sitions made available under this
14 clause within 3 years.

15 “(IV) LIMITATION.—The aggre-
16 gate number of increases in the other-
17 wise applicable resident limits for hos-
18 pitals under this clause shall be equal
19 to the number of resident positions in
20 the approved medical residency pro-
21 grams that closed on or after the date
22 described in subclause (I).

23 “(vii) SPECIAL RULE FOR ACQUIRED
24 HOSPITALS.—

1 “(I) IN GENERAL.—In the case
2 of a hospital that is acquired (through
3 any mechanism) by another entity
4 with the approval of a bankruptcy
5 court, during a period determined by
6 the Secretary (but not less than 3
7 years), the applicable resident limit of
8 the acquired hospital shall, except as
9 provided in subclause (II), be the ap-
10 pplicable resident limit of the hospital
11 that was acquired (as of the date im-
12 mediately before the acquisition), so
13 long as the acquiring entity continues
14 to operate the hospital that was ac-
15 quired and to furnish services, medical
16 residency programs, and volume of
17 patients similar to the services, med-
18 ical residency programs, and volume
19 of patients of the hospital that was
20 acquired (as determined by the Sec-
21 retary) during such period.

22 “(II) LIMITATION.—Subclause
23 (I) shall only apply in the case where
24 an acquiring entity waives the right as
25 a new provider under the program

1 under this title to have the otherwise
2 applicable resident limit of the ac-
3 quired hospital re-established or in-
4 creased.”.

5 (b) **IME.**—Section 1886(d)(5)(B)(v) of the Social Se-
6 curity Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second
7 sentence, as amended by section 3032, is amended by
8 striking “subsections (h)(7) and (h)(8)” and inserting
9 “subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and
10 (h)(8)”.

11 (c) **APPLICATION.**—The amendments made by this
12 section shall not be applied in a manner that requires re-
13 opening of any settled hospital cost reports as to which
14 there is not a jurisdictionally proper appeal pending as
15 of the date of the enactment of this Act on the issue of
16 payment for indirect costs of medical education under sec-
17 tion 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(B)) or for direct graduate medical edu-
19 cation costs under section 1886(h) of such Act (42 U.S.C.
20 Section 1395ww(h)).

21 (d) **EFFECT ON TEMPORARY FTE CAP ADJUST-**
22 **MENTS.**—The Secretary of Health and Human Services
23 shall give consideration to the effect of the amendments
24 made by this section on any temporary adjustment to a
25 hospital’s FTE cap under section 413.79(h) of title 42,

1 Code of Federal Regulations (as in effect on the date of
2 enactment of this Act) in order to ensure that there is
3 no duplication of FTE slots. Such amendments shall not
4 affect the application of section 1886(h)(4)(H)(v) of the
5 Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

6 **SEC. 3036. WORKFORCE ADVISORY COMMITTEE.**

7 (a) ESTABLISHMENT.—The Secretary shall establish
8 a Workforce Advisory Committee.

9 (b) MEMBERSHIP.—The Committee shall be com-
10 posed of members appointed by the Secretary from
11 among—

12 (1) external stakeholders and representatives of
13 health care professionals;

14 (2) schools of higher education for health care
15 professionals;

16 (3) public health experts;

17 (4) health insurers;

18 (5) business, labor, State or local workforce in-
19 vestment boards; and

20 (6) any other health professional organization
21 or practice the Secretary determines appropriate.

22 (c) DUTIES.—

23 (1) NATIONAL WORKFORCE STRATEGY.—

24 (A) IN GENERAL.—Not later than a date
25 determined appropriate by the Secretary, the

1 Committee shall develop and submit to Con-
2 gress and the heads of relevant Federal agen-
3 cies a national workforce strategy that will set
4 the United States on a path toward recruiting,
5 training, and retaining a health care workforce
6 that meets the current and projected health
7 care needs of the United States.

8 (B) CONSULTATION.—

9 (i) RELEVANT FEDERAL AGENCIES.—

10 In developing the national workforce strat-
11 egy under subparagraph (A), the Com-
12 mittee shall consult closely with the heads
13 of relevant Federal agencies, such as the
14 Office of the Administrator of the Health
15 Resources and Services Administration and
16 the Secretary of Veterans Affairs, to avoid
17 duplication of efforts by those agencies and
18 to review Federal health care workforce
19 policies on a government-wide basis.

20 (ii) STATE AND LOCAL ENTITIES.—

21 The Committee shall consult with State
22 and local entities in developing such na-
23 tional workforce strategy.

24 (2) STUDY AND BIENNIAL REPORTS ON THE
25 HEALTH CARE WORKFORCE SUPPLY.—

1 (A) STUDY.—The Committee shall conduct
2 a study on the health care workforce in the
3 United States. Such study shall include an
4 analysis of—

5 (i) the current and projected health
6 care workforce supply;

7 (ii) the current and projected demand
8 for health professionals;

9 (iii) the capacity for education and
10 training of the health care workforce;

11 (iv) the implications of current and
12 proposed Federal laws and regulations af-
13 fecting the health care workforce; and

14 (v) the health care workforce needs of
15 specific populations, including minorities,
16 rural and urban populations, and medically
17 underserved populations.

18 (B) BIENNIAL REPORTS.—

19 (i) IN GENERAL.—The Committee
20 shall, on a biennial basis, submit to Con-
21 gress and the heads of relevant Federal
22 agencies a report containing the results of
23 the study conducted under subparagraph
24 (A), together with recommendations for

1 such legislation and administrative action
2 as the Committee determines appropriate.

3 (ii) PUBLIC AVAILABILITY.—The
4 Committee shall make each report sub-
5 mitted under clause (i) available to the
6 public.

7 (3) STUDIES AND REPORTS ON OTHER HIGH-
8 PRIORITY TOPICS.—

9 (A) STUDY.—The Committee shall conduct
10 studies on specific high-priority topics, includ-
11 ing—

12 (i) efforts to integrate the health care
13 workforce into a reformed health care de-
14 livery system;

15 (ii) the implications for the health
16 care workforce as a result of greater utili-
17 zation of health information technology;

18 (iii) nursing workforce capacity;

19 (iv) mental and behavioral health care
20 workforce capacity; and

21 (v) the geographic distribution of
22 health care providers.

23 (B) REPORTS.—

24 (i) IN GENERAL.—The Committee
25 shall submit to Congress and the heads of

1 relevant Federal agencies a report con-
2 taining the results of each study conducted
3 under subparagraph (A), together with rec-
4 ommendations for such legislation and ad-
5 ministrative action as the Committee de-
6 termines appropriate.

7 (ii) PUBLIC AVAILABILITY.—The
8 Committee shall make each report sub-
9 mitted under clause (i) available to the
10 public.

11 (d) DEFINITIONS.—In this section:

12 (1) COMMITTEE.—The term “Committee”
13 means the Workforce Advisory Committee estab-
14 lished under subsection (a).

15 (2) SECRETARY.—The term “Secretary” means
16 the Secretary of Health and Human Services.

17 **SEC. 3037. DEMONSTRATION PROJECTS TO ADDRESS**
18 **HEALTH PROFESSIONS WORKFORCE NEEDS;**
19 **EXTENSION OF FAMILY-TO-FAMILY HEALTH**
20 **INFORMATION CENTERS.**

21 (a) AUTHORITY TO CONDUCT DEMONSTRATION
22 PROJECTS.—Title XI of the Social Security Act (42
23 U.S.C. 1301 et seq.) is amended by inserting after section
24 1130A, the following new section:

1 **“SEC. 1130B. DEMONSTRATION PROJECTS TO ADDRESS**
2 **HEALTH PROFESSIONS WORKFORCE NEEDS.**

3 “(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-
4 INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDU-
5 CATION, TRAINING, AND CAREER ADVANCEMENT TO AD-
6 DRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

7 “(1) AUTHORITY TO AWARD GRANTS.—The
8 Secretary, in consultation with the Secretary of
9 Labor, shall award grants to eligible entities to con-
10 duct demonstration projects that are designed to
11 provide eligible individuals with the opportunity to
12 obtain education and training for occupations in the
13 health care field that pay well and are expected to
14 either experience labor shortages or be in high de-
15 mand.

16 “(2) REQUIREMENTS.—

17 “(A) AID AND SUPPORTIVE SERVICES.—

18 “(i) IN GENERAL.—A demonstration
19 project conducted by an eligible entity
20 awarded a grant under this section shall, if
21 appropriate, provide eligible individuals
22 participating in the project with financial
23 aid, child care, case management, and
24 other supportive services.

25 “(ii) TREATMENT.—Any aid, services,
26 or incentives provided to an eligible bene-

1 ficiary participating in a demonstration
2 project under this section shall not be con-
3 sidered income, and shall not be taken into
4 account for purposes of determining the in-
5 dividual's eligibility for, or amount of, ben-
6 efits under the State TANF program, the
7 State Medicaid plan, the State Supple-
8 mental Nutrition Assistance Program
9 (SNAP), and any Housing and Urban De-
10 velopment program.

11 “(B) CONSULTATION AND COORDINA-
12 TION.—An eligible entity awarded a grant to
13 carry out a demonstration project under this
14 section shall consult with the State agency re-
15 sponsible for administering the State TANF
16 program in carrying out the project and, if the
17 entity is not a local workforce investment board,
18 also shall consult with the local workforce in-
19 vestment board for the area in which the
20 project is conducted and with the State Work-
21 force Investment Board established under sec-
22 tion 111 of the Workforce Investment Act of
23 1998 (29 U.S.C. 2821).

24 “(C) ASSURANCE OF OPPORTUNITIES FOR
25 INDIAN POPULATIONS.—The Secretary shall

1 award at least 3 grants under this subsection to
2 an eligible entity that is an Indian tribe, tribal
3 organization, or Tribal College or University.

4 “(3) REPORTS AND EVALUATION.—

5 “(A) ELIGIBLE ENTITIES.—An eligible en-
6 tity awarded a grant to conduct a demonstra-
7 tion project under this subsection shall submit
8 interim reports to the Secretary on the activi-
9 ties carried out under the project and a final
10 report on such activities upon the conclusion of
11 the entities’ participation in the project. Such
12 reports shall include assessments of the effec-
13 tiveness of such activities with respect to im-
14 proving outcomes for the eligible individuals
15 participating in the project and with respect to
16 addressing health professions workforce needs
17 in the areas in which the project is conducted.

18 “(B) EVALUATION.—The Secretary shall,
19 by grant, contract, or interagency agreement,
20 evaluate the demonstration projects conducted
21 under this subsection. Such evaluation shall in-
22 clude identification of successful activities for
23 creating opportunities for developing and sus-
24 taining, particularly with respect to low-income
25 individuals and other entry-level workers, a

1 health professions workforce that has accessible
2 entry points, that meets high standards for edu-
3 cation, training, certification, and professional
4 development, and that provides increased wages
5 and affordable benefits, including health care
6 coverage, that are responsive to the workforce’s
7 needs.

8 “(C) REPORT TO CONGRESS.—The Sec-
9 retary shall submit interim reports and, based
10 on the evaluation conducted under subpara-
11 graph (B), a final report to Congress on the
12 demonstration projects conducted under this
13 subsection.

14 “(4) DEFINITIONS.—In this subsection:

15 “(A) ELIGIBLE ENTITY.—The term ‘eligi-
16 ble entity’ means a State, an Indian tribe or
17 tribal organization, an institution of higher edu-
18 cation, a local workforce investment board es-
19 tablished under section 117 of the Workforce
20 Investment Act of 1998 (29 U.S.C. 2832), or a
21 community-based organization.

22 “(B) ELIGIBLE INDIVIDUAL.—

23 “(i) IN GENERAL.—The term ‘eligible
24 individual’ means a individual receiving as-
25 sistance under the State TANF program.

1 “(ii) OTHER LOW-INCOME INDIVID-
2 UALS.—Such term may include other low-
3 income individuals described by the eligible
4 entity in its application for a grant under
5 this section.

6 “(C) INDIAN TRIBE; TRIBAL ORGANIZA-
7 TION.—The terms ‘Indian tribe’ and ‘tribal or-
8 ganization’ have the meaning given such terms
9 in section 4 of the Indian Self-Determination
10 and Education Assistance Act (25 U.S.C.
11 450b).

12 “(D) INSTITUTION OF HIGHER EDU-
13 CATION.—The term ‘institution of higher edu-
14 cation’ has the meaning given that term in sec-
15 tion 101 of the Higher Education Act of 1965
16 (20 U.S.C. 1001).

17 “(E) STATE.—The term ‘State’ means
18 each of the 50 States, the District of Columbia,
19 the Commonwealth of Puerto Rico, the United
20 States Virgin Islands, Guam, and American
21 Samoa.

22 “(F) STATE TANF PROGRAM.—The term
23 ‘State TANF program’ means the temporary
24 assistance for needy families program funded
25 under part A of title IV.

1 “(G) TRIBAL COLLEGE OR UNIVERSITY.—

2 The term ‘Tribal College or University’ has the
3 meaning given that term in section 316(b) of
4 the Higher Education Act of 1965 (20 U.S.C.
5 1059c(b)).

6 “(b) DEMONSTRATION PROJECT TO DEVELOP
7 TRAINING AND CERTIFICATION PROGRAMS FOR PER-
8 SONAL OR HOME CARE AIDES.—

9 “(1) AUTHORITY TO AWARD GRANTS.—Not
10 later than 18 months after the date of enactment of
11 this Act, the Secretary shall award grants to eligible
12 entities that are States to conduct demonstration
13 projects for purposes of developing core training
14 competencies and certification programs for personal
15 or home care aides. The Secretary shall—

16 “(A) evaluate the efficacy of the core train-
17 ing competencies described in paragraph (3)(A)
18 for newly hired personal or home care aides and
19 the methods used by States to implement such
20 core training competencies in accordance with
21 the issues specified in paragraph (3)(B); and

22 “(B) ensure that the number of hours of
23 training provided by States under the dem-
24 onstration project with respect to such core
25 training competencies are not less than the

1 number of hours of training required under any
2 applicable State or Federal law or regulation.

3 “(2) DURATION.—A demonstration project shall
4 be conducted under this subsection for not less than
5 3 years.

6 “(3) CORE TRAINING COMPETENCIES FOR PER-
7 SONAL OR HOME CARE AIDES.—

8 “(A) IN GENERAL.—The core training
9 competencies for personal or home care aides
10 described in this subparagraph include com-
11 petencies with respect to the following areas:

12 “(i) The role of the personal or home
13 care aide (including differences between a
14 personal or home care aide employed by an
15 agency and a personal or home care aide
16 employed directly by the health care con-
17 sumer or an independent provider).

18 “(ii) Consumer rights, ethics, and
19 confidentiality (including the role of proxy
20 decision-makers in the case where a health
21 care consumer has impaired decision-mak-
22 ing capacity).

23 “(iii) Communication, cultural and
24 linguistic competence and sensitivity, prob-

1 lem solving, behavior management, and re-
2 lationship skills.

3 “(iv) Personal care skills.

4 “(v) Health care support.

5 “(vi) Nutritional support.

6 “(vii) Infection control.

7 “(viii) Safety and emergency training.

8 “(ix) Training specific to an indi-
9 vidual consumer’s needs (including older
10 individuals, younger individuals with dis-
11 abilities, individuals with developmental
12 disabilities, individuals with dementia, and
13 individuals with mental and behavioral
14 health needs).

15 “(x) Self-Care.

16 “(B) IMPLEMENTATION.—The implemen-
17 tation issues specified in this subparagraph in-
18 clude the following:

19 “(i) The length of the training.

20 “(ii) The appropriate trainer to stu-
21 dent ratio.

22 “(iii) The amount of instruction time
23 spent in the classroom as compared to on-
24 site in the home or a facility.

25 “(iv) Trainer qualifications.

1 “(v) Content for a ‘hands-on’ and
2 written certification exam.

3 “(vi) Continuing education require-
4 ments.

5 “(4) APPLICATION AND SELECTION CRI-
6 TERIA.—

7 “(A) IN GENERAL.—

8 “(i) NUMBER OF STATES.—The Sec-
9 retary shall enter into agreements with not
10 more than 6 States to conduct demonstra-
11 tion projects under this subsection.

12 “(ii) REQUIREMENTS FOR STATES.—
13 An agreement entered into under clause (i)
14 shall require that a participating State—

15 “(I) implement the core training
16 competencies described in paragraph
17 (3)(A); and

18 “(II) develop written materials
19 and protocols for such core training
20 competencies, including the develop-
21 ment of a certification test for per-
22 sonal or home care aides who have
23 completed such training competencies.

24 “(iii) CONSULTATION AND COLLABO-
25 RATION WITH COMMUNITY AND VOCA-

1 TIONAL COLLEGES.—The Secretary shall
2 encourage participating States to consult
3 with community and vocational colleges re-
4 garding the development of curricula to
5 implement the project with respect to ac-
6 tivities, as applicable, which may include
7 consideration of such colleges as partners
8 in such implementation.

9 “(B) APPLICATION AND ELIGIBILITY.—A
10 State seeking to participate in the project
11 shall—

12 “(i) submit an application to the Sec-
13 retary containing such information and at
14 such time as the Secretary may specify;

15 “(ii) meet the selection criteria estab-
16 lished under subparagraph (C); and

17 “(iii) meet such additional criteria as
18 the Secretary may specify.

19 “(C) SELECTION CRITERIA.—In selecting
20 States to participate in the program, the Sec-
21 retary shall establish criteria to ensure (if appli-
22 cable with respect to the activities involved)—

23 “(i) geographic and demographic di-
24 versity;

1 “(ii) that participating States offer
2 medical assistance for personal care serv-
3 ices under the State Medicaid plan;

4 “(iii) that the existing training stand-
5 ards for personal or home care aides in
6 each participating State—

7 “(I) are different from such
8 standards in the other participating
9 States; and

10 “(II) are different from the core
11 training competencies described in
12 paragraph (3)(A);

13 “(iv) that participating States do not
14 reduce the number of hours of training re-
15 quired under applicable State law or regu-
16 lation after being selected to participate in
17 the project; and

18 “(v) that participating States recruit
19 a minimum number of eligible health and
20 long-term care providers to participate in
21 the project.

22 “(D) TECHNICAL ASSISTANCE.—The Sec-
23 retary shall provide technical assistance to
24 States in developing written materials and pro-
25 tocols for such core training competencies.

1 “(5) EVALUATION AND REPORT.—

2 “(A) EVALUATION.—The Secretary shall
3 develop an experimental or control group test-
4 ing protocol in consultation with an inde-
5 pendent evaluation contractor selected by the
6 Secretary. Such contractor shall evaluate—

7 “(i) the impact of core training com-
8 petencies described in paragraph (3)(A),
9 including curricula developed to implement
10 such core training competencies, for per-
11 sonal or home care aides within each par-
12 ticipating State on job satisfaction, mas-
13 tery of job skills, beneficiary and family
14 caregiver satisfaction with services, and ad-
15 ditional measures determined by the Sec-
16 retary in consultation with the expert
17 panel;

18 “(ii) the impact of providing such core
19 training competencies on the existing
20 training infrastructure and resources of
21 States; and

22 “(iii) whether a minimum number of
23 hours of initial training should be required
24 for personal or home care aides and, if so,

1 what minimum number of hours should be
2 required.

3 “(B) REPORTS.—

4 “(i) REPORT ON INITIAL IMPLEMEN-
5 TATION.—Not later than 2 years after the
6 date of enactment of this Act, the Sec-
7 retary shall submit to Congress a report on
8 the initial implementation of activities con-
9 ducted under the demonstration project,
10 including any available results of the eval-
11 uation conducted under subparagraph (A)
12 with respect to such activities, together
13 with such recommendations for legislation
14 or administrative action as the Secretary
15 determines appropriate.

16 “(ii) FINAL REPORT.—Not later than
17 1 year after the completion of the dem-
18 onstration project, the Secretary shall sub-
19 mit to Congress a report containing the re-
20 sults of the evaluation conducted under
21 subparagraph (A), together with such rec-
22 ommendations for legislation or adminis-
23 trative action as the Secretary determines
24 appropriate.

25 “(6) DEFINITIONS.—In this subsection:

1 “(A) ELIGIBLE HEALTH AND LONG-TERM
2 CARE PROVIDER.—The term ‘eligible health and
3 long-term care provider’ means a personal or
4 home care agency (including personal or home
5 care public authorities), a nursing home, a
6 home health agency (as defined in section
7 1861(o)), or any other health care provider the
8 Secretary determines appropriate which—

9 “(i) is licensed or authorized to pro-
10 vide services in a participating State; and

11 “(ii) receives payment for services
12 under title XIX.

13 “(B) PERSONAL CARE SERVICES.—The
14 term ‘personal care services’ has the meaning
15 given such term for purposes of title XIX.

16 “(C) PERSONAL OR HOME CARE AIDE.—
17 The term ‘personal or home care aide’ means
18 an individual who helps individuals who are el-
19 derly, disabled, ill, or mentally disabled (includ-
20 ing an individual with Alzheimer’s disease or
21 other dementia) to live in their own home or a
22 residential care facility (such as a nursing
23 home, assisted living facility, or any other facil-
24 ity the Secretary determines appropriate) by

1 providing routine personal care services and
2 other appropriate services to the individual.

3 “(D) STATE.—The term ‘State’ has the
4 meaning given that term for purposes of title
5 XIX.

6 “(c) FUNDING.—

7 “(1) IN GENERAL.—Subject to paragraph (2),
8 out of any funds in the Treasury not otherwise ap-
9 propriated, there are appropriated to the Secretary
10 to carry out subsections (a) and (b), \$85,000,000
11 for each of fiscal years 2010 through 2014.

12 “(2) TRAINING AND CERTIFICATION PROGRAMS
13 FOR PERSONAL AND HOME CARE AIDES.—With re-
14 spect to the demonstration projects under subsection
15 (b), the Secretary shall use \$5,000,000 of the
16 amount appropriated under paragraph (1) for each
17 of fiscal years 2010 through 2012 to carry out such
18 projects. No funds appropriated under paragraph
19 (1) shall be used to carry out demonstration projects
20 under subsection (b) after fiscal year 2012.”.

21 (b) EXTENSION OF FAMILY-TO-FAMILY HEALTH IN-
22 FORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the
23 Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is
24 amended by striking “fiscal year 2009” and inserting
25 “each of fiscal years 2009 through 2012”.

1 **SEC. 3038. INCREASING TEACHING CAPACITY.**

2 (a) TEACHING HEALTH CENTERS TRAINING AND
3 ENHANCEMENT.—Part C of title VII of the Public Health
4 Service Act (42 U.S.C. 293k et. seq.) is amended by in-
5 serting after section 748 the following:

6 **“SEC. 749. TEACHING HEALTH CENTERS DEVELOPMENT**
7 **GRANTS.**

8 “(a) PROGRAM AUTHORIZED.—The Secretary may
9 award grants under this section to teaching health centers
10 for the purpose of establishing newly accredited or ex-
11 panded primary care residency programs.

12 “(b) AMOUNT AND DURATION.—Grants awarded
13 under this section shall be for a term of not more than
14 2 years and the maximum award may not be more than
15 \$500,000.

16 “(c) USE OF FUNDS.—Amounts provided under a
17 grant under this section shall be used to cover the costs
18 of—

19 “(1) establishing or expanding a primary care
20 residency training program described in subsection
21 (a), including costs associated with—

22 “(A) curriculum development;

23 “(B) recruitment, training and retention of
24 residents and faculty:

25 “(C) accreditation by the Accreditation
26 Council for Graduate Medical Education

1 (ACGME) or the American Osteopathic Asso-
2 ciation (AOA); and

3 “(D) faculty salaries during the develop-
4 ment phase; and

5 “(2) technical assistance provided by an eligible
6 entity, including costs associated with—

7 “(A) materials development;

8 “(B) staff salaries;

9 “(C) travel; and

10 “(D) administrative costs.

11 “(d) APPLICATION.—A teaching health center seek-
12 ing a grant under this section shall submit an application
13 to the Secretary at such time, in such manner, and con-
14 taining such information as the Secretary may require.

15 “(e) PRIORITY.—In selecting recipients for grants
16 under this section, the Secretary shall give priority to
17 funding residency training programs in Federally qualified
18 health centers, rural health centers, Indian health centers,
19 newly established residency programs, and integrated
20 rural training tracks and rural training tracks and
21 residencies with a mission to train physicians for rural and
22 underserved practice.

23 “(f) FURTHER PRIORITY FOR CERTAIN APPLICA-
24 TIONS.—With respect to applications for grants under this
25 section that are receiving priority under subsection (e), the

1 Secretary shall give further preference to any such appli-
2 cation that documents an existing affiliation agreement
3 with an area health education center program as defined
4 in sections 751 and 799B.

5 “(g) DEFINITIONS.—In this section:

6 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
7 tity’ means an organization capable of providing
8 technical assistance including an area health edu-
9 cation center program as defined in sections 751
10 and 799B.

11 “(2) PRIMARY CARE RESIDENCY PROGRAM.—
12 The term ‘primary care residency program’ means
13 an approved medical residency program under sec-
14 tion 1886(h)(5)(A) of the Social Security Act in
15 family medicine, general pediatrics, general internal
16 medicine, or obstetrics and gynecology.

17 “(3) TEACHING HEALTH CENTER.—The term
18 ‘teaching health center’—

19 “(A) means a facility which—

20 “(i) is a community-based, ambulatory
21 patient care center; and

22 “(ii) is establishing a new or expand-
23 ing an existing primary care residency pro-
24 gram under section 1886(h)(5)(A) of the

1 Social Security Act in a specialty which the
2 Secretary determines is in high-need;

3 “(B) includes Federally qualified health
4 centers, community health centers, health care
5 for the homeless centers, rural health centers,
6 migrant health centers, Native American health
7 centers operated by the Indian Health Service,
8 Indian tribes and tribal organizations, and
9 other not-for-profit community-based clinical
10 entities.

11 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated, \$25,000,000 for fiscal
13 year 2010, \$50,000,000 for fiscal year 2011, \$50,000,000
14 for fiscal year 2012, and such sums as may be necessary
15 for each fiscal year thereafter to carry out this section.
16 Not to exceed \$5,000,000 annually may be used for tech-
17 nical assistance program grants.”.

18 (b) NATIONAL HEALTH SERVICE CORPS TEACHING
19 CAPACITY.—Section 338C(a) of the Public Health Service
20 Act (42 U.S.C. 254m(a)) is amended to read as follows:

21 “(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—
22 Except as provided in section 338D, each individual who
23 has entered into a written contract with the Secretary
24 under section 338A or 338B shall provide service in the
25 full-time clinical practice of such individual’s profession as

1 a member of the Corps for the period of obligated service
2 provided in such contract. For the purpose of calculating
3 time spent in full-time clinical practice under this sub-
4 section, up to 50 percent of time spent teaching by a mem-
5 ber of the Corps may be counted toward his or her service
6 obligation.”.

7 (c) PAYMENTS TO QUALIFIED TEACHING HEALTH
8 CENTERS.—Title XVIII of the Social Security Act (42
9 U.S.C. 1395 et seq.), as amended by sections 3023 and
10 3024, is amended by inserting after section 1866E the fol-
11 lowing new section:

12 “PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS
13 FOR DIRECT GRADUATE MEDICAL EDUCATION EX-
14 PENSES AND OTHER INDIRECT EXPENSES ASSOCI-
15 ATED WITH OPERATING APPROVED GRADUATE MED-
16 ICAL RESIDENCY TRAINING PROGRAMS

17 “SEC. 1866F. (a) IN GENERAL.—The Secretary
18 shall, for purposes of increasing training and improving
19 access to primary care services, make payments to quali-
20 fied teaching health centers for direct graduate medical
21 education costs and other indirect costs associated with
22 operating approved graduate medical residency training
23 programs.

24 “(b) APPROVED GRADUATE MEDICAL RESIDENCY
25 TRAINING PROGRAMS.—An approved medical residency
26 training program operated by a qualified teaching health

1 center shall meet criteria for accreditation (as established
2 by the Accreditation Council for Graduate Medical Edu-
3 cation or the American Osteopathic Association).

4 “(c) DETERMINATION OF PAYMENT AND FUNDING
5 CALCULATIONS.—The Secretary shall determine the basis
6 of payment and any funding calculations necessary with
7 respect to payments for direct graduate medical education
8 expenses and other indirect expenses associated with oper-
9 ating approved graduate medical residency training pro-
10 grams.

11 “(d) CLARIFICATION REGARDING RELATIONSHIP TO
12 OTHER PAYMENTS FOR GRADUATE MEDICAL EDU-
13 CATION.—Payments under this section—

14 “(1) shall be in addition to any payments—

15 “(A) for the indirect costs of medical edu-
16 cation under section 1886(d)(5)(B); and

17 “(B) for direct graduate medical education
18 costs under section 1886(h); and

19 “(2) shall not be taken into account in applying
20 the limitation on the number of total full time equiv-
21 alent residents under section 1886(h)(4)(F) and
22 clauses (v) and (vi)(I) of section 1886(d)(5)(B).

23 “(e) REGULATIONS.—The Secretary shall promulgate
24 regulations to carry out this section.

1 “(f) FUNDING.—The Secretary shall provide for the
2 transfer, from the Federal Hospital Insurance Trust Fund
3 under section 1817, of \$230,000,000,000, for payments
4 under this section for the period of fiscal years 2011
5 through 2015. Amounts transferred under the preceding
6 sentence shall remain available until expended.

7 “(g) DEFINITIONS.—In this section:

8 “(1) APPROVED GRADUATE MEDICAL RESI-
9 DENCY TRAINING PROGRAM.—The term ‘approved
10 medical residency training program’ has the mean-
11 ing given such term in section 1886(h)(5)(A).

12 “(2) PRIMARY CARE RESIDENCY PROGRAM.—
13 The term ‘primary care residency program’ means
14 an approved medical residency training program in
15 family medicine, internal medicine, pediatrics, medi-
16 cine-pediatrics, obstetrics and gynecology, psychi-
17 atry, and geriatrics.

18 “(3) QUALIFIED TEACHING HEALTH CENTER.—

19 “(A) IN GENERAL.—The term ‘qualified
20 teaching health center’ means an entity that—

21 “(i) is a community based, ambula-
22 tory patient care center; and

23 “(ii) operates a primary care resi-
24 dency program.

1 “(B) INCLUSION OF CERTAIN ENTITIES.—

2 Such term includes the following:

3 “(i) A Federally qualified health cen-
4 ter (as defined in section 1861(aa)(4)).

5 “(ii) A community mental health cen-
6 ter (as defined in section 1861(ff)(3)(B)).

7 “(iii) A community health center.

8 “(iv) A health care for the homeless
9 center.

10 “(v) A rural health center.

11 “(vi) A migrant health center.

12 “(vii) A health center operated by the
13 Indian Health Service, an Indian tribe or
14 tribal organization, or an urban Indian or-
15 ganization (as defined in section 4 of the
16 Indian Health Care Improvement Act).

17 “(viii) An entity receiving funds under
18 title X of the Public Health Service Act.”.

19 **SEC. 3039. GRADUATE NURSE EDUCATION DEMONSTRATION PROGRAM.**
20 **TION PROGRAM.**

21 (a) IN GENERAL.—

22 (1) ESTABLISHMENT.—The Secretary shall es-
23 tablish a graduate nurse education demonstration
24 program under title XVIII of the Social Security Act
25 (42 U.S.C. 1395 et seq.) under which eligible hos-

1 pitals are reimbursed for costs described in para-
2 graph (2).

3 (2) COSTS DESCRIBED.—

4 (A) IN GENERAL.—Subject to subpara-
5 graph (B), the costs described in this para-
6 graph are educational costs, clinical instruction
7 costs, and other direct and indirect costs of the
8 eligible hospital which are attributable to pro-
9 viding advanced practice nurses with qualified
10 training.

11 (B) LIMITATION.—With respect to a year,
12 the amount reimbursed under the program may
13 not exceed the amount of costs described in
14 subparagraph (A) that are attributable to an
15 increase in the number of advanced practice
16 nurses enrolled in a program that provides
17 qualified training during the year, as compared
18 to the average number of advanced practice
19 nurses who graduated from a program that pro-
20 vides qualified training in each year during the
21 period beginning on January 1, 2006 and end-
22 ing on December 31, 2010 (as determined by
23 the Secretary).

24 (b) DEFINITIONS.—In this section:

1 (1) ADVANCED PRACTICE NURSE.—The term
2 “advanced practice nurse” includes the following:

3 (A) A clinical nurse specialist (as defined
4 in subsection (aa)(5) of section 1861 of the So-
5 cial Security Act (42 U.S.C. 1395x)).

6 (B) A nurse practitioner (as defined in
7 such subsection).

8 (C) A certified registered nurse anesthetist
9 (as defined in subsection (bb)(2) of such sec-
10 tion).

11 (D) A certified nurse midwife.

12 (2) APPLICABLE NON-HOSPITAL COMMUNITY-
13 BASED CARE SETTING.—The term “applicable non-
14 hospital community-based care setting” means a
15 non-hospital community-based care setting which
16 has entered into an agreement with the eligible hos-
17 pital under which the non-hospital community-based
18 care setting is responsible for its share of costs de-
19 scribed in subsection (a).

20 (3) APPLICABLE SCHOOL OF NURSING.—The
21 term “applicable school of nursing” means an ac-
22 credited school of nursing (as defined in section 801
23 of the Public Health Service Act) which has entered
24 into an agreement with the eligible hospital under

1 which the school of nursing is responsible for its
2 share of costs described in subsection (a).

3 (4) ELIGIBLE HOSPITAL.—The term “eligible
4 hospital” means a subsection (d) hospital (as defined
5 in section 1861(d)(1)(B) of the Social Security Act
6 (42 U.S.C. 1395x(d)(1)(B))) that—

7 (A) is affiliated with 1 or more applicable
8 schools of nursing; and

9 (B) is partnered with 2 or more applicable
10 non-hospital community-based care settings.

11 (5) PROGRAM.—The term “program” means
12 the graduate nurse education demonstration pro-
13 gram established under subsection (a).

14 (6) QUALIFIED TRAINING.—

15 (A) IN GENERAL.—The term “qualified
16 training” means training—

17 (i) that provides an advanced practice
18 nurse with the skills necessary to provide
19 primary care, preventive care, transitional
20 care, chronic care management, and other
21 services appropriate for individuals entitled
22 to, or enrolled for, benefits under part A of
23 title XVIII of the Social Security Act, or
24 enrolled under part B of such title; and

1 (ii) subject to subparagraph (B), at
2 least half of which is provided in a non-
3 hospital community-based care setting.

4 (B) WAIVER OF REQUIREMENT HALF OF
5 TRAINING BE PROVIDED IN NON-HOSPITAL
6 COMMUNITY-BASED CARE SETTING IN CERTAIN
7 AREAS.—The Secretary may waive the require-
8 ment under subparagraph (A)(ii) with respect
9 to eligible hospitals located in rural and medi-
10 cally underserved areas.

11 (7) SECRETARY.—The term “Secretary” means
12 the Secretary of Health and Human Services.

13 (c) FUNDING.—There is hereby appropriated to the
14 Secretary, out of any funds in the Treasury not otherwise
15 appropriated, \$50,000,000 for each of fiscal years 2012
16 through 2015 to carry out this section. Such amounts
17 shall remain available without fiscal year limitation.

18 **PART V—HEALTH INFORMATION TECHNOLOGY**

19 **SEC. 3041. FREE CLINICS AND CERTIFIED EHR TECH-**
20 **NOLOGY.**

21 (a) MEDICARE.—

22 (1) PAYMENT INCENTIVE.—Section 1848(o)(5)
23 of the Social Security Act (42 U.S.C. 1395w-
24 4(o)(5)) is amended—

1 (A) in subparagraph (C), by striking
2 “PROFESSIONAL.—The term” and inserting
3 “PROFESSIONAL.—

4 “(i) IN GENERAL.—The term”; and
5 (i) by adding at the end the following
6 new clause:

7 “(ii) CLARIFICATION.—Nothing in
8 this subsection shall prevent a physician
9 from being considered an eligible profes-
10 sional for purposes of this subsection as a
11 result of the physician furnishing items
12 and services in a free clinic.”; and

13 (B) by adding at the end the following new
14 subparagraph:

15 “(D) FREE CLINIC.—

16 “(i) IN GENERAL.—The term ‘free
17 clinic’ means a safety-net health care orga-
18 nization that—

19 “(I) uses volunteers to provide a
20 range of medical, dental, pharmacy, or
21 behavioral health services to economi-
22 cally disadvantaged individuals, the
23 majority of whom are uninsured or
24 underinsured; and

1 “(II) is an organization described
2 in section 501(c)(3) of the Internal
3 Revenue Code of 1986 and exempt
4 from tax under section 501(a) of such
5 Code or operates as a program or af-
6 filiate of an organization so described
7 and exempt.

8 “(ii) INCLUSION OF CERTAIN OTHER
9 ORGANIZATIONS.—An organization that
10 otherwise meets the definition under clause
11 (i), except that it charges a nominal fee to
12 patients, may still be considered a free
13 clinic for purposes of subparagraph (C)(ii)
14 if the organization provides essential serv-
15 ices regardless of the patient’s ability to
16 pay for such essential services.”.

17 (2) PAYMENT ADJUSTMENT.—Section
18 1848(a)(7)(E)(iii) of the Social Security Act (42
19 U.S.C. 1395w-4(a)(7)(E)(iii)) is amended—

20 (A) by striking “PROFESSIONAL.—The
21 term” and inserting “PROFESSIONAL.—The
22 term

23 “(I) IN GENERAL.—The term”;
24 and

1 (B) by adding at the end the following new
2 subclause:

3 “(II) CLARIFICATION.—Nothing
4 in this paragraph shall prevent a phy-
5 sician from being considered an eligi-
6 ble professional for purposes of this
7 paragraph as a result of the physician
8 furnishing items and services in a free
9 clinic (as defined in subsection
10 (o)(5)(D)).”.

11 (b) MEDICAID.—Section 1903(t)(3)(B) of the Social
12 Security Act (42 U.S.C. 1396b(t)(3)(B)) is amended by
13 adding at the end the following flush sentence:

14 “Nothing in this subsection or subsection
15 (a)(3)(F) shall prevent a Medicaid provider de-
16 scribed in clauses (i) through (v) from being
17 considered an eligible professional for purposes
18 of this subsection or subsection (a)(3)(F) as a
19 result of the Medicaid provider furnishing items
20 and services in a free clinic (as defined in sec-
21 tion 1848(o)(5)(D)).”.

1 **Subtitle B—Improving Medicare**
2 **for Patients and Providers**

3 **PART I—ENSURING BENEFICIARY ACCESS TO**
4 **PHYSICIAN CARE AND OTHER SERVICES**

5 **SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.**

6 Section 1848(d) of the Social Security Act (42 U.S.C.
7 1395w-4(d)) is amended by adding at the end the fol-
8 lowing new paragraph:

9 “(10) UPDATE FOR 2010.—

10 “(A) IN GENERAL.—Subject to paragraphs
11 (7)(B), (8)(B), and (9)(B), in lieu of the update
12 to the single conversion factor established in
13 paragraph (1)(C) that would otherwise apply
14 for 2010, the update to the single conversion
15 factor shall be 0.5 percent.

16 “(B) NO EFFECT ON COMPUTATION OF
17 CONVERSION FACTOR FOR 2011 AND SUBSE-
18 QUENT YEARS.—The conversion factor under
19 this subsection shall be computed under para-
20 graph (1)(A) for 2011 and subsequent years as
21 if subparagraph (A) had never applied.”.

1 **SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX**
2 **FLOOR AND REVISIONS TO THE PRACTICE**
3 **EXPENSE GEOGRAPHIC ADJUSTMENT UNDER**
4 **THE MEDICARE PHYSICIAN FEE SCHEDULE.**

5 (a) **EXTENSION OF WORK GPCI FLOOR.**—Section
6 1848(e)(1)(E) of the Social Security Act (42 U.S.C.
7 1395w-4(e)(1)(E)) is amended by striking “before Janu-
8 ary 1, 2010” and inserting “before January 1, 2013”.

9 (b) **PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT**
10 **FOR 2010 AND SUBSEQUENT YEARS.**—Section 1848(e)(1)
11 of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is
12 amended—

13 (1) in subparagraph (A), by striking “and (G)”
14 and inserting “(G), and (H)”; and

15 (2) by adding at the end the following new sub-
16 paragraph:

17 “(H) **PRACTICE EXPENSE GEOGRAPHIC**
18 **ADJUSTMENT FOR 2010 AND SUBSEQUENT**
19 **YEARS.**—

20 “(i) **FOR 2010.**—Subject to clause (iii),
21 for services furnished during 2010, the em-
22 ployee wage and rent portions of the prac-
23 tice expense geographic index described in
24 subparagraph (A)(i) shall reflect $\frac{3}{4}$ of the
25 difference between the relative costs of em-
26 ployee wages and rents in each of the dif-

1 ferent fee schedule areas and the national
2 average of such employee wages and rents.

3 “(ii) FOR 2011.—Subject to clause
4 (iii), for services furnished during 2011,
5 the employee wage and rent portions of the
6 practice expense geographic index de-
7 scribed in subparagraph (A)(i) shall reflect
8 $\frac{1}{2}$ of the difference between the relative
9 costs of employee wages and rents in each
10 of the different fee schedule areas and the
11 national average of such employee wages
12 and rents.

13 “(iii) HOLD HARMLESS.—The practice
14 expense portion of the geographic adjust-
15 ment factor applied in a fee schedule area
16 for services furnished in 2010 or 2011
17 shall not, as a result of the application of
18 clause (i) or (ii), be reduced below the
19 practice expense portion of the geographic
20 adjustment factor under subparagraph
21 (A)(i) (as calculated prior to the applica-
22 tion of such clause (i) or (ii), respectively)
23 for such area for such year.

24 “(iv) ANALYSIS.—The Secretary shall
25 analyze current methods of establishing

1 practice expense geographic adjustments
2 under subparagraph (A)(i) and evaluate
3 data that fairly and reliably establishes
4 distinctions in the costs of operating a
5 medical practice in the different fee sched-
6 ule areas. Such analysis shall include an
7 evaluation of the following:

8 “(I) The feasibility of using ac-
9 tual data or reliable survey data devel-
10 oped by medical organizations on the
11 costs of operating a medical practice,
12 including office rents and non-physi-
13 cian staff wages, in different fee
14 schedule areas.

15 “(II) The office expense portion
16 of the practice expense geographic ad-
17 justment described in subparagraph
18 (A)(i), including the extent to which
19 types of office expenses are deter-
20 mined in local markets instead of na-
21 tional markets.

22 “(III) The weights assigned to
23 each of the categories within the prac-
24 tice expense geographic adjustment
25 described in subparagraph (A)(i).

1 “(v) REVISION FOR 2012 AND SUBSE-
2 QUENT YEARS.—As a result of the analysis
3 described in clause (iv), the Secretary
4 shall, not later than January 1, 2012,
5 make appropriate adjustments to the prac-
6 tice expense geographic adjustment de-
7 scribed in subparagraph (A)(i) to ensure
8 accurate geographic adjustments across fee
9 schedule areas, including—

10 “(I) basing the office rents com-
11 ponent and its weight on office ex-
12 penses that vary among fee schedule
13 areas; and

14 “(II) considering a representative
15 range of professional and non-profes-
16 sional personnel employed in a med-
17 ical office based on the use of the
18 American Community Survey data or
19 other reliable data for wage adjust-
20 ments.

21 Such adjustments shall be made without
22 regard to adjustments made pursuant to
23 clauses (i) and (ii) and shall be made in a
24 budget neutral manner.

1 “(vi) SPECIAL RULE.—If the Sec-
2 retary does not complete the analysis de-
3 scribed in clause (iv) and make any adjust-
4 ments the Secretary determines appro-
5 priate for 2012 or a subsequent year under
6 clause (v), the Secretary shall apply
7 clauses (ii) and (iii) for services furnished
8 during 2012 or a subsequent year in the
9 same manner as such clauses apply for
10 services furnished during 2011.”.

11 **SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR**
12 **MEDICARE THERAPY CAPS.**

13 Section 1833(g)(5) of the Social Security Act (42
14 U.S.C. 1395l(g)(5)) is amended by striking “December
15 31, 2009” and inserting “December 31, 2011”.

16 **SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COM-**
17 **PONENT OF CERTAIN PHYSICIAN PATHOL-**
18 **OGY SERVICES.**

19 Section 542(c) of the Medicare, Medicaid, and
20 SCHIP Benefits Improvement and Protection Act of 2000
21 (as enacted into law by section 1(a)(6) of Public Law 106–
22 554), as amended by section 732 of the Medicare Prescrip-
23 tion Drug, Improvement, and Modernization Act of 2003
24 (42 U.S.C. 1395w–4 note), section 104 of division B of
25 the Tax Relief and Health Care Act of 2006 (42 U.S.C.

1 1395w-4 note), section 104 of the Medicare, Medicaid,
2 and SCHIP Extension Act of 2007 (Public Law 110-
3 173), and section 136 of the Medicare Improvements for
4 Patients and Providers Act of 2008 (Public Law 110-
5 275), is amended by striking “and 2009” and inserting
6 “2009, 2010, and 2011”.

7 **SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.**

8 (a) **GROUND AMBULANCE.**—Section 1834(l)(13)(A)
9 of the Social Security Act (42 U.S.C. 1395m(l)(13)(A))
10 is amended—

11 (1) in the matter preceding clause (i), by strik-
12 ing “before January 1, 2010” and inserting “before
13 January 1, 2012”; and

14 (2) in each of clauses (i) and (ii), by striking
15 “before January 1, 2010” and inserting “before
16 January 1, 2012”.

17 (b) **AIR AMBULANCE.**—Section 146(b)(1) of the
18 Medicare Improvements for Patients and Providers Act of
19 2008 (Public Law 110-275) is amended by striking “end-
20 ing on December 31, 2009” and inserting “ending on De-
21 cember 31, 2011”.

22 (c) **SUPER RURAL AMBULANCE.**—Section
23 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
24 1395m(l)(12)(A)) is amended by striking “2010” and in-
25 serting “2012”.

1 **SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR**
2 **LONG-TERM CARE HOSPITAL SERVICES AND**
3 **OF MORATORIUM ON THE ESTABLISHMENT**
4 **OF CERTAIN HOSPITALS AND FACILITIES.**

5 (a) **EXTENSION OF CERTAIN PAYMENT RULES.**—
6 Section 114(c) of the Medicare, Medicaid, and SCHIP Ex-
7 tension Act of 2007 (42 U.S.C. 1395ww note) is amended
8 by striking “3-year period” each place it appears and in-
9 serting “5-year period”.

10 (b) **EXTENSION OF MORATORIUM.**—Section
11 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the
12 matter preceding subparagraph (A), is amended by strik-
13 ing “3-year period” and inserting “5-year period”.

14 **SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**
15 **TAL HEALTH ADD-ON.**

16 Section 138(a)(1) of the Medicare Improvements for
17 Patients and Providers Act of 2008 (Public Law 110–275)
18 is amended by striking “December 31, 2009” and insert-
19 ing “December 31, 2011”.

1 **SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER**
2 **POST-HOSPITAL EXTENDED CARE SERVICES**
3 **AND TO PROVIDE FOR RECOGNITION OF AT-**
4 **TENDING PHYSICIAN ASSISTANTS AS AT-**
5 **TENDING PHYSICIANS TO SERVE HOSPICE**
6 **PATIENTS.**

7 (a) ORDERING POST-HOSPITAL EXTENDED CARE
8 SERVICES.—

9 (1) IN GENERAL.—Section 1814(a)(2) of the
10 Social Security Act (42 U.S.C. 1395f(a)(2)), in the
11 matter preceding subparagraph (A), is amended by
12 striking “nurse practitioner or clinical nurse spe-
13 cialist” and inserting “nurse practitioner, a clinical
14 nurse specialist, or a physician assistant (as those
15 terms are defined in section 1861(aa)(5))”.

16 (2) CONFORMING AMENDMENT.—Section
17 1814(a) of the Social Security Act (42 U.S.C.
18 1395f(a)) is amended, in the second sentence, by
19 striking “or clinical nurse specialist” and inserting
20 “clinical nurse specialist, or physician assistant”.

21 (b) RECOGNITION OF ATTENDING PHYSICIAN AS-
22 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-
23 PICE PATIENTS.—

24 (1) IN GENERAL.—Section 1861(dd)(3)(B) of
25 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))
26 is amended—

1 (A) by striking “or nurse” and inserting “,
2 the nurse”; and

3 (B) by inserting “, or the physician assist-
4 ant (as defined in such subsection)” after “sub-
5 section (aa)(5)”.

6 (2) CLARIFICATION OF HOSPICE ROLE OF PHY-
7 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of
8 the Social Security Act (42 U.S.C.
9 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a
10 physician assistant” after “a nurse practitioner”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to items and services furnished on
13 or after January 1, 2011.

14 **SEC. 3109. RECOGNITION OF CERTIFIED DIABETES EDU-**
15 **CATORS AS CERTIFIED PROVIDERS FOR PUR-**
16 **POSES OF MEDICARE DIABETES OUTPATIENT**
17 **SELF-MANAGEMENT TRAINING SERVICES.**

18 (a) IN GENERAL.—Section 1861(qq) of the Social Se-
19 curity Act (42 U.S.C. 1395x(qq)) is amended—

20 (1) in paragraph (1), by inserting “or by a cer-
21 tified diabetes educator (as defined in paragraph
22 (3))” after “paragraph (2)(B)”; and

23 (2) by adding at the end the following new
24 paragraphs:

1 “(3) For purposes of paragraph (1), the term
2 ‘certified diabetes educator’ means an individual
3 who—

4 “(A) is licensed or registered by the State
5 in which the services are performed as a health
6 care professional;

7 “(B) specializes in teaching individuals
8 with diabetes to develop the necessary skills and
9 knowledge to manage the individual’s diabetic
10 condition; and

11 “(C) is certified as a diabetes educator by
12 a recognized certifying body (as defined in
13 paragraph (4)).

14 “(4)(A) For purposes of paragraph (3)(C), the
15 term ‘recognized certifying body’ means—

16 “(i) the National Certification Board
17 for Diabetes Educators, or

18 “(ii) a certifying body for diabetes
19 educators, which is recognized by the Sec-
20 retary as authorized to grant certification
21 of diabetes educators for purposes of this
22 subsection pursuant to standards estab-
23 lished by the Secretary,

1 if the Secretary determines such Board or body,
2 respectively, meets the requirement of subpara-
3 graph (B).

4 “(B) The National Certification Board for
5 Diabetes Educators or a certifying body for dia-
6 betes educators meets the requirement of this
7 subparagraph, with respect to the certification
8 of an individual, if the Board or body, respec-
9 tively, is incorporated and registered to do busi-
10 ness in the United States and requires as a
11 condition of such certification each of the fol-
12 lowing:

13 “(i) The individual has a qualifying
14 credential in a specified health care profes-
15 sion.

16 “(ii) The individual has professional
17 practice experience in diabetes self-man-
18 agement training that includes a minimum
19 number of hours and years of experience in
20 such training.

21 “(iii) The individual has successfully
22 completed a national certification examina-
23 tion offered by such entity.

1 graph (F)(i) with respect to phar-
2 macies described in clause (ii) fur-
3 nishing such items and services, such
4 standards and accreditation require-
5 ment shall not apply to such phar-
6 macies; and

7 “(II) the Secretary may apply to
8 such pharmacies an alternative ac-
9 creditation requirement established by
10 the Secretary if the Secretary deter-
11 mines such alternative accreditation
12 requirement is more appropriate for
13 such pharmacies.

14 “(ii) PHARMACIES DESCRIBED.—A
15 pharmacy described in this clause is a
16 pharmacy that meets each of the following
17 criteria:

18 “(I) The total billings by the
19 pharmacy for such items and services
20 under this title are less than 5 percent
21 of total pharmacy sales, as determined
22 based on the average total pharmacy
23 sales for the previous 3 calendar
24 years, 3 fiscal years, or other yearly
25 period specified by the Secretary.

1 “(II) The pharmacy has been en-
2 rolled under section 1866(j) as a sup-
3 plier of durable medical equipment,
4 prosthetics, orthotics, and supplies,
5 has been issued (which may include
6 the renewal of) a provider number for
7 at least 5 years, and for which a final
8 adverse action (as defined in section
9 424.57(a) of title 42, Code of Federal
10 Regulations) has not been imposed in
11 the past 5 years.

12 “(III) The pharmacy submits to
13 the Secretary an attestation, in a
14 form and manner, and at a time,
15 specified by the Secretary, that the
16 pharmacy meets the criteria described
17 in subclauses (I) and (II). Such attes-
18 tation shall be subject to section 1001
19 of title 18, United States Code.

20 “(IV) The pharmacy agrees to
21 submit materials as requested by the
22 Secretary, or during the course of an
23 audit conducted on a random sample
24 of pharmacies selected annually, to
25 verify that the pharmacy meets the

1 criteria described in subclauses (I)
2 and (II). Materials submitted under
3 the preceding sentence shall include a
4 certification by an accountant on be-
5 half of the pharmacy or the submis-
6 sion of tax returns filed by the phar-
7 macy during the relevant periods, as
8 requested by the Secretary.”.

9 (b) EFFECTIVE DATE.—

10 (1) IN GENERAL.—The amendments made by
11 this section shall apply to items or services furnished
12 on or after January 1, 2010.

13 (2) ADMINISTRATION.—Notwithstanding any
14 other provision of law, the Secretary may implement
15 the amendments made by subsection (a) by program
16 instruction or otherwise.

17 **SEC. 3111. PART B SPECIAL ENROLLMENT PERIOD FOR DIS-**
18 **ABLED TRICARE BENEFICIARIES.**

19 (a) IN GENERAL.—

20 (1) IN GENERAL.—Section 1837 of the Social
21 Security Act (42 U.S.C. 1395p) is amended by add-
22 ing at the end the following new subsection:

23 “(1)(1) In the case of any individual who is a covered
24 beneficiary (as defined in section 1072(5) of title 10,
25 United States Code) at the time the individual is entitled

1 to part A under section 226(b) or section 226A and who
2 is eligible to enroll but who has elected not to enroll (or
3 to be deemed enrolled) during the individual's initial en-
4 rollment period, there shall be a special enrollment period
5 described in paragraph (2).

6 “(2) The special enrollment period described in this
7 paragraph, with respect to an individual, is the 12-month
8 period beginning on the day after the last day of the initial
9 enrollment period of the individual or, if later, the 12-
10 month period beginning with the month the individual is
11 notified of enrollment under this section.

12 “(3) In the case of an individual who enrolls during
13 the special enrollment period provided under paragraph
14 (1), the coverage period under this part shall begin on the
15 first day of the month in which the individual enrolls, or,
16 at the option of the individual, the first month after the
17 end of the individual's initial enrollment period.

18 “(4) An individual may only enroll during the special
19 enrollment period provided under paragraph (1) one time
20 during the individual's lifetime.

21 “(5) The Secretary shall ensure that the materials
22 relating to coverage under this part that are provided to
23 an individual described in paragraph (1) prior to the indi-
24 vidual's initial enrollment period contain information con-
25 cerning the impact of not enrolling under this part, includ-

1 ing the impact on health care benefits under the
2 TRICARE program under chapter 55 of title 10, United
3 States Code.

4 “(6) The Secretary of Defense shall collaborate with
5 the Secretary of Health and Human Services and the
6 Commissioner of Social Security to provide for the accu-
7 rate identification of individuals described in paragraph
8 (1). The Secretary of Defense shall provide such individ-
9 uals with notification with respect to this subsection. The
10 Secretary of Defense shall collaborate with the Secretary
11 of Health and Human Services and the Commissioner of
12 Social Security to ensure appropriate follow up pursuant
13 to any notification provided under the preceding sen-
14 tence.”.

15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply to elections made with
17 respect to initial enrollment periods that end after
18 the date of the enactment of this Act.

19 (b) WAIVER OF INCREASE OF PREMIUM.—Section
20 1839(b) of the Social Security Act (42 U.S.C. 1395r(b))
21 is amended by striking “section 1837(i)(4)” and inserting
22 “subsection (i)(4) or (l) of section 1837”.

23 **SEC. 3112. PAYMENT FOR BONE DENSITY TESTS.**

24 (a) PAYMENT.—

1 (1) IN GENERAL.—Section 1848 of the Social
2 Security Act (42 U.S.C. 1395w-4) is amended—

3 (A) in subsection (b)—

4 (i) in paragraph (4)(B), by inserting
5 “, and for 2010 and 2011, dual-energy x-
6 ray absorptiometry services (as described
7 in paragraph (6))” before the period at the
8 end; and

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

11 “(6) TREATMENT OF BONE MASS SCANS.—For
12 dual-energy x-ray absorptiometry services (identified
13 in 2006 by HCPCS codes 76075 and 76077 (and
14 any succeeding codes)) furnished during 2010 and
15 2011, instead of the payment amount that would
16 otherwise be determined under this section for such
17 years, the payment amount shall be equal to 70 per-
18 cent of the product of—

19 “(A) the relative value for the service (as
20 determined in subsection (c)(2)) for 2006;

21 “(B) the conversion factor (established
22 under subsection (d)) for 2006; and

23 “(C) the geographic adjustment factor (es-
24 tablished under subsection (e)(2)) for the serv-

1 ice for the fee schedule area for 2010 and 2011,
2 respectively.”; and

3 (B) in subsection (c)(2)(B)(iv)—

4 (i) in subclause (II), by striking
5 “and” at the end;

6 (ii) in subclause (III), by striking the
7 period at the end and inserting “; and”;
8 and

9 (iii) by adding at the end the fol-
10 lowing new subclause:

11 “(IV) subsection (b)(6) shall not
12 be taken into account in applying
13 clause (ii)(II) for 2010 or 2011.”.

14 (2) IMPLEMENTATION.—Notwithstanding any
15 other provision of law, the Secretary may implement
16 the amendments made by paragraph (1) by program
17 instruction or otherwise.

18 (b) STUDY AND REPORT BY THE INSTITUTE OF
19 MEDICINE.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services is authorized to enter into an
22 agreement with the Institute of Medicine of the Na-
23 tional Academies to conduct a study on the ramifica-
24 tions of Medicare payment reductions for dual-en-
25 ergy x-ray absorptiometry (as described in section

1 1848(b)(6) of the Social Security Act, as added by
2 subsection (a)(1)) during 2007, 2008, and 2009 on
3 beneficiary access to bone mass density tests.

4 (2) REPORT.—An agreement entered into under
5 paragraph (1) shall provide for the Institute of Med-
6 icine to submit to the Secretary and to Congress a
7 report containing the results of the study conducted
8 under such paragraph.

9 **SEC. 3113. REVISION TO THE MEDICARE IMPROVEMENT**
10 **FUND.**

11 Section 1898(b)(1)(A) of the Social Security Act (42
12 U.S.C. 1395iii) is amended by striking
13 “\$22,290,000,000” and inserting “\$0”.

14 **SEC. 3114. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC**
15 **LABORATORY TESTS.**

16 (a) TREATMENT.—

17 (1) IN GENERAL.—Notwithstanding sections
18 1862(a)(14) and 1866(a)(1)(H)(i) of the Social Se-
19 curity Act (42 U.S.C. 1395y(a)(14) and
20 1395cc(a)(1)(H)(i)), in the case that a laboratory
21 performs a covered complex diagnostic laboratory
22 test, with respect to a specimen collected from an in-
23 dividual during a period in which the individual is a
24 patient of a hospital, if the test is performed after
25 such period the Secretary of Health and Human

1 Services shall treat such test, for purposes of pro-
2 viding direct payment to the laboratory under sec-
3 tion 1833(h) or 1848 of such Act (42 U.S.C.
4 1395l(h) or 1395w-4), as if such specimen had been
5 collected directly by the laboratory.

6 (2) COVERED COMPLEX DIAGNOSTIC LABORA-
7 TORY TEST DEFINED.—For purposes of paragraph
8 (1), the term “covered complex diagnostic laboratory
9 test” means a diagnostic laboratory test that—

10 (A) is an analysis of gene or protein ex-
11 pression, topographic genotyping, or a cancer
12 chemotherapy sensitivity assay;

13 (B) is described in section 1861(s)(3) of
14 the Social Security Act (42 U.S.C.
15 1395x(s)(3));

16 (C) is performed only by the laboratory of-
17 fering the test; and

18 (D) is not furnished by the hospital where
19 the specimen was collected to a patient of such
20 hospital, directly or under arrangements (as de-
21 fined in section 1861(w)(1) of such Act (42
22 U.S.C. 1395x(w)(1))) made by such hospital.

23 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The provisions of subsection
2 (a) shall apply to tests furnished on or after July 1,
3 2011, and before the earlier of—

4 (A) July 1, 2013; and

5 (B) the date that the Chief Actuary of the
6 Centers for Medicare & Medicaid Services sub-
7 mits a report to the Committee on Ways and
8 Means and the Committee on Energy and Com-
9 merce of the House of Representatives and the
10 Committee on Finance of the Senate and to the
11 Secretary of Health and Human Services pur-
12 suant to paragraph (2).

13 (2) REPORT IF SPENDING LIMIT REACHED.—

14 (A) IN GENERAL.—The Chief Actuary of
15 the Centers for Medicare & Medicaid Services
16 shall monitor expenditures under title XVIII of
17 the Social Security Act during the 2-year period
18 beginning on July 1, 2011 by reason of the pro-
19 visions of subsection (a). If the Chief Actuary
20 determines that either of the conditions de-
21 scribed in subparagraph (B) have been met
22 with respect to such 2-year period, the Chief
23 Actuary shall submit a report to the Committee
24 on Ways and Means and the Committee on En-
25 ergy and Commerce of the House of Represent-

1 atives and the Committee on Finance of the
2 Senate and to the Secretary of Health and
3 Human Services that includes a statement re-
4 garding such determination.

5 (B) CONDITIONS.—The conditions de-
6 scribed in this subparagraph are, with respect
7 to the 2-year period described in subparagraph
8 (A), the following conditions:

9 (i) That expenditures under title
10 XVIII of the Social Security Act during
11 such period by reason of the provisions of
12 subsection (a) have reached \$100,000,000.

13 (ii) That payments to laboratories
14 under such title during such period by rea-
15 son of such provisions have reached
16 \$100,000,000.

17 **SEC. 3115. IMPROVED ACCESS FOR CERTIFIED-MIDWIFE**
18 **SERVICES.**

19 Section 1833(a)(1)(K) of the Social Security Act (42
20 U.S.C. 1395l(a)(1)(K)) is amended by inserting “(or 100
21 percent for services furnished on or after January 1,
22 2011)” after “1992, 65 percent”.

1 **SEC. 3116. WORKING GROUP ON ACCESS TO EMERGENCY**
2 **MEDICAL CARE.**

3 (a) **IN GENERAL.**—Not later than 60 days after the
4 date of enactment of this Act, the Secretary of Health and
5 Human Services (referred to in this section as the “Sec-
6 retary”) shall establish a Working Group on Access to
7 Emergency Medical Care (referred to in this section as
8 the “working group”).

9 (b) **MEMBERSHIP.**—The membership of the working
10 group shall include not less than 2 individuals from each
11 of the following:

12 (1) Representatives of emergency room physi-
13 cians, emergency room nurses, and other health care
14 professionals who provide emergency medical serv-
15 ices.

16 (2) Elected or appointed officials (at the Fed-
17 eral, State, and local levels) who are involved in pro-
18 grams and issues relating to the provision of emer-
19 gency medical services.

20 (3) Health care consumer advocates.

21 (4) Representatives of hospitals and health sys-
22 tems that provide emergency medical services.

23 (c) **COMPENSATION.**—The members shall serve with-
24 out compensation.

25 (d) **ADMINISTRATIVE SUPPORT.**—The Department of
26 Health and Human Services shall provide appropriate ad-

1 ministrative support and technical assistance to the work-
2 ing group. The working group may use the facilities of
3 the Department of Health and Human Services, with or
4 without reimbursement (as determined by the Secretary).

5 (e) DUTIES.—

6 (1) STUDY.—The working group shall identify
7 and examine—

8 (A) barriers contributing to delays in time-
9 ly processing of patients requiring admission as
10 an inpatient of a hospital who initially sought
11 care through the emergency department of such
12 hospital;

13 (B) factors in the health care delivery, fi-
14 nancing, and legal systems that impede or pre-
15 vent effective delivery of screening and sta-
16 bilization services furnished in hospitals that
17 have emergency departments pursuant to the
18 requirements under section 1867 of the Social
19 Security Act (42 U.S.C. 1395dd) (commonly re-
20 ferred to as the “Emergency Medical Treat-
21 ment and Labor Act” or “EMTALA”); and

22 (C) best practices to improve patient flow
23 within hospitals.

24 (2) RECOMMENDATIONS.—The working group
25 shall develop recommendations for admission, board-

1 ing, and diversion standards for hospitals to follow
2 in the delivery of emergency care to patients, as well
3 as relevant guidelines, measures, and incentives to
4 ensure proper implementation, monitoring, and en-
5 forcement of such standards.

6 (f) REPORT.—Not later than 18 months after estab-
7 lishment of the working group under subsection (a), the
8 working group shall submit to Congress and the Secretary
9 a report containing a detailed description of the rec-
10 ommended standards, guidelines, measures, and incentives
11 developed under subsection (e)(2), any best practices iden-
12 tified under subsection (e)(1)(C), and recommendations
13 for such legislative and administrative actions as the work-
14 ing group considers appropriate, including recommenda-
15 tions regarding—

16 (1) Federal programs, policies, and financing
17 needed to assure the availability of screening and
18 stabilization services furnished in hospitals that have
19 emergency departments pursuant to EMTALA (as
20 described under subsection (e)(1)(B)); and

21 (2) coordination of Federal, State, and local
22 programs for responding to disasters and emer-
23 gencies.

1 (g) TERMINATION.—The working group shall termi-
2 nate upon submission of the report described under sub-
3 section (f).

4 **PART II—RURAL PROTECTIONS**

5 **SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS**
6 **PROVISION.**

7 (a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the
8 Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is
9 amended—

10 (1) in subclause (II)—

11 (A) in the first sentence, by striking
12 “2010” and inserting “2012”; and

13 (B) in the second sentence, by striking “or
14 2009” and inserting “, 2009, 2010, or 2011”;
15 and

16 (2) in subclause (III), by striking “January 1,
17 2010” and inserting “January 1, 2012”.

18 (b) PERMITTING ALL SOLE COMMUNITY HOSPITALS
19 TO BE ELIGIBLE FOR HOLD HARMLESS.—Section
20 1833(t)(7)(D)(i)(III) of the Social Security Act (42
21 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at
22 the end the following new sentence: “In the case of covered
23 OPD services furnished on or after January 1, 2010, and
24 before January 1, 2012, the preceding sentence shall be
25 applied without regard to the 100-bed limitation.”.

1 **SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS**
2 **PAYMENTS FOR CERTAIN CLINICAL DIAG-**
3 **NOSTIC LABORATORY TESTS FURNISHED TO**
4 **HOSPITAL PATIENTS IN CERTAIN RURAL**
5 **AREAS.**

6 Section 416(b) of the Medicare Prescription Drug,
7 Improvement, and Modernization Act of 2003 (42 U.S.C.
8 1395l-4), as amended by section 105 of division B of the
9 Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l
10 note) and section 107 of the Medicare, Medicaid, and
11 SCHIP Extension Act of 2007 (42 U.S.C. 1395l note),
12 is amended by inserting “or during the 2-year period be-
13 ginning on July 1, 2010” before the period at the end.

14 **SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOS-**
15 **PITAL DEMONSTRATION PROGRAM.**

16 (a) **TWO-YEAR EXTENSION.**—Section 410A of the
17 Medicare Prescription Drug, Improvement, and Mod-
18 ernization Act of 2003 (Public Law 108-173; 117 Stat.
19 2272) is amended by adding at the end the following new
20 subsection:

21 “(g) **TWO-YEAR EXTENSION OF DEMONSTRATION**
22 **PROGRAM.**—

23 “(1) **IN GENERAL.**—Subject to the succeeding
24 provisions of this subsection, the Secretary shall con-
25 duct the demonstration program under this section
26 for an additional 2-year period (in this section re-

1 ferred to as the ‘2-year extension period’) that be-
2 gins on the date immediately following the last day
3 of the initial 5-year period under subsection (a)(5).

4 “(2) EXPANSION OF DEMONSTRATION
5 STATES.—Notwithstanding subsection (a)(2), during
6 the 2-year extension period, the program shall be
7 conducted in rural areas in any State.

8 “(3) INCREASE IN MAXIMUM NUMBER OF HOS-
9 PITALS PARTICIPATING IN THE DEMONSTRATION
10 PROGRAM.—Notwithstanding subsection (a)(4), dur-
11 ing the 2-year extension period, not more than 30
12 rural community hospitals may participate in the
13 demonstration program under this section.

14 “(4) NO AFFECT ON HOSPITALS IN DEM-
15 ONSTRATION PROGRAM ON DATE OF ENACTMENT.—
16 In the case of a rural community hospital that is
17 participating in the demonstration program under
18 this section as of the last day of the initial 5-year
19 period, the Secretary shall provide for the continued
20 participation of such rural community hospital in
21 the demonstration program during the 2-year exten-
22 sion period unless the rural community hospital
23 makes an election, in such form and manner as the
24 Secretary may specify, to discontinue such participa-
25 tion.”.

1 (b) CONFORMING AMENDMENTS.—Subsection (a)(5)
2 of section 410A of the Medicare Prescription Drug, Im-
3 provement, and Modernization Act of 2003 (Public Law
4 108–173; 117 Stat. 2272) is amended by inserting “(in
5 this section referred to as the ‘initial 5-year period’) and,
6 as provided in subsection (g), for the 2-year extension pe-
7 riod” after “5-year period”.

8 (c) TECHNICAL AMENDMENTS.—

9 (1) Subsection (b) of section 410A of the Medi-
10 care Prescription Drug, Improvement, and Mod-
11 ernization Act of 2003 (Public Law 108–173; 117
12 Stat. 2272) is amended—

13 (A) in paragraph (1)(B)(ii), by striking
14 “2)” and inserting “2))”; and

15 (B) in paragraph (2), by inserting “cost”
16 before “reporting period” the first place such
17 term appears in each of subparagraphs (A) and
18 (B).

19 (2) Subsection (f)(1) of section 410A of the
20 Medicare Prescription Drug, Improvement, and
21 Modernization Act of 2003 (Public Law 108–173;
22 117 Stat. 2272) is amended—

23 (A) in subparagraph (A)(ii), by striking
24 “paragraph (2)” and inserting “subparagraph
25 (B)”; and

1 (B) in subparagraph (B), by striking
2 “paragraph (1)(B)” and inserting “subpara-
3 graph (A)(ii)”.

4 **SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT**
5 **HOSPITAL (MDH) PROGRAM.**

6 (a) EXTENSION OF PAYMENT METHODOLOGY.—Sec-
7 tion 1886(d)(5)(G) of the Social Security Act (42 U.S.C.
8 1395ww(d)(5)(G)) is amended—

9 (1) in clause (i), by striking “October 1, 2011”
10 and inserting “October 1, 2013”; and

11 (2) in clause (ii)(II), by striking “October 1,
12 2011” and inserting “October 1, 2013”.

13 (b) CONFORMING AMENDMENTS.—

14 (1) EXTENSION OF TARGET AMOUNT.—Section
15 1886(b)(3)(D) of the Social Security Act (42 U.S.C.
16 1395ww(b)(3)(D)) is amended—

17 (A) in the matter preceding clause (i), by
18 striking “October 1, 2011” and inserting “Oc-
19 tober 1, 2013”; and

20 (B) in clause (iv), by striking “through fis-
21 cal year 2011” and inserting “through fiscal
22 year 2013”.

23 (2) PERMITTING HOSPITALS TO DECLINE RE-
24 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
25 bus Budget Reconciliation Act of 1993 (42 U.S.C.

1 1395ww note) is amended by striking “through fis-
2 cal year 2011” and inserting “through fiscal year
3 2013”.

4 **SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE**
5 **INPATIENT HOSPITAL PAYMENT ADJUST-**
6 **MENT FOR LOW-VOLUME HOSPITALS.**

7 Section 1886(d)(12) of the Social Security Act (42
8 U.S.C. 1395ww(d)(12)) is amended—

9 (1) in subparagraph (A), by inserting “or (D)”
10 after “subparagraph (B)”;

11 (2) in subparagraph (B), in the matter pre-
12 ceding clause (i), by striking “The Secretary” and
13 inserting “For discharges occurring in fiscal years
14 2005 through 2010 and for discharges occurring in
15 fiscal year 2013 and subsequent fiscal years, the
16 Secretary”;

17 (3) in subparagraph (C)(i)—

18 (A) by inserting “(or, with respect to fiscal
19 years 2011 and 2012, 15 road miles)” after
20 “25 road miles”; and

21 (B) by inserting “(or, with respect to fiscal
22 years 2011 and 2012, 1,500 discharges of indi-
23 viduals entitled to, or enrolled for, benefits
24 under part A)” after “800 discharges”; and

1 (4) by adding at the end the following new sub-
2 paragraph:

3 “(D) TEMPORARY APPLICABLE PERCENT-
4 AGE INCREASE.—For discharges occurring in
5 fiscal years 2011 and 2012, the Secretary shall
6 determine an applicable percentage increase for
7 purposes of subparagraph (A) using a contin-
8 uous linear sliding scale ranging from 25 per-
9 cent for low-volume hospitals with 200 or fewer
10 discharges of individuals entitled to, or enrolled
11 for, benefits under part A in the fiscal year to
12 0 percent for low-volume hospitals with greater
13 than 1,500 discharges of such individuals in the
14 fiscal year.”.

15 **SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION**
16 **PROJECT ON COMMUNITY HEALTH INTEGRA-**
17 **TION MODELS IN CERTAIN RURAL COUNTIES.**

18 (a) REMOVAL OF LIMITATION ON NUMBER OF ELIGI-
19 BLE COUNTIES SELECTED.—Subsection (d)(3) of section
20 123 of the Medicare Improvements for Patients and Pro-
21 viders Act of 2008 (42 U.S.C. 1395i–4 note) is amended
22 by striking “not more than 6”.

23 (b) REMOVAL OF REFERENCES TO RURAL HEALTH
24 CLINIC SERVICES AND INCLUSION OF PHYSICIANS’ SERV-

1 ICES IN SCOPE OF DEMONSTRATION PROJECT.—Such
2 section 123 is amended—

3 (1) in subsection (d)(4)(B)(i)(3), by striking
4 subclause (III); and

5 (2) in subsection (j)—

6 (A) in paragraph (8), by striking subpara-
7 graph (B) and inserting the following:

8 “(B) Physicians’ services (as defined in
9 section 1861(q) of the Social Security Act (42
10 U.S.C. 1395x(q)).”;

11 (B) by striking paragraph (9); and

12 (C) by redesignating paragraph (10) as
13 paragraph (9).

14 **SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE**
15 **PAYMENTS FOR HEALTH CARE PROVIDERS**
16 **SERVING IN RURAL AREAS.**

17 (a) STUDY.—The Medicare Payment Advisory Com-
18 mission shall conduct a study on the adequacy of pay-
19 ments for items and services furnished by providers of
20 services and suppliers in rural areas under the Medicare
21 program under title XVIII of the Social Security Act (42
22 U.S.C. 1395 et seq.). Such study shall include an analysis
23 of—

1 (1) any adjustments in payments to providers
2 of services and suppliers that furnish items and
3 services in rural areas;

4 (2) access by Medicare beneficiaries to items
5 and services in rural areas;

6 (3) the adequacy of payments to providers of
7 services and suppliers that furnish items and serv-
8 ices in rural areas; and

9 (4) the quality of care furnished in rural areas.

10 (b) REPORT.—Not later than January 1, 2011, the
11 Medicare Payment Advisory Commission shall submit to
12 Congress a report containing the results of the study con-
13 ducted under subsection (a). Such report shall include rec-
14 ommendations on appropriate modifications to any adjust-
15 ments in payments to providers of services and suppliers
16 that furnish items and services in rural areas, together
17 with recommendations for such legislation and administra-
18 tive action as the Medicare Payment Advisory Commission
19 determines appropriate.

20 **SEC. 3128. TECHNICAL CORRECTION RELATED TO CRIT-**
21 **ICAL ACCESS HOSPITAL SERVICES.**

22 (a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8)
23 of section 1834 of the Social Security Act (42 U.S.C.
24 1395m) are each amended by inserting “101 percent of”
25 before “the reasonable costs”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall take effect as if included in the enact-
3 ment of section 405(a) of the Medicare Prescription Drug,
4 Improvement, and Modernization Act of 2003 (Public Law
5 108–173; 117 Stat. 2266).

6 **SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE**
7 **RURAL HOSPITAL FLEXIBILITY PROGRAM.**

8 (a) AUTHORIZATION.—Section 1820(j) of the Social
9 Security Act (42 U.S.C. 1395i–4(j)) is amended—

10 (1) by striking “2010, and for” and inserting
11 “2010, for”; and

12 (2) by inserting “and for making grants to all
13 States under subsection (g), such sums as may be
14 necessary in each of fiscal years 2011 and 2012, to
15 remain available until expended” before the period
16 at the end.

17 (b) USE OF FUNDS.—Section 1820(g)(3) of the So-
18 cial Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

19 (1) in subparagraph (A), by inserting “and to
20 assist such hospitals in participating in delivery sys-
21 tem reforms under the provisions of and amend-
22 ments made by the America’s Healthy Future Act of
23 2009, such as value-based purchasing programs, ac-
24 countable care organizations under section 1899, the
25 National pilot program on payment bundling under

1 section 1866D, and other delivery system reform
2 programs determined appropriate by the Secretary”
3 before the period at the end; and

4 (2) in subparagraph (E)—

5 (A) by striking “, and to offset” and in-
6 serting “, to offset”; and

7 (B) by inserting “and to participate in de-
8 livery system reforms under the provisions of
9 and amendments made by the America’s
10 Healthy Future Act of 2009, such as value-
11 based purchasing programs, accountable care
12 organizations under section 1899, the National
13 pilot program on payment bundling under sec-
14 tion 1866D, and other delivery system reform
15 programs determined appropriate by the Sec-
16 retary” before the period at the end.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to grants made on or after January
19 1, 2010.

20 **PART III—IMPROVING PAYMENT ACCURACY**

21 **SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH** 22 **CARE.**

23 (a) REBASING HOME HEALTH PROSPECTIVE PAY-
24 MENT AMOUNT.—

1 ceding sentence, the Secretary shall
2 consider differences between hospital-
3 based and freestanding agencies, be-
4 tween for-profit and nonprofit agen-
5 cies, and between the resource costs of
6 urban and rural agencies. Such ad-
7 justment shall be made before the up-
8 date under subparagraph (B) is ap-
9 plied for the year.

10 “(II) TRANSITION.—The Sec-
11 retary shall provide for a 4-year
12 phase-in (in equal increments) of the
13 adjustment under subclause (I), with
14 such adjustment being fully imple-
15 mented for 2016. During each year of
16 such phase-in, the amount of any ad-
17 justment under subclause (I) for the
18 year may not exceed 3.5 percent of
19 the amount (or amounts) applicable
20 under clause (i)(III) as of the date of
21 enactment of the America’s Healthy
22 Future Act of 2009.”.

23 (2) MEDPAC STUDY AND REPORT.—

24 (A) STUDY.—The Medicare Payment Advi-
25 sory Commission shall conduct a study on the

1 implementation of the amendments made by
2 paragraph (1). Such study shall include an
3 analysis of the impact of such amendments
4 on—

- 5 (i) access to care;
- 6 (ii) quality outcomes;
- 7 (iii) the number of home health agen-
8 cies; and
- 9 (iv) rural agencies, urban agencies,
10 for-profit agencies, and nonprofit agencies.

11 (B) REPORT.—Not later than January 1,
12 2015, the Medicare Payment Advisory Commis-
13 sion shall submit to Congress a report on the
14 study conducted under subparagraph (A), to-
15 gether with recommendations for such legisla-
16 tion and administrative action as the Commis-
17 sion determines appropriate.

18 (b) PROGRAM-SPECIFIC OUTLIER CAP.—Section
19 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b))
20 is amended—

21 (1) in paragraph (3)(C), by striking “the aggre-
22 gate” and all that follows through the period at the
23 end and inserting “5 percent of the total payments
24 estimated to be made based on the prospective pay-

1 ment system under this subsection for the period.”;
2 and

3 (2) in paragraph (5)—

4 (A) by striking “OUTLIER.—The Sec-
5 retary” and inserting the following:

6 “OUTLIER.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graphs (B) and (C), the Secretary”;

9 (B) in subparagraph (A), as added by sub-
10 paragraph (A), by striking “5 percent” and in-
11 serting “2.5 percent”; and

12 (C) by adding at the end the following new
13 subparagraph:

14 “(B) PROGRAM SPECIFIC OUTLIER CAP.—
15 The estimated total amount of additional pay-
16 ments or payment adjustments made under
17 subparagraph (A) with respect to a home health
18 agency for a year (beginning with 2011) may
19 not exceed an amount equal to 10 percent of
20 the estimated total amount of payments made
21 under this section (without regard to this para-
22 graph) with respect to the home health agency
23 for the year.”.

24 (c) APPLICATION OF THE MEDICARE RURAL HOME
25 HEALTH ADD-ON POLICY.—Section 421 of the Medicare

1 Prescription Drug, Improvement, and Modernization Act
2 of 2003 (Public Law 108–173; 117 Stat. 2283), as
3 amended by section 5201(b) of the Deficit Reduction Act
4 of 2005 (Public Law 109–171; 120 Stat. 46), is amend-
5 ed—

6 (1) in the section heading, by striking “**ONE-**
7 **YEAR**” and inserting “**TEMPORARY**”; and

8 (2) in subsection (a)—

9 (A) by striking “, and episodes” and in-
10 sserting “, episodes”;

11 (B) by inserting “and episodes and visits
12 ending on or after January 1, 2010, and before
13 January 1, 2016,” after “January 1, 2007,”;
14 and

15 (C) by inserting “(or, in the case of epi-
16 sodes and visits ending on or after January 1,
17 2010, and before January 1, 2016, 3 percent)”
18 before the period at the end.

19 (d) STUDY AND REPORT ON THE DEVELOPMENT OF
20 HOME HEALTH PAYMENT REFORMS IN ORDER TO EN-
21 SURE ACCESS TO CARE AND QUALITY SERVICES.—

22 (1) IN GENERAL.—The Secretary of Health and
23 Human Services (in this section referred to as the
24 “Secretary”) shall conduct a study to evaluate the
25 costs and quality of care among efficient home

1 health agencies relative to other such agencies in
2 providing ongoing access to care and in treating
3 Medicare beneficiaries with varying severity levels of
4 illness. Such study shall include an analysis of the
5 following:

6 (A) Methods to revise the home health pro-
7 spective payment system under section 1895 of
8 the Social Security Act (42 U.S.C. 1395fff) to
9 more accurately account for the costs related to
10 patient severity of illness or to improving bene-
11 ficiary access to care, including—

12 (i) payment adjustments for services
13 that may be under- or over-valued;

14 (ii) necessary changes to reflect the
15 resource use relative to providing home
16 health services to low-income Medicare
17 beneficiaries or Medicare beneficiaries liv-
18 ing in medically underserved areas;

19 (iii) ways the outlier payment may be
20 improved to more accurately reflect the
21 cost of treating Medicare beneficiaries with
22 high severity levels of illness;

23 (iv) the role of quality of care incen-
24 tives and penalties in driving provider and
25 patient behavior;

1 (v) improvements in the application of
2 a wage index; and

3 (vi) other areas determined appro-
4 priate by the Secretary.

5 (B) The validity and reliability of re-
6 sponses on the OASIS instrument with par-
7 ticular emphasis on questions that relate to
8 higher payment under the home health prospec-
9 tive payment system and higher outcome scores
10 under Home Care Compare.

11 (C) Additional research or payment revi-
12 sions under the home health prospective pay-
13 ment system that may be necessary to set the
14 payment rates for home health services based
15 on costs of high-quality and efficient home
16 health agencies or to improve Medicare bene-
17 ficiary access to care.

18 (D) A timetable for implementation of any
19 appropriate changes based on the analysis of
20 the matters described in subparagraphs (A),
21 (B), and (C).

22 (E) Other areas determined appropriate by
23 the Secretary.

24 (2) CONSIDERATIONS.—In conducting the study
25 under paragraph (1), the Secretary shall consider

1 whether certain factors should be used to measure
2 patient severity of illness and access to care, such
3 as—

4 (A) population density and relative patient
5 access to care;

6 (B) variations in service costs for providing
7 care to individuals who are dually eligible under
8 the Medicare and Medicaid programs;

9 (C) the presence of severe or chronic dis-
10 eases, as evidenced by multiple, discontinuous
11 home health episodes;

12 (D) poverty status, as evidenced by the re-
13 ceipt of Supplemental Security Income under
14 title XVI of the Social Security Act;

15 (E) the absence of caregivers;

16 (F) language barriers;

17 (G) atypical transportation costs;

18 (H) security costs; and

19 (I) other factors determined appropriate by
20 the Secretary.

21 (3) REPORT.—Not later than March 1, 2011,
22 the Secretary shall submit to Congress a report on
23 the study conducted under paragraph (1), together
24 with recommendations for such legislation and ad-

1 ministrative action as the Secretary determines ap-
2 propriate.

3 (4) CONSULTATIONS.—In conducting the study
4 under paragraph (1) and preparing the report under
5 paragraph (3), the Secretary shall consult with—

6 (A) stakeholders representing home health
7 agencies;

8 (B) groups representing Medicare bene-
9 ficiaries;

10 (C) the Medicare Payment Advisory Com-
11 mission;

12 (D) the Inspector General of the Depart-
13 ment of Health and Human Services; and

14 (E) the Comptroller General of the United
15 States.

16 (5) TEMPORARY MEDICARE ADD-ON PAYMENT
17 BASED ON THE RESULTS OF THE STUDY.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (D), taking into account the results of
20 the study conducted under paragraph (1), the
21 Secretary may, as determined appropriate, pro-
22 vide for a temporary add-on payment for home
23 health services furnished under the Medicare
24 program during the period beginning on Janu-
25 ary 1, 2012 and ending on December 31, 2018.

1 Such add-on payment shall be targeted toward
2 ensuring access to care for Medicare bene-
3 ficiaries with high severity of levels of illness or
4 improving access to care for low-income or un-
5 derserved Medicare beneficiaries. Such add-on
6 payment, with respect to a home health service,
7 shall not exceed an amount equal to three per-
8 cent of the payment amount that would other-
9 wise be made under section 1895 of the Social
10 Security Act (42 U.S.C. 1395fff) for the serv-
11 ice.

12 (B) WAIVING BUDGET NEUTRALITY.—The
13 Secretary shall not reduce the standard pro-
14 spective payment amount (or amounts) under
15 such section 1895 applicable to home health
16 services furnished during a period to offset any
17 increase in payments during such period result-
18 ing from the application of subparagraph (A).

19 (C) NO EFFECT ON SUBSEQUENT PERI-
20 ODS.—An payment increase resulting from the
21 application of subparagraph (A) for a period—

22 (i) shall not apply to payments for
23 home health services under title XVIII
24 after such period; and

1 (ii) shall not be taken into account in
2 calculating the payment amounts applica-
3 ble for such services after such period.

4 (D) FUNDING.—The Secretary shall pro-
5 vide for the transfer from the Federal Hospital
6 Insurance Trust Fund under section 1817 of
7 the Social Security Act (42 U.S.C. 1395i) and
8 the Federal Supplementary Medical Insurance
9 Trust Fund established under section 1841 of
10 such Act (42 U.S.C. 1395t), in such proportion
11 as the Secretary determines appropriate, of
12 \$500,000,000 for the period of fiscal years
13 2012 through 2019 for the purpose of making
14 add-on payments under subparagraph (A).

15 (E) LIMITATION ON REVIEW.—There shall
16 be no administrative or judicial review under
17 section 1869, section 1878, or otherwise of the
18 implementation of this paragraph.

19 **SEC. 3132. HOSPICE REFORM.**

20 (a) HOSPICE CARE PAYMENT REFORMS.—

21 (1) IN GENERAL.—Section 1814(i) of the Social
22 Security Act (42 U.S.C. 1395f(i)) is amended by
23 adding at the end the following new paragraph:

24 “(6)(A) The Secretary shall collect additional
25 data and information as the Secretary determines

1 appropriate to revise payments for hospice care
2 under this subsection pursuant to subparagraph (D)
3 and for other purposes as determined appropriate by
4 the Secretary. The Secretary shall begin to collect
5 this data by not later than January 1, 2011.

6 “(B) The additional data and information to be
7 collected under subparagraph (A) may include data
8 and information on—

9 “(i) charges and payments;

10 “(ii) the number of days of hospice care
11 which are attributable to individuals who are
12 entitled to, or enrolled for, benefits under part
13 A or enrolled for benefits under part B; and

14 “(iii) with respect to each type of service
15 included in hospice care—

16 “(I) the number of days of hospice
17 care attributable to the type of service;

18 “(II) the cost of the type of service;

19 and

20 “(III) the amount of payment for the
21 type of service;

22 “(iv) charitable contributions and other
23 revenue of the hospice program;

24 “(v) the number of hospice visits;

1 “(vi) the type of practitioner providing the
2 visit; and

3 “(vii) the length of the visit and other
4 basic information with respect to the visit.

5 “(C) The Secretary may collect the additional
6 data and information under subparagraph (A) on
7 cost reports, claims, or other mechanisms as the
8 Secretary determines to be appropriate.

9 “(D)(i) Notwithstanding the preceding para-
10 graphs of this subsection, not later than October 1,
11 2013, the Secretary shall, by regulation, implement
12 revisions to the methodology for determining the
13 payment rates for routine home care and other serv-
14 ices included in hospice care under this part, as the
15 Secretary determines to be appropriate. Such revi-
16 sions may be based on an analysis of data and infor-
17 mation collected under subparagraph (A). Such revi-
18 sions may include adjustments to per diem payments
19 that reflect changes in resource intensity in pro-
20 viding such care and services during the course of
21 the entire episode of hospice care.

22 “(ii) Revisions in payment implemented pursu-
23 ant to subparagraph (D) shall result in the same es-
24 timated amount of aggregate expenditures under
25 this title for hospice care furnished in the fiscal year

1 in which such revisions in payment are implemented
2 as would have been made under this title for such
3 care if such revisions had not been implemented.

4 “(E) The Secretary shall consult with hospice
5 programs and the Medicare Payment Advisory Com-
6 mission regarding the additional data and informa-
7 tion to be collected under subparagraph (A) and the
8 payment revisions under subparagraph (D).”.

9 (2) CONFORMING AMENDMENTS.—Section
10 1814(i)(1)(C) of the Social Security Act (42 U.S.C.
11 1395f(i)(1)(C)) is amended—

12 (A) in clause (ii)—

13 (i) in the matter preceding subclause
14 (I), by inserting “(before 2014)” after
15 “subsequent fiscal year”; and

16 (ii) in subclause (VII), by inserting
17 “(before 2014)” after “subsequent fiscal
18 year”; and

19 (B) by adding at the end the following new
20 clause:

21 “(iii) With respect to routine home
22 care and other services included in hospice
23 care furnished on or after October 1, 2013,
24 the payment rates for such care and serv-
25 ices shall be—

1 and attests that such visit took place (in
2 accordance with procedures established by
3 the Secretary); and

4 “(ii) in the case of hospice care pro-
5 vided an individual for more than 180 days
6 by a hospice program for which the num-
7 ber of such cases for such program com-
8 prises more than a percent (specified by
9 the Secretary) of the total number of such
10 cases for all programs under this title, the
11 hospice care provided to such individual is
12 medically reviewed (in accordance with
13 procedures established by the Secretary).”.

14 **SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPOR-**
15 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

16 Section 1886 of the Social Security Act (42 U.S.C.
17 1395ww), as amended by sections 3001, 3008, and 3025,
18 is amended—

19 (1) in subsection (d)(5)(F)(i), by striking
20 “For” and inserting “Subject to subsection (r), for”;
21 and

22 (2) by adding at the end the following new sub-
23 section:

24 “(r) **ADJUSTMENTS TO MEDICARE DSH PAY-**
25 **MENTS.—**

1 “(1) EMPIRICALLY JUSTIFIED DSH PAY-
2 MENTS.—For fiscal year 2015 and each subsequent
3 fiscal year, instead of the amount of dispropor-
4 tionate share hospital payment that would otherwise
5 be made under subsection (d)(5)(F) to a subsection
6 (d) hospital for the fiscal year, the Secretary shall
7 pay to the subsection (d) hospital 25 percent of such
8 amount (which is an amount that represents the em-
9 pirically justified amount for such payment, as de-
10 termined by the Medicare Payment Advisory Com-
11 mission in its March 2007 Report to the Congress).

12 “(2) ADDITIONAL PAYMENT.—In addition to
13 the payment made to a subsection (d) hospital under
14 paragraph (1), for fiscal year 2015 and each subse-
15 quent fiscal year, the Secretary shall pay to such
16 subsection (d) hospitals an additional amount equal
17 to the product of the following factors:

18 “(A) FACTOR ONE.—A factor equal to the
19 difference between—

20 “(i) the aggregate amount of pay-
21 ments that would be made to the sub-
22 section (d) hospital under subsection
23 (d)(5)(F) if this subsection did not apply
24 for such fiscal year (as estimated by the
25 Secretary); and

1 “(ii) the aggregate amount of pay-
2 ments that are made to the subsection (d)
3 hospital under paragraph (1) for such fis-
4 cal year (as so estimated).

5 “(B) FACTOR TWO.—

6 “(i) FISCAL YEARS 2015, 2016, AND
7 2017.—For each of fiscal years 2015, 2016,
8 and 2017, a factor equal to 1 minus the
9 percent change (divided by 100) in the per-
10 cent of individuals under the age of 65 who
11 are uninsured, as determined by comparing
12 the percent of such individuals—

13 “(I) who are uninsured in 2012,
14 the last year before coverage expan-
15 sion under the America’s Healthy Fu-
16 ture Act of 2009 (as calculated by the
17 Secretary based on the most recent
18 estimates available from the Director
19 of the Congressional Budget Office
20 prior to the date of enactment of such
21 Act); and

22 “(II) who are uninsured in the
23 most recent period for which data is
24 available (as so calculated).

1 “(ii) 2018 AND SUBSEQUENT
2 YEARS.—For fiscal year 2018 and each
3 subsequent fiscal year, a factor equal to 1
4 minus the percent change (divided by 100)
5 in the percent of individuals who are unin-
6 sured, as determined by comparing the
7 percent of individuals—

8 “(I) who are uninsured in 2012
9 (as estimated by the Secretary, based
10 on data from the Census Bureau or
11 other sources the Secretary deter-
12 mines appropriate, and certified by
13 the Chief Actuary of the Centers for
14 Medicare & Medicaid Services); and

15 “(II) who are uninsured in the
16 most recent period for which data is
17 available (as so estimated and cer-
18 tified).

19 “(C) FACTOR THREE.—A factor equal to
20 the percent, for each subsection (d) hospital,
21 that represents the quotient of—

22 “(i) the amount of uncompensated
23 care for such hospital for a period selected
24 by the Secretary (as estimated by Sec-
25 retary, based on appropriate data (includ-

1 ing, in the case where the Secretary deter-
2 mines that alternative data is available
3 which is a better proxy for the costs of
4 subsection (d) hospitals for treating the
5 uninsured, the use of such alternative
6 data)); and

7 “(ii) the aggregate amount of uncom-
8 pensated care for all subsection (d) hos-
9 pitals that receive a payment under this
10 subsection for such period (as so esti-
11 mated, based on such data).

12 “(3) LIMITATIONS ON REVIEW.—There shall be
13 no administrative or judicial review under section
14 1869, section 1878, or otherwise of the following:

15 “(A) Any estimate of the Secretary for
16 purposes of determining the factors described in
17 paragraph (2).

18 “(B) Any period selected by the Secretary
19 for such purposes.

20 “(C) Any determination by the Secretary
21 to use an alternative percent under paragraph
22 (1)(B).”.

1 **SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE**
2 **SCHEDULE.**

3 (a) IN GENERAL.—Section 1848(c)(2) of the Social
4 Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by
5 adding at the end the following new subparagraphs:

6 “(K) POTENTIALLY MISVALUED CODES.—

7 “(i) IN GENERAL.—The Secretary
8 shall—

9 “(I) periodically identify services
10 as being potentially misvalued using
11 criteria specified in clause (ii); and

12 “(II) review and make appro-
13 priate adjustments to the relative val-
14 ues established under this paragraph
15 for services identified as being poten-
16 tially misvalued under subclause (I).

17 “(ii) IDENTIFICATION OF POTEN-
18 Tially MISVALUED CODES.—For purposes
19 of identifying potentially misvalued services
20 pursuant to clause (i)(I), the Secretary
21 shall examine (as the Secretary determines
22 to be appropriate) codes (and families of
23 codes as appropriate) for which there has
24 been the fastest growth; codes (and fami-
25 lies of codes as appropriate) that have ex-
26 perience substantial changes in practice

1 expenses; codes for new technologies or
2 services within an appropriate period (such
3 as 3 years) after the relative values are ini-
4 tially established for such codes; multiple
5 codes that are frequently billed in conjunc-
6 tion with furnishing a single service; codes
7 with low relative values, particularly those
8 that are often billed multiple times for a
9 single treatment; codes which have not
10 been subject to review since the implemen-
11 tation of the RBRVS (the so-called ‘Har-
12 vard-valued codes’); and such other codes
13 determined to be appropriate by the Sec-
14 retary.

15 “(iii) REVIEW AND ADJUSTMENTS.—

16 “(I) The Secretary may use ex-
17 isting processes to receive rec-
18 ommendations on the review and ap-
19 propriate adjustment of potentially
20 misvalued services described in clause
21 (i)(II).

22 “(II) The Secretary may conduct
23 surveys, other data collection activi-
24 ties, studies, or other analyses as the
25 Secretary determines to be appro-

1 appropriate to facilitate the review and ap-
2 propriate adjustment described in
3 clause (i)(II).

4 “(III) The Secretary may use
5 analytic contractors to identify and
6 analyze services identified under
7 clause (i)(I), conduct surveys or col-
8 lect data, and make recommendations
9 on the review and appropriate adjust-
10 ment of services described in clause
11 (i)(II).

12 “(IV) The Secretary may coordi-
13 nate the review and appropriate ad-
14 justment described in clause (i)(II)
15 with the periodic review described in
16 subparagraph (B).

17 “(V) As part of the review and
18 adjustment described in clause (i)(II),
19 including with respect to codes with
20 low relative values described in clause
21 (ii), the Secretary may make appro-
22 priate coding revisions (including
23 using existing processes for consider-
24 ation of coding changes) which may
25 include consolidation of individual

1 services into bundled codes for pay-
2 ment under the fee schedule under
3 subsection (b).

4 “(VI) The provisions of subpara-
5 graph (B)(ii)(II) shall apply to adjust-
6 ments to relative value units made
7 pursuant to this subparagraph in the
8 same manner as such provisions apply
9 to adjustments under subparagraph
10 (B)(ii)(II).

11 “(L) VALIDATING RELATIVE VALUE
12 UNITS.—

13 “(i) IN GENERAL.—The Secretary
14 shall establish a process to validate relative
15 value units under the fee schedule under
16 subsection (b).

17 “(ii) COMPONENTS AND ELEMENTS
18 OF WORK.—The process described in
19 clause (i) may include validation of work
20 elements (such as time, mental effort and
21 professional judgment, technical skill and
22 physical effort, and stress due to risk) in-
23 volved with furnishing a service and may
24 include validation of the pre-, post-, and
25 intra-service components of work.

1 “(iii) SCOPE OF CODES.—The valida-
2 tion of work relative value units shall in-
3 clude a sampling of codes for services that
4 is the same as the codes listed under sub-
5 paragraph (K)(ii).

6 “(iv) METHODS.—The Secretary may
7 conduct the validation under this subpara-
8 graph using methods described in sub-
9 clauses (I) through (V) of subparagraph
10 (K)(iii) as the Secretary determines to be
11 appropriate.

12 “(v) ADJUSTMENTS.—The Secretary
13 shall make appropriate adjustments to the
14 work relative value units under the fee
15 schedule under subsection (b). The provi-
16 sions of subparagraph (B)(ii)(II) shall
17 apply to adjustments to relative value units
18 made pursuant to this subparagraph in the
19 same manner as such provisions apply to
20 adjustments under subparagraph
21 (B)(ii)(II).”.

22 (b) IMPLEMENTATION.—

23 (1) ADMINISTRATION.—

24 (A) Chapter 35 of title 44, United States
25 Code and the provisions of the Federal Advisory

1 Committee Act (5 U.S.C. App.) shall not apply
2 to this section or the amendment made by this
3 section.

4 (B) Notwithstanding any other provision of
5 law, the Secretary may implement subpara-
6 graphs (K) and (L) of 1848(c)(2) of the Social
7 Security Act, as added by subsection (a), by
8 program instruction or otherwise.

9 (C) Section 4505(d) of the Balanced
10 Budget Act of 1997 is repealed.

11 (D) Except for provisions related to con-
12 fidentiality of information, the provisions of the
13 Federal Acquisition Regulation shall not apply
14 to this section or the amendment made by this
15 section.

16 (2) FOCUSING CMS RESOURCES ON POTEN-
17 Tially OVERVALUED CODES.—Section 1868(a) of
18 the Social Security Act (42 U.S.C. 1395ee(a)) is re-
19 pealed.

20 **SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION**
21 **FACTOR FOR ADVANCED IMAGING SERVICES.**

22 (a) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
23 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848
24 of the Social Security Act (42 U.S.C. 1395w) is amend-
25 ed—

1 (1) in subsection (b)(4)—

2 (A) in subparagraph (B), by striking “sub-
3 paragraph (A)” and inserting “this paragraph”;
4 and

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

7 “(C) ADJUSTMENT IN PRACTICE EXPENSE
8 TO REFLECT HIGHER PRESUMED UTILIZA-
9 TION.—In computing the number of practice
10 expense relative value units under subsection
11 (e)(2)(C)(ii) with respect to advanced diagnostic
12 imaging services (as defined in section
13 1834(e)(1)(B)), the Secretary shall adjust such
14 number of units so it reflects—

15 “(i) in the case of services furnished
16 on or after January 1, 2010, and before
17 January 1, 2013, a 65 (rather than 50
18 percent) presumed rate of utilization of im-
19 aging equipment; and

20 “(ii) in the case of services furnished
21 on or after January 1, 2013, a 75 percent
22 (rather than 50 percent) presumed rate of
23 utilization of imaging 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
11 INVOLVING CONSECUTIVE BODY PARTS.—In the
12 case of services furnished on or after January
13 1, 2010, the Secretary shall increase the reduc-
14 tion in payments attributable to the multiple
15 procedure payment reduction applicable to the
16 technical component for imaging under the final
17 rule published by the Secretary in the Federal
18 Register on November 21, 2005 (part 405 of
19 title 42, Code of Federal Regulations) from 25
20 percent to 50 percent.”.

21 (c) GAO STUDY AND REPORT.—

22 (1) STUDY.—The Comptroller General of the
23 United States (in this subsection referred to as the
24 “Comptroller General”) shall conduct a study on the
25 estimated impact of the adjustment in practice ex-

1 pense to reflect higher presumed utilization under
2 the amendments made by subsection (a) on the fol-
3 lowing:

4 (A) Medicare beneficiary access to ad-
5 vanced diagnostic imaging services (as defined
6 in section 1834(e)(1)(B) of the Social Security
7 Act (42 U.S.C. 1395m(e)(1)(B)), including
8 such access in rural areas.

9 (B) Utilization of advanced diagnostic im-
10 aging services (as so defined).

11 (C) The estimated savings to the Medicare
12 program under title XVIII of the Social Secu-
13 rity Act (42 U.S.C. 1395 et seq.) during the pe-
14 riod of 2010 through 2019 as a result of such
15 adjustment.

16 (2) REPORT.—Not later than January 1, 2013,
17 the Comptroller General shall submit to Congress a
18 report containing the results of the study conducted
19 under paragraph (1), together with recommenda-
20 tions for such legislation and administrative action
21 as the Comptroller General determines appropriate.

1 **SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN**
2 **WHEELCHAIRS.**

3 (a) IN GENERAL.—Section 1834(a)(7)(A) of the So-
4 cial Security Act (42 U.S.C. 1395m(a)(7)(A)) is amend-
5 ed—

6 (1) in clause (i)—

7 (A) in subclause (II), by inserting “sub-
8 clause (III) and” after “Subject to”; and

9 (B) by adding at the end the following new
10 subclause:

11 “(III) SPECIAL RULE FOR
12 POWER-DRIVEN WHEELCHAIRS.—For
13 purposes of payment for power-driven
14 wheelchairs, subclause (II) shall be
15 applied by substituting ‘15 percent’
16 and ‘6 percent’ for ‘10 percent’ and
17 ‘7.5 percent’, respectively.”; and

18 (2) in clause (iii)—

19 (A) in the heading, by inserting “COM-
20 PLEX, REHABILITATIVE” before “POWER-DRIV-
21 EN”; and

22 (B) by inserting “complex, rehabilitative”
23 before “power-driven”.

24 (b) TECHNICAL AMENDMENT.—Section
25 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C.

1 1395m(a)(7)(C)(ii)(II) is amended by striking “(A)(ii)
2 or”.

3 (c) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Subject to paragraph (2),
5 the amendments made by subsection (a) shall take
6 effect on January 1, 2011, and shall apply to power-
7 driven wheelchairs furnished on or after such date.

8 (2) APPLICATION TO COMPETITIVE BIDDING.—

9 The amendments made by subsection (a) shall not
10 apply to payment made for items and services fur-
11 nished pursuant to contracts entered into under sec-
12 tion 1847 of the Social Security Act (42 U.S.C.
13 1395w-3) prior to January 1, 2011, pursuant to the
14 implementation of subsection (a)(1)(B)(i)(I) of such
15 section 1847.

16 **SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.**

17 (a) EXTENSION OF SECTION 508 HOSPITAL RECLAS-
18 SIFICATIONS.—

19 (1) IN GENERAL.—Subsection (a) of section
20 106 of division B of the Tax Relief and Health Care
21 Act of 2006 (42 U.S.C. 1395 note), as amended by
22 section 117 of the Medicare, Medicaid, and SCHIP
23 Extension Act of 2007 (Public Law 110-173) and
24 section 124 of the Medicare Improvements for Pa-
25 tients and Providers Act of 2008 (Public Law 110-

1 275), is amended by striking “September 30, 2009”
2 and inserting “September 30, 2011”.

3 (2) USE OF PARTICULAR WAGE INDEX.—For
4 purposes of implementation of the amendment made
5 by this subsection, the Secretary shall use the hos-
6 pital wage index that was promulgated by the Sec-
7 retary in the Federal Register on August 27, 2009
8 (74 Fed. Reg. 43754), and any subsequent correc-
9 tions.

10 (b) PLAN FOR REFORMING THE MEDICARE HOS-
11 PITAL WAGE INDEX SYSTEM.—

12 (1) IN GENERAL.—Not later than December 31,
13 2011, the Secretary of Health and Human Services
14 (in this section referred to as the “Secretary”) shall
15 submit to Congress a report that includes a plan to
16 reform the hospital wage index system under section
17 1886 of the Social Security Act.

18 (2) DETAILS.—In developing the plan under
19 paragraph (1), the Secretary shall take into account
20 the goals for reforming such system set forth in the
21 Medicare Payment Advisory Commission June 2007
22 report entitled “Report to Congress: Promoting
23 Greater Efficiency in Medicare”, including estab-
24 lishing a new hospital compensation index system
25 that—

1 (A) uses Bureau of Labor Statistics data,
2 or other data or methodologies, to calculate rel-
3 ative wages for each geographic area involved;

4 (B) minimizes wage index adjustments be-
5 tween and within metropolitan statistical areas
6 and statewide rural areas;

7 (C) includes methods to minimize the vola-
8 tility of wage index adjustments that result
9 from implementation of policy, while maintain-
10 ing budget neutrality in applying such adjust-
11 ments;

12 (D) takes into account the effect that im-
13 plementation of the system would have on
14 health care providers and on each region of the
15 country;

16 (E) addresses issues related to occupa-
17 tional mix, such as staffing practices and ratios,
18 and any evidence on the effect on quality of
19 care or patient safety as a result of the imple-
20 mentation of the system; and

21 (F) provides for a transition.

22 (3) CONSULTATION.—In developing the plan
23 under paragraph (1), the Secretary shall consult
24 with relevant affected parties.

1 (c) USE OF PARTICULAR RATIOS FOR DETERMINING
2 RECLASSIFICATIONS.—Section 1886(d)(10)(C) of the So-
3 cial Security Act (42 U.S.C. 1395ww(d)(10)(C)) is amend-
4 ed by adding at the end the following clause:

5 “(vii) Notwithstanding any other provision of law, in
6 making decisions on applications for reclassification of a
7 subsection (d) hospital for the purposes described in clause
8 (v) for fiscal year 2011 and each subsequent fiscal year
9 (before the first fiscal year beginning on or after the date
10 that is 1 year after the Secretary submits the report to
11 Congress under section 3137(b) of the America’s Healthy
12 Future Act of 2009), the Board shall use the ratios used
13 in making such decisions as of September 30, 2008. This
14 clause shall be effected in a budget neutral manner.”.

15 **SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.**

16 Section 1833(t) of the Social Security Act (42 U.S.C.
17 1395l(t)) is amended by adding at the end the following
18 new paragraph:

19 “(18) AUTHORIZATION OF ADJUSTMENT FOR
20 CANCER HOSPITALS.—

21 “(A) STUDY.—The Secretary shall conduct
22 a study to determine if, under the system under
23 this subsection, costs incurred by hospitals de-
24 scribed in section 1886(d)(1)(B)(v) with respect
25 to ambulatory payment classification groups ex-

1 ceed those costs incurred by other hospitals fur-
2 nishing services under this subsection (as deter-
3 mined appropriate by the Secretary).

4 “(B) AUTHORIZATION OF ADJUSTMENT.—
5 Insofar as the Secretary determines under sub-
6 paragraph (A) that costs incurred by hospitals
7 described in section 1886(d)(1)(B)(v) exceed
8 those costs incurred by other hospitals fur-
9 nishing services under this subsection, the Sec-
10 retary shall provide for an appropriate adjust-
11 ment under paragraph (2)(E) to reflect those
12 higher costs effective for services furnished on
13 or after January 1, 2011.”.

14 **SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PROD-**
15 **UCTS.**

16 (a) IN GENERAL.—Section 1847A of the Social Secu-
17 rity Act (42 U.S.C. 1395w–3a) is amended—

18 (1) in subsection (b)—

19 (A) in paragraph (1)—

20 (i) in subparagraph (A), by striking
21 “or” at the end;

22 (ii) in subparagraph (B), by striking
23 the period at the end and inserting “; or”;
24 and

1 (iii) by adding at the end the fol-
2 lowing new subparagraph:

3 “(C) in the case of a biosimilar biological
4 product (as defined in subsection (e)(6)(H)),
5 the amount determined under paragraph (8).”;
6 and

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

9 “(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The
10 amount specified in this paragraph for a biosimilar
11 biological product described in paragraph (1)(C) is
12 the sum of—

13 “(A) the average sales price as determined
14 using the methodology described under para-
15 graph (6) applied to a biosimilar biological
16 product for all National Drug Codes assigned to
17 such product in the same manner as such para-
18 graph is applied to drugs described in such
19 paragraph; and

20 “(B) 6 percent of the amount determined
21 under paragraph (4) for the reference biological
22 product (as defined in subsection (e)(6)(I)).”;
23 and

24 (2) in subsection (c)(6), by adding at the end
25 the following new subparagraph:

1 “(H) BIOSIMILAR BIOLOGICAL PRODUCT.—

2 The term ‘biosimilar biological product’ means
3 a biological product approved under an abbrevi-
4 ated application for a license of a biological
5 product that relies in part on data or informa-
6 tion in an application for another biological
7 product licensed under section 351 of the Pub-
8 lic Health Service Act.

9 “(I) REFERENCE BIOLOGICAL PRODUCT.—

10 The term ‘reference biological product’ means
11 the biological product licensed under such sec-
12 tion 351 that is referred to in the application
13 described in subparagraph (H) of the biosimilar
14 biological product.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 subsection (a) shall apply to payments for biosimilar bio-
17 logical products beginning with the first day of the second
18 calendar quarter after enactment of legislation providing
19 for a biosimilar pathway (as determined by the Secretary).

20 **SEC. 3140. PUBLIC MEETING AND REPORT ON PAYMENT**
21 **SYSTEMS FOR NEW CLINICAL LABORATORY**
22 **DIAGNOSTIC TESTS.**

23 (a) PUBLIC MEETING.—The Secretary of Health and
24 Human Services (in this section referred to as the “Sec-
25 retary”) shall convene a public meeting on mechanisms of

1 payment for new clinical laboratory diagnostic tests under
2 title XVIII of the Social Security Act (42 U.S.C. 1395
3 et seq.). Such public meeting shall include a discussion
4 of how to reform such mechanisms of payment for such
5 tests under such title.

6 (b) REPORT.—The Secretary shall submit to Con-
7 gress a report containing a summary of the public meeting
8 convened under subsection (a), together with recommenda-
9 tions for such legislation and administrative action the
10 Secretary determines appropriate.

11 **SEC. 3141. MEDICARE HOSPICE CONCURRENT CARE DEM-**
12 **ONSTRATION PROGRAM.**

13 (a) ESTABLISHMENT.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services (in this section referred to as the
16 “Secretary”) shall establish a Medicare Hospice
17 Concurrent Care demonstration program at partici-
18 pating hospice programs under which Medicare
19 beneficiaries are furnished, during the same period,
20 hospice care and any other items or services covered
21 under title XVIII of the Social Security Act (42
22 U.S.C. 1395 et seq.) from funds otherwise paid
23 under such title to such hospice programs.

1 (2) DURATION.—The demonstration program
2 under this section shall be conducted for a 3-year
3 period.

4 (3) SITES.—The Secretary shall establish a
5 total of 26 sites in the United States at which the
6 demonstration program under this section shall be
7 conducted. Such sites shall be located in urban and
8 rural areas.

9 (b) INDEPENDENT EVALUATION AND REPORTS.—

10 (1) INDEPENDENT EVALUATION.—The Sec-
11 retary shall provide for the conduct of an inde-
12 pendent evaluation of the demonstration program
13 under this section. Such independent evaluation
14 shall determine whether the demonstration program
15 has improved patient care, quality of life, and cost-
16 effectiveness for Medicare beneficiaries participating
17 in the demonstration program.

18 (2) REPORTS.—The Secretary shall submit to
19 Congress a report containing the results of the eval-
20 uation conducted under paragraph (1), together with
21 such recommendations as the Secretary determines
22 appropriate.

23 (c) BUDGET NEUTRALITY.—With respect to the 3-
24 year period of the demonstration program under this sec-
25 tion, the Secretary shall ensure that the aggregate expend-

1 itures under title XVIII for such period shall not exceed
2 the aggregate expenditures that would have been expended
3 under such title if the demonstration program under this
4 section had not been implemented.

5 **SEC. 3142. APPLICATION OF BUDGET NEUTRALITY ON A NA-**
6 **TIONAL BASIS IN THE CALCULATION OF THE**
7 **MEDICARE HOSPITAL WAGE INDEX FLOOR**
8 **FOR EACH ALL-URBAN AND RURAL STATE.**

9 In the case of discharges occurring on or after Octo-
10 ber 1, 2010, for purposes of applying section 4410 of the
11 Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)
12 and paragraph (h)(4) of section 412.64 of title 42, Code
13 of Federal Regulations, the Secretary of Health and
14 Human Services shall administer subsection (b) of such
15 section 4410 and paragraph (e) of such section 412.64
16 in the same manner as the Secretary administered such
17 subsection (b) and paragraph (e) for discharges occurring
18 during fiscal year 2008 (through a uniform, national ad-
19 justment to the area wage index).

20 **SEC. 3143. HHS STUDY ON URBAN MEDICARE-DEPENDENT**
21 **HOSPITALS.**

22 (a) STUDY.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services (in this section referred to as the
25 “Secretary”) shall conduct a study on the need for

1 an additional payment for urban Medicare-depend-
2 ent hospitals for inpatient hospital services under
3 section 1886 of the Social Security Act (42 U.S.C.
4 1395ww). Such study shall include an analysis of—

5 (A) the Medicare inpatient margins of
6 urban Medicare-dependent hospitals, as com-
7 pared to other hospitals which receive 1 or more
8 additional payments or adjustments under such
9 section (including those payments or adjust-
10 ments described in paragraph (2)(A)); and

11 (B) whether payments to medicare-depend-
12 ent, small rural hospitals under subsection
13 (d)(5)(G) of such section should be applied to
14 urban Medicare-dependent hospitals.

15 (2) URBAN MEDICARE-DEPENDENT HOSPITAL
16 DEFINED.—For purposes of this section, the term
17 “urban Medicare-dependent hospital” means a sub-
18 section (d) hospital (as defined in subsection
19 (d)(1)(B) of such section) that—

20 (A) does not receive any additional pay-
21 ment or adjustment under such section, such as
22 payments for indirect medical education costs
23 under subsection (d)(5)(B) of such section, dis-
24 proportionate share payments under subsection
25 (d)(5)(A) of such section, payments to a rural

1 referral center under subsection (d)(5)(C) of
2 such section, payments to a critical access hos-
3 pital under section 1814(l) of such Act (42
4 U.S.C. 1395f(1)), payments to a sole community
5 hospital under subsection (d)(5)(D) of such sec-
6 tion 1886, or payments to a medicare-depend-
7 ent, small rural hospital under subsection
8 (d)(5)(G) of such section 1886; and

9 (B) for which more than 60 percent of its
10 inpatient days or discharges during 2 of the 3
11 most recently audited cost reporting periods for
12 which the Secretary has a settled cost report
13 were attributable to inpatients entitled to bene-
14 fits under part A of title XVIII of such Act.

15 (b) REPORT.—Not later than 9 months after the date
16 of enactment of this Act, the Secretary shall submit to
17 Congress a report containing the results of the study con-
18 ducted under subsection (a), together with recommenda-
19 tions for such legislation and administrative action as the
20 Secretary determines appropriate.

21 **Subtitle C—Provisions Relating to** 22 **Part C**

23 **SEC. 3201. MEDICARE ADVANTAGE PAYMENT.**

24 (a) MA BENCHMARK BASED ON PLAN'S COMPETI-
25 TIVE BIDS.—

1 under subsection (k)(1) for the area
2 for the year;

3 “(III) for 2012, the sum of—

4 “(aa) $\frac{2}{3}$ of the quotient
5 of—

6 “(AA) the applicable
7 amount determined under
8 subsection (k)(1) for the
9 area for the year; and

10 “(BB) 12; and

11 “(bb) $\frac{1}{3}$ of the MA competi-
12 tive benchmark amount (deter-
13 mined under paragraph (2)) for
14 the area for the month;

15 “(IV) for 2013, the sum of—

16 “(aa) $\frac{1}{3}$ of the quotient
17 of—

18 “(AA) the applicable
19 amount determined under
20 subsection (k)(1) for the
21 area for the year; and

22 “(BB) 12; and

23 “(bb) $\frac{2}{3}$ of the MA competi-
24 tive benchmark amount (as so

1 determined) for the area for the
2 month;

3 “(V) for 2014, the MA competi-
4 tive benchmark amount for the area
5 for a month in 2013 (as so deter-
6 mined), increased by the national per
7 capita MA growth percentage, de-
8 scribed in subsection (c)(6) for 2014,
9 but not taking into account any ad-
10 justment under subparagraph (C) of
11 such subsection for a year before
12 2004; and

13 “(VI) for 2015 and each subse-
14 quent year, the MA competitive
15 benchmark amount (as so determined)
16 for the area for the month; or”;

17 (iii) in clause (ii), as redesignated by
18 clause (i), by striking “subparagraph (A)”
19 and inserting “clause (i)”;

20 (D) by adding at the end the following new
21 paragraphs:

22 “(2) COMPUTATION OF MA COMPETITIVE
23 BENCHMARK AMOUNT.—

24 “(A) IN GENERAL.—Subject to subpara-
25 graph (B) and paragraph (3), for months in

1 each year (beginning with 2012) for each MA
2 payment area the Secretary shall compute an
3 MA competitive benchmark amount equal to the
4 weighted average of the unadjusted MA statu-
5 tory non-drug monthly bid amount (as defined
6 in section 1854(b)(2)(E)) for each MA plan in
7 the area, with the weight for each plan being
8 equal to the average number of beneficiaries en-
9 rolled under such plan in the reference month
10 (as defined in section 1858(f)(4), except that,
11 in applying such definition for purposes of this
12 paragraph, ‘to compute the MA competitive
13 benchmark amount under section 1853(j)(2)’
14 shall be substituted for ‘to compute the percent-
15 age specified in subparagraph (A) and other
16 relevant percentages under this part’).

17 “(B) WEIGHTING RULES.—

18 “(i) SINGLE PLAN RULE.—In the case
19 of an MA payment area in which only a
20 single MA plan is being offered, the weight
21 under subparagraph (A) shall be equal to
22 1.

23 “(ii) USE OF SIMPLE AVERAGE AMONG
24 MULTIPLE PLANS IF NO PLANS OFFERED
25 IN PREVIOUS YEAR.—In the case of an MA

1 payment area in which no MA plan was of-
2 fered in the previous year and more than
3 1 MA plan is offered in the current year,
4 the Secretary shall use a simple average of
5 the unadjusted MA statutory non-drug
6 monthly bid amount (as so defined) for
7 purposes of computing the MA competitive
8 benchmark amount under subparagraph
9 (A).

10 “(3) CAP ON MA COMPETITIVE BENCHMARK
11 AMOUNT.—In no case shall the MA competitive
12 benchmark amount for an area for a month in a
13 year be greater than the applicable amount that
14 would (but for the application of this subsection) be
15 determined under subsection (k)(1) for the area for
16 the month in the year.”; and

17 (E) in subsection (k)(2)(B)(ii)(III), by
18 striking “(j)(1)(A)” and inserting
19 “(j)(1)(A)(i)”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) Section 1853(k)(2) of the Social Secu-
22 rity Act (42 U.S.C. 1395w-23(k)(2)) is amend-
23 ed—

1 (i) in subparagraph (A), by striking
2 “through 2010” and inserting “and subse-
3 quent years”; and

4 (ii) in subparagraph (C)—

5 (I) in clause (iii), by striking
6 “and” at the end;

7 (II) in clause (iv), by striking the
8 period at the end and inserting “;
9 and”; and

10 (III) by adding at the end the
11 following new clause:

12 “(v) for 2011 and subsequent years,
13 0.00.”.

14 (B) Section 1854(b) of the Social Security
15 Act (42 U.S.C. 1395w-24(b)) is amended—

16 (i) in paragraph (3)(B)(i), by striking
17 “1853(j)(1)” and inserting
18 “1853(j)(1)(A)”; and

19 (ii) in paragraph (4)(B)(i), by striking
20 “1853(j)(2)” and inserting
21 “1853(j)(1)(B)”.

22 (C) Section 1858(f) of the Social Security
23 Act (42 U.S.C. 1395w-27(f)) is amended—

1 (i) in paragraph (1), by striking
2 “1853(j)(2)” and inserting
3 “1853(j)(1)(B)”; and

4 (ii) in paragraph (3)(A), by striking
5 “1853(j)(1)(A)” and inserting
6 “1853(j)(1)(A)(i)”.

7 (D) Section 1860C–1(d)(1)(A) of the So-
8 cial Security Act (42 U.S.C. 1395w–
9 29(d)(1)(A)) is amended by striking
10 “1853(j)(1)(A)” and inserting
11 “1853(j)(1)(A)(i)”.

12 (b) REDUCTION OF NATIONAL PER CAPITA GROWTH
13 PERCENTAGE FOR 2011.—Section 1853(e)(6) of the So-
14 cial Security Act (42 U.S.C. 1395w–23(c)(6)) is amend-
15 ed—

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

17 (2) in clause (vi)—

18 (A) by striking “for a year after 2002”
19 and inserting “for 2003 through 2010”; and

20 (B) by striking the period at the end and
21 inserting a comma; and

22 (C) by adding at the end the following new
23 clauses:

24 “(vii) for 2011, 3 percentage points;

25 and

1 “(viii) for a year after 2011, 0 per-
2 centage points.”.

3 (c) ENHANCEMENT OF BENEFICIARY REBATES.—
4 Section 1854(b)(1)(C)(i) of the Social Security Act (42
5 U.S.C. 1395w-24(b)(1)(C)(i)) is amended by inserting
6 “(or 100 percent in the case of plan years beginning on
7 or after January 1, 2014)” after “75 percent”.

8 (d) BIDDING RULES.—

9 (1) REQUIREMENTS FOR INFORMATION SUB-
10 MITTED.—Section 1854(a)(6)(A) of the Social Secu-
11 rity Act (42 U.S.C. 1395w-24(a)(6)(A)) is amended,
12 in the flush matter following clause (v), by adding
13 at the end the following sentence: “Information to
14 be submitted under this paragraph shall be certified
15 by a qualified member of the American Academy of
16 Actuaries and shall meet actuarial guidelines and
17 rules established by the Secretary under subpara-
18 graph (B)(v).”.

19 (2) ESTABLISHMENT OF ACTUARIAL GUIDE-
20 LINES.—Section 1854(a)(6)(B) of the Social Secu-
21 rity Act (42 U.S.C. 1395w-24(a)(6)(B)) is amend-
22 ed—

23 (A) in clause (i), by striking “(iii) and
24 (iv)” and inserting “(iii), (iv), and (v)”; and

1 (B) by adding at the end the following new
2 clause:

3 “(v) ESTABLISHMENT OF ACTUARIAL
4 GUIDELINES.—

5 “(I) IN GENERAL.—In order to
6 establish fair MA competitive bench-
7 marks under section 1853(j)(1)(A)(i),
8 the Secretary, acting through the
9 Chief Actuary of the Centers for
10 Medicare & Medicaid Services (in this
11 clause referred to as the ‘Chief Actu-
12 ary’), shall establish—

13 “(aa) actuarial guidelines
14 for the submission of bid infor-
15 mation under this paragraph;
16 and

17 “(bb) bidding rules that are
18 appropriate to ensure accurate
19 bids and fair competition among
20 MA plans.

21 “(II) DENIAL OF BID
22 AMOUNTS.—The Secretary shall deny
23 monthly bid amounts submitted under
24 subparagraph (A) that do not meet

1 the actuarial guidelines and rules es-
2 tablished under subclause (I).

3 “(III) REFUSAL TO ACCEPT CER-
4 TAIN BIDS DUE TO MISREPRESENTA-
5 TIONS AND FAILURES TO ADE-
6 QUATELY MEET REQUIREMENTS.—In
7 the case where the Secretary deter-
8 mines that information submitted by
9 an MA organization under subpara-
10 graph (A) contains consistent mis-
11 representations and failures to ade-
12 quately meet requirements of the or-
13 ganization, the Secretary may refuse
14 to accept any additional such bid
15 amounts from the organization for the
16 plan year and the Chief Actuary shall,
17 if the Chief Actuary determines that
18 the actuaries of the organization were
19 complicit in those misrepresentations
20 and failures, report those actuaries to
21 the Actuarial Board for Counseling
22 and Discipline.”.

23 (3) EFFECTIVE DATE.—The amendments made
24 by this subsection shall apply to bid amounts sub-
25 mitted on or after January 1, 2012.

1 (e) MA LOCAL PLAN SERVICE AREAS.—

2 (1) IN GENERAL.—Section 1853(d) of the So-
3 cial Security Act (42 U.S.C. 1395w-23(d)) is
4 amended—

5 (A) in the subsection heading, by striking
6 “MA REGION” and inserting “MA REGION; MA
7 LOCAL PLAN SERVICE AREA”;

8 (B) in paragraph (1), by striking subpara-
9 graph (A) and inserting the following:

10 “(A) with respect to an MA local plan—

11 “(i) for years before 2012, an MA
12 local area (as defined in paragraph (2));
13 and

14 “(ii) for 2012 and succeeding years, a
15 service area that is an entire urban or
16 rural area, as applicable (as described in
17 paragraph (5)); and”;

18 (C) by adding at the end the following new
19 paragraph:

20 “(5) MA LOCAL PLAN SERVICE AREA.—For
21 2012 and succeeding years, the service area for an
22 MA local plan shall be an entire urban or rural area
23 in each State as follows:

24 “(A) URBAN AREAS.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii) and subparagraphs (C) and (D), the
3 service area for an MA local plan in an
4 urban area shall be the Core Based Statis-
5 tical Area (in this paragraph referred to as
6 a ‘CBSA’) or, if applicable, a conceptually
7 similar alternative classification, as defined
8 by the Director of the Office of Manage-
9 ment and Budget.

10 “(ii) CBSA COVERING MORE THAN
11 ONE STATE.—In the case of a CBSA (or
12 alternative classification) that covers more
13 than one State, the Secretary shall divide
14 the CBSA (or alternative classification)
15 into separate service areas with respect to
16 each State covered by the CBSA (or alter-
17 native classification).

18 “(B) RURAL AREAS.—Subject to subpara-
19 graphs (C) and (D), the service area for an MA
20 local plan in a rural area shall be a county that
21 does not qualify for inclusion in a CBSA (or al-
22 ternative classification), as defined by the Di-
23 rector of the Office of Management and Budg-
24 et.

1 “(C) REFINEMENTS TO SERVICE AREAS.—
2 For 2015 and succeeding years, in order to re-
3 flect actual patterns of health care service utili-
4 zation, the Secretary may adjust the boundaries
5 of service areas for MA local plans in urban
6 areas and rural areas under subparagraphs (A)
7 and (B), respectively, but may only do so based
8 on recent analyses of actual patterns of care.

9 “(D) ADDITIONAL AUTHORITY TO MAKE
10 LIMITED EXCEPTIONS TO SERVICE AREA RE-
11 QUIREMENTS FOR MA LOCAL PLANS.—The Sec-
12 retary may, in addition to any adjustments
13 under subparagraph (C), make limited excep-
14 tions to service area requirements otherwise ap-
15 plicable under this part for MA local plans that
16 have in effect (as of the date of enactment of
17 the America’s Healthy Future Act of 2009)—

18 “(i) agreements with another MA or-
19 ganization or MA plan that preclude the
20 offering of benefits throughout an entire
21 service area; or

22 “(ii) limitations in their structural ca-
23 pacity to support adequate networks
24 throughout an entire service area as a re-

1 sult of the delivery system model of the
2 MA local plan.”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) IN GENERAL.—

5 (i) Section 1851(b)(1) of the Social
6 Security Act (42 U.S.C. 1395w–21(b)(1))
7 is amended by striking subparagraph (C).

8 (ii) Section 1853(b)(1)(B)(i) of such
9 Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

10 (I) in the matter preceding sub-
11 clause (I), by striking “MA payment
12 area” and inserting “MA local area
13 (as defined in subsection (d)(2))”; and

14 (II) in subclause (I), by striking
15 “MA payment area” and inserting
16 “MA local area (as so defined)”.

17 (iii) Section 1853(b)(4) of such Act
18 (42 U.S.C. 1395w–23(b)(4)) is amended
19 by striking “Medicare Advantage payment
20 area” and inserting “MA local area (as so
21 defined)”.

22 (iv) Section 1853(c)(1) of such Act
23 (42 U.S.C. 1395w–23(c)(1)) is amended—

24 (I) in the matter preceding sub-
25 paragraph (A), by striking “a Medi-

1 care Advantage payment area that
2 is”; and

3 (II) in subparagraph (D)(i), by
4 striking “MA payment area” and in-
5 serting “MA local area (as defined in
6 subsection (d)(2))”.

7 (v) Section 1854 of such Act (42
8 U.S.C. 1395w-24) is amended by striking
9 subsection (h).

10 (B) EFFECTIVE DATE.—The amendments
11 made by this paragraph shall take effect on
12 January 1, 2012.

13 (f) PERFORMANCE BONUSES.—

14 (1) MA PLANS.—

15 (A) IN GENERAL.—Section 1853 of the So-
16 cial Security Act (42 U.S.C. 1395w-23) is
17 amended by adding at the end the following
18 new subsection:

19 “(n) PERFORMANCE BONUSES.—

20 “(1) CARE COORDINATION AND MANAGEMENT
21 PERFORMANCE BONUS.—

22 “(A) IN GENERAL.—For years beginning
23 with 2014, subject to subparagraph (B), in the
24 case of an MA plan that conducts 1 or more
25 programs described in subparagraph (C) with

1 respect to the year, the Secretary shall, in addi-
2 tion to any other payment provided under this
3 part, make monthly payments to the MA plan
4 in an amount equal to the product of—

5 “(i) 0.5 percent of the national
6 monthly per capita cost for expenditures
7 for individuals enrolled under the original
8 medicare fee-for-service program for the
9 year; and

10 “(ii) the total number of programs de-
11 scribed in clauses (i) through (ix) of sub-
12 paragraph (C) that the Secretary deter-
13 mines the plan is conducting for the year
14 under such subparagraph.

15 “(B) LIMITATION.—In no case may the
16 total amount of payment with respect to a year
17 under subparagraph (A) be greater than 2 per-
18 cent of the national monthly per capita cost for
19 expenditures for individuals enrolled under the
20 original medicare fee-for-service program for
21 the year, as determined prior to the application
22 of risk adjustment under paragraph (4).

23 “(C) PROGRAMS DESCRIBED.—The fol-
24 lowing programs are described in this para-
25 graph:

1 “(i) Care management programs
2 that—

3 “(I) target individuals with 1 or
4 more chronic conditions;

5 “(II) identify gaps in care; and

6 “(III) facilitate improved care by
7 using additional resources like nurses,
8 nurse practitioners, and physician as-
9 sistants.

10 “(ii) Programs that focus on patient
11 education and self-management of health
12 conditions, including interventions that—

13 “(I) help manage chronic condi-
14 tions;

15 “(II) reduce declines in health
16 status; and

17 “(III) foster patient and provider
18 collaboration.

19 “(iii) Transitional care interventions
20 that focus on care provided around a hos-
21 pital inpatient episode, including programs
22 that target post-discharge patient care in
23 order to reduce unnecessary health com-
24 plications and readmissions.

1 “(iv) Patient safety programs, includ-
2 ing provisions for hospital-based patient
3 safety programs in contracts that the
4 Medicare Advantage organization offering
5 the MA plan has with hospitals.

6 “(v) Financial policies that promote
7 systematic coordination of care by primary
8 care physicians across the full spectrum of
9 specialties and sites of care, such as med-
10 ical homes, capitation arrangements, or
11 pay-for-performance programs.

12 “(vi) Programs that address, identify,
13 and ameliorate health care disparities
14 among principal at-risk subpopulations.

15 “(vii) Medication therapy manage-
16 ment programs that are more extensive
17 than is required under section 1860D-4(c)
18 (as determined by the Secretary).

19 “(viii) Health information technology
20 programs, including clinical decision sup-
21 port and other tools to facilitate data col-
22 lection and ensure patient-centered, appro-
23 priate care.

1 “(ix) Such other care management
2 and coordination programs as the Sec-
3 retary determines appropriate.

4 “(D) CONDUCT OF PROGRAM IN URBAN
5 AND RURAL AREAS.—An MA plan may conduct
6 a program described in subparagraph (C) in a
7 manner appropriate for an urban or rural area,
8 as applicable.

9 “(E) REPORTING OF DATA.—Each Medi-
10 care Advantage organization shall provide for
11 the reporting to the Secretary of information
12 specified by the Secretary (in order to deter-
13 mine whether an MA plan is eligible for a care
14 coordination and management performance
15 bonus under this paragraph) at such time and
16 in such manner as the Secretary shall specify.

17 “(F) PERIODIC AUDITING.—The Secretary
18 shall provide for the annual auditing of pro-
19 grams described in subparagraph (C) for which
20 an MA plan receives a care coordination and
21 management performance bonus under this
22 paragraph. The Comptroller General shall mon-
23 itor auditing activities conducted under this
24 subparagraph.

25 “(2) QUALITY PERFORMANCE BONUSES.—

1 “(A) QUALITY BONUS.—For years begin-
2 ning with 2014, the Secretary shall, in addition
3 to any other payment provided under this part,
4 make monthly payments to an MA plan that
5 achieves at least a 3 star rating (or comparable
6 rating) on a rating system described in sub-
7 paragraph (C) in an amount equal to—

8 “(i) in the case of a plan that achieves
9 a 3 star rating (or comparable rating) on
10 such system 2 percent of the national
11 monthly per capita cost for expenditures
12 for individuals enrolled under the original
13 medicare fee-for-service program for the
14 year; and

15 “(ii) in the case of a plan that
16 achieves a 4 or 5 star rating (or com-
17 parable rating on such system, 4 percent
18 of such national monthly per capita cost
19 for the year.

20 “(B) IMPROVED QUALITY BONUS.—For
21 years beginning with 2014, in the case of an
22 MA plan that does not receive a quality bonus
23 under subparagraph (A) and is an improved
24 quality MA plan with respect to the year (as
25 identified by the Secretary), the Secretary shall,

1 in addition to any other payment provided
2 under this part, make monthly payments to the
3 MA plan in an amount equal to 1 percent of
4 such national monthly per capita cost for the
5 year.

6 “(C) USE OF RATING SYSTEM.—For pur-
7 poses of subparagraph (A), a rating system de-
8 scribed in this paragraph is—

9 “(i) a rating system that uses up to 5
10 stars to rate clinical quality and enrollee
11 satisfaction and performance at the Medi-
12 care Advantage contract or MA plan level;
13 or

14 “(ii) such other system established by
15 the Secretary that provides for the deter-
16 mination of a comparable quality perform-
17 ance rating to the rating system described
18 in clause (i).

19 “(D) DATA USED IN DETERMINING
20 SCORE.—

21 “(i) IN GENERAL.—The rating of an
22 MA plan under the rating system described
23 in subparagraph (C) with respect to a year
24 shall be based on based on the most recent
25 data available.

1 “(ii) PLANS THAT FAIL TO REPORT
2 DATA.—An MA plan which does not report
3 data that enables the Secretary to rate the
4 plan for purposes of subparagraph (A) or
5 identify the plan for purposes of subpara-
6 graph (B) shall be counted, for purposes of
7 such rating or identification, as having the
8 lowest plan performance rating and the
9 lowest percentage improvement, respec-
10 tively.

11 “(3) QUALITY BONUS FOR NEW AND LOW EN-
12 ROLLMENT MA PLANS.—

13 “(A) NEW MA PLANS.—For years begin-
14 ning with 2014, in the case of an MA plan that
15 has been in operation for less than 3 years and
16 was not able to receive a bonus under subpara-
17 graph (A) or (B) of paragraph (2) for the year,
18 the Secretary shall, in addition to any other
19 payment provided under this part, make month-
20 ly payments to the MA plan in an amount equal
21 to 2 percent of national monthly per capita cost
22 for expenditures for individuals enrolled under
23 the original medicare fee-for-service program
24 for the year. In its fourth year of operation, the

1 MA plan shall be paid in the same manner as
2 other MA plans with comparable enrollment.

3 “(B) LOW ENROLLMENT PLANS.—For
4 years beginning with 2014, in the case of an
5 MA plan that has low enrollment (as defined by
6 the Secretary) and would not otherwise be able
7 to receive a bonus under subparagraph (A) or
8 (B) of paragraph (2) or subparagraph (A) of
9 this paragraph for the year (referred to in this
10 subparagraph as a ‘low enrollment plan’), the
11 Secretary shall use a regional or local mean of
12 the rating of all MA plans in the region or local
13 area, as determined appropriate by the Sec-
14 retary, on measures used to determine whether
15 MA plans are eligible for a quality or an im-
16 proved quality bonus, as applicable, to deter-
17 mine whether the low enrollment plan is eligible
18 for a bonus under such a subparagraph.

19 “(4) RISK ADJUSTMENT.—The Secretary shall
20 risk adjust a performance bonus under this sub-
21 section in the same manner as the Secretary risk ad-
22 justs beneficiary rebates described in section
23 1854(b)(1)(C).

24 “(5) NOTIFICATION.—The Secretary, in the an-
25 nual announcement required under subsection

1 (b)(1)(B) for 2014 and each succeeding year, shall
2 notify the Medicare Advantage organization of any
3 performance bonus (including a care coordination
4 and management performance bonus under para-
5 graph (1), a quality performance bonus under para-
6 graph (2), and a quality bonus for new and low en-
7 rollment plans under paragraph (3)) that the organi-
8 zation will receive under this subsection with respect
9 to the year. The Secretary shall provide for the pub-
10 lication of the information described in the previous
11 sentence on the Internet website of the Centers for
12 Medicare & Medicaid Services.”.

13 (B) CONFORMING AMENDMENT.—Section
14 1853(a)(1)(B) of the Social Security Act (42
15 U.S.C. 1395w–23(a)(1)(B)) is amended—

16 (i) in clause (i), by inserting “and any
17 performance bonus under subsection (n)”
18 before the period at the end; and

19 (ii) in clause (ii), by striking “(G)”
20 and inserting “(G), plus the amount (if
21 any) of any performance bonus under sub-
22 section (n)”.

23 (2) APPLICATION OF PERFORMANCE BONUSSES
24 TO MA REGIONAL PLANS.—Section 1858 of the So-

1 cial Security Act (42 U.S.C. 1395w–27a) is amend-
2 ed—

3 (A) in subsection (f)(1), by striking “sub-
4 section (e)” and inserting “subsections (e) and
5 (i)”; and

6 (B) by adding at the end the following new
7 subsection:

8 “(i) APPLICATION OF PERFORMANCE BONUSES TO
9 MA REGIONAL PLANS.—For years beginning with 2014,
10 the Secretary shall apply the performance bonuses under
11 section 1853(n) (relating to bonuses for care coordination
12 and management, quality performance, and new and low
13 enrollment MA plans) to MA regional plans in a similar
14 manner as such performance bonuses apply to MA plans
15 under such subsection.”.

16 (g) GRANDFATHERING SUPPLEMENTAL BENEFITS
17 FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF
18 COMPETITIVE BIDDING.—Section 1853 of the Social Se-
19 curity Act (42 U.S.C. 1395w–23), as amended by sub-
20 section (f), is amended by adding at the end the following
21 new subsection:

22 “(o) GRANDFATHERING SUPPLEMENTAL BENEFITS
23 FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF
24 COMPETITIVE BIDDING.—

1 “(1) IDENTIFICATION OF AREAS.—The Sec-
2 retary shall identify MA local areas in which, with
3 respect to 2011, average bids submitted by an MA
4 organization under section 1854(a) for MA local
5 plans in the area are not greater than 75 percent of
6 the adjusted average per capita cost for the year in-
7 volved, determined under section 1876(a)(4), for the
8 area for individuals who are not enrolled in an MA
9 plan under this part for the year, but adjusted to ex-
10 clude costs attributable to payments under section
11 1848(o), 1886(n), and 1886(h).

12 “(2) ELECTION TO PROVIDE REBATES TO
13 GRANDFATHERED ENROLLEES.—

14 “(A) IN GENERAL.—For years beginning
15 with 2012, each Medicare Advantage organiza-
16 tion offering an MA local plan in an area iden-
17 tified by the Secretary under paragraph (1)
18 may elect to provide rebates to grandfathered
19 enrollees under section 1854(b)(1)(C). In the
20 case where an MA organization makes such an
21 election, the monthly per capita dollar amount
22 of such rebates shall not exceed the applicable
23 amount for the year.

1 “(B) APPLICABLE AMOUNT.—For purposes
2 of this subsection, the term ‘applicable amount’
3 means—

4 “(i) for 2012, the monthly per capita
5 dollar amount of such rebates provided to
6 enrollees under the MA local plan with re-
7 spect to 2011; and

8 “(ii) for a subsequent year, 95 percent
9 of the amount determined under this sub-
10 paragraph for the preceding year.

11 “(3) SPECIAL RULES FOR PLANS IN IDENTI-
12 FIED AREAS.—Notwithstanding any other provision
13 of this part, the following shall apply with respect to
14 each Medicare Advantage organization offering an
15 MA local plan in an area identified by the Secretary
16 under paragraph (1) that makes an election de-
17 scribed in paragraph (2):

18 “(A) PAYMENTS.—The amount of the
19 monthly payment under this section to the
20 Medicare Advantage organization, with respect
21 to coverage of a grandfathered enrollee under
22 this part in the area for a month, shall be equal
23 to—

24 “(i) for 2012 and 2013, the sum of—

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1 “(I) the bid amount under sec-
2 tion 1854(a) for the MA local plan;
3 and

4 “(II) the applicable amount (as
5 defined in paragraph (2)(B)) for the
6 MA local plan for the year.

7 “(ii) for 2014 and subsequent years,
8 the sum of—

9 “(I) the MA competitive bench-
10 mark amount under subsection
11 (j)(1)(A)(i) for the area for the
12 month, adjusted, only to the extent
13 the Secretary determines necessary, to
14 account for induced utilization as a
15 result of rebates provided to grand-
16 fathered enrollees (except that such
17 adjustment shall not exceed 0.5 per-
18 cent of such MA competitive bench-
19 mark amount); and

20 “(II) the applicable amount (as
21 so defined) for the MA local plan for
22 the year.

23 “(B) REQUIREMENT TO SUBMIT BIDS
24 UNDER COMPETITIVE BIDDING.—The Medicare
25 Advantage organization shall submit a single

1 bid amount under section 1854(a) for the MA
2 local plan. The Medicare Advantage organiza-
3 tion shall remove from such bid amount any ef-
4 fects of induced demand for care that may re-
5 sult from the higher rebates available to grand-
6 fathered enrollees under this subsection.

7 “(C) NONAPPLICATION OF BONUS PAY-
8 MENTS AND ANY OTHER REBATES.—The Medi-
9 care Advantage organization offering the MA
10 local plan shall not be eligible for any bonus
11 payment under subsection (n) or any rebate
12 under this part (other than as provided under
13 this subsection) with respect to grandfathered
14 enrollees.

15 “(D) NONAPPLICATION OF SERVICE
16 AREAS.—The service areas established under
17 subsection (d)(5) shall not apply with respect to
18 the MA local plan in the area so identified.

19 “(E) NONAPPLICATION OF LIMITATION ON
20 APPLICATION OF PLAN REBATES TOWARD PAY-
21 MENT OF PART B PREMIUM.—Notwithstanding
22 clause (iii) of section 1854(b)(1)(C), in the case
23 of a grandfathered enrollee, a rebate under such
24 section may be used for the purpose described
25 in clause (ii)(III) of such section.

1 “(F) RISK ADJUSTMENT.—The Secretary
2 shall risk adjust rebates to grandfathered en-
3 rollees under this subsection in the same man-
4 ner as the Secretary risk adjusts beneficiary re-
5 bates described in section 1854(b)(1)(C).

6 “(4) DEFINITION OF GRANDFATHERED EN-
7 ROLLEE.—In this subsection, the term ‘grand-
8 fathered enrollee’ means an individual who is en-
9 rolled (as of the date of enactment of this sub-
10 section) in an MA local plan in an area that is iden-
11 tified by the Secretary under paragraph (1).”.

12 (h) TRANSITIONAL EXTRA BENEFITS.—Section 1853
13 of the Social Security Act (42 U.S.C. 1395w-23), as
14 amended by subsections (f) and (g), is amended by adding
15 at the end the following new subsection:

16 “(p) TRANSITIONAL EXTRA BENEFITS.—

17 “(1) IN GENERAL.—For years beginning with
18 2012, the Secretary shall provide transitional re-
19 bates under section 1854(b)(1)(C) for the provision
20 of extra benefits (as specified by the Secretary) to
21 enrollees described in paragraph (2).

22 “(2) ENROLLEES DESCRIBED.—An enrollee de-
23 scribed in this paragraph is an individual who—

24 “(A) enrolls in an MA local plan in an ap-
25 plicable area; and

1 “(B) experiences a significant reduction in
2 extra benefits described in clause (ii) of section
3 1854(b)(1)(C) as a result of competitive bidding
4 under this part (as determined by the Sec-
5 retary).

6 “(3) APPLICABLE AREAS.—In this subsection,
7 the term ‘applicable area’ means the following:

8 “(A) The 2 largest metropolitan statistical
9 areas, if the Secretary determines that the total
10 amount of such extra benefits for each enrollee
11 for the month in those areas is greater than
12 \$100.

13 “(B) A county where—

14 “(i) the MA area-specific non-drug
15 monthly benchmark amount for a month in
16 2011 is equal to the legacy urban floor
17 amount (as described in subsection
18 (c)(1)(B)(iii)), as determined by the Sec-
19 retary for the area for 2011;

20 “(ii) the percentage of Medicare Ad-
21 vantage eligible beneficiaries in the county
22 who are enrolled in an MA plan for 2011
23 is greater than 30 percent (as determined
24 by the Secretary); and

1 “(iii) average bids submitted by an
2 MA organization under section 1854(a) for
3 MA local plans in the county for 2011 are
4 not greater than the adjusted average per
5 capita cost for the year involved, deter-
6 mined under section 1876(a)(4), for the
7 county for individuals who are not enrolled
8 in an MA plan under this part for the
9 year, but adjusted to exclude costs attrib-
10 utable to payments under section 1848(o),
11 1886(n), and 1886(h).

12 “(C) If the Secretary determines appro-
13 priate, a county contiguous to an area or coun-
14 ty described in subparagraph (A) or (B), re-
15 spectively.

16 “(4) REVIEW OF PLAN BIDS.—In the case of a
17 bid submitted by an MA organization under section
18 1854(a) for an MA local plan in an applicable area,
19 the Secretary shall review such bid in order to en-
20 sure that extra benefits (as specified by the Sec-
21 retary) are provided to enrollees described in para-
22 graph (2).

23 “(5) FUNDING.—The Secretary shall provide
24 for the transfer from the Federal Hospital Insurance
25 Trust Fund under section 1817 and the Federal

1 Supplementary Medical Insurance Trust Fund es-
2 tablished under section 1841, in such proportion as
3 the Secretary determines appropriate, of
4 \$5,000,000,000 for the period of fiscal years 2012
5 through 2019 for the purpose of providing transi-
6 tional rebates under section 1854(b)(1)(C) for the
7 provision of extra benefits under this subsection.”.

8 (i) NONAPPLICATION OF COMPETITIVE BIDDING AND
9 RELATED PROVISIONS AND CLARIFICATION OF MA PAY-
10 MENT AREA FOR PACE PROGRAMS.—

11 (1) NONAPPLICATION OF COMPETITIVE BID-
12 DING AND RELATED PROVISIONS FOR PACE PRO-
13 GRAMS.—Section 1894 of the Social Security Act
14 (42 U.S.C. 1395eee) is amended—

15 (A) by redesignating subsections (h) and
16 (i) as subsections (i) and (j), respectively;

17 (B) by inserting after subsection (g) the
18 following new subsection:

19 “(h) NONAPPLICATION OF COMPETITIVE BIDDING
20 AND RELATED PROVISIONS UNDER PART C.—With re-
21 spect to a PACE program under this section, the following
22 provisions (and regulations relating to such provisions)
23 shall not apply:

1 “(1) Section 1853(j)(1)(A)(i), relating to MA
2 area-specific non-drug monthly benchmark amount
3 being based on competitive bids.

4 “(2) Section 1853(d)(5), relating to the estab-
5 lishment of MA local plan service areas.

6 “(3) Section 1853(n), relating to the payment
7 of performance bonuses.

8 “(4) Section 1853(o), relating to
9 grandfathering supplemental benefits for current en-
10 rollees after implementation of competitive bidding.

11 “(5) Section 1853(p), relating to transitional
12 extra benefits.”.

13 (2) SPECIAL RULE FOR MA PAYMENT AREA FOR
14 PACE PROGRAMS.—Section 1853(d) of the Social Se-
15 curity Act (42 U.S.C. 1395w-23(d)), as amended by
16 subsection (e), is amended by adding at the end the
17 following new paragraph:

18 “(6) SPECIAL RULE FOR MA PAYMENT AREA
19 FOR PACE PROGRAMS.—For years beginning with
20 2012, in the case of a PACE program under section
21 1894, the MA payment area shall be the MA local
22 area (as defined in paragraph (2)).”.

23 (j) LIMITATION ON EFFECTIVE DATE.—Notwith-
24 standing any other provision of this section or the amend-
25 ments made by this section, such provisions or amend-

1 ments shall not take effect if the Chief Actuary of the Cen-
2 ters for Medicare & Medicaid Services certifies, not later
3 than 3 months after the date of enactment of this Act,
4 that Medicare beneficiaries currently enrolled in Medicare
5 Advantage plans will, as a result of the implementation
6 of those provisions or amendments, lose basic benefits
7 which are available under parts A and B of title XVIII
8 of the Social Security Act to individuals entitled to bene-
9 fits under such part A and enrolled under such part B.

10 **SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.**

11 (a) LIMITATION ON VARIATION OF COST SHARING
12 FOR CERTAIN BENEFITS.—

13 (1) IN GENERAL.—Section 1852(a)(1)(B) of the
14 Social Security Act (42 U.S.C. 1395w–22(a)(1)(B))
15 is amended—

16 (A) in clause (i), by inserting “, subject to
17 clause (iii),” after “and B or”; and

18 (B) by adding at the end the following new
19 clauses:

20 “(iii) LIMITATION ON VARIATION OF
21 COST SHARING FOR CERTAIN BENEFITS.—

22 Subject to clause (v), cost-sharing for serv-
23 ices described in clause (iv) shall not ex-
24 ceed the cost-sharing required for those
25 services under parts A and B.

1 “(iv) SERVICES DESCRIBED.—The fol-
2 lowing services are described in this clause:

3 “(I) Chemotherapy administra-
4 tion services.

5 “(II) Renal dialysis services (as
6 defined in section 1881(b)(14)(B)).

7 “(III) Skilled nursing care.

8 “(IV) Such other services that
9 the Secretary determines appropriate
10 (including services that the Secretary
11 determines require a high level of pre-
12 dictability and transparency for bene-
13 ficiaries).

14 “(v) EXCEPTION.—In the case of
15 services described in clause (iv) for which
16 there is no cost-sharing required under
17 parts A and B, cost-sharing may be re-
18 quired for those services in accordance
19 with clause (i).”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by this subsection shall apply to plan years begin-
22 ning on or after January 1, 2011.

23 (b) APPLICATION OF REBATES, PERFORMANCE BO-
24 NUSES, AND PREMIUMS.—

1 and B and for qualified prescription
2 drug coverage under part D, including
3 the reduction of any deductibles, co-
4 payments, and maximum limitations
5 on out-of-pocket expenses otherwise
6 applicable. Any reduction of maximum
7 limitations on out-of-pocket expenses
8 under the preceding sentence shall
9 apply to all benefits under the original
10 medicare fee-for-service program op-
11 tion. The Secretary may provide guid-
12 ance on meaningfully reducing cost-
13 sharing under this subclause, except
14 that such guidance may not require a
15 particular amount of cost-sharing or
16 reduction in cost-sharing.

17 “(II) Second, to use the next
18 most significant share to meaningfully
19 provide coverage of preventive and
20 wellness health care benefits (as de-
21 fined by the Secretary) which are not
22 benefits under the original medicare
23 fee-for-service program, such as smok-
24 ing cessation, a free flu shot, and an
25 annual physical examination.

1 “(III) Third, to use the remain-
2 ing share to meaningfully provide cov-
3 erage of other health care benefits
4 which are not benefits under the origi-
5 nal medicare fee-for-service program,
6 such as eye examinations and dental
7 coverage, and are not benefits de-
8 scribed in subclause (II).”.

9 (2) APPLICATION OF PERFORMANCE BO-
10 NUSES.—Section 1853(n) of the Social Security Act,
11 as added by section 3201(f), is amended by adding
12 at the end the following new paragraph:

13 “(6) APPLICATION OF PERFORMANCE BO-
14 NUSES.—For plan years beginning on or after Janu-
15 ary 1, 2014, any performance bonus paid to an MA
16 plan under this subsection shall be used for the pur-
17 poses, and in the priority order, described in sub-
18 clauses (I) through (III) of section
19 1854(b)(1)(C)(iii).”.

20 (3) APPLICATION OF MA MONTHLY SUPPLE-
21 MENTARY BENEFICIARY PREMIUM.—Section
22 1854(b)(2)(C) of the Social Security Act (42 U.S.C.
23 1395w-24(b)(2)(C)) is amended—

24 (A) by striking “PREMIUM.—The term”
25 and inserting “PREMIUM.—

1 “(i) IN GENERAL.—The term”; and
2 (i) by adding at the end the following
3 new clause:
4 “(ii) APPLICATION OF MA MONTHLY
5 SUPPLEMENTARY BENEFICIARY PRE-
6 MIUM.—For plan years beginning on or
7 after January 1, 2012, any MA monthly
8 supplementary beneficiary premium
9 charged to an individual enrolled in an MA
10 plan shall be used for the purposes, and in
11 the priority order, described in subclauses
12 (I) through (III) of paragraph
13 (1)(C)(iii).”.

14 (c) CATEGORIZATION OF MEDICARE ADVANTAGE
15 PLANS.—

16 (1) IN GENERAL.—Section 1851 of the Social
17 Security Act (42 U.S.C. 1395w–21) is amended by
18 adding at the end the following new subsection:

19 “(k) CATEGORIZATION OF PLANS.—

20 “(1) IN GENERAL.—Not later than January 1,
21 2011, the Secretary shall establish 2 or more cat-
22 egories of MA plans offered by Medicare Advantage
23 organizations based on the ratio of the amount de-
24 scribed in paragraph (2) to the aggregate monthly
25 bid amount submitted under clause (i) of section

1 1854(a)(6)(A) for the year, expressed as a percent-
2 age.

3 “(2) AMOUNT DESCRIBED.—The amount de-
4 scribed in this paragraph is the sum of—

5 “(A) the amount of such aggregate month-
6 ly bid amount that is attributable under clause
7 (ii)(III) of such section to the provision of sup-
8 plemental health care benefits; and

9 “(B) the amount (if any) of any rebate
10 under section 1853(a)(1)(E).

11 “(3) REQUIRED INCLUSION OF CATEGORY IN
12 PLAN NAME AND MARKETING MATERIALS.—For plan
13 years beginning on or after January 1, 2011, a
14 Medicare Advantage organization shall ensure that
15 the name of each MA plan offered by the Medicare
16 Advantage organization and any marketing mate-
17 rials with respect to such plan include the category
18 of the plan, as determined under paragraph (1).”.

19 (2) REQUIRED INCLUSION OF CATEGORY IN IN-
20 FORMATION PROVIDED TO PROMOTE INFORMED
21 CHOICE.—Section 1851(d)(4) of the Social Security
22 Act (42 U.S.C. 1395w–21(d)(4)) is amended by add-
23 ing at the end the following new subparagraph:

24 “(F) INFORMATION REGARDING PLAN CAT-
25 EGORY.—For plan years beginning on or after

1 January 1, 2011, the category of the plan (as
2 determined under subsection (k)(1)).”.

3 **SEC. 3203. APPLICATION OF CODING INTENSITY ADJUST-**
4 **MENT DURING MA PAYMENT TRANSITION.**

5 Section 1853(a)(1)(C) of the Social Security Act (42
6 U.S.C. 1395w-23(a)(1)(C)) is amended by adding at the
7 end the following new clause:

8 “(iii) APPLICATION OF CODING IN-
9 TENSITY ADJUSTMENT FOR 2011 AND SUB-
10 SEQUENT YEARS.—

11 “(I) REQUIREMENT TO APPLY IN
12 2011 THROUGH 2013.—In order to en-
13 sure payment accuracy, the Secretary
14 shall conduct an analysis of the dif-
15 ferences described in clause (ii)(I).
16 The Secretary shall ensure that the
17 results of such analysis are incor-
18 porated into the risk scores for 2011,
19 2012, and 2013.

20 “(II) AUTHORITY TO APPLY IN
21 2014 AND SUBSEQUENT YEARS.—The
22 Secretary may, as appropriate, incor-
23 porate the results of such analysis
24 into the risk scores for 2014 and sub-
25 sequent years.”.

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1 **SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY**
2 **ELECTION PERIODS.**

3 (a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT
4 FROM MA PLANS TO ELECT TO RECEIVE BENEFITS
5 UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE
6 PROGRAM.—

7 (1) IN GENERAL.—Section 1851(e)(2)(C) of the
8 Social Security Act (42 U.S.C. 1395w-1(e)(2)(C)) is
9 amended to read as follows:

10 “(C) ANNUAL 45-DAY PERIOD FOR
11 DISENROLLMENT FROM MA PLANS TO ELECT TO
12 RECEIVE BENEFITS UNDER THE ORIGINAL
13 MEDICARE FEE-FOR-SERVICE PROGRAM.—Sub-
14 ject to subparagraph (D), at any time during
15 the first 45 days of a year (beginning with
16 2011), an individual who is enrolled in a Medi-
17 care Advantage plan may change the election
18 under subsection (a)(1), but only with respect
19 to coverage under the original medicare fee-for-
20 service program under parts A and B.”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply with respect to 2011
23 and succeeding years.

24 (b) TIMING OF THE ANNUAL, COORDINATED ELEC-
25 TION PERIOD UNDER PARTS C AND D.—Section

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1 1851(e)(3)(B) of the Social Security Act (42 U.S.C.
2 1395w-1(e)(3)(B)) is amended—

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

4 (2) in clause (iv)—

5 (A) by striking “and succeeding years”
6 and inserting “, 2008, 2009, and 2010”; and

7 (B) by striking the period at the end and
8 inserting “; and”; and

9 (3) by adding at the end the following new
10 clause:

11 “(v) with respect to 2012 and suc-
12 ceeding years, the period beginning on Oc-
13 tober 15 and ending on December 7 of the
14 year before such year.”.

15 **SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR**
16 **SPECIAL NEEDS INDIVIDUALS.**

17 (a) **EXTENSION OF SNP AUTHORITY.**—Section
18 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-
19 28(f)(1)), as amended by section 164(a) of the Medicare
20 Improvements for Patients and Providers Act of 2008
21 (Public Law 110-275), is amended by striking “2011”
22 and inserting “2014”.

23 (b) **AUTHORITY TO APPLY FRAILTY ADJUSTMENT**
24 **UNDER PACE PAYMENT RULES.**—Section 1853(a)(1)(B)

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1 of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(B))
2 is amended by adding at the end the following new clause:

3 “(iv) AUTHORITY TO APPLY FRAILTY
4 ADJUSTMENT UNDER PACE PAYMENT
5 RULES FOR CERTAIN SPECIALIZED MA
6 PLANS FOR SPECIAL NEEDS INDIVID-
7 UALS.—

8 “(I) IN GENERAL.—Notwith-
9 standing the preceding provisions of
10 this paragraph, for plan year 2011
11 and subsequent plan years, in the case
12 of a plan described in subclause (II),
13 the Secretary may apply the payment
14 rules under section 1894(d) (other
15 than paragraph (3) of such section)
16 rather than the payment rules that
17 would otherwise apply under this part,
18 but only to the extent necessary to re-
19 flect the costs of treating high con-
20 centrations of frail individuals.

21 “(II) PLAN DESCRIBED.—A plan
22 described in this subclause is a spe-
23 cialized MA plan for special needs in-
24 dividuals described in section
25 1859(b)(6)(B)(ii) that is fully inte-

1 grated with capitated contracts with
2 States for Medicaid benefits, including
3 long-term care, and that have similar
4 average levels of frailty (as deter-
5 mined by the Secretary) as the PACE
6 program.”.

7 (c) TRANSITION AND EXCEPTION REGARDING RE-
8 STRICTION ON ENROLLMENT.—Section 1859(f) of the So-
9 cial Security Act (42 U.S.C. 1395w–28(f)) is amended by
10 adding at the end the following new paragraph:

11 “(6) TRANSITION AND EXCEPTION REGARDING
12 RESTRICTION ON ENROLLMENT.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (C), the Secretary shall establish proce-
15 dures for the transition of applicable individuals
16 to—

17 “(i) a Medicare Advantage plan that
18 is not a specialized MA plan for special
19 needs individuals (as defined in subsection
20 (b)(6)); or

21 “(ii) the original medicare fee-for-
22 service program under parts A and B.

23 “(B) APPLICABLE INDIVIDUALS.—For pur-
24 poses of clause (i), the term ‘applicable indi-
25 vidual’ means an individual who—

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1 “(i) is enrolled under a specialized
2 MA plan for special needs individuals (as
3 defined in subsection (b)(6)); and

4 “(ii) is not within the 1 or more of
5 the classes of special needs individuals to
6 which enrollment under the plan is re-
7 stricted to.

8 “(C) EXCEPTION.—The Secretary shall
9 provide for an exception to the transition de-
10 scribed in subparagraph (A) for a limited pe-
11 riod of time for individuals enrolled under a
12 specialized MA plan for special needs individ-
13 uals described in subsection (b)(6)(B)(ii) who
14 are no longer eligible for medical assistance
15 under title XIX.

16 “(D) TIMELINE FOR INITIAL TRANSI-
17 TION.—The Secretary shall ensure that applica-
18 ble individuals enrolled in a specialized MA plan
19 for special needs individuals (as defined in sub-
20 section (b)(6)) prior to January 1, 2010, are
21 transitioned to a plan or the program described
22 in subparagraph (A) by not later than January
23 1, 2013.”.

24 (d) TEMPORARY EXTENSION OF AUTHORITY TO OP-
25 ERATE BUT NO SERVICE AREA EXPANSION FOR DUAL

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1 SNPS THAT DO NOT MEET CERTAIN REQUIREMENTS.—

2 Section 164(c)(2) of the Medicare Improvements for Pa-

3 tients and Providers Act of 2008 (Public Law 110–275)

4 is amended by striking “December 31, 2010” and insert-

5 ing “December 31, 2012”.

6 (e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS

7 BE NCQA APPROVED.—Section 1859(f) of the Social Se-

8 curity Act (42 U.S.C. 1395w–28(f)), as amended by sub-

9 sections (a) and (c), is amended—

10 (1) in paragraph (2), by adding at the end the

11 following new subparagraph:

12 “(C) If applicable, the plan meets the re-

13 quirement described in paragraph (7).”;

14 (2) in paragraph (3), by adding at the end the

15 following new subparagraph:

16 “(E) If applicable, the plan meets the re-

17 quirement described in paragraph (7).”;

18 (3) in paragraph (4), by adding at the end the

19 following new subparagraph:

20 “(C) If applicable, the plan meets the re-

21 quirement described in paragraph (7).”; and

22 (4) by adding at the end the following new

23 paragraph:

24 “(7) AUTHORITY TO REQUIRE SPECIAL NEEDS

25 PLANS BE NCQA APPROVED.—For 2012 and subse-

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1 special needs individuals (as defined
2 in section 1859(b)(6)).

3 “(II) INDIVIDUALS DE-
4 SCRIBED.—An individual described in
5 this subclause is a special needs indi-
6 vidual described in subsection
7 (b)(6)(B)(iii) who enrolls in a special-
8 ized MA plan for special needs indi-
9 viduals on or after January 1, 2011.

10 “(III) EVALUATION.—For 2011
11 and periodically thereafter, the Sec-
12 retary shall evaluate and revise the
13 risk adjustment system under this
14 subparagraph in order to, as accu-
15 rately as possible, account for higher
16 medical and care coordination costs
17 associated with frailty, individuals
18 with multiple, comorbid chronic condi-
19 tions, and individuals with a diagnosis
20 of mental illness, and also to account
21 for costs that may be associated with
22 higher concentrations of beneficiaries
23 with those conditions.

24 “(IV) PUBLICATION OF EVALUA-
25 TION AND REVISIONS.—The Secretary

1 shall publish, as part of an announce-
2 ment under subsection (b), a descrip-
3 tion of any evaluation conducted
4 under subclause (III) during the pre-
5 ceding year and any revisions made
6 under such subclause as a result of
7 such evaluation.”.

8 (g) TECHNICAL CORRECTION.—Section 1859(f)(5) of
9 the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is
10 amended, in the matter preceding subparagraph (A), by
11 striking “described in subsection (b)(6)(B)(i)”.

12 **SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.**

13 Section 1876(h)(5)(C)(ii) of the Social Security Act
14 (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the mat-
15 ter preceding subclause (I), by striking “January 1, 2010”
16 and inserting “January 1, 2013”.

17 **SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-**
18 **FOR-SERVICE PLANS.**

19 (a) CLARIFICATION REGARDING DEFINITION OF
20 NETWORK AREA.—

21 (1) IN GENERAL.—Section 1852(d)(5)(B) of
22 the Social Security Act (42 U.S.C. 1395w–
23 22(d)(5)(B)) is amended by striking “network-based
24 plans” and inserting “Medicare Advantage organiza-
25 tions offering a network-based plan”.

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1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall take effect as if included in
3 the enactment of section 162 of the Medicare Im-
4 provements for Patients and Providers Act of 2008
5 (Public Law 110–275; 122 Stat. 2569).

6 (b) APPLICATION OF SERVICE AREA WAIVER TO
7 CERTAIN EMPLOYER PLANS.—For plan year 2011 and
8 subsequent plan years, to the extent that the Secretary
9 of Health and Human Services is applying the 2008 serv-
10 ice area extension waiver policy (as modified in the April
11 11, 2008, Centers for Medicare & Medicaid Services’
12 memorandum with the subject “2009 Employer Group
13 Waiver-Modification of the 2008 Service Area Extension
14 Waiver Granted to Certain MA Local Coordinated Care
15 Plans”) to Medicare Advantage coordinated care plans,
16 the Secretary shall extend the application of such waiver
17 policy to employers who contract directly with the Sec-
18 retary as a Medicare Advantage private fee-for-service
19 plan under section 1857(i)(2) of the Social Security Act
20 (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as
21 of October 1, 2009.

1 **SEC. 3208. MAKING SENIOR HOUSING FACILITY DEM-**
2 **ONSTRATION PERMANENT.**

3 (a) IN GENERAL.—Section 1859 of the Social Secu-
4 rity Act (42 U.S.C. 1395w–28) is amended by adding at
5 the end the following new subsection:

6 “(g) SPECIAL RULES FOR SENIOR HOUSING FACIL-
7 ITY PLANS.—

8 “(1) IN GENERAL.—In the case of a Medicare
9 Advantage senior housing facility plan described in
10 paragraph (2), notwithstanding any other provision
11 of this part to the contrary and in accordance with
12 regulations of the Secretary, the service area of such
13 plan may be limited to a senior housing facility in
14 a geographic area.

15 “(2) MEDICARE ADVANTAGE SENIOR HOUSING
16 FACILITY PLAN DESCRIBED.—For purposes of this
17 subsection, a Medicare Advantage senior housing fa-
18 cility plan is a Medicare Advantage plan that—

19 “(A) restricts enrollment of individuals
20 under this part to individuals who reside in a
21 continuing care retirement community (as de-
22 fined in section 1852(l)(4)(B));

23 “(B) provides primary care services onsite
24 and has a ratio of accessible physicians to bene-
25 ficiaries that the Secretary determines is ade-
26 quate;

1 “(C) provides transportation services for
2 beneficiaries to specialty providers outside of
3 the facility; and

4 “(D) has participated (as of December 31,
5 2009) in a demonstration project established by
6 the Secretary under which such a plan was of-
7 fered for not less than 1 year.”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 this section shall take effect on January 1, 2010, and shall
10 apply to plan years beginning on or after such date.

11 **SEC. 3209. DEVELOPMENT OF NEW STANDARDS FOR CER-**
12 **TAIN MEDIGAP PLANS.**

13 (a) IN GENERAL.—Section 1882 of the Social Secu-
14 rity Act (42 U.S.C. 1395ss) is amended by adding at the
15 end the following new subsection:

16 “(y) DEVELOPMENT OF NEW STANDARDS FOR CER-
17 TAIN MEDICARE SUPPLEMENTAL POLICIES.—

18 “(1) IN GENERAL.—The Secretary shall request
19 the National Association of Insurance Commis-
20 sioners to review and revise the standards for benefit
21 packages described in paragraph (2) under sub-
22 section (p)(1), to otherwise update standards to in-
23 clude requirements for nominal cost sharing to en-
24 courage the use of appropriate physicians’ services
25 under part B. Such revisions shall be based on evi-

1 dence published in peer-reviewed journals or current
2 examples used by integrated delivery systems and
3 made consistent with the rules applicable under sub-
4 section (p)(1)(E) with the reference to the ‘1991
5 NAIC Model Regulation’ deemed a reference to the
6 NAIC Model Regulation as published in the Federal
7 Register on December 4, 1998, and as subsequently
8 updated by the National Association of Insurance
9 Commissioners to reflect previous changes in law
10 and the reference to ‘date of enactment of this sub-
11 section’ deemed a reference to the date of enactment
12 of the America’s Healthy Future Act of 2009. To
13 the extent practicable, such revision shall provide for
14 the implementation of revised standards for benefit
15 packages as of January 1, 2015.

16 “(2) BENEFIT PACKAGES DESCRIBED.—The
17 benefit packages described in this paragraph are
18 benefit packages classified as ‘C’ and ‘F’.”.

19 (b) CONFORMING AMENDMENT.—Section 1882(o)(1)
20 of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is
21 amended by striking “, and (w)” and inserting “(w), and
22 (y)”.

1 **Subtitle D—Medicare Part D Im-**
2 **provements for Prescription**
3 **Drug Plans and MA-PD Plans**

4 **SEC. 3301. MEDICARE PRESCRIPTION DRUG DISCOUNT**
5 **PROGRAM FOR BRAND-NAME DRUGS.**

6 (a) CONDITION FOR COVERAGE OF DRUGS UNDER
7 PART D.—Part D of Title XVIII of the Social Security
8 Act (42 U.S.C. 1395w–101 et seq.), is amended by adding
9 at the end the following new section:

10 “CONDITION FOR COVERAGE OF DRUGS UNDER THIS
11 PART

12 “SEC. 1860D–43. (a) IN GENERAL.—In order for
13 coverage to be available under this part for covered part
14 D drugs (as defined in section 1860D–2(e)) of a manufac-
15 turer, the manufacturer must—

16 “(1) participate in the Medicare prescription
17 drug discount program under section 1860D–14A;

18 “(2) have entered into and have in effect an
19 agreement described in subsection (b) of such sec-
20 tion with the Secretary; and

21 “(3) have entered into and have in effect, under
22 terms and conditions specified by the Secretary, a
23 contract with a third party that the Secretary has
24 entered into a contract with under subsection (d)(3)
25 of such section.

1 “(b) EFFECTIVE DATE.—Subsection (a) shall apply
2 to covered part D drugs dispensed under this part on or
3 after July 1, 2010.

4 “(c) AUTHORIZING COVERAGE FOR DRUGS NOT COV-
5 ERED UNDER AGREEMENTS.—Subsection (a) shall not
6 apply to the dispensing of a covered part D drug if—

7 “(1) the Secretary has made a determination
8 that the availability of the drug is essential to the
9 health of beneficiaries under this part; or

10 “(2) the Secretary determines that in the period
11 beginning on July 1, 2010, and ending on December
12 31, 2010, there were extenuating circumstances.

13 “(d) DEFINITION OF MANUFACTURER.—In this sec-
14 tion, the term ‘manufacturer’ has the meaning given such
15 term in section 1860D–14(g)(5).”.

16 (b) MEDICARE PRESCRIPTION DRUG DISCOUNT PRO-
17 GRAM FOR BRAND-NAME DRUGS.—Part D of title XVIII
18 of the Social Security Act (42 U.S.C. 1395w–101) is
19 amended by inserting after section 1860D–14 the fol-
20 lowing new section:

21 “MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM
22 FOR BRAND-NAME DRUGS

23 “SEC. 1860D–14A. (a) ESTABLISHMENT.—The Sec-
24 retary shall establish a Medicare prescription drug dis-
25 count program (in this section referred to as the ‘pro-
26 gram’) by not later than July 1, 2010. Under the pro-

1 gram, the Secretary shall enter into agreements described
2 in subsection (b) with manufacturers and provide for the
3 performance of the duties described in subsection (c)(1).

4 “(b) TERMS OF AGREEMENT.—

5 “(1) IN GENERAL.—

6 “(A) AGREEMENT.—An agreement under
7 this section shall require the manufacturer to
8 provide applicable beneficiaries access to dis-
9 counted prices for applicable drugs of the man-
10 ufacturer.

11 “(B) PROVISION OF DISCOUNTED PRICES
12 AT THE POINT-OF-SALE.—Except as provided in
13 subsection (c)(1)(A)(iii), such discounted prices
14 shall be provided to the applicable beneficiary at
15 the pharmacy or by the mail order service at
16 the point-of-sale of an applicable drug.

17 “(C) TIMING OF AGREEMENT.—

18 “(i) SPECIAL RULE FOR 2010 AND
19 2011.—In order for an agreement with a
20 manufacturer to be in effect under this
21 section with respect to the period begin-
22 ning on July 1, 2010, and ending on De-
23 cember 31, 2011, the manufacturer shall
24 enter into such agreement not later than
25 March 1, 2010.

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1 “(ii) 2012 AND SUBSEQUENT
2 YEARS.—In order for an agreement with a
3 manufacturer to be in effect under this
4 section with respect to plan year 2012 or
5 a subsequent plan year, the manufacturer
6 shall enter into such agreement (or such
7 agreement shall be renewed under para-
8 graph (4)(A)) not later than January 30 of
9 the preceding year.

10 “(2) PROVISION OF APPROPRIATE DATA.—Each
11 manufacturer with an agreement in effect under this
12 section shall collect and have available appropriate
13 data, as determined by the Secretary, to ensure that
14 it can demonstrate compliance with the requirements
15 of paragraph (1).

16 “(3) COMPLIANCE WITH REQUIREMENTS FOR
17 ADMINISTRATION OF PROGRAM.—Each manufac-
18 turer with an agreement in effect under this section
19 shall comply with requirements imposed by the Sec-
20 retary or a third party with a contract under sub-
21 section (d)(3), as applicable, for purposes of admin-
22 istering the program, including any determination
23 under clause (i) of subsection (c)(1)(A) or proce-
24 dures established under such subsection (c)(1)(A).

25 “(4) LENGTH OF AGREEMENT.—

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1 “(A) IN GENERAL.—An agreement under
2 this section shall be effective for an initial pe-
3 riod of not less than 18 months and shall be
4 automatically renewed for a period of not less
5 than 1 year unless terminated under subpara-
6 graph (B).

7 “(B) TERMINATION.—

8 “(i) BY THE SECRETARY.—The Sec-
9 retary may provide for termination of an
10 agreement under this section for violation
11 of the requirements of the agreement or
12 other good cause shown. Such termination
13 shall not be effective earlier than 30 days
14 after the date of notice of such termi-
15 nation. The Secretary shall provide, upon
16 request, a manufacturer with a hearing
17 concerning such a termination, but such
18 hearing shall not delay the effective date of
19 the termination.

20 “(ii) BY A MANUFACTURER.—A man-
21 ufacturer may terminate an agreement
22 under this section for any reason. Any
23 such termination shall not be effective,
24 with respect to a plan year—

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1 “(I) if the termination occurs be-
2 fore January 30 of a plan year, the
3 end of the plan year; and

4 “(II) if the termination occurs on
5 or after January 30 of a plan year,
6 the end of the succeeding plan year.

7 “(iii) EFFECTIVENESS OF TERMI-
8 NATION.—Any termination under this sub-
9 paragraph shall not affect discounts for
10 applicable drugs of the manufacturer that
11 are due under the agreement before the ef-
12 fective date of its termination.

13 “(iv) NOTICE TO THIRD PARTY.—The
14 Secretary shall provide notice of such ter-
15 mination to a third party with a contract
16 under subsection (d)(3) within not less
17 than 30 days before the effective date of
18 such termination.

19 “(c) DUTIES DESCRIBED AND SPECIAL RULE FOR
20 SUPPLEMENTAL BENEFITS.—

21 “(1) DUTIES DESCRIBED.—The duties de-
22 scribed in this subsection are the following:

23 “(A) ADMINISTRATION OF PROGRAM.—Ad-
24 ministering the program, including—

1 “(i) the determination of the amount
2 of the discounted price of an applicable
3 drug of a manufacturer;

4 “(ii) except as provided in clause (iii),
5 the establishment of procedures under
6 which discounted prices are provided to ap-
7 plicable beneficiaries at pharmacies or by
8 mail order service at the point-of-sale of an
9 applicable drug;

10 “(iii) in the case where, during the pe-
11 riod beginning on July 1, 2010, and end-
12 ing on December 31, 2011, it is not prac-
13 ticable to provide such discounted prices at
14 the point-of-sale (as described in clause
15 (ii)), the establishment of procedures to
16 provide such discounted prices as soon as
17 practicable after the point-of-sale;

18 “(iv) the establishment of procedures
19 to ensure that, not later than the applica-
20 ble number of calendar days after the dis-
21 pensing of an applicable drug by a phar-
22 macy or mail order service, the pharmacy
23 or mail order service is reimbursed for an
24 amount equal to the difference between—

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1 “(I) the negotiated price of the
2 applicable drug; and

3 “(II) the discounted price of the
4 applicable drug;

5 “(v) the establishment of procedures
6 to ensure that the discounted price for an
7 applicable drug under this section is ap-
8 plied before any coverage or financial as-
9 sistance under other health benefit plans
10 or programs that provide coverage or fi-
11 nancial assistance for the purchase or pro-
12 vision of prescription drug coverage on be-
13 half of applicable beneficiaries as the Sec-
14 retary may specify; and

15 “(vi) the establishment of procedures
16 to implement the special rule for supple-
17 mental benefits under paragraph (2).

18 “(B) MONITORING COMPLIANCE.—

19 “(i) IN GENERAL.—Monitoring com-
20 pliance by a manufacturer with the terms
21 of an agreement under this section.

22 “(ii) NOTIFICATION.—If a third party
23 with a contract under subsection (d)(3) de-
24 termines that the manufacturer is not in
25 compliance with such agreement, the third

1 party shall notify the Secretary of such
2 noncompliance for appropriate enforcement
3 under subsection (e).

4 “(2) SPECIAL RULE FOR SUPPLEMENTAL BENE-
5 FITS.—For plan year 2010 and each subsequent
6 plan year, in the case where an applicable bene-
7 ficiary has supplemental benefits with respect to ap-
8 plicable drugs under the prescription drug plan or
9 MA–PD plan that the applicable beneficiary is en-
10 rolled in, the applicable beneficiary shall not be pro-
11 vided a discounted price for an applicable drug
12 under this section until after such supplemental ben-
13 efits have been applied with respect to the applicable
14 drug.

15 “(d) ADMINISTRATION.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 the Secretary shall provide for the implementation of
18 this section, including the performance of the duties
19 described in subsection (c)(1).

20 “(2) LIMITATION.—

21 “(A) IN GENERAL.—Subject to subpara-
22 graph (B), in providing for such implementa-
23 tion, the Secretary shall not receive or dis-
24 tribute any funds of a manufacturer under the
25 program.

1 “(B) EXCEPTION.—The limitation under
2 subparagraph (A) shall not apply to the Sec-
3 retary with respect to drugs dispensed during
4 the period beginning on July 1, 2010, and end-
5 ing on December 31, 2010, but only if the Sec-
6 retary determines that the exception to such
7 limitation under this subparagraph is necessary
8 in order for the Secretary to begin implementa-
9 tion of this section and provide applicable bene-
10 ficiaries timely access to discounted prices dur-
11 ing such period.

12 “(3) CONTRACT WITH THIRD PARTIES.—The
13 Secretary shall enter into a contract with 1 or more
14 third parties to administer the requirements estab-
15 lished by the Secretary in order to carry out this
16 section. At a minimum, the contract with a third
17 party under the preceding sentence shall require
18 that the third party—

19 “(A) receive and transmit information be-
20 tween the Secretary, manufacturers, and other
21 individuals or entities the Secretary determines
22 appropriate; and

23 “(B) receive, distribute, or facilitate the
24 distribution of funds of manufacturers to ap-
25 propriate individuals or entities in order to

1 meet the obligations of manufacturers under
2 agreements under this section.

3 “(4) PERFORMANCE REQUIREMENTS.—The
4 Secretary shall establish performance requirements
5 for a third party with a contract under paragraph
6 (3).

7 “(5) IMPLEMENTATION.—The Secretary may
8 implement the program under this section by pro-
9 gram instruction or otherwise.

10 “(6) ADMINISTRATION.—Chapter 35 of title 44,
11 United States Code, shall not apply to the program
12 under this section.

13 “(e) ENFORCEMENT.—

14 “(1) AUDITS.—Each manufacturer with an
15 agreement in effect under this section shall be sub-
16 ject to periodic audit by the Secretary.

17 “(2) CIVIL MONEY PENALTY.—

18 “(A) IN GENERAL.—The Secretary shall
19 impose a civil money penalty on a manufacturer
20 that fails to provide applicable beneficiaries dis-
21 counts for applicable drugs of the manufacturer
22 in accordance with such agreement for each
23 such failure in an amount the Secretary deter-
24 mines is commensurate with the sum of—

1 “(i) the amount that the manufac-
2 turer would have paid with respect to such
3 discounts under the agreement; and

4 “(ii) 25 percent of such amount.

5 “(B) APPLICATION.—The provisions of
6 section 1128A (other than subsections (a) and
7 (b)) shall apply to a civil money penalty under
8 this paragraph in the same manner as such
9 provisions apply to a penalty or proceeding
10 under section 1128A(a).

11 “(f) CLARIFICATION REGARDING AVAILABILITY OF
12 OTHER COVERED PART D DRUGS.—Nothing in this sec-
13 tion shall prevent an applicable beneficiary from pur-
14 chasing a covered part D drug that is not an applicable
15 drug (including a generic drug or a drug that is not on
16 the formulary of the prescription drug plan or MA–PD
17 plan that the applicable beneficiary is enrolled in).

18 “(g) DEFINITIONS.—In this section:

19 “(1) APPLICABLE BENEFICIARY.—The term
20 ‘applicable beneficiary’ means an individual who—

21 “(A) is enrolled in a prescription drug plan
22 or an MA–PD plan;

23 “(B) is not enrolled in a qualified retiree
24 prescription drug plan;

1 “(C) is not entitled to an income-related
2 subsidy under section 1860D–14(a);

3 “(D) is not subject to a reduction in pre-
4 mium subsidy under section 1839(i) or an in-
5 crease in the base beneficiary premium under
6 section 1860D–13(a)(7); and

7 “(E) who—

8 “(i) has reached or exceeded the ini-
9 tial coverage limit under section 1860D–
10 2(b)(3) during the year; and

11 “(ii) has not incurred costs for cov-
12 ered part D drugs in the year equal to the
13 annual out-of-pocket threshold specified in
14 section 1860D–2(b)(4)(B).

15 “(2) APPLICABLE DRUG.—The term ‘applicable
16 drug’ means, with respect to an applicable bene-
17 ficiary, a covered part D drug—

18 “(A) approved under a new drug applica-
19 tion under section 505(b) of the Federal Food,
20 Drug, and Cosmetic Act; and

21 “(B)(i) if the PDP sponsor of the prescrip-
22 tion drug plan or the MA organization offering
23 the MA–PD plan uses a formulary, which is on
24 the formulary of the prescription drug plan or

1 MA–PD plan that the applicable beneficiary is
2 enrolled in;

3 “(ii) if the PDP sponsor of the prescrip-
4 tion drug plan or the MA organization offering
5 the MA–PD plan does not use a formulary, for
6 which benefits are available under the prescrip-
7 tion drug plan or MA–PD plan that the appli-
8 cable beneficiary is enrolled in; or

9 “(iii) is provided through an exception or
10 appeal.

11 “(3) APPLICABLE NUMBER OF CALENDAR
12 DAYS.—The term ‘applicable number of calendar
13 days’ means—

14 “(A) with respect to claims for reimburse-
15 ment submitted electronically, 14 days; and

16 “(B) with respect to claims for reimburse-
17 ment submitted otherwise, 30 days.

18 “(4) DISCOUNTED PRICE.—

19 “(A) IN GENERAL.—The term ‘discounted
20 price’ means 50 percent of the negotiated price
21 of the applicable drug of a manufacturer.

22 “(B) CLARIFICATION.—Nothing in this
23 section shall be construed as affecting the re-
24 sponsibility of an applicable beneficiary for pay-
25 ment of a dispensing fee for an applicable drug.

1 “(5) MANUFACTURER.—The term ‘manufac-
2 turer’ means any entity which is engaged in the pro-
3 duction, preparation, propagation, compounding,
4 conversion, or processing of prescription drug prod-
5 ucts, either directly or indirectly by extraction from
6 substances of natural origin, or independently by
7 means of chemical synthesis, or by a combination of
8 extraction and chemical synthesis. Such term does
9 not include a wholesale distributor of drugs or a re-
10 tail pharmacy licensed under State law.

11 “(6) NEGOTIATED PRICE.—The term ‘nego-
12 tiated price’ has the meaning given such term in sec-
13 tion 423.100 of title 42, Code of Federal Regula-
14 tions (as in effect on the date of enactment of this
15 section), except that such negotiated price shall not
16 include any dispensing fee for the applicable drug.

17 “(7) QUALIFIED RETIREE PRESCRIPTION DRUG
18 PLAN.—The term ‘qualified retiree prescription drug
19 plan’ has the meaning given such term in section
20 1860D–22(a)(2).”.

21 (c) INCLUSION IN INCURRED COSTS.—

22 (1) IN GENERAL.—Section 1860D–2(b)(4) of
23 the Social Security Act (42 U.S.C. 1395w–
24 102(b)(4)) is amended—

1 (A) in subparagraph (C), in the matter
2 preceding clause (i), by striking “In applying”
3 and inserting “Except as provided in subpara-
4 graph (E), in applying”; and

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

7 “(E) INCLUSION OF COSTS OF APPLICABLE
8 DRUGS UNDER MEDICARE PRESCRIPTION DRUG
9 DISCOUNT PROGRAM.—In applying subpara-
10 graph (A), incurred costs shall include the ne-
11 gotiated price (as defined in paragraph (6) of
12 section 1860D–14A(g)) of an applicable drug
13 (as defined in paragraph (2) of such section) of
14 a manufacturer) that is furnished to an applica-
15 ble beneficiary (as defined in paragraph (1) of
16 such section) under the Medicare prescription
17 drug discount program under section 1860D–
18 14A, regardless of whether part of such costs
19 were paid by a manufacturer under such pro-
20 gram.”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by this section shall apply to costs incurred on or
23 after July 1, 2010.

24 (d) CONFORMING AMENDMENT PERMITTING PRE-
25 SCRIPTION DRUG DISCOUNTS.—

1 (1) IN GENERAL.—Section 1128B(b)(3) of the
2 Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is
3 amended—

4 (A) by striking “and” at the end of sub-
5 paragraph (G);

6 (B) by striking “1853(a)(4).” at the end of
7 the first subparagraph (H) and inserting
8 “1853(a)(4);”;

9 (C) by redesignating the second subpara-
10 graph (H) as subparagraph (I) and by striking
11 the period at the end and inserting “; and”;
12 and

13 (D) by adding at the end the following new
14 subparagraph:

15 “(J) a discount in the price of an applica-
16 ble drug (as defined in paragraph (2) of section
17 1860D–14A(g)) of a manufacturer) that is fur-
18 nished to an applicable beneficiary (as defined
19 in paragraph (1) of such section) under the
20 Medicare prescription drug discount program
21 under section 1860D–14A.”.

22 (2) EFFECTIVE DATE.—The amendments made
23 by this section shall apply to drugs dispensed on or
24 after July 1, 2010.

1 **SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDI-**
2 **CARE PART D LOW-INCOME BENCHMARK**
3 **PREMIUM.**

4 (a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii)
5 of the Social Security Act (42 U.S.C. 1395w–
6 114(b)(2)(B)(iii)) is amended by inserting “, determined
7 without regard to any reduction in such premium as a re-
8 sult of any beneficiary rebate under section 1854(b)(1)(C)
9 or bonus payment under section 1853(n)” before the pe-
10 riod at the end.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to premiums for months begin-
13 ning on or after January 1, 2011.

14 **SEC. 3303. VOLUNTARY DE MINIMUS POLICY FOR SUBSIDY**
15 **ELIGIBLE INDIVIDUALS UNDER PRESCRIP-**
16 **TION DRUG PLANS AND MA-PD PLANS.**

17 (a) IN GENERAL.—Section 1860D–14(a) of the So-
18 cial Security Act (42 U.S.C. 1395w–114(a)) is amended
19 by adding at the end the following new paragraph:

20 “(5) WAIVER OF DE MINIMUS PREMIUMS.—The
21 Secretary shall, under procedures established by the
22 Secretary, permit a prescription drug plan or an
23 MA–PD plan to waive the monthly beneficiary pre-
24 mium for a subsidy eligible individual if the amount
25 of such premium is de minimus. If such premium is
26 waived under the plan, the Secretary shall not reas-

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1 sign subsidy eligible individuals enrolled in the plan
2 to other plans based on the fact that the monthly
3 beneficiary premium under the plan was greater
4 than the low-income benchmark premium amount.”.

5 (b) AUTHORIZING THE SECRETARY TO AUTO-EN-
6 ROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT
7 WAIVE DE MINIMUS PREMIUMS.—Section 1860D–1(b)(1)
8 of the Social Security Act (42 U.S.C. 1395w–101(b)(1))
9 is amended—

10 (1) in subparagraph (C), by inserting “except
11 as provided in subparagraph (D),” after “shall in-
12 clude,”

13 (2) by adding at the end the following new sub-
14 paragraph:

15 “(D) SPECIAL RULE FOR PLANS THAT
16 WAIVE DE MINIMUS PREMIUMS.—The process
17 established under subparagraph (A) may in-
18 clude, in the case of a part D eligible individual
19 who is a subsidy eligible individual (as defined
20 in section 1860D–14(a)(3)) who has failed to
21 enroll in a prescription drug plan or an MA–PD
22 plan, for the enrollment in a prescription drug
23 plan or MA–PD plan that has waived the
24 monthly beneficiary premium for such subsidy
25 eligible individual under section 1860D–

1 14(a)(5). If there is more than one such plan
2 available, the Secretary shall enroll such an in-
3 dividual under the preceding sentence on a ran-
4 dom basis among all such plans in the PDP re-
5 gion. Nothing in the previous sentence shall
6 prevent such an individual from declining or
7 changing such enrollment.”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this subsection shall apply to premiums for months, and
10 enrollments for plan years, beginning on or after January
11 1, 2011.

12 **SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS RE-**
13 **GARDING ELIGIBILITY FOR LOW-INCOME AS-**
14 **SISTANCE.**

15 (a) IN GENERAL.—Section 1860D-14(a)(3)(B) of
16 the Social Security Act (42 U.S.C. 1395w-114(a)(3)(B))
17 is amended by adding at the end the following new clause:

18 “(vi) SPECIAL RULE FOR WIDOWS
19 AND WIDOWERS.—Notwithstanding the
20 preceding provisions of this subparagraph,
21 in the case of an individual whose spouse
22 dies during the effective period for a deter-
23 mination or redetermination that has been
24 made under this subparagraph, such effec-
25 tive period shall be extended through the

1 date that is 1 year after the date on which
2 the determination or redetermination
3 would (but for the application of this
4 clause) otherwise cease to be effective.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall take effect on January 1, 2011.

7 **SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGI-**
8 **BLE INDIVIDUALS REASSIGNED TO PRE-**
9 **SCRIPTION DRUG PLANS AND MA-PD PLANS.**

10 Section 1860D–14 of the Social Security Act (42
11 U.S.C. 1395w–114) is amended—

12 (1) by redesignating subsection (d) as sub-
13 section (e); and

14 (2) by inserting after subsection (c) the fol-
15 lowing new subsection:

16 “(d) FACILITATION OF REASSIGNMENTS.—Beginning
17 not later than January 1, 2011, the Secretary shall, in
18 the case of a subsidy eligible individual who is enrolled
19 in one prescription drug plan and is subsequently reas-
20 signed by the Secretary to a new prescription drug plan,
21 provide the individual, within 30 days of such reassign-
22 ment, with—

23 “(1) information on formulary differences be-
24 tween the individual’s former plan and the plan to

1 which the individual is reassigned with respect to the
2 individual's drug regimens; and

3 “(2) a description of the individual's right to
4 request a coverage determination, exception, or re-
5 consideration under section 1860D-4(g), bring an
6 appeal under section 1860D-4(h), or resolve a griev-
7 ance under section 1860D-4(f).”.

8 **SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR**
9 **LOW-INCOME PROGRAMS.**

10 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**
11 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section
12 119 of the Medicare Improvements for Patients and Pro-
13 viders Act of 2008 (42 U.S.C. 1395b-3 note) is amended
14 by striking “(42 U.S.C. 1395w-23(f))” and all that fol-
15 lows through the period at the end and inserting “(42
16 U.S.C. 1395w-23(f)), to the Centers for Medicare & Med-
17 icaid Services Program Management Account—

18 “(i) for fiscal year 2009, of
19 \$7,500,000; and

20 “(ii) for the period of fiscal years
21 2010 through 2012, of \$15,000,000.

22 Amounts appropriated under this subparagraph
23 shall remain available until expended.”.

24 (b) **ADDITIONAL FUNDING FOR AREA AGENCIES ON**
25 **AGING.**—Subsection (b)(1)(B) of such section 119 is

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1 amended by striking “(42 U.S.C. 1395w–23(f))” and all
2 that follows through the period at the end and inserting
3 “(42 U.S.C. 1395w–23(f)), to the Administration on
4 Aging—

5 “(i) for fiscal year 2009, of
6 \$7,500,000; and

7 “(ii) for the period of fiscal years
8 2010 through 2012, of \$15,000,000.

9 Amounts appropriated under this subparagraph
10 shall remain available until expended.”.

11 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
12 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of
13 such section 119 is amended by striking “(42 U.S.C.
14 1395w–23(f))” and all that follows through the period at
15 the end and inserting “(42 U.S.C. 1395w–23(f)), to the
16 Administration on Aging—

17 “(i) for fiscal year 2009, of
18 \$5,000,000; and

19 “(ii) for the period of fiscal years
20 2010 through 2012, of \$10,000,000.

21 Amounts appropriated under this subparagraph
22 shall remain available until expended.”.

23 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
24 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
25 ENROLLMENT.—Subsection (d)(2) of such section 119 is

1 amended by striking “(42 U.S.C. 1395w–23(f))” and all
2 that follows through the period at the end and inserting
3 “(42 U.S.C. 1395w–23(f)), to the Administration on
4 Aging—

5 “(i) for fiscal year 2009, of
6 \$5,000,000; and

7 “(ii) for the period of fiscal years
8 2010 through 2012, of \$5,000,000.

9 Amounts appropriated under this subparagraph
10 shall remain available until expended.”.

11 (e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
12 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such
13 section 119 is amended by adding at the end the following
14 new subsection:

15 “(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
16 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The
17 Secretary may request that an entity awarded a grant
18 under this section support the conduct of outreach activi-
19 ties aimed at preventing disease and promoting wellness.
20 Notwithstanding any other provision of this section, an en-
21 tity may use a grant awarded under this subsection to sup-
22 port the conduct of activities described in the preceding
23 sentence.”.

1 **SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR**
2 **PRESCRIPTION DRUG PLANS AND MA-PD**
3 **PLANS WITH RESPECT TO CERTAIN CAT-**
4 **EGORIES OR CLASSES OF DRUGS.**

5 (a) IMPROVING FORMULARY REQUIREMENTS.—Sec-
6 tion 1860D–4(b)(3)(G) of the Social Security Act is
7 amended to read as follows:

8 “(G) REQUIRED INCLUSION OF DRUGS IN
9 CERTAIN CATEGORIES AND CLASSES.—

10 “(i) FORMULARY REQUIREMENTS.—

11 “(I) IN GENERAL.—Subject to
12 subclause (II), a PDP sponsor offer-
13 ing a prescription drug plan shall be
14 required to include all covered part D
15 drugs in the categories and classes
16 identified by the Secretary under
17 clause (ii)(I)

18 “(II) EXCEPTIONS.—The Sec-
19 retary may establish exceptions that
20 permit a PDP sponsor offering a pre-
21 scription drug plan to exclude from its
22 formulary a particular covered part D
23 drug in a category or class that is
24 otherwise required to be included in
25 the formulary under subclause (I) (or
26 to otherwise limit access to such a

1 drug, including through prior author-
2 ization or utilization management).

3 “(ii) IDENTIFICATION OF DRUGS IN
4 CERTAIN CATEGORIES AND CLASSES.—

5 “(I) IN GENERAL.—Subject to
6 clause (iv), the Secretary shall iden-
7 tify, as appropriate, categories and
8 classes of drugs for which the Sec-
9 retary determines are of clinical con-
10 cern.

11 “(II) CRITERIA.—The Secretary
12 shall use criteria established by the
13 Secretary in making any determina-
14 tion under subclause (I).

15 “(iii) IMPLEMENTATION.—The Sec-
16 retary shall establish the criteria under
17 clause (ii)(II) and any exceptions under
18 clause (i)(II) through the promulgation of
19 a regulation which includes a public notice
20 and comment period.

21 “(iv) REQUIREMENT FOR CERTAIN
22 CATEGORIES AND CLASSES UNTIL CRI-
23 TERIA ESTABLISHED.—Until such time as
24 the Secretary establishes the criteria under
25 clause (ii)(II) the following categories and

1 classes of drugs shall be identified under
2 clause (ii)(I):

3 “(I) Anticonvulsants.

4 “(II) Antidepressants.

5 “(III) Antineoplastics.

6 “(IV) Antipsychotics.

7 “(V) Antiretrovirals.

8 “(VI) Immunosuppressants for
9 the treatment of transplant rejection.”
10

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to plan year 2011 and subsequent
13 plan years.

14 **SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR**
15 **HIGH-INCOME BENEFICIARIES.**

16 (a) INCOME-RELATED INCREASE IN PART D PRE-
17 MIUM.—

18 (1) IN GENERAL.—Section 1860D–13(a) of the
19 Social Security Act (42 U.S.C. 1395w–113(a)) is
20 amended by adding at the end the following new
21 paragraph:

22 “(7) INCREASE IN BASE BENEFICIARY PREMIUM
23 BASED ON INCOME.—

24 “(A) IN GENERAL.—In the case of an indi-
25 vidual whose modified adjusted gross income

1 exceeds the threshold amount applicable under
2 paragraph (2) of section 1839(i) (including ap-
3 plication of paragraph (5) of such section) for
4 the calendar year, the monthly amount of the
5 beneficiary premium applicable under this sec-
6 tion for a month after December 2010 shall be
7 increased by the monthly adjustment amount
8 specified in subparagraph (B).

9 “(B) MONTHLY ADJUSTMENT AMOUNT.—
10 The monthly adjustment amount specified in
11 this subparagraph for an individual for a month
12 in a year is equal to the product of—

13 “(i) the quotient obtained by divid-
14 ing—

15 “(I) the applicable percentage de-
16 termined under paragraph (3)(C) of
17 section 1839(i) (including application
18 of paragraph (5) of such section) for
19 the individual for the calendar year
20 reduced by 25.5 percent; by

21 “(II) 25.5 percent; and

22 “(ii) the base beneficiary premium (as
23 computed under paragraph (2)).

24 “(C) MODIFIED ADJUSTED GROSS IN-
25 COME.—For purposes of this paragraph, the

1 term ‘modified adjusted gross income’ has the
2 meaning given such term in subparagraph (A)
3 of section 1839(i)(4), determined for the tax-
4 able year applicable under subparagraphs (B)
5 and (C) of such section.

6 “(D) DETERMINATION BY COMMISSIONER
7 OF SOCIAL SECURITY.—The Commissioner of
8 Social Security shall make any determination
9 necessary to carry out the income-related in-
10 crease in the base beneficiary premium under
11 this paragraph.

12 “(E) PROCEDURES TO ASSURE CORRECT
13 INCOME-RELATED INCREASE IN BASE BENE-
14 FICIARY PREMIUM.—

15 “(i) DISCLOSURE OF BASE BENE-
16 FICIARY PREMIUM.—Not later than Sep-
17 tember 15 of each year beginning with
18 2010, the Secretary shall disclose to the
19 Commissioner of Social Security the
20 amount of the base beneficiary premium
21 (as computed under paragraph (2)) for the
22 purpose of carrying out the income-related
23 increase in the base beneficiary premium
24 under this paragraph with respect to the
25 following year.

1 “(ii) ADDITIONAL DISCLOSURE.—Not
2 later than October 15 of each year begin-
3 ning with 2010, the Secretary shall dis-
4 close to the Commissioner of Social Secu-
5 rity the following information for the pur-
6 pose of carrying out the income-related in-
7 crease in the base beneficiary premium
8 under this paragraph with respect to the
9 following year:

10 “(I) The modified adjusted gross
11 income threshold applicable under
12 paragraph (2) of section 1839(i) (in-
13 cluding application of paragraph (5)
14 of such section).

15 “(II) The applicable percentage
16 determined under paragraph (3)(C) of
17 section 1839(i) (including application
18 of paragraph (5) of such section).

19 “(III) The monthly adjustment
20 amount specified in subparagraph
21 (B).

22 “(IV) Any other information the
23 Commissioner of Social Security de-
24 termines necessary to carry out the
25 income-related increase in the base

1 beneficiary premium under this para-
2 graph.

3 “(F) RULE OF CONSTRUCTION.—The for-
4 mula used to determine the monthly adjustment
5 amount specified under subparagraph (B) shall
6 only be used for the purpose of determining
7 such monthly adjustment amount under such
8 subparagraph.”.

9 (2) COLLECTION OF MONTHLY ADJUSTMENT
10 AMOUNT.—Section 1860D–13(c) of the Social Secu-
11 rity Act (42 U.S.C. 1395w–113(c)) is amended—

12 (A) in paragraph (1), by striking “(2) and
13 (3)” and inserting “(2), (3), and (4)”; and

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

16 “(4) COLLECTION OF MONTHLY ADJUSTMENT
17 AMOUNT.—

18 “(A) IN GENERAL.—Notwithstanding any
19 provision of this subsection or section
20 1854(d)(2), subject to subparagraph (B), the
21 amount of the income-related increase in the
22 base beneficiary premium for an individual for
23 a month (as determined under subsection
24 (a)(7)) shall be paid through withholding from

1 benefit payments in the manner provided under
2 section 1840.

3 “(B) AGREEMENTS.—In the case where
4 the monthly benefit payments of an individual
5 that are withheld under subparagraph (A) are
6 insufficient to pay the amount described in such
7 subparagraph, the Commissioner of Social Se-
8 curity shall enter into agreements with the Sec-
9 retary, the Director of the Office of Personnel
10 Management, and the Railroad Retirement
11 Board as necessary in order to allow other
12 agencies to collect the amount described in sub-
13 paragraph (A) that was not withheld under
14 such subparagraph.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) MEDICARE.—Section 1860D–13(a)(1) of
17 the Social Security Act (42 U.S.C. 1395w–
18 113(a)(1)) is amended—

19 (A) by redesignating subparagraph (F) as
20 subparagraph (G);

21 (B) in subparagraph (G), as redesignated
22 by subparagraph (A), by striking “(D) and
23 (E)” and inserting “(D), (E), and (F)”; and

24 (C) by inserting after subparagraph (E)
25 the following new subparagraph:

1 “(F) INCREASE BASED ON INCOME.—The
2 monthly beneficiary premium shall be increased
3 pursuant to paragraph (7).”.

4 (2) INTERNAL REVENUE CODE.—Section
5 6103(l)(20) of the Internal Revenue Code of 1986
6 (relating to disclosure of return information to carry
7 out Medicare part B premium subsidy adjustment)
8 is amended—

9 (A) in the heading, by inserting “AND
10 PART D BASE BENEFICIARY PREMIUM IN-
11 CREASE” and inserting “PART B PREMIUM SUB-
12 SIDY ADJUSTMENT”;

13 (B) in subparagraph (A)—

14 (i) in the matter preceding clause (i),
15 by inserting “or increase under section
16 1860D–13(a)(7)” after “1839(i)”; and

17 (ii) in clause (vii), by inserting after
18 “subsection (i) of such section” the fol-
19 lowing: “or increase under section 1860D–
20 13(a)(7) of such Act”; and

21 (C) in subparagraph (B)—

22 (i) by striking “Return information”
23 and inserting the following:

24 “(i) IN GENERAL.—Return informa-
25 tion”;

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1 (ii) by inserting “or increase under
2 such section 1860D–13(a)(7)” before the
3 period at the end;

4 (iii) as amended by clause (i), by in-
5 sserting “or for the purpose of resolving
6 taxpayer appeals with respect to any such
7 premium adjustment or increase” before
8 the period at the end; and

9 (iv) by adding at the end the following
10 new clause:

11 “(ii) DISCLOSURE TO OTHER AGEN-
12 CIES.—Officers, employees, and contrac-
13 tors of the Social Security Administration
14 may disclose—

15 “(I) the taxpayer identity infor-
16 mation and the amount of the pre-
17 mium subsidy adjustment or premium
18 increase with respect to a taxpayer de-
19 scribed in subparagraph (A) to offi-
20 cers, employees, and contractors of
21 the Centers for Medicare and Med-
22 icaid Services, to the extent that such
23 disclosure is necessary for the collec-
24 tion of the premium subsidy amount
25 or the increased premium amount,

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1 “(II) the taxpayer identity infor-
2 mation and the amount of the pre-
3 mium subsidy adjustment or the in-
4 creased premium amount with respect
5 to a taxpayer described in subpara-
6 graph (A) to officers and employees of
7 the Office of Personnel Management
8 and the Railroad Retirement Board,
9 to the extent that such disclosure is
10 necessary for the collection of the pre-
11 mium subsidy amount or the in-
12 creased premium amount,

13 “(III) return information with re-
14 spect to a taxpayer described in sub-
15 paragraph (A) to officers and employ-
16 ees of the Department of Health and
17 Human Services to the extent nec-
18 essary to resolve administrative ap-
19 peals of such premium subsidy adjust-
20 ment or increased premium, and

21 “(IV) return information with re-
22 spect to a taxpayer described in sub-
23 paragraph (A) to officers and employ-
24 ees of the Department of Justice for
25 use in judicial proceedings to the ex-

1 tent necessary to carry out the pur-
2 poses described in clause (i).”.

3 **SEC. 3309. SIMPLIFICATION OF PLAN INFORMATION.**

4 (a) PRESCRIPTION DRUG PLANS.—Section 1860D-
5 1(c) of the Social Security Act (42 U.S.C. 1395w-101(c))
6 is amended by adding at the end the following new para-
7 graph:

8 “(5) CATEGORIZATION OF PLANS.—

9 “(A) IN GENERAL.—The Secretary shall
10 do the following:

11 “(i) Establish 2 or more categories of
12 prescription drug plans offered by PDP
13 sponsors and MA-PD plans offered by
14 Medicare Advantage organizations based
15 on the actuarial value or range of values of
16 the prescription drug benefits, including
17 supplemental prescription drug coverage,
18 provided under the plans as of the date of
19 enactment of this subsection.

20 “(ii) Develop standardized nomen-
21 clature, definitions, and language to de-
22 scribe the prescription drug benefits pro-
23 vided under the plans in each such cat-
24 egory.

1 “(iii) Ensure that the Medicare Pre-
2 scription Drug Plan Finder on the Internet
3 website of the Department of Health and
4 Human Services includes the plan name
5 under subparagraph (B).

6 “(iv) In establishing categories of pre-
7 scription drug plans and MA–PD plans
8 under clause (i), the Secretary shall ensure
9 that there is a meaningful difference be-
10 tween the actuarial value of prescription
11 drug benefits provided under the plans in
12 different categories.

13 “(B) REQUIRED INCLUSION OF CATEGORY
14 IN PLAN NAME AND MARKETING MATERIALS.—
15 For plan years beginning on or after January
16 1, 2011, a PDP sponsor shall ensure that the
17 name of each prescription drug plan offered by
18 the PDP sponsor and any marketing materials
19 with respect to such plan include the category
20 of the plan, as determined under subparagraph
21 (A) (using standardized nomenclature, defini-
22 tions, and language developed by the Secretary
23 under such subparagraph).”.

1 (b) MA–PD PLANS.—Section 1856(f)(3) of the So-
2 cial Security Act (42 U.S.C. 1395w–26(f)(3)) is amended
3 by adding at the end the following new subparagraph:

4 “(D) REQUIRED INCLUSION OF CATEGORY
5 IN PLAN NAME AND MARKETING MATERIALS.—
6 Section 1860D–1(c)(5)(B).”.

7 **SEC. 3310. LIMITATION ON REMOVAL OR CHANGE OF COV-**
8 **ERAGE OF COVERED PART D DRUGS UNDER**
9 **A FORMULARY UNDER A PRESCRIPTION**
10 **DRUG PLAN OR AN MA-PD PLAN.**

11 (a) LIMITATION ON REMOVAL OR CHANGE.—Section
12 1860D–4(b)(3)(E) of the Social Security Act (42 U.S.C.
13 1395w–104(b)(3)(E)) is amended to read as follows:

14 “(E) REMOVING OR CHANGING A DRUG ON
15 A FORMULARY.—

16 “(i) LIMITATION.—Subject to clause
17 (ii), with respect to plan years beginning
18 on or after January 1, 2011, the PDP
19 sponsor of a prescription drug plan may
20 not remove a covered part D drug from the
21 plan formulary, apply a cost or utilization
22 management tool that imposes a restriction
23 or limitation on the coverage of such a
24 drug (such as through the application of a
25 preferred status, usage restriction, step

1 therapy, prior authorization, or quantity
2 limitation), or increase the cost-sharing of
3 such a drug (such as through placement of
4 a drug on a tier that would result in high-
5 er cost-sharing for a beneficiary) other
6 than on a date specified by the Secretary
7 (but not later than the date on which PDP
8 sponsors begin marketing their plans with
9 respect to the immediately succeeding plan
10 year).

11 “(ii) EXCEPTIONS TO LIMITATION ON
12 REMOVAL.—Subject to clause (iii), clause
13 (i) shall not apply with respect to a cov-
14 ered part D drug that—

15 “(I) is a brand name drug for
16 which there is a generic drug ap-
17 proved under section 505(j) of the
18 Food and Drug Cosmetic Act that is
19 placed on the market during the pe-
20 riod in which there are limitations on
21 removal or change in the formulary
22 under clause (i);

23 “(II) is a drug for which the
24 Commissioner of Food and Drugs
25 issues a safety warning that would im-

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1 pose a restriction on the drug or re-
2 quire a drug label warning during the
3 plan year;

4 “(III) is a drug that the Phar-
5 macy and Therapeutic Committee of
6 the plan determines, based directly on
7 evidence from peer-reviewed research,
8 has a lower safety profile than is ap-
9 propriate or is ineffective; or

10 “(IV) for which the Secretary es-
11 tablishes a specific exception through
12 the promulgation of regulations relat-
13 ing to plan formularies.

14 “(iii) LIMITED APPLICATION OF EX-
15 CEPTIONS TO DRUGS IN CERTAIN CAT-
16 EGORIES AND CLASSES.—Subclauses (I),
17 (III), and (IV) of clause (ii) shall not apply
18 to a drug in a category or class identified
19 under subparagraph (G)(i).

20 “(iv) NOTICE OF REMOVAL UNDER
21 APPLICATION OF EXCEPTION TO LIMITA-
22 TION.—The PDP sponsor of a prescription
23 drug plan shall provide appropriate notice
24 (such as under subsection (a)(3) and in-
25 cluding the annual notice under subsection

1 (a)(5)) of any removal or change under
2 clause (ii) to the Secretary, affected enroll-
3 ees, physicians, pharmacies, and phar-
4 macists.”.

5 (b) NOTICE FOR CHANGE IN FORMULARY AND
6 OTHER RESTRICTIONS OR LIMITATIONS ON COVERAGE.—

7 (1) IN GENERAL.—Section 1860D–4(a) of the
8 Social Security Act (42 U.S.C. 1395w–104(a)) is
9 amended by adding at the end the following new
10 paragraph:

11 “(5) ANNUAL NOTICE OF CHANGES IN FOR-
12 MULARY AND OTHER RESTRICTIONS OR LIMITATIONS
13 ON COVERAGE.—Each PDP sponsor of a prescrip-
14 tion drug plan shall furnish to each enrollee at the
15 time of each annual coordinated election period (re-
16 ferred to in section 1860D–1(b)(1)(B)(iii)) for a
17 plan year a notice of any changes in the formulary
18 or other restrictions or limitations on coverage of
19 any covered part D drug under the plan that will
20 take effect for the plan year.”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply to annual coordinated
23 election periods beginning on or after January 1,
24 2010.

1 **SEC. 3311. ELIMINATION OF COST SHARING FOR CERTAIN**
2 **DUAL ELIGIBLE INDIVIDUALS.**

3 Section 1860D–14(a)(1)(D)(i) of the Social Security
4 Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by in-
5 serting “or, effective on a date specified by the Secretary
6 (but in no case earlier than January 1, 2012), who would
7 be such an institutionalized individual or couple, if the
8 full-benefit dual eligible individual were not receiving serv-
9 ices under a home and community-based waiver authorized
10 for a State under section 1115 or subsection (c) or (d)
11 of section 1915 or under a State plan amendment under
12 subsection (i) of such section or services provided through
13 enrollment in a medicaid managed care organization”
14 after “1902(q)(1)(B))”.

15 **SEC. 3312. REDUCING WASTEFUL DISPENSING OF OUT-**
16 **PATIENT PRESCRIPTION DRUGS IN LONG-**
17 **TERM CARE FACILITIES UNDER PRESCRIP-**
18 **TION DRUG PLANS AND MA-PD PLANS.**

19 (a) IN GENERAL.—Section 1860D–4(c) of the Social
20 Security Act (42 U.S.C. 1395w–104(c)) is amended by
21 adding at the end the following new paragraph:

22 “(3) REDUCING WASTEFUL DISPENSING OF
23 OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM
24 CARE FACILITIES.—The Secretary shall require PDP
25 sponsors of prescription drug plans to utilize specific
26 drug dispensing techniques, as determined by the

1 Secretary, such as weekly, daily, or automated dose
2 dispensing, when dispensing medications to enrollees
3 who reside in a long-term care facility in order to re-
4 duce waste associated with 30-day fills.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall apply to plan years beginning on or
7 after January 1, 2012.

8 **SEC. 3313. IMPROVED MEDICARE PRESCRIPTION DRUG**
9 **PLAN AND MA-PD PLAN COMPLAINT SYSTEM.**

10 (a) PLAN COMPLAINT SYSTEM.—

11 (1) IN GENERAL.—The Secretary shall develop
12 and maintain a compliant system to collect and
13 maintain information on MA-PD plan and prescrip-
14 tion drug plan complaints that are received (includ-
15 ing by telephone, letter, e-mail, or any other means)
16 by the Secretary (including by a regional office of
17 the Department of Health and Human Services, the
18 Medicare Beneficiary Ombudsman, a sub-contractor,
19 a carrier, a fiscal intermediary, and a Medicare ad-
20 ministrative contractor under section 1874A of the
21 Social Security Act (42 U.S.C. 1395kk)) through
22 the date on which the complaint is resolved.

23 (2) MODEL ELECTRONIC COMPLAINT FORM.—
24 The Secretary shall develop a model electronic com-
25 plaint form to be used for reporting plan complaints

1 under the system. Such form shall be prominently
2 displayed on the front page of the Medicare.gov
3 Internet website and on the Internet website of the
4 Medicare Beneficiary Ombudsman.

5 (3) ANNUAL REPORTS BY THE SECRETARY.—
6 The Secretary shall submit to Congress an annual
7 report on the system. Such study shall include an
8 analysis of the number and types of complaints re-
9 ported in the system, geographic variations in such
10 complaints, the timeliness of agency or plan re-
11 sponses to such complaints, and the resolution of
12 such complaints.

13 (4) DEFINITIONS.—In this section:

14 (A) MA-PD PLAN.—The term “MA-PD
15 plan” has the meaning given such term in sec-
16 tion 1860D-41(a)(9) of such Act (42 U.S.C.
17 1395w-151(a)(9)).

18 (B) PRESCRIPTION DRUG PLAN.—The
19 term “prescription drug plan” has the meaning
20 given such term in section 1860D-41(a)(14) of
21 such Act (42 U.S.C. 1395w-151(a)(14)).

22 (C) SECRETARY.—The term “Secretary”
23 means the Secretary of Health and Human
24 Services.

1 (D) SYSTEM.—The term “system” means
2 the plan complaint system developed and main-
3 tained under paragraph (1).

4 (b) FUNDING.—There are authorized to be appro-
5 priated such sums as may be necessary for the costs of
6 carrying out this section.

7 **SEC. 3314. UNIFORM EXCEPTIONS AND APPEALS PROCESS**
8 **FOR PRESCRIPTION DRUG PLANS AND MA-PD**
9 **PLANS.**

10 (a) IN GENERAL.—Section 1860D–4(b)(3) of the So-
11 cial Security Act (42 U.S.C. 1395w–104(b)(3)) is amend-
12 ed by adding at the end the following new subparagraph:

13 “(H) USE OF SINGLE, UNIFORM EXCEP-
14 TIONS AND APPEALS PROCESS.—Notwith-
15 standing any other provision of this part, each
16 PDP sponsor of a prescription drug plan shall,
17 to the extent the Secretary determines fea-
18 sible—

19 “(i) use a single, uniform exceptions
20 and appeals process (including a single,
21 uniform model form for use under such
22 process) with respect to the determination
23 of prescription drug coverage for an en-
24 rollee under the plan; and

1 “(ii) provide instant access to such
2 process by enrollees through a toll-free
3 telephone number and an Internet
4 website.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall apply to exceptions and appeals on
7 or after January 1, 2012.

8 **SEC. 3315. OFFICE OF THE INSPECTOR GENERAL STUDIES**
9 **AND REPORTS.**

10 (a) STUDY AND ANNUAL REPORT ON PART D
11 FORMULARIES’ INCLUSION OF DRUGS COMMONLY USED
12 BY DUAL ELIGIBLES.—

13 (1) STUDY.—The Inspector General of the De-
14 partment of Health and Human Services shall con-
15 duct a study of the extent to which formularies used
16 by prescription drug plans and MA–PD plans under
17 part D include drugs commonly used by full-benefit
18 dual eligible individuals (as defined in section
19 1935(e)(6) of the Social Security Act (42 U.S.C.
20 1396u–5(c)(6))).

21 (2) ANNUAL REPORTS.—Not later than July 1
22 of each year (beginning with 2011), the Inspector
23 General shall submit to Congress a report on the
24 study conducted under paragraph (1), together with

1 such recommendations as the Inspector General de-
2 termines appropriate.

3 (b) STUDY AND REPORT ON PRESCRIPTION DRUG
4 PRICES UNDER MEDICARE PART D AND MEDICAID.—

5 (1) STUDY.—

6 (A) IN GENERAL.—The Inspector General
7 of the Department of Health and Human Serv-
8 ices shall conduct a study on prices for covered
9 part D drugs under the Medicare prescription
10 drug program under part D of title XVIII of
11 the Social Security Act and for covered out-
12 patient drugs under title XIX. Such study shall
13 include the following:

14 (i) A comparison, with respect to the
15 200 most frequently dispensed covered
16 part D drugs under such program and cov-
17 ered outpatient drugs under such title (as
18 determined by the Inspector General based
19 on volume and expenditures), of—

20 (I) the prices paid for covered
21 part D drugs by PDP sponsors of
22 prescription drug plans and Medicare
23 Advantage organizations offering MA-
24 PD plans; and

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1 (II) the prices paid for covered
2 outpatient drugs by a State plan
3 under title XIX.

4 (ii) An assessment of—

5 (I) the financial impact of any
6 discrepancies in such prices on the
7 Federal government; and

8 (II) the financial impact of any
9 such discrepancies on enrollees under
10 part D or individuals eligible for med-
11 ical assistance under a State plan
12 under title XIX.

13 (B) PRICE.—For purposes of subpara-
14 graph (A), the price of a covered part D drug
15 or a covered outpatient drug shall include any
16 rebate or discount under such program or such
17 title, respectively, including any negotiated price
18 concession described in section 1860D-
19 2(d)(1)(B) of the Social Security Act (42
20 U.S.C. 1395w-102(d)(1)(B)) or rebate under
21 an agreement under section 1927 of the Social
22 Security Act (42 U.S.C. 1396r-8).

23 (C) AUTHORITY TO COLLECT ANY NEC-
24 ESSARY INFORMATION.—Notwithstanding any
25 other provision of law, the Inspector General of

1 the Department of Health and Human Services
2 shall be able to collect any information related
3 to the prices of covered part D drugs under
4 such program and covered outpatient drugs
5 under such title XIX necessary to carry out the
6 comparison under subparagraph (A).

7 (2) REPORT.—

8 (A) IN GENERAL.—Not later than October
9 1, 2011, subject to subparagraph (B), the In-
10 spector General shall submit to Congress a re-
11 port containing the results of the study con-
12 ducted under paragraph (1), together with rec-
13 ommendations for such legislation and adminis-
14 trative action as the Inspector General deter-
15 mines appropriate.

16 (B) LIMITATION ON INFORMATION CON-
17 TAINED IN REPORT.—The report submitted
18 under subparagraph (A) shall not include any
19 information that the Inspector General deter-
20 mines is proprietary or is likely to negatively
21 impact the ability of a PDP sponsor or a State
22 plan under title XIX to negotiate prices for cov-
23 ered part D drugs or covered outpatient drugs,
24 respectively.

25 (3) DEFINITIONS.—In this section:

1 (A) COVERED PART D DRUG.—The term
2 “covered part D drug” has the meaning given
3 such term in section 1860D–2(e) of the Social
4 Security Act (42 U.S.C. 1395w–102(e)).

5 (B) COVERED OUTPATIENT DRUG.—The
6 term “covered outpatient drug” has the mean-
7 ing given such term in section 1927(k) of such
8 Act (42 U.S.C. 1396r(k)).

9 (C) MA–PD PLAN.—The term “MA–PD
10 plan” has the meaning given such term in sec-
11 tion 1860D–41(a)(9) of such Act (42 U.S.C.
12 1395w–151(a)(9)).

13 (D) MEDICARE ADVANTAGE ORGANIZA-
14 TION.—The term “Medicare Advantage organi-
15 zation” has the meaning given such term in
16 section 1859(a)(1) of such Act (42 U.S.C.
17 1395w–28)(a)(1)).

18 (E) PDP SPONSOR.—The term “PDP
19 sponsor” has the meaning given such term in
20 section 1860D–41(a)(13) of such Act (42
21 U.S.C. 1395w–151(a)(13)).

22 (F) PRESCRIPTION DRUG PLAN.—The
23 term “prescription drug plan” has the meaning
24 given such term in section 1860D–41(a)(14) of
25 such Act (42 U.S.C. 1395w–151(a)(14)).

1 **SEC. 3316. HHS STUDY AND ANNUAL REPORTS ON COV-**
2 **ERAGE FOR DUAL ELIGIBLES.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the
6 “Secretary”) shall conduct a study to track—

7 (A) how many of the new full benefit dual
8 eligible individuals (as defined in section
9 1935(c)(6) of the Social Security Act (42
10 U.S.C. 1395u–5(c)(6))) enroll in a plan under
11 part D of title XVIII of such Act and receive
12 retroactive prescription drug coverage under the
13 plan; and

14 (B) if such retroactive coverage is provided
15 to such individuals—

16 (i) the number of months of coverage
17 provided; and

18 (ii) the amount of reimbursements to
19 individuals and to individuals that made
20 payments for prescription drugs on their
21 behalf for costs incurred during retroactive
22 coverage periods.

23 (2) DATA TO USE.—In conducting the study
24 with respect to the requirements under paragraph
25 (1)(B), the Secretary shall examine prescription
26 drug utilization data reported by prescription drug

1 plans under part D of title XVIII of the Social Secu-
2 rity Act (42 U.S.C. 1395w–101 et seq.).

3 (b) ANNUAL REPORTS ON ONGOING STUDY.—Not
4 later than January 1 of each year (beginning with 2012),
5 the Secretary shall submit a report to Congress containing
6 the results of the study conducted under subsection (a),
7 together with recommendations for such legislation and
8 administrative action as the Secretary determines appro-
9 priate.

10 (c) ANNUAL REPORTS ON SPENDING AND OUT-
11 COMES.—Not later than January 1 of each year (begin-
12 ning with 2013), the Secretary shall collect data and sub-
13 mit a report to Congress that includes the following infor-
14 mation:

15 (1) Annual total expenditures (disaggregated by
16 Federal and State expenditures) for dually eligible
17 beneficiaries under title XVIII and under State
18 plans and waivers under title XIX.

19 (2) An analysis of health outcomes for dually
20 eligible beneficiaries, disaggregated by subtypes of
21 beneficiaries (as determined by the Secretary).

22 (3) An analysis of the extent to which dually el-
23 igible beneficiaries are able to access benefits under
24 title XVIII and under State plans and waivers under
25 title XIX.

1 **SEC. 3317. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
2 **SISTANCE PROGRAMS AND INDIAN HEALTH**
3 **SERVICE IN PROVIDING PRESCRIPTION**
4 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**
5 **ET THRESHOLD UNDER PART D.**

6 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
7 Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is
8 amended—

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

10 (2) in clause (ii)—

11 (A) by striking “such costs shall be treated
12 as incurred only if” and inserting “subject to
13 clause (iii), such costs shall be treated as in-
14 curred only if”;

15 (B) by striking “, under section 1860D–
16 14, or under a State Pharmaceutical Assistance
17 Program”; and

18 (C) by striking the period at the end and
19 inserting “; and”; and

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

22 “(iii) such costs shall be treated as in-
23 curred and shall not be considered to be
24 reimbursed under clause (ii) if such costs
25 are borne or paid—

26 “(I) under section 1860D–14;

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1 “(II) under a State Pharma-
2 ceutical Assistance Program;

3 “(III) by the Indian Health Serv-
4 ice, an Indian tribe or tribal organiza-
5 tion, or an urban Indian organization
6 (as defined in section 4 of the Indian
7 Health Care Improvement Act); or

8 “(IV) under an AIDS Drug As-
9 sistance Program under part B of
10 title XXVI of the Public Health Serv-
11 ice Act.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to costs incurred on or after
14 January 1, 2011.

15 **Subtitle E—Ensuring Medicare**
16 **Sustainability**

17 **SEC. 3401. REVISION OF CERTAIN MARKET BASKET UP-**
18 **DATES AND INCORPORATION OF PRODUC-**
19 **TIVITY IMPROVEMENTS INTO MARKET BAS-**
20 **KET UPDATES THAT DO NOT ALREADY IN-**
21 **CORPORATE SUCH IMPROVEMENTS.**

22 (a) INPATIENT ACUTE HOSPITALS.—Section
23 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
24 1395ww(b)(3)(B)) is amended—

25 (1) in clause (i)—

1 (A) in subclause (XIX), by striking “and”
2 at the end;

3 (B) in subclause (XX)—

4 (i) by striking “for each subsequent
5 fiscal year” and inserting “for each of fis-
6 cal years 2007 through 2009”; and

7 (ii) by striking the period at the end
8 and inserting a semicolon; and

9 (iii) by adding at the end the fol-
10 lowing new subclauses:

11 “(XXI) for each of fiscal years
12 2010 through 2019, subject to clause
13 (viii), the market basket percentage
14 increase for hospitals in all areas
15 minus the additional adjustment fac-
16 tor described in clause (x); and

17 “(XXII) for each subsequent fis-
18 cal year, subject to clause (viii), the
19 market basket percentage increase for
20 hospitals in all areas.”;

21 (2) in clause (iii)—

22 (A) by striking “(iii) For purposes of this
23 subparagraph,” and inserting “(iii)(I) For pur-
24 poses of this subparagraph,”;

1 (B) in subclause (I), as added by subpara-
2 graph (A), by adding at the end the following
3 new sentences: “For 2012 and each subsequent
4 fiscal year, such increase shall be reduced by
5 the productivity adjustment described in sub-
6 clause (II). Except as otherwise provided, any
7 reference to the increase described in this
8 clause shall be a reference to the percentage in-
9 crease described in this subclause minus the
10 percentage change described subclause (II).”

11 (C) by adding at the end the following new
12 subclause:

13 “(II) The productivity adjustment described in this
14 subclause, with respect to an increase or change for a fis-
15 cal year or year or cost reporting period, or other annual
16 period, is a productivity adjustment equal to the 10-year
17 moving average of changes in annual economy-wide pri-
18 vate nonfarm business multi-factor productivity (as pro-
19 jected by the Secretary for the applicable fiscal year, year,
20 cost reporting period, or other annual period).”; and

21 (D) by adding at the end the following new
22 clauses:

23 “(x) For purposes of clause (i)(XXI), the additional
24 adjustment factor described in this clause is—

1 “(I) for each of fiscal years 2010 and 2011,
2 0.25 percent; and

3 “(II) subject to clause (xi), for each of fiscal
4 years 2012 through 2019, 0.2 percent.

5 “(xi) If, for each of fiscal years 2014 through 2019,
6 the total percentage of the non-elderly insured population
7 for the preceding fiscal year is greater than 5 percentage
8 points below the projection of the total percentage of the
9 non-elderly insured population for such preceding fiscal
10 year (as of the date of enactment of the America’s Healthy
11 Future Act of 2009), as estimated by the Secretary, the
12 additional adjustment factor described in clause (x) for the
13 fiscal year shall be 0.0 percent.”.

14 (b) SKILLED NURSING FACILITIES.—Section
15 1888(e)(5)(B) of the Social Security Act (42 U.S.C.
16 1395yy(e)(4)) is amended by adding at the end the fol-
17 lowing new sentence: “For fiscal year 2012 and each sub-
18 sequent fiscal year, the percentage described in the pre-
19 ceding sentence shall be reduced by the productivity ad-
20 justment described in section 1886(b)(3)(B)(iii)(II).”.

21 (c) LONG-TERM CARE HOSPITALS.—Section 1886(m)
22 of the Social Security Act (42 U.S.C. 1395ww(m)) is
23 amended by adding at the end the following new para-
24 graphs:

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1 “(3) IMPLEMENTATION FOR RATE YEAR 2010
2 AND SUBSEQUENT YEARS.—In implementing the
3 system described in paragraph (1) for rate year
4 2010 and each subsequent rate year, to the extent
5 that an annual percentage increase factor applies to
6 a standard Federal rate for discharges for the hos-
7 pital during the rate year, the following shall apply:

8 “(A) UPDATE FOR RATE YEARS 2010
9 THROUGH 2019.—For discharges occurring dur-
10 ing each of rate years 2010 through 2019, the
11 standard Federal rate for such discharges for
12 the hospital shall be increased by the annual
13 percentage increase factor minus the additional
14 adjustment factor described in paragraph (4).

15 “(B) PRODUCTIVITY ADJUSTMENT.—For
16 discharges occurring during rate year 2012 and
17 each subsequent rate year, such annual percent-
18 age increase factor shall be reduced by the pro-
19 ductivity adjustment described in section
20 1886(b)(3)(B)(iii)(II).

21 “(4) ADDITIONAL ADJUSTMENT FACTOR DE-
22 SCRIBED.—

23 “(A) IN GENERAL.—For purposes of para-
24 graph (3)(A), the additional adjustment factor
25 described in this paragraph is—

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1 “(i) for each of rate years 2010 and
2 2011, 0.25 percent; and

3 “(ii) subject to subparagraph (B), for
4 each of rate years 2012 through 2019, 0.2
5 percent.

6 “(B) REDUCTION OF ADJUSTMENT FAC-
7 TOR FOR CERTAIN HOSPITALS.—If, for each of
8 rate years 2014 through 2019, the total per-
9 centage of the non-elderly insured population
10 for the preceding rate year is greater than 5
11 percentage points below the projection of the
12 total percentage of the non-elderly insured pop-
13 ulation for such preceding rate year (as of the
14 date of enactment of the America’s Healthy Fu-
15 ture Act of 2009), as estimated by the Sec-
16 retary, the additional adjustment factor de-
17 scribed in subparagraph (A) for the rate year
18 shall be 0.0 percent.”.

19 (d) INPATIENT REHABILITATION FACILITIES.—Sec-
20 tion 1886(j)(3) of the Social Security Act (42 U.S.C.
21 1395ww(j)(3)(C)) is amended—

22 (1) in subparagraph (A)(i), by inserting “(for
23 fiscal years before 2010 and for fiscal year 2020 and
24 subsequent fiscal years)” after “2000 and”;

1 (2) in subparagraph (C), by adding at the end
2 the following new sentence: “For fiscal year 2012
3 and each subsequent fiscal year, the appropriate per-
4 centage increase described in the preceding sentence
5 shall be reduced by the productivity adjustment de-
6 scribed in section 1886(b)(3)(B)(iii)(II).”; and

7 (3) by adding at the end the following new sub-
8 paragraph:

9 “(D) UPDATE FOR FISCAL YEARS 2010
10 THROUGH 2019.—

11 “(i) IN GENERAL.—For purposes of
12 this subsection for payment units in each
13 of fiscal years 2010 through 2019, the
14 payment rate determined under this para-
15 graph shall be increased by the increase
16 factor described in subparagraph (C)
17 minus the additional adjustment factor de-
18 scribed in clause (ii).

19 “(ii) ADDITIONAL ADJUSTMENT FAC-
20 TOR DESCRIBED.—For purposes of clause
21 (i), the additional adjustment factor de-
22 scribed in this clause is—

23 “(I) for each of fiscal years 2010
24 and 2011, 0.25 percent; and

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1 (I) by striking “any subsequent
2 year” and inserting “each of 2007,
3 2008, 2009, and 2010”; and

4 (II) by striking the period at the
5 end and inserting a semicolon; and

6 (iii) by adding at the end the fol-
7 lowing subclauses:

8 “(VI) each of 2011 and 2012,
9 subject to clause (v), the home health
10 market basket percentage increase
11 minus the additional adjustment fac-
12 tor described in subparagraph (D);
13 and

14 “(VII) any subsequent year, sub-
15 ject to clause (v), the home health
16 market basket percentage increase.”;
17 and

18 (B) in clause (iii), by inserting “(including,
19 for 2015 and each subsequent year, being re-
20 duced by the productivity adjustment described
21 in section 1886(b)(3)(B)(iii)(II))” after “in the
22 same manner”; and

23 (2) by adding at the end the following new sub-
24 paragraph:

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1 “(D) ADDITIONAL ADJUSTMENT FACTOR
2 DESCRIBED.—For purposes of subparagraph
3 (B)(ii)(VI), the additional adjustment factor de-
4 scribed in this subparagraph is 1.0 percent.”.

5 (f) PSYCHIATRIC HOSPITALS.—Section 1886 of the
6 Social Security Act, as amended by sections 3001, 3008,
7 3025, 3133, is amended by adding at the end the following
8 new subsection:

9 “(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC
10 HOSPITALS.—

11 “(1) REFERENCE TO ESTABLISHMENT AND IM-
12 PLEMENTATION OF SYSTEM.—For provisions related
13 to the establishment and implementation of a pro-
14 spective payment system for payments under this
15 title for inpatient hospital services furnished by psy-
16 chiatric hospitals (as described in clause (i) of sub-
17 section (d)(1)(B) and psychiatric units (as described
18 in the matter following clause (v) of such sub-
19 section), see section 124 of the Medicare, Medicaid,
20 and SCHIP Balanced Budget Refinement Act of
21 1999.

22 “(2) IMPLEMENTATION FOR RATE YEAR BEGIN-
23 NING IN 2010 AND SUBSEQUENT RATE YEARS.—In
24 implementing the system described in paragraph (1)
25 for the rate year beginning in 2010 and any subse-

1 “(ii) subject to subparagraph (B), for
2 each of the rate years beginning in 2012
3 through 2019, 0.2 percent.

4 “(B) REDUCTION OF ADJUSTMENT FAC-
5 TOR FOR CERTAIN PSYCHIATRIC HOSPITALS
6 AND UNITS.—If, for each of the rate years be-
7 ginning in 2014 through 2019, the total per-
8 centage of the non-elderly insured population
9 for the rate year beginning in the preceding
10 year is greater than 5 percentage points below
11 the projection of the total percentage of the
12 non-elderly insured population for the rate year
13 beginning in such preceding year (as of the date
14 of enactment of the America’s Healthy Future
15 Act of 2009), as estimated by the Secretary,
16 the additional adjustment factor described in
17 subparagraph (A) for the rate year shall be 0.0
18 percent.”.

19 (g) HOSPICE CARE.—Section 1814(i)(1)(C) of the
20 Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amend-
21 ed by section 3132, is amended—

22 (1) in clause (ii)—

23 (A) in subclause (VI), by striking “and” at
24 the end; and

25 (B) in subclause (VII)—

1 (i) by striking “for a subsequent fiscal
2 year (before fiscal year 2014)” and insert-
3 ing “for each of fiscal years 2003 through
4 2012”;

5 (ii) by striking the period at the end
6 and inserting “; and”; and

7 (iii) by adding at the end the fol-
8 lowing new subclause:

9 “(VIII) for fiscal year 2013, the market basket
10 percentage increase for the fiscal year (which is re-
11 duced by the productivity adjustment described in
12 section 1886(b)(3)(B)(iii)(II)) minus the additional
13 adjustment factor described in clause (iv).”;

14 (2) in clause (iii)—

15 (A) in subclause (I)—

16 (i) by inserting “(which is reduced by
17 the productivity adjustment described in
18 section 1886(b)(3)(B)(iii)(II)) minus the
19 additional adjustment factor described in
20 clause (iv)” before the semicolon at the
21 end; and

22 (ii) by striking “and” at the end;

23 (B) in subclause (II)—

24 (i) by striking “for a subsequent fiscal
25 year” and inserting “for each of fiscal

1 years 2015 through 2019, subject to clause
2 (v),”;

3 (ii) by inserting “(which is reduced by
4 the productivity adjustment described in
5 section 1886(b)(3)(B)(iii)(II)) minus the
6 additional adjustment factor described in
7 clause (iv)” after “for the fiscal year”; and

8 (iii) by striking the period at the end
9 and inserting “; and”; and

10 (C) by adding at the end the following new
11 subclause:

12 “(III) for a subsequent fiscal year, the payment
13 rates in effect under this clause during the previous
14 fiscal year increased by the market basket percent-
15 age increase for the fiscal year (which is reduced by
16 the productivity adjustment described in section
17 1886(b)(3)(B)(iii)(II)).”; and

18 (3) by adding at the end the following new
19 clauses:

20 “(iv) For purposes of clause (ii)(VIII) and clause
21 (iii)(II), the additional adjustment factor described in this
22 clause is 0.5 percent.

23 “(v) If, for each of fiscal years 2014 through 2019,
24 the total percentage of the non-elderly insured population
25 for the preceding fiscal year is greater than 5 percentage

1 points below the projection of the total percentage of the
2 non-elderly insured population for such preceding fiscal
3 year (as of the date of enactment of the America’s Healthy
4 Future Act of 2009), as estimated by the Secretary, the
5 additional adjustment factor described in clause (iv) for
6 the fiscal year shall be 0.0 percent”.

7 (h) DIALYSIS.—Section 1881(b)(14)(F) of the Social
8 Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended by
9 striking “minus 1.0 percentage points” and inserting “re-
10 duced by the productivity adjustment described in section
11 1886(b)(3)(B)(iii)(II)” each place it appears in clauses (i)
12 and (ii)(II).

13 (i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of
14 the Social Security Act (42 U.S.C. 1395l(t)(3)) is amend-
15 ed—

16 (1) in subparagraph (C)(iv)—

17 (A) in the first sentence, by inserting
18 (which, for fiscal year 2012 and each subse-
19 quent fiscal year, is reduced by the productivity
20 adjustment described in section
21 1886(b)(3)(B)(iii)(II) after
22 “1886(b)(3)(B)(iii)”;

23 (B) in the second sentence, by inserting “,
24 and which, for 2012 and each subsequent year,
25 is reduced by the productivity adjustment de-

1 each of 2014 through 2019, the total per-
2 centage of the non-elderly insured popu-
3 lation for the preceding year is greater
4 than 5 percentage points below the projec-
5 tion of the total percentage of the non-el-
6 derly insured population for such preceding
7 year (as of the date of enactment of the
8 America’s Healthy Future Act of 2009), as
9 estimated by the Secretary, the additional
10 adjustment factor described in clause (ii)
11 for the year shall be 0.0 percent.”.

12 (j) AMBULANCE SERVICES.—Section 1834(l)(3)(B)
13 of the Social Security Act (42 U.S.C. 1395m(l)(3)(B)) is
14 amended by inserting before the period at the end the fol-
15 lowing: “and, in the case of 2011 and each subsequent
16 year, reduced by the productivity adjustment described in
17 section 1886(b)(3)(B)(iii)(II)”.

18 (k) AMBULATORY SURGICAL CENTER SERVICES.—
19 Section 1833(i)(2)(D) of the Social Security Act (42
20 U.S.C. 1395l(i)(2)(D)) is amended—

21 (1) by redesignating clause (v) as clause (vi);

22 and

23 (2) by inserting after clause (iv) the following
24 new clause:

1 “(v) In implementing the system de-
2 scribed in clause (i), for services furnished
3 during 2011 and each subsequent year, to
4 the extent that an annual percentage
5 change factor applies, such factor shall be
6 reduced by the productivity adjustment de-
7 scribed in section 1886(b)(3)(B)(iii)(II).”.

8 (l) LABORATORY SERVICES.—Section 1833(h)(2)(A)
9 of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is
10 amended—

11 (1) in clause (i), by striking “minus, for each
12 of the years 2009 through 2013, 0.5 percentage
13 points” and inserting “reduced, for 2011 and each
14 subsequent year, by the productivity adjustment de-
15 scribed in section 1886(b)(3)(B)(iii)(II), except that
16 the application of such productivity adjustment shall
17 not result in the annual adjustment under this
18 clause being less than 0.0”; and

19 (2) in clause (ii)—

20 (A) by striking “and” at the end of sub-
21 clause (III);

22 (B) by striking the period at the end of
23 subclause (IV) and inserting a comma; and

24 (C) by adding at the end the following new
25 subclauses:

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1 “(V) the annual adjustment in
2 the fee schedules, as determined
3 under clause (i), for each of 2009 and
4 2010 shall be reduced by 0.5 percent-
5 age points,

6 “(VI) the annual adjustment in
7 the fee schedules, as determined
8 under clause (i), for each of the years
9 2011 through 2014 shall be reduced
10 by 1.75 percentage points (which may
11 include a reduction below zero), and

12 “(VII) the annual adjustment in
13 the fee schedules, as determined
14 under clause (i), for 2015 shall be re-
15 duced by 1.95 percentage points
16 (which may include a reduction below
17 zero).”.

18 (m) CERTAIN DURABLE MEDICAL EQUIPMENT.—
19 Section 1834(a)(14) of the Social Security Act (42 U.S.C.
20 1395m(a)(14)) is amended—

21 (1) by redesignating subparagraphs (L) and
22 (M) as subparagraphs (M) and (N), respectively;

23 (2) in subparagraph (K), by striking “2011,
24 2012, and 2013,”;

1 (3) by inserting after subparagraph (K), the
2 following new subparagraph:

3 “(L) for 2011, 2012, and 2013, the per-
4 centage increase in the consumer price index for
5 all urban consumers (U.S. urban average) for
6 the 12-month period ending with June of the
7 previous year, reduced by the productivity ad-
8 justment described in section
9 1886(b)(3)(B)(iii)(II);”.

10 (4) in subparagraph (M), as redesignated by
11 paragraph (1)—

12 (A) in clause (i), by striking “, plus 2.0
13 percentage points”; and

14 (B) in each of clauses (i) and (ii), by in-
15 serting “reduced by the productivity adjustment
16 described in section 1886(b)(3)(B)(iii)(II),”
17 after “June 2013,”; and

18 (5) in subparagraph (N), as redesignated by
19 paragraph (1), by inserting “, reduced by the pro-
20 ductivity adjustment described in section
21 1886(b)(3)(B)(iii)(II)” before the period at the end.

22 (n) PROSTHETIC DEVICES, ORTHOTICS, AND PROS-
23 THETICS.—Section 1834(h)(4)(A)(x) of the Social Secu-
24 rity Act (42 U.S.C. 1395m(h)(4)(A)(x)) is amended by in-
25 serting “and, in the case of 2011 and each subsequent

1 year, reduced by the productivity adjustment described in
2 section 1886(b)(3)(B)(iii)(II)” before the semicolon at the
3 end.

4 (o) OTHER ITEMS.—The second sentence of section
5 1842(s)(1) of the Social Security Act (42 U.S.C.
6 1395u(s)(1)), in the matter preceding subparagraph (A),
7 is amended by inserting “and, in the case of 2011 and
8 each subsequent year, reduced by the productivity adjust-
9 ment described in section 1886(b)(3)(B)(iii)(II)” after
10 “preceding year”.

11 (p) NO APPLICATION PRIOR TO JANUARY 1, 2010.—
12 Notwithstanding the preceding provisions of this section—

13 (1) the amendments made by subsections (a),
14 (c), and (d) shall not apply to discharges occurring
15 before January 1, 2010; and

16 (2) the amendments made by subsection (f)
17 shall not apply to days occurring before January 1,
18 2010.

19 **SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULA-**
20 **TION OF PART B PREMIUMS.**

21 Section 1839(i) of the Social Security Act (42 U.S.C.
22 1395r(i)) is amended—

23 (1) in paragraph (2), in the matter preceding
24 subparagraph (A), by inserting “subject to para-
25 graph (6),” after “subsection,”;

1 (2) in paragraph (3)(A)(i), by striking “The ap-
2 plicable” and inserting “Subject to paragraph (6),
3 the applicable”;

4 (3) by redesignating paragraph (6) as para-
5 graph (7); and

6 (4) by inserting after paragraph (5) the fol-
7 lowing new paragraph:

8 “(6) TEMPORARY ADJUSTMENT TO INCOME
9 THRESHOLDS.—Notwithstanding any other provision
10 of this subsection, during the period beginning on
11 January 1, 2011, and ending on December 31,
12 2019—

13 “(A) the threshold amount otherwise appli-
14 cable under paragraph (2) shall be equal to
15 such amount for 2010; and

16 “(B) the dollar amounts otherwise applica-
17 ble under paragraph (3)(C)(i) shall be equal to
18 such dollar amounts for 2010.”.

19 **SEC. 3403. MEDICARE COMMISSION.**

20 (a) COMMISSION.—

21 (1) IN GENERAL.—Title XVIII of the Social Se-
22 curity Act (42 U.S.C. 1395 et seq.), as amended by
23 section 3022, is amended by adding at the end the
24 following new section:

1 “MEDICARE COMMISSION

2 “SEC. 1899A. (a) ESTABLISHMENT.—There is estab-
3 lished an independent commission to be known as the
4 ‘Medicare Commission’

5 “(b) PURPOSE.—It is the purpose of this section to,
6 in accordance with the following provisions of this section,
7 reduce the per capita rate of growth in Medicare spend-
8 ing—

9 “(1) by requiring the Chief Actuary of the Cen-
10 ters for Medicare & Medicaid Services to determine
11 in each year to which this section applies (in this
12 section referred to as ‘a determination year ’) the
13 projected per capita growth rate under Medicare for
14 the second year following the determination year (in
15 this section referred to as ‘an implementation year’);

16 “(2) if the projection for the implementation
17 year exceeds the target growth rate for that year, by
18 requiring the Commission to develop and submit
19 during the first year following the determination
20 year (in this section referred to as ‘a proposal year
21 ’) a proposal to reduce the Medicare per capita
22 growth rate to the extent required by this section;
23 and

1 “(3) by requiring the Secretary to implement
2 such proposals unless Congress enacts legislation
3 pursuant to this section.

4 “(c) COMMISSION PROPOSALS.—

5 “(1) DEVELOPMENT AND SUBMISSION.—

6 “(A) IN GENERAL.—The Commission shall
7 develop and submit detailed and specific pro-
8 posals to Congress in accordance with the suc-
9 ceeding provisions of this section.

10 “(B) ADVISORY REPORTS.—Beginning
11 January 1, 2014, the Commission may submit
12 to Congress advisory reports on matters related
13 to the Medicare program, regardless of whether
14 or not the Commission submitted a proposal for
15 such year. Such a report may, for years prior
16 to 2020, include recommendations regarding
17 improvements to payment systems for providers
18 of services and suppliers who are not otherwise
19 subject to the scope of the Commission’s rec-
20 ommendations in a proposal under this section.
21 Any advisory report submitted under this sub-
22 paragraph shall not be subject to the rules for
23 congressional consideration under subsection
24 (d).

25 “(2) SCOPE OF PROPOSALS.—

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1 “(A) REQUIREMENTS.—Each proposal
2 submitted under this section in a proposal year
3 shall meet each of the following requirements:

4 “(i) If the Chief Actuary of the Cen-
5 ters for Medicare & Medicaid Services has
6 made a determination under paragraph
7 (5)(A) in the determination year, the pro-
8 posal shall include recommendations so
9 that the proposal as a whole (after taking
10 into account recommendations under
11 clause (v)) will result in a net reduction in
12 total Medicare program spending in the
13 implementation year equal to the applica-
14 ble savings target established under para-
15 graph (5)(B) for such implementation
16 year. In determining whether a proposal
17 meets the requirement of the preceding
18 sentence, reductions in Medicare program
19 spending during the 3-month period imme-
20 diately preceding the implementation year
21 shall be counted to the extent that such re-
22 ductions are a result of the implementation
23 of recommendations contained in the pro-
24 posal for a change in the payment rate for
25 an item or service that was effective during

1 such period pursuant to subsection
2 (e)(2)(A).

3 “(ii) The proposal shall not include
4 any recommendation to ration health care,
5 raise revenues or Medicare beneficiary pre-
6 miums under section 1818, 1818A, or
7 1839, increase Medicare beneficiary cost-
8 sharing (including deductibles, coinsur-
9 ance, and copayments), or otherwise re-
10 strict benefits or modify eligibility criteria.

11 “(iii) In the case of proposals sub-
12 mitted prior to December 31, 2018, the
13 proposal shall not include any rec-
14 ommendation that would impact, prior to
15 December 31, 2019, providers of services
16 (as defined in section 1861(u)) and sup-
17 pliers (as defined in section 1861(d))
18 scheduled to receive a reduction to the in-
19 flationary payment updates of such pro-
20 viders of services and suppliers in excess of
21 a reduction due to productivity in a year in
22 which such recommendations would take
23 effect.

24 “(iv) As appropriate, the proposal
25 shall include recommendations to reduce

1 Medicare payments under parts C and D,
2 such as reductions under such parts in the
3 Federal premium subsidies to Medicare
4 Advantage and prescription drug plans and
5 the performance bonuses.

6 “(v) The proposal shall include rec-
7 ommendations with respect to administra-
8 tive funding for the Secretary to carry out
9 the recommendations contained in the pro-
10 posal.

11 “(B) ADDITIONAL CONSIDERATIONS.—In
12 developing and submitting each proposal under
13 this section in a proposal year, the Commission
14 shall, to the extent feasible—

15 “(i) include recommendations that
16 target reductions in Medicare program
17 spending to sources of excess cost growth;

18 “(ii) include recommendations that—

19 “(I) improve the health care de-
20 livery system and health outcomes, in-
21 cluding by promoting integrated care,
22 care coordination, prevention and
23 wellness, and quality and efficiency
24 improvement; and

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1 “(II) protect and improve Medi-
2 care beneficiaries’ access to necessary
3 and evidence-based items and services,
4 including in rural and frontier areas;

5 “(iii) give priority to recommendations
6 that extend Medicare solvency;

7 “(iv) consider the effects on Medicare
8 beneficiaries of changes in payments to
9 providers of services (as defined in section
10 1861(u)) and suppliers (as defined in sec-
11 tion 1861(d));

12 “(v) consider the effects of the rec-
13 ommendations on providers of services and
14 suppliers with actual or projected negative
15 cost margins or payment updates; and

16 “(vi) consider the unique needs of
17 Medicare beneficiaries who are dually eligi-
18 ble for Medicare and the Medicaid program
19 under title XIX.

20 “(C) NO INCREASE IN TOTAL MEDICARE
21 PROGRAM SPENDING.—Each proposal submitted
22 under this section shall be designed in such a
23 manner that implementation of the rec-
24 ommendations contained in the proposal would
25 not be expected to result, over the 10-year pe-

1 riod starting with the implementation year, in
2 any increase in the total amount of net Medi-
3 care program spending relative to the total
4 amount of net Medicare program spending that
5 would have occurred absent such implementa-
6 tion.

7 “(D) CONSULTATION WITH MEDPAC.—The
8 Commission shall submit a draft copy of each
9 proposal to be submitted to Congress under this
10 section to the Medicare Payment Advisory Com-
11 mission established under section 1805 for its
12 review. The commission shall submit such draft
13 copy by not later than September 1 of the year
14 preceding the year for which the proposal is to
15 be submitted. Not later than February 1 of the
16 succeeding year, the Medicare Payment Advi-
17 sory Commission shall submit a report to Con-
18 gress on the results of such review.

19 “(E) REVIEW AND COMMENT BY THE SEC-
20 RETARY.—The Commission shall submit a draft
21 copy of each proposal to be submitted to Con-
22 gress under this section to the Secretary for the
23 Secretary’s review and comment. The Commis-
24 sion shall submit such draft copy by not later
25 than September 1 of the year preceding the

1 year for which the proposal is to be submitted.
2 Not later than February 1 of the succeeding
3 year, the Secretary shall submit a report to
4 Congress on the results of such review, unless
5 the Secretary submits a proposal under para-
6 graph (3)(C) in that year.

7 “(F) CONSULTATIONS.—In carrying out
8 its duties under this section, the Commission
9 shall engage in regular consultations with the
10 Medicaid and CHIP Payment and Access Com-
11 mission under section 1900.

12 “(3) SUBMISSION.—

13 “(A) REQUIRED INFORMATION.—Each
14 proposal submitted by the Commission to Con-
15 gress under this section shall include—

16 “(i) an explanation of each rec-
17 ommendation contained in the proposal
18 and the reasons for including such rec-
19 ommendation; and

20 “(ii) an actuarial opinion by the Chief
21 Actuary of the Centers for Medicare &
22 Medicaid Services certifying that the pro-
23 posal meets the requirements of subpara-
24 graphs (A)(i) and (C) of paragraph (2).

25 “(B) DATES FOR SUBMISSION.—

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1 “(i) IN GENERAL.—Except as pro-
2 vided in clause (ii) and subsection
3 (f)(3)(B), the Commission shall submit a
4 proposal to Congress on January 1, 2014,
5 and annually thereafter.

6 “(ii) EXCEPTION.—The Commission
7 shall not submit a proposal to Congress
8 under this section in a proposal year if the
9 year is—

10 “(I) a year for which the Chief
11 Actuary of the Centers for Medicare &
12 Medicaid Services make a determina-
13 tion in the determination year under
14 paragraph (4)(A) that the growth rate
15 described in clause (i) of such para-
16 graph does not exceed the growth rate
17 described in clause (ii) of such para-
18 graph; or

19 “(II) a year in which the percent-
20 age increase (if any) for the medical
21 care expenditure category of the Con-
22 sumer Price Index for All Urban Con-
23 sumers (United States city average)
24 for the implementation year is less
25 than the percentage increase (if any)

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1 in the Consumer Price Index for All
2 Urban Consumers (all items; United
3 States city average) for such imple-
4 mentation year;

5 “(III) the year referred to in sub-
6 section (f)(1)(A).

7 “(iii) START-UP PERIOD.—The Com-
8 mission may not submit a proposal to Con-
9 gress prior to January 1, 2014.

10 “(C) CONTINGENT SECRETARIAL SUBMIS-
11 SION.—If, with respect to a proposal year, the
12 Commission is required to but fails to submit a
13 proposal by the deadline applicable under sub-
14 paragraph (B)(i), the Secretary shall submit a
15 detailed and specific proposal to Congress that
16 satisfies the requirements of subparagraph (A)
17 and subparagraphs (A), (B), and (C) of para-
18 graph (2) not later than January 5 of the year.
19 The Secretary shall transmit a copy of the pro-
20 posal to the Medicare Payment Advisory Com-
21 mission for its review. The Medicare Payment
22 Advisory Commission shall submit a report to
23 Congress on the results of such review by Feb-
24 ruary 1 of the year.

1 “(4) PER CAPITA GROWTH RATE PROJECTIONS
2 BY CHIEF ACTUARY.—

3 “(A) IN GENERAL.—Subject to subsection
4 (f)(3)(A), not later than April 30, 2013, and
5 annually thereafter, the Chief Actuary of the
6 Centers for Medicare & Medicaid Services shall
7 determine in each such year whether—

8 “(i) the projected Medicare per capita
9 growth rate for the implementation year
10 (as determined under subparagraph (B));
11 exceeds

12 “(ii) the projected Medicare per capita
13 target growth rate for the implementation
14 year (as determined under subparagraph
15 (C)).

16 “(B) MEDICARE PER CAPITA GROWTH
17 RATE.—

18 “(i) IN GENERAL.—For purposes of
19 this section, the Medicare per capita
20 growth rate for an implementation year
21 shall be calculated as the projected 5-year
22 average (ending with such year) of the
23 growth in Medicare program spending per
24 unduplicated enrollee.

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1 “(ii) REQUIREMENT.—The projection
2 under clause (i) shall—

3 “(I) to the extent that there is
4 projected to be a negative update to
5 the single conversion factor applicable
6 to payments for physicians’ services
7 under section 1848(d) furnished in
8 the proposal year or the implementa-
9 tion year, assume that such update
10 for such services is 0 percent rather
11 than the negative percent that would
12 otherwise apply; and

13 “(II) take into account any deliv-
14 ery system reforms or other payment
15 changes that have been enacted or
16 published in final rules but not yet
17 implemented as of the making of such
18 calculation.

19 “(C) MEDICARE PER CAPITA TARGET
20 GROWTH RATE.—For purposes of this section,
21 the Medicare per capita target growth rate for
22 an implementation year shall be calculated as
23 the projected 5-year average (ending with such
24 year) percentage increase in—

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1 “(i) in the case of a determination
2 year that is prior to 2018, the average of
3 the projected percentage increase (if any)
4 in—

5 “(I) the Consumer Price Index
6 for All Urban Consumers (all items;
7 United States city average); and

8 “(II) the medical care expendi-
9 ture category of the Consumer Price
10 Index for All Urban Consumers
11 (United States city average); and

12 “(ii) in the case of a determination
13 year that is after 2017, the nominal gross
14 domestic product per capita plus 1.0 per-
15 centage point.

16 “(5) SAVINGS REQUIREMENT.—

17 “(A) IN GENERAL.—If, with respect to a
18 determination year, the Chief Actuary of the
19 Centers for Medicare & Medicaid Services
20 makes a determination under paragraph (4)(A)
21 that the growth rate described in clause (i) of
22 such paragraph exceeds the growth rate de-
23 scribed in clause (ii) of such paragraph, the
24 Chief Actuary shall establish an applicable sav-
25 ings target for the implementation year.

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1 “(B) APPLICABLE SAVINGS TARGET.—For
2 purposes of this section, the applicable savings
3 target for an implementation year shall be an
4 amount equal to the product of—

5 “(i) the total amount of projected
6 Medicare program spending for the pro-
7 posal year; and

8 “(ii) the applicable percent for the im-
9 plementation year.

10 “(C) APPLICABLE PERCENT.—For pur-
11 poses of subparagraph (B), the applicable per-
12 cent for a projection is the lesser of—

13 “(i) in the case of—

14 “(I) implementation year 2015,
15 0.5 percent;

16 “(II) implementation year 2016,
17 1.0 percent;

18 “(III) implementation year 2017,
19 1.25 percent; and

20 “(IV) implementation year 2018
21 or any subsequent implementation
22 year, 1.5 percent; and

23 “(ii) the projected excess for the im-
24 plementation year (expressed as a percent)
25 determined under subparagraph (A).

1 “(d) CONGRESSIONAL CONSIDERATION.—

2 “(1) COMMITTEE CONSIDERATION OF PRO-
3 POSAL; DISCHARGE; CONTINGENCY FOR INTRODUC-
4 TION.—Not later than April 1 of any proposal year
5 in which a Commission proposal or Secretarial pro-
6 posal is submitted to Congress under this section,
7 the appropriate committees of Congress shall report
8 legislation implementing the recommendations con-
9 tained in the proposal or legislation that satisfies the
10 requirements of subparagraphs (A), (B), and (C) of
11 subsection (c)(2). If, with respect to the House in-
12 volved, any such committee has not reported such
13 legislation by such date, such committees shall be
14 deemed to be discharged from further consideration
15 of the proposal and any member of the House of
16 Representatives or the Senate, respectively, may in-
17 troduce legislation implementing the recommenda-
18 tions contained in the proposal and such legislation
19 shall be placed on the appropriate calendar of the
20 House involved.

21 “(2) EXPEDITED PROCEDURE.—

22 “(A) CONSIDERATION.—If legislation is re-
23 ported out of committee or legislation is intro-
24 duced under paragraph (1), not later than 15
25 calendar days after the date on which a com-

1 mittee has been or could have been discharged
2 from consideration of such legislation or such
3 legislation is introduced, the Speaker of the
4 House of Representatives, or the Speaker's des-
5 ignee, or the majority leader of the Senate, or
6 the leader's designee, shall move to proceed to
7 the consideration of the legislation. It shall also
8 be in order for any member of the Senate or
9 the House of Representatives, respectively, to
10 move to proceed to the consideration of the leg-
11 islation at any time after the conclusion of such
12 15-day period. All points of order against the
13 legislation (and against consideration of the leg-
14 islation) with the exception of points of order
15 under the Congressional Budget Act of 1974
16 and points of order to strike any matters extra-
17 neous to Medicare are waived. A motion to pro-
18 ceed to the consideration of the legislation is
19 privileged in the Senate and highly privileged in
20 the House of Representatives and is not debat-
21 able. The motion is not subject to amendment,
22 to a motion to postpone consideration of the
23 legislation, or to a motion to proceed to the
24 consideration of other business. A motion to re-
25 consider the vote by which the motion to pro-

1 ceed is agreed to or not agreed to shall not be
2 in order. If the motion to proceed is agreed to,
3 the Senate or the House of Representatives, as
4 the case may be, shall immediately proceed to
5 consideration of the legislation in accordance
6 with the Standing Rules of the Senate or the
7 House of Representatives, as the case may be,
8 without intervening motion, order, or other
9 business, and the resolution shall remain the
10 unfinished business of the Senate or the House
11 of Representatives, as the case may be, until
12 disposed of.

13 “(B) CONSIDERATION BY OTHER
14 HOUSE.—If, before the passage by one House
15 of the legislation that was introduced in such
16 House, such House receives from the other
17 House legislation as passed by such other
18 House—

19 “(i) the legislation of the other House
20 shall not be referred to a committee and
21 shall immediately displace the legislation
22 that was reported or introduced in the
23 House in receipt of the legislation of the
24 other House; and

1 “(ii) the legislation of the other House
2 shall immediately be considered by the re-
3 ceiving House under the same procedures
4 applicable to legislation reported by or dis-
5 charged from a committee or introduced
6 under paragraph (1).

7 Upon disposition of legislation that is received
8 by one House from the other House, it shall no
9 longer be in order to consider the legislation
10 that was reported or introduced in the receiving
11 House.

12 “(C) SENATE LIMITS ON DEBATE.—In the
13 Senate, consideration of the legislation and on
14 all debatable motions and appeals in connection
15 therewith shall not exceed a total of 30 hours,
16 which shall be divided equally between those fa-
17 voring and those opposing the legislation. A mo-
18 tion further to limit debate on the legislation is
19 in order and is not debatable. Any debatable
20 motion or appeal is debatable for not to exceed
21 1 hour, to be divided equally between those fa-
22 voring and those opposing the motion or appeal.
23 All time used for consideration of the legisla-
24 tion, including time used for quorum calls and

1 voting, shall be counted against the total 30
2 hours of consideration.

3 “(D) CONSIDERATION IN CONFERENCE.—

4 Immediately upon a final passage of the legisla-
5 tion that results in a disagreement between the
6 two Houses of Congress with respect to the leg-
7 islation, conferees shall be appointed and a con-
8 ference convened. Not later than 15 days after
9 the date on which conferees are appointed (ex-
10 cluding periods in which one or both Houses
11 are in recess), the conferees shall file a report
12 with the Senate and the House of Representa-
13 tives resolving the differences between the
14 Houses on the legislation. Notwithstanding any
15 other rule of the Senate or the House of Rep-
16 resentatives, it shall be in order to immediately
17 consider a report of a committee of conference
18 on the legislation filed in accordance with this
19 subsection. Debate in the Senate and the House
20 of Representatives on the conference report
21 shall be limited to 10 hours, equally divided and
22 controlled by the majority and minority leaders
23 of the Senate or their designees and the Speak-
24 er of the House of Representatives and the mi-
25 nority leader of the House of Representatives or

1 their designees. A vote on final passage of the
2 conference report shall occur immediately at the
3 conclusion or yielding back of all time for de-
4 bate on the conference report.

5 “(3) RULES OF THE SENATE AND HOUSE OF
6 REPRESENTATIVES.—This subsection and subsection
7 (f)(2) are enacted by Congress—

8 “(A) as an exercise of the rulemaking
9 power of the Senate and House of Representa-
10 tives, respectively, and is deemed to be part of
11 the rules of each House, respectively, but appli-
12 cable only with respect to the procedure to be
13 followed in that House in the case of legislation
14 under this section, and it supersedes other rules
15 only to the extent that it is inconsistent with
16 such rules; and

17 “(B) with full recognition of the constitu-
18 tional right of either House to change the rules
19 (so far as they relate to the procedure of that
20 House) at any time, in the same manner, and
21 to the same extent as in the case of any other
22 rule of that House.

23 “(e) IMPLEMENTATION OF PROPOSAL.—

24 “(1) IN GENERAL.—Notwithstanding any other
25 provision of law, the Secretary shall, except as pro-

1 vided in paragraph (3), implement the recommenda-
2 tions contained in a proposal submitted by the Com-
3 mission or the Secretary to Congress under this sec-
4 tion on August 15 of the year in which the proposal
5 is so submitted.

6 “(2) APPLICATION.—

7 “(A) IN GENERAL.—A recommendation de-
8 scribed in paragraph (1) shall apply as follows:

9 “(i) In the case of a recommendation
10 that is a change in the payment rate for
11 an item or service under Medicare in which
12 payment rates change on a fiscal year
13 basis (or a cost reporting period basis that
14 relates to a fiscal year), on a calendar year
15 basis (or a cost reporting period basis that
16 relates to a calendar year), or on a rate
17 year basis (or a cost reporting period basis
18 that relates to a rate year), such rec-
19 ommendation shall apply to items and
20 services furnished on the first day of the
21 first fiscal year, calendar year, or rate year
22 (as the case may be) that begins after such
23 August 15.

24 “(ii) In the case of a recommendation
25 relating to payments to plans under parts

1 C and D, such recommendation shall apply
2 to plan years beginning on the first day of
3 the first calendar year that begins after
4 such August 15.

5 “(iii) In the case of any other rec-
6 ommendation, such recommendation shall
7 be addressed in the regular regulatory
8 process timeframe and shall apply as soon
9 as practicable.

10 “(B) INTERIM FINAL RULEMAKING.—The
11 Secretary may use interim final rulemaking to
12 implement any recommendation described in
13 paragraph (1).

14 “(3) EXCEPTION.—The Secretary shall not be
15 required to implement the recommendations con-
16 tained in a proposal submitted in a proposal year by
17 the Commission or the Secretary to Congress under
18 this section if—

19 “(A) prior to August 15 of the proposal
20 year, Federal legislation is enacted that satis-
21 fies the requirements of subparagraphs (A),
22 (B), and (C) of subsection (c)(2), and which
23 may implement all, some, or none of the rec-
24 ommendations contained in the proposal; or

1 “(B) in the case of implementation year
2 2020 and subsequent implementation years, a
3 joint resolution described in subsection (f)(1) is
4 enacted not later than August 15, 2017.

5 “(4) NO AFFECT ON AUTHORITY TO IMPLE-
6 MENT CERTAIN PROVISIONS.—Nothing in paragraph
7 (3) shall be construed to affect the authority of the
8 Secretary to implement any recommendation con-
9 tained in a proposal or advisory report under this
10 section to the extent that the Secretary otherwise
11 has the authority to implement such recommenda-
12 tion administratively.

13 “(5) LIMITATION ON REVIEW.—There shall be
14 no administrative or judicial review under section
15 1869, section 1878, or otherwise of the implementa-
16 tion by the Secretary under this subsection of the
17 recommendations contained in a proposal.

18 “(f) JOINT RESOLUTION REQUIRED TO DIS-
19 CONTINUE AUTOMATIC IMPLEMENTATION OF REC-
20 COMMENDATIONS IN PROPOSALS.—

21 “(1) IN GENERAL.—For purposes of subsection
22 (e)(3)(B), a joint resolution described in this para-
23 graph means only a joint resolution—

24 “(A) that is introduced in 2017 by not
25 later than February 1 of such year;

1 “(B) which does not have a preamble;

2 “(C) the title of which is as follows: ‘Joint
3 resolution approving the discontinuation of the
4 process for consideration and automatic imple-
5 mentation of the biennial proposal of the Medi-
6 care Commission under section 1899A of the
7 Social Security Act’; and

8 “(D) the matter after the resolving clause
9 of which is as follows: ‘That Congress approves
10 the discontinuation of the process for consider-
11 ation and automatic implementation of the bi-
12 ennial proposal of the Medicare Commission
13 under section 1899A of the Social Security
14 Act.’.

15 “(2) PROCEDURE.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), the procedures described in sub-
18 sections (b)(1), (c), (d), and (f) of section 802
19 of title 5, United States Code, shall apply to the
20 consideration of a joint resolution described in
21 paragraph (1).

22 “(B) TERMS AND EXCEPTIONS.—For pur-
23 poses of this subsection—

24 “(i) the references to ‘subsection (a)’
25 in subsections (b)(1)(A), (c), (d), and (f) of

1 section 802 of that title shall be considered
2 to refer to paragraph (1) of this sub-
3 section; and

4 “(ii) the 20 calendar day period de-
5 scribed in section 802(c) shall be consid-
6 ered to refer to the period ending on the
7 20th calendar day occurring after the date
8 on which a resolution described in para-
9 graph (1) is introduced.

10 “(C) EXCLUDED DAYS.—For purposes of
11 determining the period specified in subpara-
12 graph (B), there shall be excluded any days ei-
13 ther House of Congress is adjourned for more
14 than 3 days during a session of Congress.

15 “(3) TERMINATION.—If a joint resolution de-
16 scribed in paragraph (1) is enacted not later than
17 August 15, 2017—

18 “(A) the Chief Actuary of the Medicare &
19 Medicaid Services shall not make any deter-
20 minations under paragraph (4) after the date of
21 the enactment of such joint resolution;

22 “(B) the Commission shall not submit any
23 proposals or advisory reports to Congress under
24 this section after the date of the enactment of
25 such joint resolution; and

1 “(C) the Commission and the consumer
2 advisory council under subsection (k) shall ter-
3 minate 60 days after the date of the enactment
4 of such joint resolution.

5 “(g) COMMISSION MEMBERSHIP; TERMS OF OFFICE;
6 CHAIRPERSON; REMOVAL.—

7 “(1) MEMBERSHIP.—

8 “(A) IN GENERAL.—The Commission shall
9 be composed of—

10 “(i) 15 members appointed by the
11 President, by and with the advice and con-
12 sent of the Senate; and

13 “(ii) the Secretary, the Administrator
14 of the Center for Medicare & Medicaid
15 Services, and the Administrator of the
16 Health Resources and Services Administra-
17 tion, all of whom shall serve ex officio as
18 nonvoting members of the Commission.

19 “(B) QUALIFICATIONS.—

20 “(i) IN GENERAL.—The appointed
21 membership of the Commission shall in-
22 clude individuals with national recognition
23 for their expertise in health finance and ec-
24 onomics, actuarial science, health facility
25 management, health plans and integrated

1 delivery systems, reimbursement of health
2 facilities, allopathic and osteopathic physi-
3 cians, and other providers of health serv-
4 ices, and other related fields, who provide
5 a mix of different professionals, broad geo-
6 graphic representation, and a balance be-
7 tween urban and rural representatives.

8 “(ii) INCLUSION.—The appointed
9 membership of the Commission shall in-
10 clude (but not be limited to) physicians
11 and other health professionals, experts in
12 the area of pharmaco-economics or pre-
13 scription drug benefit programs, employ-
14 ers, third-party payers, individuals skilled
15 in the conduct and interpretation of bio-
16 medical, health services, and health eco-
17 nomics research and expertise in outcomes
18 and effectiveness research and technology
19 assessment. Such membership shall also
20 include representatives of consumers and
21 the elderly.

22 “(iii) MAJORITY NONPROVIDERS.—In-
23 dividuals who are directly involved in the
24 provision or management of the delivery of
25 items and services covered under this title

1 shall not constitute a majority of the ap-
2 pointed membership of the Commission.

3 “(C) ETHICAL DISCLOSURE.—The Presi-
4 dent shall establish a system for public disclo-
5 sure by appointed members of the Commission
6 of financial and other potential conflicts of in-
7 terest relating to such members. Appointed
8 members of the Commission shall be treated as
9 officers in the executive branch for purposes of
10 applying title I of the Ethics in Government Act
11 of 1978 (Public Law 95–521).

12 “(D) CONFLICTS OF INTEREST.—No indi-
13 vidual may serve as an appointed member if
14 that individual engages in any other business,
15 vocation, or employment.

16 “(E) CONSULTATION WITH CONGRESS.—In
17 selecting individuals for nominations for ap-
18 pointments to the Commission, the President
19 shall consult with—

20 “(i) the majority leader of the Senate
21 concerning the appointment of 3 members;

22 “(ii) the Speaker of the House of
23 Representatives concerning the appoint-
24 ment of 3 members;

1 “(iii) the minority leader of the Sen-
2 ate concerning the appointment of 3 mem-
3 bers; and

4 “(iv) the minority leader of the House
5 of Representatives concerning the appoint-
6 ment of 3 members.

7 “(2) TERM OF OFFICE.—Each appointed mem-
8 ber shall hold office for a term of 6 years except
9 that—

10 “(A) a member appointed to fill a vacancy
11 occurring prior to the expiration of the term for
12 which that member’s predecessor was appointed
13 shall be appointed for the remainder of such
14 term;

15 “(B) a member may continue to serve after
16 the expiration of the member’s term until a suc-
17 cessor has taken office; and

18 “(C) of the members first appointed under
19 this section, 5 shall be appointed for a term of
20 1 year, 5 shall be appointed for a term of 3
21 years, and 5 shall be appointed for a term of
22 6 years, the term of each to be designated by
23 the President at the time of nomination.

24 “(3) CHAIRPERSON.—

1 “(A) IN GENERAL.—The Chairperson shall
2 be appointed by the President, by and with the
3 advice and consent of the Senate, from among
4 the members of the Commission.

5 “(B) DUTIES.—The Chairperson shall be
6 the principal executive officer of the Commis-
7 sion, and shall exercise all of the executive and
8 administrative functions of the Commission, in-
9 cluding functions of the Commission with re-
10 spect to—

11 “(i) the appointment and supervision
12 of personnel employed by the Commission;

13 “(ii) the distribution of business
14 among personnel appointed and supervised
15 by the Chairperson and among administra-
16 tive units of the Commission; and

17 “(iii) the use and expenditure of
18 funds.

19 “(C) GOVERNANCE.—In carrying out any
20 of the functions under subparagraph (B), the
21 Chairperson shall be governed by the general
22 policies established by the Commission and by
23 the decisions, findings, and determinations the
24 Commission shall by law be authorized to make.

1 “(D) REQUESTS FOR APPROPRIATIONS.—
2 Requests or estimates for regular, supple-
3 mental, or deficiency appropriations on behalf
4 of the Commission may not be submitted by the
5 Chairperson without the prior approval of a ma-
6 jority vote of the Commission.

7 “(4) REMOVAL.—Any appointed member may
8 be removed by the President for neglect of duty or
9 malfeasance in office, but for no other cause.

10 “(h) VACANCIES; QUORUM; SEAL; VICE CHAIR-
11 PERSON; VOTING ON REPORTS.—

12 “(1) VACANCIES.—No vacancy on the Commis-
13 sion shall impair the right of the remaining members
14 to exercise all the powers of the Commission.

15 “(2) QUORUM.—A majority of the appointed
16 members of the Commission shall constitute a
17 quorum for the transaction of business, but a lesser
18 number of members may hold hearings.

19 “(3) SEAL.—The Commission shall have an of-
20 ficial seal, of which judicial notice shall be taken.

21 “(4) VICE CHAIRPERSON.—The Commission
22 shall annually elect a Vice Chairperson to act in the
23 absence or disability of the Chairperson or in case
24 of a vacancy in the office of the Chairperson.

1 “(5) VOTING ON PROPOSALS.—Any proposal of
2 the Commission must be approved by the majority
3 of appointed members present.

4 “(i) POWERS OF THE COMMISSION.—

5 “(1) HEARINGS.—The Commission may hold
6 such hearings, sit and act at such times and places,
7 take such testimony, and receive such evidence as
8 the Commission considers advisable to carry out this
9 section.

10 “(2) AUTHORITY TO INFORM RESEARCH PRIOR-
11 ITIES FOR DATA COLLECTION.—The Commission
12 may advise the Secretary on priorities for health
13 services research, particularly as such priorities per-
14 tain to necessary changes and issues regarding pay-
15 ment reforms under Medicare.

16 “(3) OBTAINING OFFICIAL DATA.—The Com-
17 mission may secure directly from any department or
18 agency of the United States information necessary
19 to enable it to carry out this section. Upon request
20 of the Chairperson, the head of that department or
21 agency shall furnish that information to the Com-
22 mission on an agreed upon schedule.

23 “(4) POSTAL SERVICES.—The Commission may
24 use the United States mails in the same manner and

1 under the same conditions as other departments and
2 agencies of the Federal Government.

3 “(5) GIFTS.—The Commission may accept, use,
4 and dispose of gifts or donations of services or prop-
5 erty.

6 “(6) OFFICES.—The Commission shall main-
7 tain a principal office and such field offices as it de-
8 termines necessary, and may meet and exercise any
9 of its powers at any other place.

10 “(j) PERSONNEL MATTERS.—

11 “(1) COMPENSATION OF MEMBERS AND CHAIR-
12 PERSON.—Each appointed member, other than the
13 Chairperson, shall be compensated at a rate equal to
14 the annual rate of basic pay prescribed for level III
15 of the Executive Schedule under section 5315 of title
16 5, United States Code. The Chairperson shall be
17 compensated at a rate equal to the daily equivalent
18 of the annual rate of basic pay prescribed for level
19 II of the Executive Schedule under section 5315 of
20 title 5, United States Code.

21 “(2) TRAVEL EXPENSES.—The appointed mem-
22 bers shall be allowed travel expenses, including per
23 diem in lieu of subsistence, at rates authorized for
24 employees of agencies under subchapter I of chapter
25 57 of title 5, United States Code, while away from

1 their homes or regular places of business in the per-
2 formance of services for the Commission.

3 “(3) STAFF.—

4 “(A) IN GENERAL.—The Chairperson may,
5 without regard to the civil service laws and reg-
6 ulations, appoint and terminate an executive di-
7 rector and such other additional personnel as
8 may be necessary to enable the Commission to
9 perform its duties. The employment of an exec-
10 utive director shall be subject to confirmation
11 by the Commission.

12 “(B) COMPENSATION.—The Chairperson
13 may fix the compensation of the executive direc-
14 tor and other personnel without regard to chap-
15 ter 51 and subchapter III of chapter 53 of title
16 5, United States Code, relating to classification
17 of positions and General Schedule pay rates, ex-
18 cept that the rate of pay for the executive direc-
19 tor and other personnel may not exceed the rate
20 payable for level V of the Executive Schedule
21 under section 5316 of such title.

22 “(4) DETAIL OF GOVERNMENT EMPLOYEES.—
23 Any Federal Government employee may be detailed
24 to the Commission without reimbursement, and such

1 detail shall be without interruption or loss of civil
2 service status or privilege.

3 “(5) PROCUREMENT OF TEMPORARY AND
4 INTERMITTENT SERVICES.—The Chairperson may
5 procure temporary and intermittent services under
6 section 3109(b) of title 5, United States Code, at
7 rates for individuals which do not exceed the daily
8 equivalent of the annual rate of basic pay prescribed
9 for level V of the Executive Schedule under section
10 5316 of such title.

11 “(k) CONSUMER ADVISORY COUNCIL.—

12 “(1) IN GENERAL.—There is established a con-
13 sumer advisory council to advise the Commission on
14 the impact of payment policies under this title on
15 consumers.

16 “(2) MEMBERSHIP.—

17 “(A) NUMBER AND APPOINTMENT.—The
18 consumer advisory council shall be composed of
19 10 consumer representatives appointed by the
20 Comptroller General of the United States, 1
21 from among each of the 10 regions established
22 by the Secretary as of the date of enactment of
23 this section.

1 “(B) QUALIFICATIONS.—The membership
2 of the council shall represent the interests of
3 consumers and particular communities.

4 “(3) DUTIES.—The consumer advisory council
5 shall, subject to the call of the Commission, meet
6 not less frequently than 2 times each year in the
7 District of Columbia.

8 “(4) OPEN MEETINGS.—Meetings of the con-
9 sumer advisory council shall be open to the public.

10 “(5) ELECTION OF OFFICERS.—Members of the
11 consumer advisory council shall elect their own offi-
12 cers.

13 “(6) APPLICATION OF FACa.—The Federal Ad-
14 visory Committee Act (5 U.S.C. App.) shall apply to
15 the consumer advisory council except that section 14
16 of such Act shall not apply.

17 “(1) DEFINITIONS.—In this section:

18 “(1) APPROPRIATE COMMITTEES OF CON-
19 GRESS.—The term ‘appropriate committees of Con-
20 gress’ means the Committee on Ways and Means
21 and the Committee on Energy and Commerce of the
22 House of Representatives and the Committee on Fi-
23 nance of the Senate.

24 “(2) COMMISSION; CHAIRPERSON; MEMBER.—
25 The terms ‘Commission’, ‘Chairperson’, and ‘Mem-

1 ber’ mean the Medicare Commission established
2 under subsection (a) and the Chairperson and any
3 Member thereof, respectively.

4 “(3) MEDICARE.—The term ‘Medicare’ means
5 the program established under this title, including
6 parts A, B, C, and D.

7 “(4) MEDICARE BENEFICIARY.—The term
8 ‘Medicare beneficiary’ means an individual who is
9 entitled to, or enrolled for, benefits under part A or
10 enrolled for benefits under part B.

11 “(5) MEDICARE PROGRAM SPENDING.—The
12 term ‘Medicare program spending’ means program
13 spending under parts A, B, and D net of premiums.

14 “(m) FUNDING.—

15 “(1) IN GENERAL.—There are appropriated to
16 the Commission to carry out its duties and func-
17 tions—

18 “(A) for fiscal year 2012, \$15,000,000;

19 and

20 “(B) for each subsequent fiscal year, the
21 amount appropriated under this paragraph for
22 the previous fiscal year increased by the annual
23 percentage increase in the Consumer Price
24 Index for All Urban Consumers (all items;

1 United States city average) as of June of the
2 previous fiscal year.

3 “(2) FROM TRUST FUNDS.—Sixty percent of
4 amounts appropriated under paragraph (1) shall be
5 derived by transfer from the Federal Hospital Insur-
6 ance Trust Fund under section 1817 and 40 percent
7 of amounts appropriated under such paragraph shall
8 be derived by transfer from the Federal Supple-
9 mentary Medical Insurance Trust Fund under sec-
10 tion 1841.”.

11 (2) LOBBYING COOLING-OFF PERIOD FOR MEM-
12 BERS OF THE MEDICARE COMMISSION.—Section
13 207(c) of title 18, United States Code, is amended
14 by inserting at the end the following:

15 “(3) MEMBERS OF THE MEDICARE COMMIS-
16 SION.—

17 “(A) IN GENERAL.—Paragraph (1) shall
18 apply to a member of the Medicare Commission
19 under section 1899A.

20 “(B) AGENCIES AND CONGRESS.—For pur-
21 poses of paragraph (1), the agency in which the
22 individual described in subparagraph (A) served
23 shall be considered to be the Medicare Commis-
24 sion, the Department of Health and Human
25 Services, and the relevant committees of juris-

1 diction of Congress, including the Committee on
2 Ways and Means and the Committee on Energy
3 and Commerce of the House of Representatives
4 and the Committee on Finance of the Senate.”.

5 (b) GAO STUDY AND REPORT ON DETERMINATION
6 AND IMPLEMENTATION OF PAYMENT AND COVERAGE
7 POLICIES UNDER THE MEDICARE PROGRAM.—

8 (1) INITIAL STUDY AND REPORT.—

9 (A) STUDY.—The Comptroller General of
10 the United States (in this section referred to as
11 the “Comptroller General”) shall conduct a
12 study on changes to payment policies, meth-
13 odologies, and rates and coverage policies and
14 methodologies under the Medicare program
15 under title XVIII of the Social Security Act as
16 a result of the recommendations contained in
17 the proposals made by the Medicare Commis-
18 sion under section 1899A of such Act (as added
19 by subsection (a)), including an analysis of the
20 effect of such recommendations on—

21 (i) Medicare beneficiary access to pro-
22 viders and items and services;

23 (ii) the affordability of Medicare pre-
24 miums and cost-sharing (including
25 deductibles, coinsurance, and copayments);

1 (iii) the potential impact of changes
2 on other government or private-sector pur-
3 chasers and payers of care; and

4 (iv) quality of patient care, including
5 patient experience, outcomes, and other
6 measures of care.

7 (B) REPORT.—Not later than July 1,
8 2015, the Comptroller General shall submit to
9 Congress a report containing the results of the
10 study conducted under subparagraph (A), to-
11 gether with recommendations for such legisla-
12 tion and administrative action as the Comp-
13 troller General determines appropriate.

14 (2) SUBSEQUENT STUDIES AND REPORTS.—The
15 Comptroller General shall periodically conduct such
16 additional studies and submit reports to Congress on
17 changes to Medicare payments policies, methodolo-
18 gies, and rates and coverage policies and methodolo-
19 gies as the Comptroller General determines appro-
20 priate, in consultation with the appropriate commit-
21 tees of jurisdiction of Congress.

22 (c) CONFORMING AMENDMENTS.—Section 1805(b)
23 of the Social Security Act (42 U.S.C. 1395b–6(b)) is
24 amended—

1 (1) by redesignating paragraphs (4) through
2 (8) as paragraphs (5) through (9), respectively; and
3 (2) by inserting after paragraph (3) the fol-
4 lowing:

5 “(4) REVIEW AND COMMENT ON MEDICARE
6 COMMISSION OR SECRETARIAL PROPOSAL.—If the
7 Medicare Commission (as established under sub-
8 section (a) of section 1899A) or the Secretary sub-
9 mits a proposal to the Commission under such sec-
10 tion in a year, the Commission shall review the pro-
11 posal and, not later than February 1 of that year,
12 submit to the appropriate committees of Congress
13 written comments on such proposal. Such comments
14 may include such recommendations as the Commis-
15 sion deems appropriate.”.

16 **SEC. 3404. ENSURING MEDICARE SAVINGS ARE KEPT IN**
17 **THE MEDICARE PROGRAM.**

18 No reduction in outlays under the Medicare program
19 under title XVIII of the Social Security Act under the pro-
20 visions of and amendments made by this Act may be uti-
21 lized to offset any outlays under any other program or
22 activity of the Federal government.

1 **Subtitle F—Comparative**
2 **Effectiveness Research**

3 **SEC. 3501. COMPARATIVE EFFECTIVENESS RESEARCH.**

4 (a) IN GENERAL.—Title XI of the Social Security Act
5 (42 U.S.C. 1301 et seq.) is amended by adding at the end
6 the following new part:

7 “PART D—COMPARATIVE EFFECTIVENESS RESEARCH

8 “COMPARATIVE EFFECTIVENESS RESEARCH

9 “SEC. 1181. (a) DEFINITIONS.—In this section:

10 “(1) BOARD.—The term ‘Board’ means the
11 Board of Governors established under subsection (f).

12 “(2) COMPARATIVE CLINICAL EFFECTIVENESS
13 RESEARCH.—

14 “(A) IN GENERAL.—The term ‘compara-
15 tive clinical effectiveness research’ means re-
16 search evaluating and comparing the clinical ef-
17 fectiveness, risks, and benefits of 2 or more
18 medical treatments, services, and items de-
19 scribed in subparagraph (B).

20 “(B) MEDICAL TREATMENTS, SERVICES,
21 AND ITEMS DESCRIBED.—The medical treat-
22 ments, services, and items described in this sub-
23 paragraph are health care interventions, proto-
24 cols for treatment, care management, and deliv-
25 ery, procedures, medical devices, diagnostic

1 tools, pharmaceuticals (including drugs and
2 biologicals), and any other strategies or items
3 being used in the treatment, management, and
4 diagnosis of, or prevention of illness or injury
5 in, patients.

6 “(3) COMPARATIVE EFFECTIVENESS RE-
7 SEARCH.—The term ‘comparative effectiveness re-
8 search’ means research evaluating and comparing
9 the implications and outcomes of 2 or more health
10 care strategies to address a particular medical condi-
11 tion for specific patient populations.

12 “(4) CONFLICTS OF INTEREST.—The term
13 ‘conflicts of interest’ means associations, including
14 financial and personal, that may be reasonably as-
15 sumed to have the potential to bias an individual’s
16 decisions in matters related to the Institute or the
17 conduct of activities under this section.

18 “(5) INSTITUTE.—The term ‘Institute’ means
19 the ‘Patient-Centered Outcomes Research Institute’
20 established under subsection (b)(1).

21 “(b) PATIENT-CENTERED OUTCOMES RESEARCH IN-
22 STITUTE.—

23 “(1) ESTABLISHMENT.—There is authorized to
24 be established a nonprofit corporation, to be known
25 as the ‘Patient-Centered Outcomes Research Insti-

1 tute’ which is neither an agency nor establishment
2 of the United States Government.

3 “(2) APPLICATION OF PROVISIONS.—The Insti-
4 tute shall be subject to the provisions of this section,
5 and, to the extent consistent with this section, to the
6 District of Columbia Nonprofit Corporation Act.

7 “(3) FUNDING OF COMPARATIVE EFFECTIVE-
8 NESS RESEARCH.—For fiscal year 2010 and each
9 subsequent fiscal year, amounts in the Patient-Cen-
10 tered Outcomes Research Trust Fund (referred to in
11 this section as the ‘PCORTF’) under section 9511
12 of the Internal Revenue Code of 1986 shall be avail-
13 able, without further appropriation, to the Institute
14 to carry out this section.

15 “(c) PURPOSE.—The purpose of the Institute is to
16 assist patients, clinicians, purchasers, and policy-makers
17 in making informed health decisions by advancing the
18 quality and relevance of evidence concerning the manner
19 in which diseases, disorders, and other health conditions
20 can effectively and appropriately be prevented, diagnosed,
21 treated, monitored, and managed through research and
22 evidence synthesis that considers variations in patient sub-
23 populations, and the dissemination of research findings
24 with respect to the relative clinical outcomes, clinical effec-

1 tiveness, and appropriateness of the medical treatments,
2 services, and items described in subsection (a)(2)(B).

3 “(d) DUTIES.—

4 “(1) IDENTIFYING RESEARCH PRIORITIES AND
5 ESTABLISHING RESEARCH PROJECT AGENDA.—

6 “(A) IDENTIFYING RESEARCH PRIOR-
7 ITIES.—The Institute shall identify national
8 priorities for comparative clinical effectiveness
9 research, taking into account factors, includ-
10 ing—

11 “(i) disease incidence, prevalence, and
12 burden in the United States;

13 “(ii) evidence gaps in terms of clinical
14 outcomes;

15 “(iii) practice variations, including
16 variations in delivery and outcomes by ge-
17 ography, treatment site, provider type, and
18 patient subgroup;

19 “(iv) the potential for new evidence
20 concerning certain categories of health care
21 services or treatments to improve patient
22 health and well-being and the quality of
23 care;

24 “(v) the effect or potential for an ef-
25 fect on health expenditures associated with

1 a health condition or the use of a par-
2 ticular medical treatment, service, or item;

3 “(vi) the effect or potential for an ef-
4 fect on patient needs, outcomes, and pref-
5 erences, including quality of life; and

6 “(vii) the relevance to assisting pa-
7 tients and clinicians in making informed
8 health decisions.

9 “(B) ESTABLISHING RESEARCH PROJECT
10 AGENDA.—

11 “(i) IN GENERAL.—The Institute shall
12 establish and update a research project
13 agenda for comparative clinical effective-
14 ness research to address the priorities
15 identified under subparagraph (A), taking
16 into consideration the types of such re-
17 search that might address each priority
18 and the relative value (determined based
19 on the cost of conducting such research
20 compared to the potential usefulness of the
21 information produced by such research) as-
22 sociated with the different types of re-
23 search, and such other factors as the Insti-
24 tute determines appropriate.

1 “(ii) CONSIDERATION OF NEED TO
2 CONDUCT A SYSTEMATIC REVIEW.—In es-
3 tablishing and updating the research
4 project agenda under clause (i), the Insti-
5 tute shall consider the need to conduct a
6 systematic review of existing research be-
7 fore providing for the conduct of new re-
8 search under paragraph (2)(A).

9 “(2) CARRYING OUT RESEARCH PROJECT AGEN-
10 DA.—

11 “(A) COMPARATIVE CLINICAL EFFECTIVE-
12 NESS RESEARCH.—In carrying out the research
13 project agenda established under paragraph
14 (1)(B), the Institute shall provide for the con-
15 duct of appropriate research and the synthesis
16 of evidence, in accordance with the methodo-
17 logical standards adopted under paragraph
18 (10), using methods, including the following:

19 “(i) Systematic reviews and assess-
20 ments of existing research and evidence.

21 “(ii) Primary research, such as ran-
22 domized clinical trials, molecularly in-
23 formed trials, and observational studies.

24 “(iii) Any other methodologies rec-
25 ommended by the methodology committee

1 established under paragraph (7) that are
2 adopted by the Board under paragraph
3 (10).

4 “(B) CONTRACTS FOR THE MANAGEMENT
5 AND CONDUCT OF RESEARCH.—

6 “(i) IN GENERAL.—The Institute may
7 enter into contracts for the management
8 and conduct of research in accordance with
9 the research project agenda established
10 under paragraph (1)(B) with the following:

11 “(I) Agencies and instrumental-
12 ities of the Federal Government that
13 have experience in conducting com-
14 parative clinical effectiveness research,
15 such as the Agency for Healthcare
16 Research and Quality, to the extent
17 that such contracts are authorized
18 under the governing statutes of such
19 agencies and instrumentalities.

20 “(II) Appropriate private sector
21 research or study-conducting entities
22 that have demonstrated the experience
23 and capacity to achieve the goals of
24 comparative effectiveness research.

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1 “(ii) CONDITIONS FOR CONTRACTS.—

2 A contract entered into under this sub-
3 paragraph shall require that the agency,
4 instrumentality, or other entity—

5 “(I) abide by the transparency
6 and conflicts of interest requirements
7 that apply to the Institute with re-
8 spect to the research managed or con-
9 ducted under such contract;

10 “(II) comply with the methodo-
11 logical standards adopted under para-
12 graph (10) with respect to such re-
13 search;

14 “(III) take into consideration
15 public comments on the study design
16 that are transmitted by the Institute
17 to the agency, instrumentality, or
18 other entity under subsection
19 (i)(1)(B) during the finalization of the
20 study design and transmit responses
21 to such comments to the Institute,
22 which will publish such comments, re-
23 sponses, and finalized study design in
24 accordance with subsection

1 (i)(3)(A)(iii) prior to the conduct of
2 such research;

3 “(IV) in the case where the agen-
4 cy, instrumentality, or other entity is
5 managing or conducting a compara-
6 tive effectiveness research study for a
7 rare disease, consult with the expert
8 advisory panel for rare disease ap-
9 pointed under paragraph (5)(A)(iii)
10 with respect to such research study;
11 and

12 “(V) subject to clause (iv), per-
13 mit a researcher who conducts origi-
14 nal research under the contract for
15 the agency, instrumentality, or other
16 entity to have such research published
17 in a peer-reviewed journal or other
18 publication.

19 “(iii) COVERAGE OF COPAYMENTS OR
20 COINSURANCE.—A contract entered into
21 under this subparagraph may allow for the
22 coverage of copayments or coinsurance, or
23 allow for other appropriate measures, to
24 the extent that such coverage or other
25 measures are necessary to preserve the va-

1 lidity of a research project, such as in the
2 case where the research project must be
3 blinded.

4 “(iv) REQUIREMENTS FOR PUBLICA-
5 TION OF RESEARCH.—

6 “(I) IN GENERAL.—Any research
7 published under clause (ii)(V) shall be
8 within the bounds of and entirely con-
9 sistent with the evidence and findings
10 produced under the contract with the
11 Institute under this subparagraph and
12 disseminated by the Institute under
13 paragraph (9).

14 “(II) LIMITATION ON CON-
15 TRACTING WITH CERTAIN AGENCIES,
16 INSTRUMENTALITIES, AND ENTI-
17 TIES.—In the case where the Institute
18 determines that such published re-
19 search does not meet the requirements
20 under subclause (I), the Institute
21 shall not enter into another contract
22 with the agency, instrumentality, or
23 entity which managed or conducted
24 such research under a contract under
25 this subparagraph for a period deter-

1 mined appropriate by the Institute
2 (but not less than 5 years).

3 “(C) REVIEW AND UPDATE OF EVI-
4 DENCE.—The Institute shall review and update
5 evidence on a periodic basis, in order to take
6 into account new research, evolving evidence,
7 advances in medical technology, and changes in
8 the standard of care as they become available,
9 as appropriate.

10 “(D) TAKING INTO ACCOUNT POTENTIAL
11 DIFFERENCES.—Research shall—

12 “(i) be designed, as appropriate, to
13 take into account the potential for dif-
14 ferences in the effectiveness of health care
15 treatments, services, and items as used
16 with various subpopulations, such as racial
17 and ethnic minorities, women, age, and
18 groups of individuals with different
19 comorbidities, genetic and molecular sub-
20 types, or quality of life preferences; and

21 “(ii) include members of such sub-
22 populations as subjects in the research as
23 feasible and appropriate.

24 “(E) DIFFERENCES IN TREATMENT MO-
25 DALITIES.—Research shall be designed, as ap-

1 appropriate, to take into account different charac-
2 teristics of treatment modalities that may affect
3 research outcomes, such as the phase of the
4 treatment modality in the innovation cycle and
5 the impact of the skill of the operator of the
6 treatment modality.

7 “(3) STUDY AND REPORT ON FEASIBILITY OF
8 CONDUCTING RESEARCH IN-HOUSE.—

9 “(A) STUDY.—The Institute shall conduct
10 a study on the feasibility of conducting research
11 in-house.

12 “(B) REPORT.—Not later than 5 years
13 after the date of enactment of this section, the
14 Institute shall submit a report to Congress con-
15 taining the results of the study conducted under
16 subparagraph (A).

17 “(4) DATA COLLECTION.—

18 “(A) IN GENERAL.—The Secretary shall,
19 with appropriate safeguards for privacy, make
20 available to the Institute such data collected by
21 the Centers for Medicare & Medicaid Services
22 under the programs under titles XVIII, XIX,
23 and XXI as the Institute may require to carry
24 out this section. The Institute may also request
25 and, if such request is granted, obtain data

1 from Federal, State, or private entities, includ-
2 ing data from clinical databases and registries.

3 “(B) USE OF DATA.—The Institute shall
4 only use data provided to the Institute under
5 subparagraph (A) in accordance with laws and
6 regulations governing the release and use of
7 such data, including applicable confidentiality
8 and privacy standards.

9 “(5) APPOINTING EXPERT ADVISORY PANELS.—

10 “(A) APPOINTMENT.—

11 “(i) IN GENERAL.—The Institute
12 shall, as appropriate, appoint expert advi-
13 sory panels to assist in identifying research
14 priorities and establishing the research
15 project agenda under paragraph (1). Pan-
16 els shall advise the Institute in matters
17 such as identifying gaps in and updating
18 medical evidence in order to ensure that
19 the information produced from such re-
20 search is clinically relevant to decisions
21 made by clinicians and patients at the
22 point of care.

23 “(ii) EXPERT ADVISORY PANELS FOR
24 PRIMARY RESEARCH.—The Institute shall
25 appoint expert advisory panels in carrying

1 out the research project agenda under
2 paragraph (2)(A)(ii). Such expert advisory
3 panels shall, upon request, advise the Insti-
4 tute and the agency, instrumentality, or
5 entity conducting the research on the re-
6 search question involved and the research
7 design or protocol, including the appro-
8 priate comparator technologies, important
9 patient subgroups, and other parameters of
10 the research, as necessary. Upon the re-
11 quest of such agency, instrumentality, or
12 entity, such panels shall be available as a
13 resource for technical questions that may
14 arise during the conduct of such research.

15 “(iii) EXPERT ADVISORY PANEL FOR
16 RARE DISEASE.—In the case of a compara-
17 tive effectiveness research study for rare
18 disease, the Institute shall appoint an ex-
19 pert advisory panel for purposes of assist-
20 ing in the design of such research study
21 and determining the relative value and fea-
22 sibility of conducting such research study.

23 “(B) COMPOSITION.—

24 “(i) IN GENERAL.—An expert advi-
25 sory panel appointed under subparagraph

1 (A) shall include individuals who have ex-
2 perience in the relevant topic, project, or
3 category for which the panel is established,
4 including—

5 “(I) practicing and research clini-
6 cians (including relevant specialists
7 and subspecialists), patients, and rep-
8 resentatives of patients; and

9 “(II) experts in scientific and
10 health services research, health serv-
11 ices delivery, and evidence-based medi-
12 cine.

13 “(ii) INCLUSION OF REPRESENTA-
14 TIVES OF MANUFACTURERS OF MEDICAL
15 TECHNOLOGY.—An expert advisory panel
16 appointed under subparagraph (A) may in-
17 clude a representative of each manufac-
18 turer of each medical technology that is in-
19 cluded under the relevant topic, project, or
20 category for which the panel is established.

21 “(6) SUPPORTING PATIENT AND CONSUMER
22 REPRESENTATIVES.—The Institute shall provide
23 support and resources to help patient and consumer
24 representatives on the Board and expert advisory
25 panels appointed by the Institute under paragraph

1 (5) to effectively participate in technical discussions
2 regarding complex research topics. Such support
3 shall include initial and continuing education to fa-
4 cilitate effective engagement in activities undertaken
5 by the Institute and may include regular and ongo-
6 ing opportunities for patient and consumer rep-
7 resentatives to interact with each other and to ex-
8 change information and support regarding their in-
9 volvement in the Institute's activities. The Institute
10 shall provide per diem and other appropriate com-
11 pensation to patient and consumer representatives
12 for their time spent participating in the activities of
13 the Institute under this paragraph.

14 “(7) ESTABLISHING METHODOLOGY COM-
15 MITTEE.—

16 “(A) IN GENERAL.—The Institute shall es-
17 tablish a standing methodology committee to
18 carry out the functions described in subpara-
19 graph (C).

20 “(B) APPOINTMENT AND COMPOSITION.—
21 The methodology committee established under
22 subparagraph (A) shall be composed of not
23 more than 17 members appointed by the Comp-
24 troller General of the United States. Members
25 appointed to the methodology committee shall

1 be experts in their scientific field, such as
2 health services research, clinical research, com-
3 parative effectiveness research, biostatistics,
4 genomics, and research methodologies. Stake-
5 holders with such expertise may be appointed to
6 the methodology committee.

7 “(C) FUNCTIONS.—Subject to subpara-
8 graph (D), the methodology committee shall
9 work to develop and improve the science and
10 methods of comparative effectiveness research
11 by undertaking, directly or through subcontract,
12 the following activities:

13 “(i) Not later than 2 years after the
14 date on which the members of the method-
15 ology committee are appointed under sub-
16 paragraph (B), developing and periodically
17 updating the following:

18 “(I) Establish and maintain
19 methodological standards for com-
20 parative clinical effectiveness research
21 on major categories of interventions to
22 prevent, diagnose, or treat a clinical
23 condition or improve the delivery of
24 care. Such methodological standards
25 shall provide specific criteria for inter-

1 nal validity, generalizability, feasi-
2 bility, and timeliness of such research
3 and for clinical outcomes measures,
4 risk adjustment, and other relevant
5 aspects of research and assessment
6 with respect to the design of such re-
7 search. Any methodological standards
8 developed and updated under this sub-
9 clause shall be scientifically based and
10 include methods by which new infor-
11 mation, data, or advances in tech-
12 nology are considered and incor-
13 porated into ongoing research projects
14 by the Institute, as appropriate. The
15 process for developing and updating
16 such standards shall include input
17 from relevant experts, stakeholders,
18 and decisionmakers, and shall provide
19 opportunities for public comment.
20 Such standards shall also include
21 methods by which patient subpopula-
22 tions can be accounted for and evalu-
23 ated in different types of research. As
24 appropriate, such standards shall
25 build on existing work on methodo-

1 logical standards for defined cat-
2 egories of health interventions and for
3 each of the major categories of com-
4 parative effectiveness research meth-
5 ods (determined as of the date of en-
6 actment of the America’s Healthy Fu-
7 ture Act of 2009).

8 “(II) A translation table that is
9 designed to provide guidance and act
10 as a reference for the Board to deter-
11 mine research methods that are most
12 likely to address each specific com-
13 parative clinical effectiveness research
14 question.

15 “(ii) Not later than 3 years after such
16 date, examining the following:

17 “(I) Methods by which various
18 aspects of the health care delivery sys-
19 tem (such as benefit design and per-
20 formance, and health services organi-
21 zation, management, information com-
22 munication, and delivery) could be as-
23 sessed and compared for their relative
24 effectiveness, benefits, risks, advan-

1 tages, and disadvantages in a scientif-
2 ically valid and standardized way.

3 “(II) Methods by which efficiency
4 and value (including the full range of
5 harms and benefits, such as quality of
6 life) could be assessed in a scientif-
7 ically valid and standardized way.

8 “(D) CONSULTATION AND CONDUCT OF
9 EXAMINATIONS.—

10 “(i) IN GENERAL.—Subject to clause
11 (iii), in undertaking the activities described
12 in subparagraph (C), the methodology
13 committee shall—

14 “(I) consult or contract with 1 or
15 more of the entities described in
16 clause (ii); and

17 “(II) consult with stakeholders
18 and other entities knowledgeable in
19 relevant fields, as appropriate.

20 “(ii) ENTITIES DESCRIBED.—The fol-
21 lowing entities are described in this clause:

22 “(I) The Institute of Medicine of
23 the National Academies.

24 “(II) The Agency for Healthcare
25 Research and Quality.

1 essary to comply with such methodological
2 standards.

3 “(8) PROVIDING FOR A PEER-REVIEW PROCESS
4 FOR PRIMARY RESEARCH.—

5 “(A) IN GENERAL.—The Institute shall en-
6 sure that there is a process for peer review of
7 the research conducted under paragraph
8 (2)(A)(ii). Under such process—

9 “(i) evidence from research conducted
10 under such paragraph shall be reviewed to
11 assess scientific integrity and adherence to
12 methodological standards adopted under
13 paragraph (10); and

14 “(ii) a list of the names of individuals
15 contributing to any peer-review process
16 during the preceding year or years shall be
17 made public and included in annual reports
18 in accordance with paragraph (12)(D).

19 “(B) COMPOSITION.—Such peer-review
20 process shall be designed in a manner so as to
21 avoid bias and conflicts of interest on the part
22 of the reviewers and shall be composed of ex-
23 perts in the scientific field relevant to the re-
24 search under review.

25 “(C) USE OF EXISTING PROCESSES.—

1 “(i) PROCESSES OF ANOTHER ENTI-
2 TY.—In the case where the Institute enters
3 into a contract or other agreement with
4 another entity for the conduct or manage-
5 ment of research under this section, the
6 Institute may utilize the peer-review proc-
7 ess of such entity if such process meets the
8 requirements under subparagraphs (A) and
9 (B).

10 “(ii) PROCESSES OF APPROPRIATE
11 MEDICAL JOURNALS.—The Institute may
12 utilize the peer-review process of appro-
13 priate medical journals if such process
14 meets the requirements under subpara-
15 graphs (A) and (B).

16 “(9) DISSEMINATION OF RESEARCH FIND-
17 INGS.—

18 “(A) IN GENERAL.—The Institute shall
19 disseminate research findings to clinicians, pa-
20 tients, and the general public in accordance
21 with the dissemination protocols and strategies
22 adopted under paragraph (10). Research find-
23 ings disseminated—

24 “(i) shall convey findings of research
25 so that they are comprehensible and useful

1 to patients and providers in making health
2 care decisions;

3 “(ii) shall discuss findings and other
4 considerations specific to certain sub-
5 populations, risk factors, and
6 comorbidities, as appropriate;

7 “(iii) shall include considerations such
8 as limitations of research and what further
9 research may be needed, as appropriate;

10 “(iv) shall not include practice guide-
11 lines, coverage recommendations, or policy
12 recommendations; and

13 “(v) shall not include any data the
14 dissemination of which would violate the
15 privacy of research participants or violate
16 any confidentiality agreements made with
17 respect to the use of data under this sec-
18 tion.

19 “(B) DISSEMINATION PROTOCOLS AND
20 STRATEGIES.—The Institute shall develop pro-
21 tocols and strategies for the appropriate dis-
22 semination of research findings in order to en-
23 sure effective communication of such findings
24 and the use and incorporation of such findings
25 into relevant activities for the purpose of in-

1 forming higher quality and more effective and
2 timely decisions regarding medical treatments,
3 services, and items. In developing and adopting
4 such protocols and strategies, the Institute shall
5 consult with stakeholders, including practicing
6 clinicians and patients, concerning the types of
7 dissemination that will be most useful to the
8 end users of the information and may provide
9 for the utilization of multiple formats for con-
10 veying findings to different audiences.

11 “(C) DEFINITION OF RESEARCH FIND-
12 INGS.—In this paragraph, the term ‘research
13 findings’ means the results of a study or assess-
14 ment.

15 “(10) ADOPTION.—Subject to subsection
16 (i)(1)(A)(i), the Institute shall adopt the national
17 priorities identified under paragraph (1)(A), the re-
18 search project agenda established under paragraph
19 (1)(B), the methodological standards developed and
20 updated by the methodology committee under para-
21 graph (7)(C)(i), any peer-review process provided
22 under paragraph (8), and dissemination protocols
23 and strategies developed under paragraph (9)(B) by
24 majority vote. In the case where the Institute does
25 not adopt such national priorities, research project

1 agenda, methodological standards, peer-review proc-
2 ess, or dissemination protocols and strategies in ac-
3 cordance with the preceding sentence, the national
4 priorities, research project agenda, methodological
5 standards, peer-review process, or dissemination pro-
6 tocols and strategies shall be referred to the appro-
7 priate staff or entity within the Institute (or, in the
8 case of the methodological standards, the method-
9 ology committee) for further review.

10 “(11) COORDINATION OF RESEARCH AND RE-
11 SOURCES AND BUILDING CAPACITY FOR RE-
12 SEARCH.—

13 “(A) COORDINATION OF RESEARCH AND
14 RESOURCES.—The Institute shall coordinate re-
15 search conducted, commissioned, or otherwise
16 funded under this section with comparative clin-
17 ical effectiveness and other relevant research
18 and related efforts conducted by public and pri-
19 vate agencies and organizations in order to en-
20 sure the most efficient use of the Institute’s re-
21 sources and that research is not duplicated un-
22 necessarily.

23 “(B) BUILDING CAPACITY FOR RE-
24 SEARCH.—The Institute may build capacity for
25 comparative clinical effectiveness research and

1 methodologies, including research training and
2 development of data resources (such as clinical
3 registries), through appropriate activities, in-
4 cluding using up to 20 percent of the amounts
5 appropriated or credited to the PCORTF under
6 section 9511(b) of the Internal Revenue Code
7 of 1986 with respect to a fiscal year to fund ex-
8 tramural efforts of organizations such as the
9 Cochrane Collaboration (or a successor organi-
10 zation) and other organizations (including pub-
11 lic-private partnerships) in order to develop and
12 maintain a comprehensive, interoperable data
13 network to collect, link, and analyze data on
14 outcomes and effectiveness from multiple
15 sources, including electronic health records.

16 “(C) INCLUSION IN ANNUAL REPORTS.—
17 The Institute shall report on any coordination
18 and capacity building conducted under this
19 paragraph in annual reports in accordance with
20 paragraph (12)(E).

21 “(12) ANNUAL REPORTS.—The Institute shall
22 submit an annual report to Congress and the Presi-
23 dent, and shall make the annual report available to
24 the public. Such report shall contain—

1 “(A) a description of the activities con-
2 ducted under this section during the preceding
3 year, including the use of amounts appropriated
4 or credited to the PCORTF under section
5 9511(b) of the Internal Revenue Code of 1986
6 to carry out this section, research projects com-
7 pleted and underway, and a summary of the
8 findings of such projects;

9 “(B) the research project agenda and
10 budget of the Institute for the following year;

11 “(C) a description of research priorities
12 identified under paragraph (1)(A), dissemina-
13 tion protocols and strategies developed by the
14 Institute under paragraph (9)(B), and meth-
15 odological standards developed and updated by
16 the methodology committee under paragraph
17 (7)(C)(i) that are adopted under paragraph
18 (10) during the preceding year;

19 “(D) the names of individuals contributing
20 to any peer-review process provided under para-
21 graph (8) during the preceding year or years, in
22 a manner such that those individuals cannot be
23 identified with a particular research project;

24 “(E) a description of efforts by the Insti-
25 tute under paragraph (11) to—

1 “(i) coordinate the research con-
2 ducted, commissioned, or otherwise funded
3 under this section and the resources of the
4 Institute with research and related efforts
5 conducted by other private and public enti-
6 ties; and

7 “(ii) build capacity for comparative
8 clinical effectiveness research and other
9 relevant research and related efforts
10 through appropriate activities; and

11 “(F) any other relevant information (in-
12 cluding information on the membership of the
13 Board, expert advisory panels appointed under
14 paragraph (5), the methodology committee es-
15 tablished under paragraph (7), and the execu-
16 tive staff of the Institute, any conflicts of inter-
17 est with respect to the members of such Board,
18 expert advisory panels, and methodology com-
19 mittee, or with respect to any individuals se-
20 lected for employment as executive staff of the
21 Institute, and any bylaws adopted by the Board
22 during the preceding year).

23 “(e) ADMINISTRATION.—

24 “(1) IN GENERAL.—Subject to paragraph (2),
25 the Board shall carry out the duties of the Institute.

1 “(2) NONDELEGABLE DUTIES.—The activities
2 described in subsections (d)(1) and (d)(10) are non-
3 delegable.

4 “(f) BOARD OF GOVERNORS.—

5 “(1) IN GENERAL.—The Institute shall have a
6 Board of Governors, which shall consist of 15 mem-
7 bers appointed by the Comptroller General of the
8 United States not later than 6 months after the date
9 of enactment of this section, as follows:

10 “(A) 3 members representing patients and
11 health care consumers.

12 “(B) 3 members representing practicing
13 physicians, including surgeons.

14 “(C) 3 members representing private pay-
15 ers, of whom at least 1 member shall represent
16 health insurance issuers and at least 1 member
17 shall represent employers who self-insure em-
18 ployee benefits.

19 “(D) 3 members representing pharma-
20 ceutical, device, and diagnostic manufacturers
21 or developers.

22 “(E) 1 member representing nonprofit or-
23 ganizations involved in health services research.

1 “(F) 1 member representing organizations
2 that focus on quality measurement and im-
3 provement or decision support.

4 “(G) 1 member representing independent
5 health services researchers.

6 “(2) QUALIFICATIONS.—

7 “(A) DIVERSE REPRESENTATION OF PER-
8 SPECTIVES.—The Board shall represent a broad
9 range of perspectives and collectively have sci-
10 entific expertise in clinical health sciences re-
11 search, including epidemiology, decisions
12 sciences, health economics, and statistics.

13 “(B) CONFLICTS OF INTEREST.—

14 “(i) IN GENERAL.—In appointing
15 members of the Board, the Comptroller
16 General of the United States shall take
17 into consideration any conflicts of interest
18 of potential appointees. Any conflicts of in-
19 terest of members appointed to the Board
20 shall be disclosed in accordance with sub-
21 section (i)(4)(B).

22 “(ii) RECUSAL.—A member of the
23 Board shall be recused from participating
24 with respect to a particular research
25 project or other matter considered by the

1 Board in carrying out its research project
2 agenda under subsection (d)(2) in the case
3 where the member (or an immediate family
4 member of such member) has a financial
5 or personal interest directly related to the
6 research project or the matter that could
7 affect or be affected by such participation.

8 “(3) TERMS.—

9 “(A) IN GENERAL.—A member of the
10 Board shall be appointed for a term of 6 years,
11 except with respect to the members first ap-
12 pointed—

13 “(i) 6 shall be appointed for a term of
14 6 years;

15 “(ii) 6 shall be appointed for a term
16 of 4 years; and

17 “(iii) 6 shall be appointed for a term
18 of 2 years.

19 “(B) LIMITATION.—No individual shall be
20 appointed to the Board for more than 2 terms.

21 “(C) EXPIRATION OF TERM.—Any member
22 of the Board whose term has expired may serve
23 until such member’s successor has taken office,
24 or until the end of the calendar year in which

1 such member's term has expired, whichever is
2 earlier.

3 “(D) VACANCIES.—

4 “(i) IN GENERAL.—Any member ap-
5 pointed to fill a vacancy prior to the expi-
6 ration of the term for which such mem-
7 ber's predecessor was appointed shall be
8 appointed for the remainder of such term.

9 “(ii) VACANCIES NOT TO AFFECT
10 POWER OF BOARD.—A vacancy on the
11 Board shall not affect its powers, but shall
12 be filled in the same manner as the origi-
13 nal appointment was made.

14 “(4) CHAIRPERSON AND VICE-CHAIRPERSON.—

15 “(A) IN GENERAL.—The Comptroller Gen-
16 eral of the United States shall designate a
17 Chairperson and Vice-Chairperson of the Board
18 from among the members of the Board.

19 “(B) TERM.—The members so designated
20 shall serve as Chairperson and Vice-Chair-
21 person of the Board for a period of 3 years.

22 “(5) COMPENSATION.—

23 “(A) IN GENERAL.—A member of the
24 Board shall be entitled to compensation at the
25 per diem equivalent of the rate provided for

1 level IV of the Executive Schedule under section
2 5315 of title 5, United States Code.

3 “(B) TRAVEL EXPENSES.—While away
4 from home or regular place of business in the
5 performance of duties for the Board, each mem-
6 ber of the Board may receive reasonable travel,
7 subsistence, and other necessary expenses.

8 “(6) DIRECTOR AND STAFF; EXPERTS AND
9 CONSULTANTS.—The Board may—

10 “(A) employ and fix the compensation of
11 an executive director and such other personnel
12 as may be necessary to carry out the duties of
13 the Institute;

14 “(B) seek such assistance and support as
15 may be required in the performance of the du-
16 ties of the Institute from appropriate depart-
17 ments and agencies of the Federal Government;

18 “(C) enter into contracts or make other ar-
19 rangements and make such payments as may
20 be necessary for performance of the duties of
21 the Institute;

22 “(D) provide travel, subsistence, and per
23 diem compensation for individuals performing
24 the duties of the Institute, including members
25 of any expert advisory panel appointed under

1 subsection (d)(5), members of the methodology
2 committee established under subsection (d)(7),
3 and individuals selected to contribute to any
4 peer-review process under subsection (d)(8);
5 and

6 “(E) prescribe such rules, regulations, and
7 bylaws as the Board determines necessary with
8 respect to the internal organization and oper-
9 ation of the Institute.

10 “(7) MEETINGS AND HEARINGS.—The Board
11 shall meet and hold hearings at the call of the
12 Chairperson or a majority of its members. In the
13 case where the Board is meeting on matters not re-
14 lated to personnel, Board meetings shall be open to
15 the public and advertised through public notice at
16 least 7 days prior to the meeting.

17 “(8) QUORUM.—A majority of the members of
18 the Board shall constitute a quorum for purposes of
19 conducting the duties of the Institute, but a lesser
20 number of members may meet and hold hearings.

21 “(g) FINANCIAL OVERSIGHT.—

22 “(1) CONTRACT FOR AUDIT.—The Institute
23 shall provide for the conduct of financial audits of
24 the Institute on an annual basis by a private entity
25 with expertise in conducting financial audits.

1 “(2) REVIEW OF AUDIT AND REPORT TO CON-
2 GRESS.—The Comptroller General of the United
3 States shall—

4 “(A) review the results of the audits con-
5 ducted under paragraph (1); and

6 “(B) submit a report to Congress con-
7 taining the results of such audits and review.

8 “(h) GOVERNMENTAL OVERSIGHT.—

9 “(1) REVIEW AND REPORTS.—

10 “(A) IN GENERAL.—The Comptroller Gen-
11 eral of the United States shall review the fol-
12 lowing:

13 “(i) Processes established by the In-
14 stitute, including those with respect to the
15 identification of research priorities under
16 subsection (d)(1)(A) and the conduct of re-
17 search projects under this section. Such re-
18 view shall determine whether information
19 produced by such research projects—

20 “(I) is objective and credible;

21 “(II) is produced in a manner
22 consistent with the requirements
23 under this section; and

24 “(III) is developed through a
25 transparent process.

1 “(ii) The overall effect of the Institute
2 and the effectiveness of activities con-
3 ducted under this section, including an as-
4 sessment of—

5 “(I) the utilization of the find-
6 ings of research conducted under this
7 section by health care decisionmakers;
8 and

9 “(II) the effect of the Institute
10 and such activities on innovation and
11 on the health economy of the United
12 States.

13 “(B) REPORTS.—Not later than 5 years
14 after the date of enactment of this section, and
15 not less frequently than every 5 years there-
16 after, the Comptroller General of the United
17 States shall submit a report to Congress con-
18 taining the results of the review conducted
19 under subparagraph (A), together with rec-
20 ommendations for such legislation and adminis-
21 trative action as the Comptroller General deter-
22 mines appropriate.

23 “(2) FUNDING ASSESSMENT.—

24 “(A) IN GENERAL.—The Comptroller Gen-
25 eral of the United States shall assess the ade-

1 quacy and use of funding for the Institute and
2 activities conducted under this section under
3 the PCORTF under section 9511 of the Inter-
4 nal Revenue Code of 1986. Such assessment
5 shall include a determination as to whether,
6 based on the utilization of findings by public
7 and private payers, each of the following are
8 appropriate sources of funding for the Institute,
9 including a determination of whether such
10 sources of funding should be continued or ad-
11 justed, or whether other sources of funding not
12 described in clauses (i) through (iii) would be
13 appropriate:

14 “(i) The transfer of funds from the
15 Federal Hospital Insurance Trust Fund
16 under section 1817 and the Federal Sup-
17 plementary Medical Insurance Trust Fund
18 under section 1841 to the PCORTF under
19 section 1183.

20 “(ii) The amounts appropriated under
21 subparagraphs (A), (B), (C), (D)(ii), and
22 (E)(ii) of subsection (b)(1) of such section
23 9511.

1 “(iii) Private sector contributions
2 under subparagraphs (D)(i) and (E)(i) of
3 such subsection (b)(1).

4 “(B) REPORT.—Not later than 8 years
5 after the date of enactment of this section, the
6 Comptroller General of the United States shall
7 submit a report to Congress containing the re-
8 sults of the assessment conducted under sub-
9 paragraph (A), together with recommendations
10 for such legislation and administrative action as
11 the Comptroller General determines appro-
12 priate.

13 “(i) ENSURING TRANSPARENCY, CREDIBILITY, AND
14 ACCESS.—The Institute shall establish procedures to en-
15 sure that the following requirements for ensuring trans-
16 parency, credibility, and access are met:

17 “(1) PUBLIC COMMENT PERIODS.—

18 “(A) IN GENERAL.—The Institute shall
19 provide for a public comment period of not less
20 than 45 and not more than 60 days at the fol-
21 lowing times:

22 “(i) Prior to the adoption of the na-
23 tional priorities identified under subsection
24 (d)(1)(A), the research project agenda es-
25 tablished under subsection (d)(1)(B), the

1 methodological standards developed and
2 updated by the methodology committee
3 under subsection (d)(7)(C)(i), the peer-re-
4 view process generally provided under sub-
5 section (d)(8), and dissemination protocols
6 and strategies developed by the Institute
7 under subsection (d)(9)(B) in accordance
8 with subsection (d)(10).

9 “(ii) Prior to the finalization of indi-
10 vidual study designs.

11 “(iii) After the release of draft find-
12 ings with respect to a systematic review
13 and assessment of existing research and
14 evidence under subsection (d)(2)(A)(i).

15 “(B) TRANSMISSION OF PUBLIC COM-
16 MENTS ON STUDY DESIGN.—The Institute shall
17 transmit public comments submitted during the
18 public comment period described in subpara-
19 graph (A)(ii) to the entity conducting research
20 with respect to which the individual study de-
21 sign is being finalized.

22 “(2) ADDITIONAL FORUMS.—The Institute
23 shall, in addition to the public comment periods de-
24 scribed in paragraph (1)(A), support forums to in-
25 crease public awareness and obtain and incorporate

1 public input and feedback through media (such as
2 an Internet website) on the following:

3 “(A) The identification of research prior-
4 ities, including research topics, and the estab-
5 lishment of the research project agenda under
6 subparagraphs (A) and (B), respectively, of
7 subsection (d)(1).

8 “(B) Research findings.

9 “(C) Any other duties, activities, or proc-
10 esses the Institute determines appropriate.

11 “(3) PUBLIC AVAILABILITY.—The Institute
12 shall make available to the public and disclose
13 through the official public Internet website of the In-
14 stitute, and through other forums and media the In-
15 stitute determines appropriate, the following:

16 “(A) The process and methods for the con-
17 duct of research under this section, including—

18 “(i) the identity of the entity con-
19 ducting such research;

20 “(ii) any links the entity has to indus-
21 try (including such links that are not di-
22 rectly tied to the particular research being
23 conducted under this section);

24 “(iii) draft study designs (including
25 research questions and the finalized study

1 design, together with public comments on
2 such study design and responses to such
3 comments);

4 “(iv) research protocols (including
5 measures taken, methods of research,
6 methods of analysis, research results, and
7 such other information as the Institute de-
8 termines appropriate) with respect to each
9 medical treatment, service, and item de-
10 scribed in subsection (a)(2)(B);

11 “(v) any key decisions made by the
12 Institute and any appropriate committees
13 of the Institute;

14 “(vi) the identity of investigators con-
15 ducting such research and any conflicts of
16 interest of such investigators; and

17 “(vii) any progress reports the Insti-
18 tute determines appropriate.

19 “(B) Notice of each of the public comment
20 periods under paragraph (1)(A), including
21 deadlines for public comments for such periods.

22 “(C) Public comments submitted during
23 each of the public comment periods under para-
24 graph (1)(A), including such public comments

1 submitted on draft findings under clause (iii) of
2 such paragraph.

3 “(D) Bylaws, processes, and proceedings of
4 the Institute, to the extent practicable and as
5 the Institute determines appropriate.

6 “(E) Not later than 90 days after receipt
7 by the Institute of a relevant report or research
8 findings, appropriate information contained in
9 such report or findings.

10 “(4) CONFLICTS OF INTEREST.—The Institute
11 shall—

12 “(A) in appointing members to an expert
13 advisory panel under subsection (d)(5) and the
14 methodology committee under subsection (d)(7),
15 and in selecting individuals to contribute to any
16 peer-review process under subsection (d)(8) and
17 for employment as executive staff of the Insti-
18 tute, take into consideration any conflicts of in-
19 terest of potential appointees, participants, and
20 staff; and

21 “(B) include a description of any such con-
22 flicts of interest and conflicts of interest of
23 Board members in the annual report under sub-
24 section (d)(12), except that, in the case of indi-
25 viduals contributing to any such peer review

1 process, such description shall be in a manner
2 such that those individuals cannot be identified
3 with a particular research project.

4 “(j) RULES.—

5 “(1) GIFTS.—The Institute, or the Board and
6 staff of the Institute acting on behalf of the Insti-
7 tute, may not accept gifts, bequeaths, or donations
8 of services or property.

9 “(2) ESTABLISHMENT AND PROHIBITION ON
10 ACCEPTING OUTSIDE FUNDING OR CONTRIBU-
11 TIONS.—The Institute may not—

12 “(A) establish a corporation other than as
13 provided under this section; or

14 “(B) accept any funds or contributions
15 other than as provided under this part.

16 “(k) RULES OF CONSTRUCTION.—

17 “(1) COVERAGE.—Nothing in this section shall
18 be construed—

19 “(A) to permit the Institute to mandate
20 coverage, reimbursement, or other policies for
21 any public or private payer; or

22 “(B) as preventing the Secretary from cov-
23 ering the routine costs of clinical care received
24 by an individual entitled to, or enrolled for, ben-
25 efits under title XVIII, XIX, or XXI in the case

1 where such individual is participating in a clin-
2 ical trial and such costs would otherwise be cov-
3 ered under such title with respect to the bene-
4 ficiary.

5 “(2) REPORTS AND FINDINGS.—None of the re-
6 ports submitted under this section or research find-
7 ings disseminated by the Institute shall be construed
8 as mandates, guidelines, or recommendations for
9 payment, coverage, or treatment.

10 “LIMITATIONS ON CERTAIN USES OF COMPARATIVE
11 EFFECTIVENESS RESEARCH

12 “SEC. 1182. (a) The Secretary may only use evidence
13 and findings from comparative effectiveness research con-
14 ducted under section 1181 to make a determination re-
15 garding coverage under title XVIII if such use is through
16 an iterative and transparent process which meets the fol-
17 lowing requirements:

18 “(1) Stakeholders and other individuals have
19 the opportunity to provide informed and relevant in-
20 formation with respect to the determination.

21 “(2) Stakeholders and other individuals have
22 the opportunity to review draft proposals of the de-
23 termination and submit public comments with re-
24 spect to such draft proposals.

25 “(3) In making the determination, the Sec-
26 retary considers—

1 “(A) other relevant evidence, studies, and
2 research in addition to such comparative effec-
3 tiveness research; and

4 “(B) evidence and research that dem-
5 onstrates or suggests a benefit of coverage with
6 respect to a specific subpopulation of individ-
7 uals, even if the evidence and findings from the
8 comparative effectiveness research demonstrates
9 or suggests that, on average, with respect to the
10 general population the benefits of coverage do
11 not exceed the harm.

12 “(b) Nothing in this section shall be construed as—

13 “(1) superceding or modifying the coverage of
14 items or services under title XVIII that the Sec-
15 retary determines are reasonable and necessary
16 under section 1862(l)(1); or

17 “(2) authorizing the Secretary to deny coverage
18 of items or services under such title solely on the
19 basis of comparative effectiveness research.

20 “(c)(1) The Secretary shall not use evidence or find-
21 ings from comparative effectiveness research conducted
22 under section 1181 in determining coverage, reimburse-
23 ment, or incentive programs under title XVIII in a manner
24 that treats extending the life of an elderly, disabled, or
25 terminally ill individual as of lower value than extending

1 the life of an individual who is younger, nondisabled, or
2 not terminally ill.

3 “(2) Paragraph (1) shall not be construed as pre-
4 venting the Secretary from using evidence or findings from
5 such comparative effectiveness research in determining
6 coverage, reimbursement, or incentive programs under
7 title XVIII based upon a comparison of the difference in
8 the effectiveness of alternative treatments in extending an
9 individual’s life due to the individual’s age, disability, or
10 terminal illness.

11 “(d)(1) The Secretary shall not use evidence or find-
12 ings from comparative effectiveness research conducted
13 under section 1181 in determining coverage, reimburse-
14 ment, or incentive programs under title XVIII in a manner
15 that precludes, or with an intent to discourage, an indi-
16 vidual from choosing a health care treatment based on
17 how the individual values the tradeoff between extending
18 the length of their life and the risk of disability.

19 “(2)(A) Paragraph (1) shall not be construed to—

20 “(i) limit the application of differential copay-
21 ments under title XVIII based on factors such as
22 cost or type of service; or

23 “(ii) prevent the Secretary from using evidence
24 or findings from such comparative effectiveness re-
25 search in determining coverage, reimbursement, or

1 incentive programs under such title based upon a
2 comparison of the difference in the effectiveness of
3 alternative health care treatments in extending an
4 individual's life due to that individual's age, dis-
5 ability, or terminal illness.

6 “(3) Nothing in the provisions of, or amendments
7 made by the America's Healthy Future Act of 2009, shall
8 be construed to limit comparative effectiveness research
9 or any other research, evaluation, or dissemination of in-
10 formation concerning the likelihood that a health care
11 treatment will result in disability.

12 “(e)(1) The Patient-Centered Outcomes Research In-
13 stitute established under section 1181(b)(1) shall not de-
14 velop or employ a dollars-per-quality adjusted life year (or
15 similar measure that discounts the value of a life because
16 of an individual's disability) as a threshold to establish
17 what type of health care is cost effective or recommended.

18 “(2) The Secretary shall not utilize such an adjusted
19 life year (or such a similar measure) as a threshold to
20 determine coverage, reimbursement, or incentive programs
21 under title XVIII.

22 “TRUST FUND TRANSFERS TO PATIENT-CENTERED
23 OUTCOMES RESEARCH TRUST FUND

24 “SEC. 1183. (a) IN GENERAL.—The Secretary shall
25 provide for the transfer, from the Federal Hospital Insur-
26 ance Trust Fund under section 1817 and the Federal Sup-

1 plementary Medical Insurance Trust Fund under section
2 1841, in proportion (as estimated by the Secretary) to the
3 total expenditures during such fiscal year that are made
4 under title XVIII from the respective trust fund, to the
5 Patient-Centered Outcomes Research Trust Fund (re-
6 ferred to in this section as the ‘PCORTF’) under section
7 9511 of the Internal Revenue Code of 1986, the following:

8 “(1) For fiscal year 2013, an amount equal to
9 \$1 multiplied by the average number of individuals
10 entitled to benefits under part A, or enrolled under
11 part B, of title XVIII during such fiscal year.

12 “(2) For each of fiscal years 2014, 2015, 2016,
13 2017, 2018, and 2019, an amount equal to \$2 mul-
14 tiplied by the average number of individuals entitled
15 to benefits under part A, or enrolled under part B,
16 of title XVIII during such fiscal year.

17 “(b) ADJUSTMENTS FOR INCREASES IN HEALTH
18 CARE SPENDING.—In the case of any fiscal year begin-
19 ning after September 30, 2014, the dollar amount in effect
20 under subsection (a)(2) for such fiscal year shall be equal
21 to the sum of such dollar amount for the previous fiscal
22 year (determined after the application of this subsection),
23 plus an amount equal to the product of—

24 “(1) such dollar amount for the previous fiscal
25 year, multiplied by

1 “(2) the percentage increase in the projected
2 per capita amount of National Health Expenditures
3 from the calendar year in which the previous fiscal
4 year ends to the calendar year in which the fiscal
5 year involved ends, as most recently published by the
6 Secretary before the beginning of the fiscal year.”.

7 (b) COORDINATION WITH PROVIDER EDUCATION
8 AND TECHNICAL ASSISTANCE.—Section 1889(a) of the
9 Social Security Act (42 U.S.C. 1395zz(a)) is amended by
10 inserting “and to enhance the understanding of and utili-
11 zation by providers of services and suppliers of research
12 findings disseminated by the Patient-Centered Outcomes
13 Research Institute established under section 1181” before
14 the period at the end.

15 (c) PATIENT-CENTERED OUTCOMES RESEARCH
16 TRUST FUND; FINANCING FOR TRUST FUND.—

17 (1) ESTABLISHMENT OF TRUST FUND.—

18 (A) IN GENERAL.—Subchapter A of chap-
19 ter 98 of the Internal Revenue Code of 1986
20 (relating to establishment of trust funds) is
21 amended by adding at the end the following
22 new section:

1 **“SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH**
2 **TRUST FUND.**

3 “(a) CREATION OF TRUST FUND.—There is estab-
4 lished in the Treasury of the United States a trust fund
5 to be known as the ‘Patient-Centered Outcomes Research
6 Trust Fund’ (hereafter in this section referred to as the
7 ‘PCORTF’), consisting of such amounts as may be appro-
8 priated or credited to such Trust Fund as provided in this
9 section and section 9602(b).

10 “(b) TRANSFERS TO FUND.—

11 “(1) APPROPRIATION.—There are hereby ap-
12 propriated to the Trust Fund the following:

13 “(A) For fiscal year 2010, \$10,000,000.

14 “(B) For fiscal year 2011, \$50,000,000.

15 “(C) For fiscal year 2012, \$150,000,000.

16 “(D) For fiscal year 2013—

17 “(i) an amount equivalent to the net
18 revenues received in the Treasury from the
19 fees imposed under subchapter B of chap-
20 ter 34 (relating to fees on health insurance
21 and self-insured plans) for such fiscal year;
22 and

23 “(ii) \$150,000,000.

24 “(E) For each of fiscal years 2014, 2015,
25 2016, 2017, 2018, and 2019—

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1 “(i) an amount equivalent to the net
2 revenues received in the Treasury from the
3 fees imposed under subchapter B of chap-
4 ter 34 (relating to fees on health insurance
5 and self-insured plans) for such fiscal year;
6 and

7 “(ii) \$150,000,000.

8 The amounts appropriated under subparagraphs
9 (A), (B), (C), (D)(ii), and (E)(ii) shall be trans-
10 ferred from the general fund of the Treasury, from
11 funds not otherwise appropriated.

12 “(2) TRUST FUND TRANSFERS.—In addition to
13 the amounts appropriated under paragraph (1),
14 there shall be credited to the PCORTF the amounts
15 transferred under section 1183 of the Social Secu-
16 rity Act.

17 “(3) AMERICAN RECOVERY AND REINVESTMENT
18 FUNDS.—In addition to the amounts appropriated
19 under paragraph (1) and the amounts credited
20 under paragraph (2), of amounts appropriated for
21 comparative effectiveness research to be allocated at
22 the discretion of the Secretary of Health and
23 Human Services under the heading Agency for
24 Healthcare Research and Quality under the heading
25 Department of Health and Human Services under

1 title VIII of Division A of the American Recovery
2 and Reinvestment Act of 2009 (Public Law 111–5),
3 \$10,000,000 shall be transferred to the Trust Fund.

4 “(4) LIMITATION ON TRANSFERS TO PCORTF.—
5 No amount may be appropriated or transferred to
6 the PCORTF on and after the date of any expendi-
7 ture from the PCORTF which is not an expenditure
8 permitted under this section. The determination of
9 whether an expenditure is so permitted shall be
10 made without regard to—

11 “(A) any provision of law which is not con-
12 tained or referenced in this chapter or in a rev-
13 enue Act, and

14 “(B) whether such provision of law is a
15 subsequently enacted provision or directly or in-
16 directly seeks to waive the application of this
17 paragraph.

18 “(c) TRUSTEE.—The Secretary of Health and
19 Human Services shall be a trustee of the PCORTF.

20 “(d) EXPENDITURES FROM FUND.—Amounts in the
21 PCORTF are available, without further appropriation, to
22 the Patient-Centered Outcomes Research Institute estab-
23 lished by section 3501(a) of the America’s Healthy Future
24 Act of 2009 for carrying out part D of title XI of the

1 Social Security Act (as in effect on the date of enactment
2 of such Act).

3 “(e) NET REVENUES.—For purposes of this section,
4 the term ‘net revenues’ means the amount estimated by
5 the Secretary of the Treasury based on the excess of—

6 “(1) the fees received in the Treasury under
7 subchapter B of chapter 34, over

8 “(2) the decrease in the tax imposed by chapter
9 1 resulting from the fees imposed by such sub-
10 chapter.

11 “(f) TERMINATION.—No amounts shall be available
12 for expenditure from the PCORTF after September 30,
13 2019, and any amounts in such Trust Fund after such
14 date shall be transferred to the general fund of the Treas-
15 ury.”.

16 (B) CLERICAL AMENDMENT.—The table of
17 sections for subchapter A of chapter 98 of such
18 Code is amended by adding at the end the fol-
19 lowing new item:

“Sec. 9511. Patient-Centered Outcomes Research Trust Fund.”.

20 (2) FINANCING FOR FUND FROM FEES ON IN-
21 SURED AND SELF-INSURED HEALTH PLANS.—

22 (A) GENERAL RULE.—Chapter 34 of the
23 Internal Revenue Code of 1986 is amended by
24 adding at the end the following new subchapter:

1 “(3) TREATMENT OF PREPAID HEALTH COV-
2 ERAGE ARRANGEMENTS.—

3 “(A) IN GENERAL.—In the case of any ar-
4 rangement described in subparagraph (B)—

5 “(i) such arrangement shall be treated
6 as a specified health insurance policy, and

7 “(ii) the person referred to in such
8 subparagraph shall be treated as the
9 issuer.

10 “(B) DESCRIPTION OF ARRANGEMENTS.—

11 An arrangement is described in this subpara-
12 graph if under such arrangement fixed pay-
13 ments or premiums are received as consider-
14 ation for any person’s agreement to provide or
15 arrange for the provision of accident or health
16 coverage to residents of the United States, re-
17 gardless of how such coverage is provided or ar-
18 ranged to be provided.

19 “(d) ADJUSTMENTS FOR INCREASES IN HEALTH
20 CARE SPENDING.—In the case of any policy year ending
21 in any fiscal year beginning after September 30, 2014, the
22 dollar amount in effect under subsection (a) for such pol-
23 icy year shall be equal to the sum of such dollar amount
24 for policy years ending in the previous fiscal year (deter-

1 mined after the application of this subsection), plus an
2 amount equal to the product of—

3 “(1) such dollar amount for policy years ending
4 in the previous fiscal year, multiplied by

5 “(2) the percentage increase in the projected
6 per capita amount of National Health Expenditures
7 from the calendar year in which the previous fiscal
8 year ends to the calendar year in which the fiscal
9 year involved ends, as most recently published by the
10 Secretary of Health and Human Services before the
11 beginning of the fiscal year.

12 “(e) TERMINATION.—This section shall not apply to
13 policy years ending after September 30, 2019.

14 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

15 “(a) IMPOSITION OF FEE.—In the case of any appli-
16 cable self-insured health plan for each plan year ending
17 after September 30, 2012, there is hereby imposed a fee
18 equal to \$2 (\$1 in the case of plan years ending during
19 fiscal year 2013) multiplied by the average number of lives
20 covered under the plan.

21 “(b) LIABILITY FOR FEE.—

22 “(1) IN GENERAL.—The fee imposed by sub-
23 section (a) shall be paid by the plan sponsor.

24 “(2) PLAN SPONSOR.—For purposes of para-
25 graph (1) the term ‘plan sponsor’ means—

1 “(A) the employer in the case of a plan es-
2 tablished or maintained by a single employer,

3 “(B) the employee organization in the case
4 of a plan established or maintained by an em-
5 ployee organization,

6 “(C) in the case of—

7 “(i) a plan established or maintained
8 by 2 or more employers or jointly by 1 or
9 more employers and 1 or more employee
10 organizations,

11 “(ii) a multiple employer welfare ar-
12 rangement, or

13 “(iii) a voluntary employees’ bene-
14 ficiary association described in section
15 501(c)(9),

16 the association, committee, joint board of trust-
17 ees, or other similar group of representatives of
18 the parties who establish or maintain the plan,
19 or

20 “(D) the cooperative or association de-
21 scribed in subsection (c)(2)(F) in the case of a
22 plan established or maintained by such a coop-
23 erative or association.

24 “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—

25 For purposes of this section, the term ‘applicable self-in-

1 sured health plan' means any plan for providing accident
2 or health coverage if—

3 “(1) any portion of such coverage is provided
4 other than through an insurance policy, and

5 “(2) such plan is established or maintained—

6 “(A) by 1 or more employers for the ben-
7 efit of their employees or former employees,

8 “(B) by 1 or more employee organizations
9 for the benefit of their members or former
10 members,

11 “(C) jointly by 1 or more employers and 1
12 or more employee organizations for the benefit
13 of employees or former employees,

14 “(D) by a voluntary employees' beneficiary
15 association described in section 501(c)(9),

16 “(E) by any organization described in sec-
17 tion 501(c)(6), or

18 “(F) in the case of a plan not described in
19 the preceding subparagraphs, by a multiple em-
20 ployer welfare arrangement (as defined in sec-
21 tion 3(40) of Employee Retirement Income Se-
22 curity Act of 1974), a rural electric cooperative
23 (as defined in section 3(40)(B)(iv) of such Act),
24 or a rural telephone cooperative association (as
25 defined in section 3(40)(B)(v) of such Act).

1 “(d) ADJUSTMENTS FOR INCREASES IN HEALTH
2 CARE SPENDING.—In the case of any plan year ending
3 in any fiscal year beginning after September 30, 2014, the
4 dollar amount in effect under subsection (a) for such plan
5 year shall be equal to the sum of such dollar amount for
6 plan years ending in the previous fiscal year (determined
7 after the application of this subsection), plus an amount
8 equal to the product of—

9 “(1) such dollar amount for plan years ending
10 in the previous fiscal year, multiplied by

11 “(2) the percentage increase in the projected
12 per capita amount of National Health Expenditures
13 from the calendar year in which the previous fiscal
14 year ends to the calendar year in which the fiscal
15 year involved ends, as most recently published by the
16 Secretary of Health and Human Services before the
17 beginning of the fiscal year.

18 “(e) TERMINATION.—This section shall not apply to
19 plan years ending after September 30, 2019.

20 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

21 “(a) DEFINITIONS.—For purposes of this sub-
22 chapter—

23 “(1) ACCIDENT AND HEALTH COVERAGE.—The
24 term ‘accident and health coverage’ means any cov-
25 erage which, if provided by an insurance policy,

1 would cause such policy to be a specified health in-
2 surance policy (as defined in section 4375(c)).

3 “(2) INSURANCE POLICY.—The term ‘insurance
4 policy’ means any policy or other instrument where-
5 by a contract of insurance is issued, renewed, or ex-
6 tended.

7 “(3) UNITED STATES.—The term ‘United
8 States’ includes any possession of the United States.

9 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

10 “(1) IN GENERAL.—For purposes of this sub-
11 chapter—

12 “(A) the term ‘person’ includes any gov-
13 ernmental entity, and

14 “(B) notwithstanding any other law or rule
15 of law, governmental entities shall not be ex-
16 empt from the fees imposed by this subchapter
17 except as provided in paragraph (2).

18 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
19 PROGRAMS.—In the case of an exempt governmental
20 program, no fee shall be imposed under section 4375
21 or section 4376 on any covered life under such pro-
22 gram.

23 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
24 FINED.—For purposes of this subchapter, the term
25 ‘exempt governmental program’ means—

1 “(A) any insurance program established
2 under title XVIII of the Social Security Act,

3 “(B) the medical assistance program es-
4 tablished by title XIX or XXI of the Social Se-
5 curity Act,

6 “(C) any program established by Federal
7 law for providing medical care (other than
8 through insurance policies) to individuals (or
9 the spouses and dependents thereof) by reason
10 of such individuals being—

11 “(i) members of the Armed Forces of
12 the United States, or

13 “(ii) veterans, and

14 “(D) any program established by Federal
15 law for providing medical care (other than
16 through insurance policies) to members of In-
17 dian tribes (as defined in section 4(d) of the In-
18 dian Health Care Improvement Act).

19 “(c) TREATMENT AS TAX.—For purposes of subtitle
20 F, the fees imposed by this subchapter shall be treated
21 as if they were taxes.

22 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
23 standing any other provision of law, no amount collected
24 under this subchapter shall be covered over to any posses-
25 sion of the United States.”.

1191

1 (B) CLERICAL AMENDMENTS.—

2 (i) Chapter 34 of such Code is amend-
3 ed by striking the chapter heading and in-
4 serting the following:

5 **“CHAPTER 34—TAXES ON CERTAIN**
6 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

7 **“Subchapter A—Policies Issued By Foreign**
8 **Insurers”.**

9 (ii) The table of chapters for subtitle
10 D of such Code is amended by striking the
11 item relating to chapter 34 and inserting
12 the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

13 (d) TAX-EXEMPT STATUS OF THE PATIENT-CEN-
14 TERED OUTCOMES RESEARCH INSTITUTE.—Subsection
15 501(l) of the Internal Revenue Code of 1986 is amended
16 by adding at the end the following new paragraph:

17 “(4) The Patient-Centered Outcomes Research
18 Institute established under section 1181(b) of the
19 Social Security Act.”.

1 **SEC. 3502. COORDINATION WITH FEDERAL COORDINATING**
2 **COUNCIL FOR COMPARATIVE EFFECTIVE-**
3 **NESS RESEARCH.**

4 Section 804 of Division A of the American Recovery
5 and Reinvestment Act of 2009 (42 U.S.C. 299b–8) is
6 amended—

7 (1) in subsection (c)—

8 (A) in paragraph (1), by striking “and” at
9 the end;

10 (B) in paragraph (2), by striking the pe-
11 riod at the end and inserting “; and”; and

12 (C) by adding at the end the following new
13 paragraph:

14 “(3) provide support to the Patient-Centered
15 Outcomes Research Institute established under sec-
16 tion 1181(b)(1) of the Social Security Act (referred
17 to in this section as the ‘Institute’).”;

18 (2) in subsection (e)(2), by striking “regarding
19 its activities” and all that follows through the period
20 at the end and inserting “containing—

21 “(A) an inventory of its activities with re-
22 spect to comparative effectiveness research con-
23 ducted by relevant Federal departments and
24 agencies; and

1 “(B) recommendations concerning better
2 coordination of comparative effectiveness re-
3 search by such departments and agencies.”;

4 (3) by redesignating subsection (g) as sub-
5 section (h); and

6 (4) by inserting after subsection (f) the fol-
7 lowing new subsection:

8 “(g) COORDINATION WITH THE PATIENT-CENTERED
9 OUTCOMES RESEARCH INSTITUTE.—The Council shall co-
10 ordinate with the Institute in carrying out its duties under
11 this section.”.

12 **SEC. 3503. GAO REPORT ON NATIONAL COVERAGE DETER-**
13 **MINATIONS PROCESS.**

14 Not later than 18 months after the date of enactment
15 of this Act, the Comptroller General of the United States
16 shall submit a report to Congress on the process for mak-
17 ing national coverage determinations (as defined in section
18 1869(f)(1)(B) of the Social Security Act (42 U.S.C.
19 1395ff(f)(1)(B))) under the Medicare program under title
20 XVIII of the Social Security Act. Such report shall include
21 a determination whether, in initiating and conducting such
22 process, the Secretary of Health and Human Services has
23 complied with applicable law and regulations, including re-
24 quirements for consultation with appropriate outside ex-
25 perts, providing appropriate notice and comment opportu-

1 nities to the public, and making information and data
2 (other than proprietary data) considered in making such
3 determinations available to the public and to nonvoting
4 members of any advisory committees established to advise
5 the Secretary with respect to such determinations.

6 **Subtitle G—Administrative**
7 **Simplification**

8 **SEC. 3601. ADMINISTRATIVE SIMPLIFICATION.**

9 (a) OPERATING RULES FOR HEALTH INFORMATION
10 TRANSACTIONS.—

11 (1) DEFINITION OF OPERATING RULES.—Sec-
12 tion 1171 of the Social Security Act (42 U.S.C.
13 1320d) is amended by adding at the end the fol-
14 lowing:

15 “(9) OPERATING RULES.—The term ‘operating
16 rules’ means the necessary business rules and guide-
17 lines for the electronic exchange of information that
18 are not defined by a standard or its implementation
19 specifications as adopted for purposes of this part.”.

20 (2) OPERATING RULES AND COMPLIANCE.—
21 Section 1173 of the Social Security Act (42 U.S.C.
22 1320d–2) is amended—

23 (A) in subsection (a)(2), by adding at the
24 end the following new subparagraph:

25 “(J) Electronic funds transfers.”; and

1 (B) by adding at the end the following new
2 subsections:

3 “(g) OPERATING RULES.—

4 “(1) IN GENERAL.—The Secretary shall adopt
5 a single set of operating rules for each transaction
6 described in subsection (a)(2) with the goal of cre-
7 ating as much uniformity in the implementation of
8 the electronic standards as possible. Such operating
9 rules shall be consensus-based and reflect the nec-
10 essary business rules affecting health plans and
11 health care providers and the manner in which they
12 operate pursuant to standards issued under Health
13 Insurance Portability and Accountability Act of
14 1996.

15 “(2) OPERATING RULES DEVELOPMENT.—In
16 adopting operating rules under this subsection, the
17 Secretary shall rely on recommendations for oper-
18 ating rules developed by a qualified nonprofit entity,
19 as selected by the Secretary, that meets the fol-
20 lowing requirements:

21 “(A) The entity focuses its mission on ad-
22 ministrative simplification.

23 “(B) The entity demonstrates an estab-
24 lished multi-stakeholder and consensus-based
25 process for development of operating rules, in-

1 including representation by or participation from
2 health plans, health care providers, vendors, rel-
3 evant Federal agencies, and other standard de-
4 velopment organizations.

5 “(C) The entity has established a public
6 set of guiding principles that ensure the oper-
7 ating rules and process are open and trans-
8 parent.

9 “(D) The entity coordinates its activities
10 with the HIT Policy Committee and the HIT
11 Standards Committee (as established under
12 title XXX of the Public Health Service Act)
13 and complements the efforts of the Office of the
14 National Healthcare Coordinator and its related
15 health information exchange goals.

16 “(E) The entity incorporates national
17 standards, including the transaction standards
18 issued under Health Insurance Portability and
19 Accountability Act of 1996.

20 “(F) The entity supports nondiscrimina-
21 tion and conflict of interest policies that dem-
22 onstrate a commitment to open, fair, and non-
23 discriminatory practices.

24 “(G) The entity allows for public review
25 and updates of the operating rules.

1 “(3) REVIEW AND RECOMMENDATIONS.—The
2 National Committee on Vital and Health Statistics
3 shall—

4 “(A) review the operating rules developed
5 by a nonprofit entity described under paragraph
6 (2);

7 “(B) determine whether such rules rep-
8 resent a consensus view of the health care in-
9 dustry and are consistent with and do not alter
10 current standards;

11 “(C) evaluate whether such rules are con-
12 sistent with electronic standards adopted for
13 health information technology; and

14 “(D) submit to the Secretary a rec-
15 ommendation as to whether the Secretary
16 should adopt such rules.

17 “(4) IMPLEMENTATION.—

18 “(A) IN GENERAL.—The Secretary shall
19 adopt operating rules under this subsection, by
20 regulation in accordance with subparagraph
21 (C), following consideration of the rules devel-
22 oped by the non-profit entity described in para-
23 graph (2) and the recommendation submitted
24 by the National Committee on Vital and Health

1 Statistics under paragraph (3)(D) and having
2 ensured consultation with providers.

3 “(B) ADOPTION REQUIREMENTS; EFFEC-
4 TIVE DATES.—

5 “(i) ELIGIBILITY FOR A HEALTH
6 PLAN AND HEALTH CLAIM STATUS.—The
7 set of operating rules for transactions for
8 eligibility for a health plan and health
9 claim status shall be adopted not later
10 than July 1, 2011, in a manner ensuring
11 that such rules are effective not later than
12 January 1, 2013, and may allow for the
13 use of a machine readable identification
14 card.

15 “(ii) ELECTRONIC FUNDS TRANSFERS
16 AND HEALTH CARE PAYMENT AND REMIT-
17 TANCE ADVICE.—The set of operating
18 rules for electronic funds transfers and
19 health care payment and remittance advice
20 shall be adopted not later than July 1,
21 2012, in a manner ensuring that such
22 rules are effective not later than January
23 1, 2014.

24 “(iii) OTHER COMPLETED TRANS-
25 ACTIONS.—The set of operating rules for

1 the remainder of the completed trans-
2 actions described in subsection (a)(2), in-
3 cluding health claims or equivalent encoun-
4 ter information, enrollment and
5 disenrollment in a health plan, health plan
6 premium payments, and referral certifi-
7 cation and authorization, shall be adopted
8 not later than July 1, 2014, in a manner
9 ensuring that such rules are effective not
10 later than January 1, 2016.

11 “(C) EXPEDITED RULEMAKING.—The Sec-
12 retary shall promulgate an interim final rule
13 applying any standard or operating rule rec-
14 ommended by the National Committee on Vital
15 and Health Statistics pursuant to paragraph
16 (3). The Secretary shall accept public comments
17 on any interim final rule published under this
18 subparagraph for 60 days after the date of such
19 publication.

20 “(h) COMPLIANCE.—

21 “(1) HEALTH PLAN CERTIFICATION.—

22 “(A) ELIGIBILITY FOR A HEALTH PLAN,
23 HEALTH CLAIM STATUS, ELECTRONIC FUNDS
24 TRANSFERS, HEALTH CARE PAYMENT AND RE-
25 MITTANCE ADVICE.—Not later than December

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1 31, 2013, a health plan shall file a statement
2 with the Secretary, in such form as the Sec-
3 retary may require, certifying that the data and
4 information systems for such plan are in com-
5 pliance with any applicable standards (as de-
6 scribed under paragraph (7) of section 1171)
7 and operating rules (as described under para-
8 graph (9) of such section) for electronic funds
9 transfers, eligibility for a health plan, health
10 claim status, and health care payment and re-
11 mittance advice, respectively.

12 “(B) OTHER COMPLETED TRANS-
13 ACTIONS.—Not later than December 31, 2015,
14 a health plan shall file a statement with the
15 Secretary, in such form as the Secretary may
16 require, certifying that the data and informa-
17 tion systems for such plan are in compliance
18 with any applicable standards and operating
19 rules for the remainder of the completed trans-
20 actions described in subsection (a)(2), including
21 health claims or equivalent encounter informa-
22 tion, enrollment and disenrollment in a health
23 plan, health plan premium payments, and refer-
24 ral certification and authorization, respectively.
25 A health plan shall provide the same level of

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1 documentation to certify compliance with such
2 transactions as is required to certify compliance
3 with the transactions specified in subparagraph
4 (A).

5 “(2) DOCUMENTATION OF COMPLIANCE.—A
6 health plan shall provide the Secretary, in such form
7 as the Secretary may require, with adequate docu-
8 mentation of compliance with the standards and op-
9 erating rules described under paragraph (1). A
10 health plan shall not be considered to have provided
11 adequate documentation and shall not be certified as
12 being in compliance with such standards, unless the
13 health plan—

14 “(A) demonstrates to the Secretary that
15 the plan conducts the electronic transactions
16 specified in paragraph (1) in a manner that
17 fully complies with the regulations of the Sec-
18 retary; and

19 “(B) provides documentation showing that
20 the plan has completed end-to-end testing for
21 such transactions with their partners, such as
22 hospitals and physicians.

23 “(3) SERVICE CONTRACTS.—A health plan shall
24 be required to comply with any applicable certifi-
25 cation and compliance requirements (and provide the

1 Secretary with adequate documentation of such com-
2 pliance) under this subsection for any entities that
3 provide services pursuant to a contract with such
4 health plan.

5 “(4) CERTIFICATION BY OUTSIDE ENTITY.—
6 The Secretary may contract with an independent,
7 outside entity to certify that a health plan has com-
8 plied with the requirements under this subsection,
9 provided that the certification standards employed
10 by such entities are in accordance with any stand-
11 ards or rules issued by the Secretary.

12 “(5) COMPLIANCE WITH REVISED STANDARDS
13 AND RULES.—A health plan (including entities de-
14 scribed under paragraph (3)) shall comply with the
15 certification and documentation requirements under
16 this subsection for any interim final rule promul-
17 gated by the Secretary under subsection (i) that
18 amends any standard or operating rule described
19 under paragraph (1) of this subsection. A health
20 plan shall comply with such requirements not later
21 than the effective date of the applicable interim final
22 rule.

23 “(6) AUDITS OF HEALTH PLANS.—The Sec-
24 retary shall conduct periodic audits to ensure that
25 health plans (including entities described under

1 paragraph (3)) are in compliance with any standards
2 and operating rules that are described under para-
3 graph (1).

4 “(i) REVIEW AND AMENDMENT OF STANDARDS AND
5 RULES.—

6 “(1) ESTABLISHMENT.—Not later than Janu-
7 ary 1, 2014, the Secretary shall establish a review
8 committee (as described under paragraph (4)).

9 “(2) EVALUATIONS AND REPORTS.—

10 “(A) HEARINGS.—Not later than April 1,
11 2014, and not less than biennially thereafter,
12 the Secretary, acting through the review com-
13 mittee, shall conduct hearings to evaluate and
14 review the existing standards and operating
15 rules established under this section.

16 “(B) REPORT.—Not later than July 1,
17 2014, and not less than biennially thereafter,
18 the review committee shall provide rec-
19 ommendations for updating and improving such
20 standards and rules. The review committee
21 shall recommend a single set of operating rules
22 per transaction standard and maintain the goal
23 of creating as much uniformity as possible in
24 the implementation of the electronic standards.

25 “(3) INTERIM FINAL RULEMAKING.—

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1 “(A) IN GENERAL.—Any recommendations
2 to amend existing standards and operating
3 rules that have been approved by the review
4 committee and reported to the Secretary under
5 paragraph (2)(B) shall be adopted by the Sec-
6 retary through promulgation of an interim final
7 rule not later than 90 days after receipt of the
8 committee’s report.

9 “(B) PUBLIC COMMENT.—

10 “(i) PUBLIC COMMENT PERIOD.—The
11 Secretary shall accept public comments on
12 any interim final rule published under this
13 paragraph for 60 days after the date of
14 such publication.

15 “(ii) EFFECTIVE DATE.—The effective
16 date of any amendment to existing stand-
17 ards or operating rules that is adopted
18 through an interim final rule published
19 under this paragraph shall be 25 months
20 following the close of such public comment
21 period.

22 “(4) REVIEW COMMITTEE.—

23 “(A) DEFINITION.—For the purposes of
24 this subsection, the term ‘review committee’
25 means a committee within the Department of

1 Health and Human services that has been des-
2 igned by the Secretary to carry out this sub-
3 section, including—

4 “(i) the National Committee on Vital
5 and Health Statistics; or

6 “(ii) any appropriate committee as de-
7 termined by the Secretary.

8 “(B) COORDINATION OF HIT STAND-
9 ARDS.—In developing recommendations under
10 this subsection, the review committee shall con-
11 sider the standards approved by the Office of
12 the National Coordinator for Health Informa-
13 tion Technology.

14 “(j) PENALTIES.—

15 “(1) PENALTY FEE.—

16 “(A) IN GENERAL.—Not later than April
17 1, 2014, and annually thereafter, the Secretary
18 shall assess a penalty fee (as determined under
19 subparagraph (B)) against a health plan that
20 has failed to meet the requirements under sub-
21 section (h) with respect to certification and doc-
22 umentation of compliance with the standards
23 (and their operating rules) as described under
24 paragraph (1) of such subsection.

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1 “(B) FEE AMOUNT.—Subject to subpara-
2 graphs (C), (D), and (E), the Secretary shall
3 assess a penalty fee against a health plan in the
4 amount of \$1 per covered life until certification
5 is complete. The penalty shall be assessed per
6 person covered by the plan for which its data
7 systems for major medical policies are not in
8 compliance and shall be imposed against the
9 health plan for each day that the plan is not in
10 compliance with the requirements under sub-
11 section (h).

12 “(C) ADDITIONAL PENALTY FOR MIS-
13 REPRESENTATION.—A health plan that know-
14 ingly provides inaccurate or incomplete informa-
15 tion in a statement of certification or docu-
16 mentation of compliance under subsection (h)
17 shall be subject to a penalty fee that is double
18 the amount that would otherwise be imposed
19 under this subsection.

20 “(D) ANNUAL FEE INCREASE.—The
21 amount of the penalty fee imposed under this
22 subsection shall be increased on an annual basis
23 by the annual percentage increase in total na-
24 tional health care expenditures, as determined
25 by the Secretary.

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1 “(E) PENALTY LIMIT.—A penalty fee as-
2 sessed against a health plan under this sub-
3 section shall not exceed, on an annual basis—

4 “(i) an amount equal to \$20 per cov-
5 ered life under such plan; or

6 “(ii) an amount equal to \$40 per cov-
7 ered life under the plan if such plan has
8 knowingly provided inaccurate or incom-
9 plete information (as described under sub-
10 paragraph (C)).

11 “(F) DETERMINATION OF COVERED INDI-
12 VIDUALS.—The Secretary shall determine the
13 number of covered lives under a health plan
14 based upon the most recent statements and fil-
15 ings that have been submitted by such plan to
16 the Securities and Exchange Commission.

17 “(2) NOTICE AND DISPUTE PROCEDURE.—The
18 Secretary shall establish a procedure for assessment
19 of penalty fees under this subsection that provides a
20 health plan with reasonable notice and a dispute res-
21 olution procedure prior to provision of a notice of as-
22 sessment by the Secretary of the Treasury (as de-
23 scribed under paragraph (4)(B)).

24 “(3) PENALTY FEE REPORT.—Not later than
25 May 1, 2014, and annually thereafter, the Secretary

1 shall provide the Secretary of the Treasury with a
2 report identifying those health plans that have been
3 assessed a penalty fee under this subsection.

4 “(4) COLLECTION OF PENALTY FEE.—

5 “(A) IN GENERAL.—The Secretary of the
6 Treasury, acting through the Financial Man-
7 agement Service, shall administer the collection
8 of penalty fees from health plans that have been
9 identified by the Secretary in the penalty fee re-
10 port provided under paragraph (3).

11 “(B) NOTICE.—Not later than August 1,
12 2014, and annually thereafter, the Secretary of
13 the Treasury shall provide notice to each health
14 plan that has been assessed a penalty fee by the
15 Secretary under this subsection. Such notice
16 shall include the amount of the penalty fee as-
17 sessed by the Secretary and the due date for
18 payment of such fee to the Secretary of the
19 Treasury (as described in subparagraph (C)).

20 “(C) PAYMENT DUE DATE.—Payment by a
21 health plan for a penalty fee assessed under
22 this subsection shall be made to the Secretary
23 of the Treasury not later than November 1,
24 2014, and annually thereafter.

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1 “(D) UNPAID PENALTY FEES.—Any
2 amount of a penalty fee assessed against a
3 health plan under this subsection for which pay-
4 ment has not been made by the due date pro-
5 vided under subparagraph (C) shall be—

6 “(i) increased by the interest accrued
7 on such amount, as determined pursuant
8 to the underpayment rate established
9 under section 6601 of the Internal Rev-
10 enue Code of 1986; and

11 “(ii) treated as a past-due, legally en-
12 forceable debt owed to a Federal agency
13 for purposes of section 6402(d) of the In-
14 ternal Revenue Code of 1986.

15 “(E) ADMINISTRATIVE FEES.—Any fee
16 charged or allocated for collection activities con-
17 ducted by the Financial Management Service
18 will be passed on to a health plan on a pro-rata
19 basis and added to any penalty fee collected
20 from the plan.”.

21 (b) PROMULGATION OF RULES.—

22 (1) UNIQUE HEALTH PLAN IDENTIFIER.—The
23 Secretary shall promulgate a final rule to establish
24 a unique health plan identifier (as described in sec-
25 tion 1173(b) of the Social Security Act (42 U.S.C.

1 1320d-2(b))) based on the input of the National
2 Committee of Vital and Health Statistics. The Sec-
3 retary may do so on an interim final basis and such
4 rule shall be effective not later than October 1,
5 2012.

6 (2) ELECTRONIC FUNDS TRANSFER.—The Sec-
7 retary shall promulgate a final rule to establish a
8 standard for electronic funds transfers (as described
9 in section 1173(a)(2)(J) of the Social Security Act,
10 as added by subsection (a)(2)(A)). The Secretary
11 may do so on an interim final basis and shall adopt
12 such standard not later than January 1, 2012, in a
13 manner ensuring that such standard is effective not
14 later than January 1, 2014.

15 (c) EXPANSION OF ELECTRONIC TRANSACTIONS IN
16 MEDICARE.—Section 1862(a) of the Social Security Act
17 (42 U.S.C. 1395y(a)) is amended—

18 (1) in paragraph (23), by striking the “or” at
19 the end;

20 (2) in paragraph (24), by striking the period
21 and inserting “; or”; and

22 (3) by inserting after paragraph (24) the fol-
23 lowing new paragraph:

24 “(25) not later than January 1, 2014, for
25 which the payment is other than by electronic funds

1 transfer (EFT) or an electronic remittance in a form
2 as specified in ASC X12 835 Health Care Payment
3 and Remittance Advice or subsequent standard.”.

4 (d) **MEDICARE AND MEDICAID COMPLIANCE RE-**
5 **PORTS.**—Not later than July 1, 2013, the Secretary of
6 Health and Human Services shall submit a report to the
7 Chairs and Ranking Members of the Committee on Ways
8 and Means and the Committee on Energy and Commerce
9 of the House of Representatives and the Chairs and Rank-
10 ing Members of the Committee on Health, Education,
11 Labor, and Pensions and the Committee on Finance of
12 the Senate on the extent to which the Medicare program
13 and providers that serve beneficiaries under that program,
14 and State Medicaid programs and providers that serve
15 beneficiaries under those programs, transact electronically
16 in accordance with transaction standards issued under the
17 Health Insurance Portability and Accountability Act of
18 1996, part C of title XI of the Social Security Act, and
19 regulations promulgated under such Acts.

20 **Subtitle H—Sense of the Senate**
21 **Regarding Medical Malpractice**

22 **SEC. 3701. SENSE OF THE SENATE REGARDING MEDICAL**
23 **MALPRACTICE.**

24 It is the sense of the Senate that—

1 (1) health care reform presents an opportunity
2 to address issues related to medical malpractice and
3 medical liability insurance;

4 (2) States should be encouraged to develop and
5 test alternatives to the existing civil litigation system
6 as a way of improving patient safety, reducing med-
7 ical errors, encouraging the efficient resolution of
8 disputes, increasing the availability of prompt and
9 fair resolution of disputes, and improving access to
10 liability insurance, while preserving an individual's
11 right to seek redress in court; and

12 (3) Congress should consider establishing a
13 State demonstration program to evaluate alter-
14 natives to the existing civil litigation system with re-
15 spect to the resolution of medical malpractice claims.

1 **TITLE IV—TRANSPARENCY AND**
2 **PROGRAM INTEGRITY**
3 **Subtitle A—Limitation on Medicare**
4 **Exception to the Prohibition on**
5 **Certain Physician Referrals for**
6 **Hospitals**

7 **SEC. 4001. LIMITATION ON MEDICARE EXCEPTION TO THE**
8 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
9 **FERRALS FOR HOSPITALS.**

10 (a) IN GENERAL.—Section 1877 of the Social Secu-
11 rity Act (42 U.S.C. 1395nn) is amended—

12 (1) in subsection (d)(2)—

13 (A) in subparagraph (A), by striking
14 “and” at the end;

15 (B) in subparagraph (B), by striking the
16 period at the end and inserting “; and”; and

17 (C) by adding at the end the following new
18 subparagraph:

19 “(C) in the case where the entity is a hos-
20 pital, the hospital meets the requirements of
21 paragraph (3)(D).”;

22 (2) in subsection (d)(3)—

23 (A) in subparagraph (B), by striking
24 “and” at the end;

1 (B) in subparagraph (C), by striking the
2 period at the end and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(D) the hospital meets the requirements
6 described in subsection (i)(1) not later than 18
7 months after the date of the enactment of this
8 subparagraph.”; and

9 (3) by adding at the end the following new sub-
10 section:

11 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY
12 FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO
13 OWNERSHIP OR INVESTMENT PROHIBITION.—

14 “(1) REQUIREMENTS DESCRIBED.—For pur-
15 poses of subsection (d)(3)(D), the requirements de-
16 scribed in this paragraph for a hospital are as fol-
17 lows:

18 “(A) PROVIDER AGREEMENT.—The hos-
19 pital had—

20 “(i) physician ownership or invest-
21 ment on November 1, 2009; and

22 “(ii) a provider agreement under sec-
23 tion 1866 in effect on such date.

24 “(B) LIMITATION ON EXPANSION OF FA-
25 CILITY CAPACITY.—Except as provided in para-

1 graph (3), the number of operating rooms, pro-
2 cedure rooms, and beds for which the hospital
3 is licensed at any time on or after the date of
4 the enactment of this subsection is no greater
5 than the number of operating rooms, procedure
6 rooms, and beds for which the hospital is li-
7 censed as of such date.

8 “(C) PREVENTING CONFLICTS OF INTER-
9 EST.—

10 “(i) The hospital submits to the Sec-
11 retary an annual report containing a de-
12 tailed description of—

13 “(I) the identity of each physi-
14 cian owner or investor and any other
15 owners or investors of the hospital;
16 and

17 “(II) the nature and extent of all
18 ownership and investment interests in
19 the hospital.

20 “(ii) The hospital has procedures in
21 place to require that any referring physi-
22 cian owner or investor discloses to the pa-
23 tient being referred, by a time that permits
24 the patient to make a meaningful decision

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1 regarding the receipt of care, as deter-
2 mined by the Secretary—

3 “(I) the ownership or investment
4 interest, as applicable, of such refer-
5 ring physician in the hospital; and

6 “(II) if applicable, any such own-
7 ership or investment interest of the
8 treating physician.

9 “(iii) The hospital does not condition
10 any physician ownership or investment in-
11 terests either directly or indirectly on the
12 physician owner or investor making or in-
13 fluencing referrals to the hospital or other-
14 wise generating business for the hospital.

15 “(iv) The hospital discloses the fact
16 that the hospital is partially owned or in-
17 vested in by physicians—

18 “(I) on any public website for the
19 hospital; and

20 “(II) in any public advertising
21 for the hospital.

22 “(D) ENSURING BONA FIDE INVEST-
23 MENT.—

24 “(i) The percentage of the total value
25 of the ownership or investment interests

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1 held in the hospital, or in an entity whose
2 assets include the hospital, by physician
3 owners or investors in the aggregate does
4 not exceed such percentage as of the date
5 of enactment of this subsection.

6 “(ii) Any ownership or investment in-
7 terests that the hospital offers to a physi-
8 cian owner or investor are not offered on
9 more favorable terms than the terms of-
10 fered to a person who is not a physician
11 owner or investor.

12 “(iii) The hospital (or any owner or
13 investor in the hospital) does not directly
14 or indirectly provide loans or financing for
15 any investment in the hospital by a physi-
16 cian owner or investor.

17 “(iv) The hospital (or any owner or
18 investor in the hospital) does not directly
19 or indirectly guarantee a loan, make a pay-
20 ment toward a loan, or otherwise subsidize
21 a loan, for any individual physician owner
22 or investor or group of physician owners or
23 investors that is related to acquiring any
24 ownership or investment interest in the
25 hospital.

1 “(v) Ownership or investment returns
2 are distributed to each owner or investor in
3 the hospital in an amount that is directly
4 proportional to the ownership or invest-
5 ment interest of such owner or investor in
6 the hospital.

7 “(vi) Physician owners and investors
8 do not receive, directly or indirectly, any
9 guaranteed receipt of or right to purchase
10 other business interests related to the hos-
11 pital, including the purchase or lease of
12 any property under the control of other
13 owners or investors in the hospital or lo-
14 cated near the premises of the hospital.

15 “(vii) The hospital does not offer a
16 physician owner or investor the oppor-
17 tunity to purchase or lease any property
18 under the control of the hospital or any
19 other owner or investor in the hospital on
20 more favorable terms than the terms of-
21 fered to an individual who is not a physi-
22 cian owner or investor.

23 “(E) PATIENT SAFETY.—

24 “(i) Insofar as the hospital admits a
25 patient and does not have any physician

1 available on the premises to provide serv-
2 ices during all hours in which the hospital
3 is providing services to such patient, before
4 admitting the patient—

5 “(I) the hospital discloses such
6 fact to a patient; and

7 “(II) following such disclosure,
8 the hospital receives from the patient
9 a signed acknowledgment that the pa-
10 tient understands such fact.

11 “(ii) The hospital has the capacity
12 to—

13 “(I) provide assessment and ini-
14 tial treatment for patients; and

15 “(II) refer and transfer patients
16 to hospitals with the capability to
17 treat the needs of the patient in-
18 volved.

19 “(F) LIMITATION ON APPLICATION TO
20 CERTAIN CONVERTED FACILITIES.—The hos-
21 pital was not converted from an ambulatory
22 surgical center to a hospital on or after the date
23 of enactment of this subsection.

24 “(2) PUBLICATION OF INFORMATION RE-
25 PORTED.—The Secretary shall publish, and update

1 on an annual basis, the information submitted by
2 hospitals under paragraph (1)(C)(i) on the public
3 Internet website of the Centers for Medicare & Med-
4 icaid Services.

5 “(3) EXCEPTION TO PROHIBITION ON EXPAN-
6 SION OF FACILITY CAPACITY.—

7 “(A) PROCESS.—

8 “(i) ESTABLISHMENT.—The Secretary
9 shall establish and implement a process
10 under which an applicable hospital (as de-
11 fined in subparagraph (E)) may apply for
12 an exception from the requirement under
13 paragraph (1)(B).

14 “(ii) OPPORTUNITY FOR COMMUNITY
15 INPUT.—The process under clause (i) shall
16 provide individuals and entities in the com-
17 munity in which the applicable hospital ap-
18 plying for an exception is located with the
19 opportunity to provide input with respect
20 to the application.

21 “(iii) TIMING FOR IMPLEMENTA-
22 TION.—The Secretary shall implement the
23 process under clause (i) on May 1, 2011.

24 “(iv) REGULATIONS.—Not later than
25 April 1, 2011, the Secretary shall promul-

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1 gate regulations to carry out the process
2 under clause (i).

3 “(B) FREQUENCY.—The process described
4 in subparagraph (A) shall permit an applicable
5 hospital to apply for an exception up to once
6 every 2 years.

7 “(C) PERMITTED INCREASE.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii) and subparagraph (D), an applicable
10 hospital granted an exception under the
11 process described in subparagraph (A) may
12 increase the number of operating rooms,
13 procedure rooms, and beds for which the
14 applicable hospital is licensed above the
15 baseline number of operating rooms, proce-
16 dure rooms, and beds of the applicable
17 hospital (or, if the applicable hospital has
18 been granted a previous exception under
19 this paragraph, above the number of oper-
20 ating rooms, procedure rooms, and beds
21 for which the hospital is licensed after the
22 application of the most recent increase
23 under such an exception).

24 “(ii) 100 PERCENT INCREASE LIMITA-
25 TION.—The Secretary shall not permit an

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1 increase in the number of operating rooms,
2 procedure rooms, and beds for which an
3 applicable hospital is licensed under clause
4 (i) to the extent such increase would result
5 in the number of operating rooms, proce-
6 dure rooms, and beds for which the appli-
7 cable hospital is licensed exceeding 200
8 percent of the baseline number of oper-
9 ating rooms, procedure rooms, and beds of
10 the applicable hospital.

11 “(iii) BASELINE NUMBER OF OPER-
12 ATING ROOMS, PROCEDURE ROOMS, AND
13 BEDS.—In this paragraph, the term ‘base-
14 line number of operating rooms, procedure
15 rooms, and beds’ means the number of op-
16 erating rooms, procedure rooms, and beds
17 for which the applicable hospital is licensed
18 as of the date of enactment of this sub-
19 section.

20 “(D) INCREASE LIMITED TO FACILITIES
21 ON THE MAIN CAMPUS OF THE HOSPITAL.—
22 Any increase in the number of operating rooms,
23 procedure rooms, and beds for which an appli-
24 cable hospital is licensed pursuant to this para-

1 graph may only occur in facilities on the main
2 campus of the applicable hospital.

3 “(E) APPLICABLE HOSPITAL.—In this
4 paragraph, the term ‘applicable hospital’ means
5 a hospital—

6 “(i) that is located in a county in
7 which the percentage increase in the popu-
8 lation during the most recent 5-year period
9 (as of the date of the application under
10 subparagraph (A)) is at least 150 percent
11 of the percentage increase in the popu-
12 lation growth of the State in which the
13 hospital is located during that period, as
14 estimated by Bureau of the Census;

15 “(ii) whose annual percent of total in-
16 patient admissions that represent inpatient
17 admissions under the program under title
18 XIX is equal to or greater than the aver-
19 age percent with respect to such admis-
20 sions for all hospitals located in the county
21 in which the hospital is located;

22 “(iii) that does not discriminate
23 against beneficiaries of Federal health care
24 programs and does not permit physicians

1 practicing at the hospital to discriminate
2 against such beneficiaries;

3 “(iv) that is located in a State in
4 which the average bed capacity in the
5 State is less than the national average bed
6 capacity; and

7 “(v) that has an average bed occu-
8 pancy rate that is greater than the average
9 bed occupancy rate in the State in which
10 the hospital is located.

11 “(F) PROCEDURE ROOMS.—In this sub-
12 section, the term ‘procedure rooms’ includes
13 rooms in which catheterizations, angiographies,
14 angiograms, and endoscopies are performed, ex-
15 cept such term shall not include emergency
16 rooms or departments (exclusive of rooms in
17 which catheterizations, angiographies,
18 angiograms, and endoscopies are performed).

19 “(G) PUBLICATION OF FINAL DECI-
20 SIONS.—Not later than 60 days after receiving
21 a complete application under this paragraph,
22 the Secretary shall publish in the Federal Reg-
23 ister the final decision with respect to such ap-
24 plication.

1 “(H) LIMITATION ON REVIEW.—There
2 shall be no administrative or judicial review
3 under section 1869, section 1878, or otherwise
4 of the process under this paragraph (including
5 the establishment of such process).

6 “(4) COLLECTION OF OWNERSHIP AND INVEST-
7 MENT INFORMATION.—For purposes of subpara-
8 graphs (A)(i) and (D)(i) of paragraph (1), the Sec-
9 retary shall collect physician ownership and invest-
10 ment information for each hospital.

11 “(5) PHYSICIAN OWNER OR INVESTOR DE-
12 FINED.—For purposes of this subsection, the term
13 ‘physician owner or investor’ means a physician (or
14 an immediate family member of such physician) with
15 a direct or an indirect ownership or investment in-
16 terest in the hospital.

17 “(6) CLARIFICATION.—Nothing in this sub-
18 section shall be construed as preventing the Sec-
19 retary from revoking a hospital’s provider agreement
20 if not in compliance with regulations implementing
21 section 1866.”.

22 (b) ENFORCEMENT.—

23 (1) ENSURING COMPLIANCE.—The Secretary of
24 Health and Human Services shall establish policies
25 and procedures to ensure compliance with the re-

1 requirements described in subsection (i)(1) of section
2 1877 of the Social Security Act, as added by sub-
3 section (a)(3), beginning on the date such require-
4 ments first apply. Such policies and procedures may
5 include unannounced site reviews of hospitals.

6 (2) AUDITS.—Beginning not later than August
7 1, 2011, the Secretary of Health and Human Serv-
8 ices shall conduct audits to determine if hospitals
9 violate the requirements referred to in paragraph
10 (1).

11 **Subtitle B—Physician Ownership** 12 **and Other Transparency**

13 **SEC. 4101. TRANSPARENCY REPORTS AND REPORTING OF** 14 **PHYSICIAN OWNERSHIP OR INVESTMENT IN-** 15 **TERESTS.**

16 Part A of title XI of the Social Security Act (42
17 U.S.C. 1301 et seq.) is amended by inserting after section
18 1128F the following new section:

19 **“SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING** 20 **OF PHYSICIAN OWNERSHIP OR INVESTMENT** 21 **INTERESTS.**

22 “(a) TRANSPARENCY REPORTS.—

23 “(1) PAYMENTS OR OTHER TRANSFERS OF
24 VALUE.—

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1 “(A) IN GENERAL.—On March 31, 2012,
2 and on the 90th day of each calendar year be-
3 ginning thereafter, any applicable manufacturer
4 that provides a payment or other transfer of
5 value to a covered recipient (or to an entity or
6 individual at the request of or designated on be-
7 half of a covered recipient), shall submit to the
8 Secretary, in such electronic form as the Sec-
9 retary shall require, the following information
10 with respect to the preceding calendar year:

11 “(i) The name of the covered recipi-
12 ent.

13 “(ii) The business address of the cov-
14 ered recipient and, in the case of a covered
15 recipient who is a physician, the specialty
16 and National Provider Identifier of the
17 covered recipient.

18 “(iii) The amount of the payment or
19 other transfer of value.

20 “(iv) The dates on which the payment
21 or other transfer of value was provided to
22 the covered recipient.

23 “(v) A description of the form of the
24 payment or other transfer of value, indi-

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1 cated (as appropriate for all that apply)

2 as—

3 “(I) cash or a cash equivalent;

4 “(II) in-kind items or services;

5 “(III) stock, a stock option, or

6 any other ownership interest, divi-

7 dend, profit, or other return on invest-

8 ment; or

9 “(IV) any other form of payment

10 or other transfer of value (as defined

11 by the Secretary).

12 “(vi) A description of the nature of

13 the payment or other transfer of value, in-

14 dicated (as appropriate for all that apply)

15 as—

16 “(I) consulting fees;

17 “(II) compensation for services

18 other than consulting;

19 “(III) honoraria;

20 “(IV) gift;

21 “(V) entertainment;

22 “(VI) food;

23 “(VII) travel (including the speci-

24 fied destinations);

25 “(VIII) education;

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1 “(IX) research;

2 “(X) charitable contribution;

3 “(XI) royalty or license;

4 “(XII) current or prospective
5 ownership or investment interest;

6 “(XIII) direct compensation for
7 serving as faculty or as a speaker for
8 a medical education program;

9 “(XIV) grant; or

10 “(XV) any other nature of the
11 payment or other transfer of value (as
12 defined by the Secretary).

13 “(vii) If the payment or other transfer
14 of value is related to marketing, education,
15 or research specific to a covered drug, de-
16 vice, biological, or medical supply, the
17 name of that covered drug, device, biologi-
18 cal, or medical supply.

19 “(viii) Any other categories of infor-
20 mation regarding the payment or other
21 transfer of value the Secretary determines
22 appropriate.

23 “(B) SPECIAL RULE FOR CERTAIN PAY-
24 MENTS OR OTHER TRANSFERS OF VALUE.—In
25 the case where an applicable manufacturer pro-

1 vides a payment or other transfer of value to an
2 entity or individual at the request of or des-
3 ignated on behalf of a covered recipient, the ap-
4 plicable manufacturer shall disclose that pay-
5 ment or other transfer of value under the name
6 of the covered recipient.

7 “(2) PHYSICIAN OWNERSHIP.—In addition to
8 the requirement under paragraph (1)(A), on March
9 31, 2012, and on the 90th day of each calendar year
10 beginning thereafter, any applicable manufacturer or
11 applicable group purchasing organization shall sub-
12 mit to the Secretary, in such electronic form as the
13 Secretary shall require, the following information re-
14 garding any ownership or investment interest (other
15 than an ownership or investment interest in a pub-
16 licly traded security and mutual fund, as described
17 in section 1877(e)) held by a physician (or an imme-
18 diate family member of such physician (as defined
19 for purposes of section 1877(a))) in the applicable
20 manufacturer or applicable group purchasing organi-
21 zation during the preceding year:

22 “(A) The dollar amount invested by each
23 physician holding such an ownership or invest-
24 ment interest.

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1 “(B) The value and terms of each such
2 ownership or investment interest.

3 “(C) Any payment or other transfer of
4 value provided to a physician holding such an
5 ownership or investment interest (or to an enti-
6 ty or individual at the request of or designated
7 on behalf of a physician holding such an owner-
8 ship or investment interest), including the infor-
9 mation described in clauses (i) through (viii) of
10 paragraph (1)(A), except that in applying such
11 clauses, ‘physician’ shall be substituted for ‘cov-
12 ered recipient’ each place it appears.

13 “(D) Any other information regarding the
14 ownership or investment interest the Secretary
15 determines appropriate.

16 “(b) PENALTIES FOR NONCOMPLIANCE.—

17 “(1) FAILURE TO REPORT.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (B) except as provided in paragraph (2),
20 any applicable manufacturer or applicable
21 group purchasing organization that fails to sub-
22 mit information required under subsection (a)
23 in a timely manner in accordance with rules or
24 regulations promulgated to carry out such sub-
25 section, shall be subject to a civil money penalty

1 of not less than \$1,000, but not more than
2 \$10,000, for each payment or other transfer of
3 value or ownership or investment interest not
4 reported as required under such subsection.
5 Such penalty shall be imposed and collected in
6 the same manner as civil money penalties under
7 subsection (a) of section 1128A are imposed
8 and collected under that section.

9 “(B) LIMITATION.—The total amount of
10 civil money penalties imposed under subpara-
11 graph (A) with respect to each annual submis-
12 sion of information under subsection (a) by an
13 applicable manufacturer or applicable group
14 purchasing organization shall not exceed
15 \$150,000.

16 “(2) KNOWING FAILURE TO REPORT.—

17 “(A) IN GENERAL.—Subject to subpara-
18 graph (B), any applicable manufacturer or ap-
19 plicable group purchasing organization that
20 knowingly fails to submit information required
21 under subsection (a) in a timely manner in ac-
22 cordance with rules or regulations promulgated
23 to carry out such subsection, shall be subject to
24 a civil money penalty of not less than \$10,000,
25 but not more than \$100,000, for each payment

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1 or other transfer of value or ownership or in-
2 vestment interest not reported as required
3 under such subsection. Such penalty shall be
4 imposed and collected in the same manner as
5 civil money penalties under subsection (a) of
6 section 1128A are imposed and collected under
7 that section.

8 “(B) LIMITATION.—The total amount of
9 civil money penalties imposed under subpara-
10 graph (A) with respect to each annual submis-
11 sion of information under subsection (a) by an
12 applicable manufacturer or applicable group
13 purchasing organization shall not exceed
14 \$1,000,000.

15 “(3) USE OF FUNDS.—Funds collected by the
16 Secretary as a result of the imposition of a civil
17 money penalty under this subsection shall be used to
18 carry out this section.

19 “(c) PROCEDURES FOR SUBMISSION OF INFORMA-
20 TION AND PUBLIC AVAILABILITY.—

21 “(1) IN GENERAL.—

22 “(A) ESTABLISHMENT.—Not later than
23 October 1, 2010, the Secretary shall establish
24 procedures—

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1 “(i) for applicable manufacturers and
2 applicable group purchasing organizations
3 to submit information to the Secretary
4 under subsection (a); and

5 “(ii) for the Secretary to make such
6 information submitted available to the pub-
7 lic.

8 “(B) DEFINITION OF TERMS.—The proce-
9 dures established under subparagraph (A) shall
10 provide for the definition of terms (other than
11 those terms defined in subsection (e)), as ap-
12 propriate, for purposes of this section.

13 “(C) PUBLIC AVAILABILITY.—Except as
14 provided in subparagraph (E), the procedures
15 established under subparagraph (A)(ii) shall en-
16 sure that, not later than September 30, 2012,
17 and on June 30 of each calendar year beginning
18 thereafter, the information submitted under
19 subsection (a) with respect to the preceding cal-
20 endar year is made available through an Inter-
21 net website that—

22 “(i) is searchable and is in a format
23 that is clear and understandable;

24 “(ii) contains information that is pre-
25 sented by the name of the applicable man-

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1 manufacturer or applicable group purchasing
2 organization, the name of the covered re-
3 cipient, the business address of the covered
4 recipient, the specialty of the covered re-
5 cipient, the value of the payment or other
6 transfer of value, the date on which the
7 payment or other transfer of value was
8 provided to the covered recipient, the form
9 of the payment or other transfer of value,
10 indicated (as appropriate) under subsection
11 (a)(1)(A)(v), the nature of the payment or
12 other transfer of value, indicated (as ap-
13 propriate) under subsection (a)(1)(A)(vi),
14 and the name of the covered drug, device,
15 biological, or medical supply, as applicable;
16 “(iii) contains information that is able
17 to be easily aggregated and downloaded;
18 “(iv) contains a description of any en-
19 forcement actions taken to carry out this
20 section, including any penalties imposed
21 under subsection (b), during the preceding
22 year;
23 “(v) contains background information
24 on industry-physician relationships;

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1 “(vi) in the case of information sub-
2 mitted with respect to a payment or other
3 transfer of value described in subpara-
4 graph (E)(i), lists such information sepa-
5 rately from the other information sub-
6 mitted under subsection (a) and designates
7 such separately listed information as fund-
8 ing for clinical research;

9 “(vii) contains any other information
10 the Secretary determines would be helpful
11 to the average consumer;

12 “(viii) does not contain the National
13 Provider Identifier of the covered recipient,
14 and

15 “(ix) subject to subparagraph (D),
16 provides the applicable manufacturer, ap-
17 plicable group purchasing organization, or
18 covered recipient an opportunity to review
19 and submit corrections to the information
20 submitted with respect to the applicable
21 manufacturer, applicable group purchasing
22 organization, or covered recipient, respec-
23 tively, for a period of not less than 45 days
24 prior to such information being made
25 available to the public.

1 “(D) CLARIFICATION OF TIME PERIOD FOR
2 REVIEW AND CORRECTIONS.—In no case may
3 the 45-day period for review and submission of
4 corrections to information under subparagraph
5 (C)(ix) prevent such information from being
6 made available to the public in accordance with
7 the dates described in the matter preceding
8 clause (i) in subparagraph (C).

9 “(E) DELAYED PUBLICATION FOR PAY-
10 MENTS MADE PURSUANT TO PRODUCT RE-
11 SEARCH OR DEVELOPMENT AGREEMENTS AND
12 CLINICAL INVESTIGATIONS.—

13 “(i) IN GENERAL.—In the case of in-
14 formation submitted under subsection (a)
15 with respect to a payment or other transfer
16 of value made to a covered recipient by an
17 applicable manufacturer pursuant to a
18 product research or development agree-
19 ment for services furnished in connection
20 with research on a potential new medical
21 technology or a new application of an ex-
22 isting medical technology or the develop-
23 ment of a new drug, device, biological, or
24 medical supply, or by an applicable manu-
25 facturer in connection with a clinical inves-

1 tigation regarding a new drug, device, bio-
2 logical, or medical supply, the procedures
3 established under subparagraph (A)(ii)
4 shall provide that such information is
5 made available to the public on the first
6 date described in the matter preceding
7 clause (i) in subparagraph (C) after the
8 earlier of the following:

9 “(I) The date of the approval or
10 clearance of the covered drug, device,
11 biological, or medical supply by the
12 Food and Drug Administration.

13 “(II) Four calendar years after
14 the date such payment or other trans-
15 fer of value was made.

16 “(ii) CONFIDENTIALITY OF INFORMA-
17 TION PRIOR TO PUBLICATION.—Informa-
18 tion described in clause (i) shall be consid-
19 ered confidential and shall not be subject
20 to disclosure under section 552 of title 5,
21 United States Code, or any other similar
22 Federal, State, or local law, until on or
23 after the date on which the information is
24 made available to the public under such
25 clause.

1 “(2) CONSULTATION.—In establishing the pro-
2 cedures under paragraph (1), the Secretary shall
3 consult with the Inspector General of the Depart-
4 ment of Health and Human Services, affected indus-
5 try, consumers, consumer advocates, and other inter-
6 ested parties in order to ensure that the information
7 made available to the public under such paragraph
8 is presented in the appropriate overall context.

9 “(d) ANNUAL REPORTS AND RELATION TO STATE
10 LAWS.—

11 “(1) ANNUAL REPORT TO CONGRESS.—Not
12 later than April 1 of each year beginning with 2012,
13 the Secretary shall submit to Congress a report that
14 includes the following:

15 “(A) The information submitted under
16 subsection (a) during the preceding year, aggre-
17 gated for each applicable manufacturer and ap-
18 plicable group purchasing organization that
19 submitted such information during such year
20 (except, in the case of information submitted
21 with respect to a payment or other transfer of
22 value described in subsection (c)(1)(E)(i), such
23 information shall be included in the first report
24 submitted to Congress after the date on which

1 such information is made available to the public
2 under such subsection).

3 “(B) A description of any enforcement ac-
4 tions taken to carry out this section, including
5 any penalties imposed under subsection (b),
6 during the preceding year.

7 “(2) ANNUAL REPORTS TO STATES.—Not later
8 than September 30, 2012 and on June 30 of each
9 calendar year thereafter, the Secretary shall submit
10 to States a report that includes a summary of the
11 information submitted under subsection (a) during
12 the preceding year with respect to covered recipients
13 in the State (except, in the case of information sub-
14 mitted with respect to a payment or other transfer
15 of value described in subsection (c)(1)(E)(i), such in-
16 formation shall be included in the first report sub-
17 mitted to States after the date on which such infor-
18 mation is made available to the public under such
19 subsection).

20 “(3) RELATION TO STATE LAWS.—

21 “(A) IN GENERAL.—In the case of a pay-
22 ment or other transfer of value provided by an
23 applicable manufacturer that is received by a
24 covered recipient (as defined in subsection (e))
25 on or after January 1, 2011, subject to sub-

1 paragraph (B), the provisions of this section
2 shall preempt any statute or regulation of a
3 State or of a political subdivision of a State
4 that requires an applicable manufacturer (as so
5 defined) to disclose or report, in any format,
6 the type of information (as described in sub-
7 section (a)) regarding such payment or other
8 transfer of value.

9 “(B) NO PREEMPTION OF ADDITIONAL RE-
10 QUIREMENTS.—Subparagraph (A) shall not
11 preempt any statute or regulation of a State or
12 of a political subdivision of a State that re-
13 quires the disclosure or reporting of informa-
14 tion—

15 “(i) not of the type required to be dis-
16 closed or reported under this section;

17 “(ii) described in subsection
18 (e)(10)(B), except in the case of informa-
19 tion described in clause (i) of such sub-
20 section;

21 “(iii) by any person or entity other
22 than an applicable manufacturer (as so de-
23 fined) or a covered recipient (as defined in
24 subsection (e)); or

1 “(iv) to a Federal, State, or local gov-
2 ernmental agency for public health surveil-
3 lance, investigation, or other public health
4 purposes or health oversight purposes.

5 “(C) Nothing in subparagraph (A) shall be
6 construed to limit the discovery or admissibility
7 of information described in such subparagraph
8 in a criminal, civil, or administrative pro-
9 ceeding.

10 “(4) CONSULTATION.—The Secretary shall con-
11 sult with the Inspector General of the Department
12 of Health and Human Services on the implementa-
13 tion of this section.

14 “(e) DEFINITIONS.—In this section:

15 “(1) APPLICABLE GROUP PURCHASING ORGANI-
16 ZATION.—The term ‘applicable group purchasing or-
17 ganization’ means a group purchasing organization
18 (as defined by the Secretary) that purchases, ar-
19 ranges for, or negotiates the purchase of a covered
20 drug, device, biological, or medical supply which is
21 operating in the United States, or in a territory,
22 possession, or commonwealth of the United States.

23 “(2) APPLICABLE MANUFACTURER.—The term
24 ‘applicable manufacturer’ means a manufacturer of
25 a covered drug, device, biological, or medical supply

1 which is operating in the United States, or in a ter-
2 ritory, possession, or commonwealth of the United
3 States.

4 “(3) CLINICAL INVESTIGATION.—The term
5 ‘clinical investigation’ means any experiment involv-
6 ing 1 or more human subjects, or materials derived
7 from human subjects, in which a drug or device is
8 administered, dispensed, or used.

9 “(4) COVERED DEVICE.—The term ‘covered de-
10 vice’ means any device for which payment is avail-
11 able under title XVIII or a State plan under title
12 XIX or XXI (or a waiver of such a plan).

13 “(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR
14 MEDICAL SUPPLY.—The term ‘covered drug, device,
15 biological, or medical supply’ means any drug, bio-
16 logical product, device, or medical supply for which
17 payment is available under title XVIII or a State
18 plan under title XIX or XXI (or a waiver of such
19 a plan).

20 “(6) COVERED RECIPIENT.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), the term ‘covered recipient’
23 means the following:

24 “(i) A physician.

25 “(ii) A teaching hospital.

1 “(B) EXCLUSION.—Such term does not in-
2 clude a physician who is an employee of the ap-
3 plicable manufacturer that is required to submit
4 information under subsection (a).

5 “(7) EMPLOYEE.—The term ‘employee’ has the
6 meaning given such term in section 1877(h)(2).

7 “(8) KNOWINGLY.—The term ‘knowingly’ has
8 the meaning given such term in section 3729(b) of
9 title 31, United States Code.

10 “(9) MANUFACTURER OF A COVERED DRUG,
11 DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The
12 term ‘manufacturer of a covered drug, device, bio-
13 logical, or medical supply’ means any entity which is
14 engaged in the production, preparation, propagation,
15 compounding, or conversion of a covered drug, de-
16 vice, biological, or medical supply (or any entity
17 under common ownership with such entity which
18 provides assistance or support to such entity with re-
19 spect to the production, preparation, propagation,
20 compounding, conversion, marketing, promotion,
21 sale, or distribution of a covered drug, device, bio-
22 logical, or medical supply).

23 “(10) PAYMENT OR OTHER TRANSFER OF
24 VALUE.—

1 “(A) IN GENERAL.—The term ‘payment or
2 other transfer of value’ means a transfer of
3 anything of value. Such term does not include
4 a transfer of anything of value that is made in-
5 directly to a covered recipient through a third
6 party in connection with an activity or service
7 in the case where the applicable manufacturer
8 is unaware of the identity of the covered recipi-
9 ent.

10 “(B) EXCLUSIONS.—An applicable manu-
11 facturer shall not be required to submit infor-
12 mation under subsection (a) with respect to the
13 following:

14 “(i) A transfer of anything the value
15 of which is less than \$10, unless the aggre-
16 gate amount transferred to, requested by,
17 or designated on behalf of the covered re-
18 cipient by the applicable manufacturer dur-
19 ing the calendar year exceeds \$100. For
20 calendar years after 2012, the dollar
21 amounts specified in the preceding sen-
22 tence shall be increased by the same per-
23 centage as the percentage increase in the
24 consumer price index for all urban con-
25 sumers (all items; U.S. city average) for

1 the 12-month period ending with June of
2 the previous year.

3 “(ii) Product samples that are not in-
4 tended to be sold and are intended for pa-
5 tient use.

6 “(iii) Educational materials that di-
7 rectly benefit patients or are intended for
8 patient use.

9 “(iv) The loan of a covered device for
10 a short-term trial period, not to exceed 90
11 days, to permit evaluation of the covered
12 device by the covered recipient.

13 “(v) Items or services provided under
14 a contractual warranty, including the re-
15 placement of a covered device, where the
16 terms of the warranty are set forth in the
17 purchase or lease agreement for the cov-
18 ered device.

19 “(vi) A transfer of anything of value
20 to a covered recipient when the covered re-
21 cipient is a patient and not acting in the
22 professional capacity of a covered recipient.

23 “(vii) Discounts (including rebates).

24 “(viii) In-kind items used for the pro-
25 vision of charity care.

1 “(ix) A dividend or other profit dis-
2 tribution from, or ownership or investment
3 interest in, a publicly traded security and
4 mutual fund (as described in section
5 1877(c)).

6 “(x) In the case of an applicable man-
7 ufacturer who offers a self-insured plan,
8 payments for the provision of health care
9 to employees under the plan.

10 “(xi) In the case of a covered recipi-
11 ent who is a licensed non-medical profes-
12 sional, a transfer of anything of value to
13 the covered recipient if the transfer is pay-
14 ment solely for the non-medical profes-
15 sional services of such licensed non-medical
16 professional.

17 “(xii) In the case of a covered recipi-
18 ent who is a physician, a transfer of any-
19 thing of value to the covered recipient if
20 the transfer is payment solely for the serv-
21 ices of the covered recipient with respect to
22 a civil or criminal action or an administra-
23 tive proceeding.

24 “(11) PHYSICIAN.—The term ‘physician’ has
25 the meaning given that term in section 1861(r).”.

1 **SEC. 4102. DISCLOSURE REQUIREMENTS FOR IN-OFFICE**
2 **ANCILLARY SERVICES EXCEPTION TO THE**
3 **PROHIBITION ON PHYSICIAN SELF-REFER-**
4 **RAL FOR CERTAIN IMAGING SERVICES.**

5 (a) **IN GENERAL.**—Section 1877(b)(2) of the Social
6 Security Act (42 U.S.C. 1395nn(b)(2)) is amended by
7 adding at the end the following new sentence: “Such re-
8 quirements shall, with respect to magnetic resonance im-
9 aging, computed tomography, positron emission tomog-
10 raphy, and any other designated health services specified
11 under subsection (h)(6)(D) that the Secretary determines
12 appropriate, include a requirement that the referring phy-
13 sician inform the individual in writing at the time of the
14 referral that the individual may obtain the services for
15 which the individual is being referred from a person other
16 than a person described in subparagraph (A)(i) and pro-
17 vide such individual with a written list of suppliers (as
18 defined in section 1861(d)) who furnish such services in
19 the area in which such individual resides.”.

20 (b) **EFFECTIVE DATE.**—The amendment made by
21 this section shall apply to services furnished on or after
22 January 1, 2010.

23 **SEC. 4103. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.**

24 Part A of title XI of the Social Security Act (42
25 U.S.C. 1301 et seq.), as amended by section 4101, is

1 amended by inserting after section 1128G the following
2 new section:

3 **“SEC. 1128H. REPORTING OF INFORMATION RELATING TO**
4 **DRUG SAMPLES.**

5 “(a) IN GENERAL.—Not later than April 1 of each
6 year (beginning with 2012), each manufacturer and au-
7 thorized distributor of record of an applicable drug shall
8 submit to the Secretary (in a form and manner specified
9 by the Secretary) the following information with respect
10 to the preceding year:

11 “(1) In the case of a manufacturer or author-
12 ized distributor of record which makes distributions
13 by mail or common carrier under subsection (d)(2)
14 of section 503 of the Federal Food, Drug, and Cos-
15 metic Act (21 U.S.C. 353), the identity and quantity
16 of drug samples requested and the identity and
17 quantity of drug samples distributed under such
18 subsection during that year, aggregated by—

19 “(A) the name, address, professional des-
20 ignation, and signature of the practitioner mak-
21 ing the request under subparagraph (A)(i) of
22 such subsection, or of any individual who makes
23 or signs for the request on behalf of the practi-
24 tioner; and

1 “(B) any other category of information de-
2 termined appropriate by the Secretary.

3 “(2) In the case of a manufacturer or author-
4 ized distributor of record which makes distributions
5 by means other than mail or common carrier under
6 subsection (d)(3) of such section 503, the identity
7 and quantity of drug samples requested and the
8 identity and quantity of drug samples distributed
9 under such subsection during that year, aggregated
10 by—

11 “(A) the name, address, professional des-
12 ignation, and signature of the practitioner mak-
13 ing the request under subparagraph (A)(i) of
14 such subsection, or of any individual who makes
15 or signs for the request on behalf of the practi-
16 tioner; and

17 “(B) any other category of information de-
18 termined appropriate by the Secretary.

19 “(b) DEFINITIONS.—In this section:

20 “(1) APPLICABLE DRUG.—The term ‘applicable
21 drug’ means a drug—

22 “(A) which is subject to subsection (b) of
23 such section 503; and

1 “(B) for which payment is available under
2 title XVIII or a State plan under title XIX or
3 XXI (or a waiver of such a plan).

4 “(2) AUTHORIZED DISTRIBUTOR OF RECORD.—
5 The term ‘authorized distributor of record’ has the
6 meaning given that term in subsection (e)(3)(A) of
7 such section.

8 “(3) MANUFACTURER.—The term ‘manufac-
9 turer’ has the meaning given that term for purposes
10 of subsection (d) of such section.”.

11 **Subtitle C—Nursing Home**
12 **Transparency and Improvement**

13 **PART I—IMPROVING TRANSPARENCY OF**
14 **INFORMATION**

15 **SEC. 4201. REQUIRED DISCLOSURE OF OWNERSHIP AND**
16 **ADDITIONAL DISCLOSABLE PARTIES INFOR-**
17 **MATION.**

18 (a) IN GENERAL.—Section 1124 of the Social Secu-
19 rity Act (42 U.S.C. 1320a-3) is amended by adding at
20 the end the following new subsection:

21 “(c) REQUIRED DISCLOSURE OF OWNERSHIP AND
22 ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

23 “(1) DISCLOSURE.—A facility shall have the in-
24 formation described in paragraph (2) available—

1 “(A) during the period beginning on the
2 date of the enactment of this subsection and
3 ending on the date such information is made
4 available to the public under section 4201(b) of
5 the America’s Healthy Future Act of 2009 for
6 submission to the Secretary, the Inspector Gen-
7 eral of the Department of Health and Human
8 Services, the State in which the facility is lo-
9 cated, and the State long-term care ombudsman
10 in the case where the Secretary, the Inspector
11 General, the State, or the State long-term care
12 ombudsman requests such information; and

13 “(B) beginning on the effective date of the
14 final regulations promulgated under paragraph
15 (3)(A), for reporting such information in ac-
16 cordance with such final regulations.

17 Nothing in subparagraph (A) shall be construed as
18 authorizing a facility to dispose of or delete informa-
19 tion described in such subparagraph after the effec-
20 tive date of the final regulations promulgated under
21 paragraph (3)(A).

22 “(2) INFORMATION DESCRIBED.—

23 “(A) IN GENERAL.—The following infor-
24 mation is described in this paragraph:

1 “(i) The information described in sub-
2 sections (a) and (b), subject to subpara-
3 graph (C).

4 “(ii) The identity of and information
5 on—

6 “(I) each member of the gov-
7 erning body of the facility, including
8 the name, title, and period of service
9 of each such member;

10 “(II) each person or entity who is
11 an officer, director, member, partner,
12 trustee, or managing employee of the
13 facility, including the name, title, and
14 period of service of each such person
15 or entity; and

16 “(III) each person or entity who
17 is an additional disclosable party of
18 the facility.

19 “(iii) The organizational structure of
20 each additional disclosable party of the fa-
21 cility and a description of the relationship
22 of each such additional disclosable party to
23 the facility and to one another.

24 “(B) SPECIAL RULE WHERE INFORMATION
25 IS ALREADY REPORTED OR SUBMITTED.—To

1 the extent that information reported by a facil-
2 ity to the Internal Revenue Service on Form
3 990, information submitted by a facility to the
4 Securities and Exchange Commission, or infor-
5 mation otherwise submitted to the Secretary or
6 any other Federal agency contains the informa-
7 tion described in clauses (i), (ii), or (iii) of sub-
8 paragraph (A), the facility may provide such
9 Form or such information submitted to meet
10 the requirements of paragraph (1).

11 “(C) SPECIAL RULE.—In applying sub-
12 paragraph (A)(i)—

13 “(i) with respect to subsections (a)
14 and (b), ‘ownership or control interest’
15 shall include direct or indirect interests, in-
16 cluding such interests in intermediate enti-
17 ties; and

18 “(ii) subsection (a)(3)(A)(ii) shall in-
19 clude the owner of a whole or part interest
20 in any mortgage, deed of trust, note, or
21 other obligation secured, in whole or in
22 part, by the entity or any of the property
23 or assets thereof, if the interest is equal to
24 or exceeds 5 percent of the total property
25 or assets of the entirety.

1 “(3) REPORTING.—

2 “(A) IN GENERAL.—Not later than the
3 date that is 2 years after the date of the enact-
4 ment of this subsection, the Secretary shall pro-
5 mulgate final regulations requiring, effective on
6 the date that is 90 days after the date on which
7 such final regulations are published in the Fed-
8 eral Register, a facility to report the informa-
9 tion described in paragraph (2) to the Secretary
10 in a standardized format, and such other regu-
11 lations as are necessary to carry out this sub-
12 section. Such final regulations shall ensure that
13 the facility certifies, as a condition of participa-
14 tion and payment under the program under
15 title XVIII or XIX, that the information re-
16 ported by the facility in accordance with such
17 final regulations is, to the maximum extent
18 practicable (as determined by the facility), ac-
19 curate and current.

20 “(B) GUIDANCE.—The Secretary shall pro-
21 vide guidance and technical assistance to States
22 on how to adopt the standardized format under
23 subparagraph (A).

24 “(4) NO EFFECT ON EXISTING REPORTING RE-
25 QUIREMENTS.—Nothing in this subsection shall re-

1 duce, diminish, or alter any reporting requirement
2 for a facility that is in effect as of the date of the
3 enactment of this subsection.

4 “(5) DEFINITIONS.—In this subsection:

5 “(A) ADDITIONAL DISCLOSABLE PARTY.—

6 The term ‘additional disclosable party’ means,
7 with respect to a facility, any person or entity
8 who—

9 “(i) exercises operational, financial, or
10 managerial control over the facility or a
11 part thereof, or provides policies or proce-
12 dures for any of the operations of the facil-
13 ity, or provides financial or cash manage-
14 ment services to the facility;

15 “(ii) leases or subleases real property
16 to the facility, or owns a whole or part in-
17 terest equal to or exceeding 5 percent of
18 the total value of such real property; or

19 “(iii) provides management or admin-
20 istrative services, management or clinical
21 consulting services, or accounting or finan-
22 cial services to the facility.

23 “(B) FACILITY.—The term ‘facility’ means
24 a disclosing entity which is—

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1 “(i) a skilled nursing facility (as de-
2 fined in section 1819(a)); or

3 “(ii) a nursing facility (as defined in
4 section 1919(a)).

5 “(C) MANAGING EMPLOYEE.—The term
6 ‘managing employee’ means, with respect to a
7 facility, an individual (including a general man-
8 ager, business manager, administrator, director,
9 or consultant) who directly or indirectly man-
10 ages, advises, or supervises any element of the
11 practices, finances, or operations of the facility.

12 “(D) ORGANIZATIONAL STRUCTURE.—The
13 term ‘organizational structure’ means, in the
14 case of—

15 “(i) a corporation, the officers, direc-
16 tors, and shareholders of the corporation
17 who have an ownership interest in the cor-
18 poration which is equal to or exceeds 5
19 percent;

20 “(ii) a limited liability company, the
21 members and managers of the limited li-
22 ability company (including, as applicable,
23 what percentage each member and man-
24 ager has of the ownership interest in the
25 limited liability company);

1 “(iii) a general partnership, the part-
2 ners of the general partnership;

3 “(iv) a limited partnership, the gen-
4 eral partners and any limited partners of
5 the limited partnership who have an own-
6 ership interest in the limited partnership
7 which is equal to or exceeds 10 percent;

8 “(v) a trust, the trustees of the trust;

9 “(vi) an individual, contact informa-
10 tion for the individual; and

11 “(vii) any other person or entity, such
12 information as the Secretary determines
13 appropriate.”.

14 (b) PUBLIC AVAILABILITY OF INFORMATION.—Not
15 later than the date that is 1 year after the date on which
16 the final regulations promulgated under section
17 1124(c)(3)(A) of the Social Security Act, as added by sub-
18 section (a), are published in the Federal Register, the Sec-
19 retary of Health and Human Services shall make the in-
20 formation reported in accordance with such final regula-
21 tions available to the public in accordance with procedures
22 established by the Secretary.

23 (c) CONFORMING AMENDMENTS.—

24 (1) IN GENERAL.—

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1 (A) SKILLED NURSING FACILITIES.—Sec-
2 tion 1819(d)(1) of the Social Security Act (42
3 U.S.C. 1395i–3(d)(1)) is amended by striking
4 subparagraph (B) and redesignating subpara-
5 graph (C) as subparagraph (B).

6 (B) NURSING FACILITIES.—Section
7 1919(d)(1) of the Social Security Act (42
8 U.S.C. 1396r(d)(1)) is amended by striking
9 subparagraph (B) and redesignating subpara-
10 graph (C) as subparagraph (B).

11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall take effect on the date on
13 which the Secretary makes the information described
14 in subsection (b)(1) available to the public under
15 such subsection.

16 **SEC. 4202. ACCOUNTABILITY REQUIREMENTS FOR SKILLED**
17 **NURSING FACILITIES AND NURSING FACILI-**
18 **TIES.**

19 Part A of title XI of the Social Security Act (42
20 U.S.C. 1301 et seq.), as amended by section 4103, is
21 amended by inserting after section 1128H the following
22 new section:

1 **“SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILI-**
2 **TIES.**

3 “(a) DEFINITION OF FACILITY.—In this section, the
4 term ‘facility’ means—

5 “(1) a skilled nursing facility (as defined in sec-
6 tion 1819(a)); or

7 “(2) a nursing facility (as defined in section
8 1919(a)).

9 “(b) EFFECTIVE COMPLIANCE AND ETHICS PRO-
10 GRAMS.—

11 “(1) REQUIREMENT.—On or after the date that
12 is 36 months after the date of the enactment of this
13 section, a facility shall, with respect to the entity
14 that operates the facility (in this subparagraph re-
15 ferred to as the ‘operating organization’ or ‘organi-
16 zation’), have in operation a compliance and ethics
17 program that is effective in preventing and detecting
18 criminal, civil, and administrative violations under
19 this Act and in promoting quality of care consistent
20 with regulations developed under paragraph (2).

21 “(2) DEVELOPMENT OF REGULATIONS.—

22 “(A) IN GENERAL.—Not later than the
23 date that is 2 years after such date of the en-
24 actment, the Secretary, working jointly with the
25 Inspector General of the Department of Health
26 and Human Services, shall promulgate regula-

1 tions for an effective compliance and ethics pro-
2 gram for operating organizations, which may
3 include a model compliance program.

4 “(B) DESIGN OF REGULATIONS.—Such
5 regulations with respect to specific elements or
6 formality of a program may vary with the size
7 of the organization, such that larger organiza-
8 tions should have a more formal program and
9 include established written policies defining the
10 standards and procedures to be followed by its
11 employees. Such requirements may specifically
12 apply to the corporate level management of
13 multi unit nursing home chains.

14 “(C) EVALUATION.—Not later than 3
15 years after the date of the promulgation of reg-
16 ulations under this paragraph, the Secretary
17 shall complete an evaluation of the compliance
18 and ethics programs required to be established
19 under this subsection. Such evaluation shall de-
20 termine if such programs led to changes in defi-
21 ciency citations, changes in quality perform-
22 ance, or changes in other metrics of patient
23 quality of care. The Secretary shall submit to
24 Congress a report on such evaluation and shall
25 include in such report such recommendations

1 regarding changes in the requirements for such
2 programs as the Secretary determines appro-
3 priate.

4 “(3) REQUIREMENTS FOR COMPLIANCE AND
5 ETHICS PROGRAMS.—In this subsection, the term
6 ‘compliance and ethics program’ means, with respect
7 to a facility, a program of the operating organization
8 that—

9 “(A) has been reasonably designed, imple-
10 mented, and enforced so that it generally will be
11 effective in preventing and detecting criminal,
12 civil, and administrative violations under this
13 Act and in promoting quality of care; and

14 “(B) includes at least the required compo-
15 nents specified in paragraph (4).

16 “(4) REQUIRED COMPONENTS OF PROGRAM.—
17 The required components of a compliance and ethics
18 program of an operating organization are the fol-
19 lowing:

20 “(A) The organization must have estab-
21 lished compliance standards and procedures to
22 be followed by its employees and other agents
23 that are reasonably capable of reducing the
24 prospect of criminal, civil, and administrative
25 violations under this Act.

1 “(B) Specific individuals within high-level
2 personnel of the organization must have been
3 assigned overall responsibility to oversee compli-
4 ance with such standards and procedures and
5 have sufficient resources and authority to as-
6 sure such compliance.

7 “(C) The organization must have used due
8 care not to delegate substantial discretionary
9 authority to individuals whom the organization
10 knew, or should have known through the exer-
11 cise of due diligence, had a propensity to en-
12 gage in criminal, civil, and administrative viola-
13 tions under this Act.

14 “(D) The organization must have taken
15 steps to communicate effectively its standards
16 and procedures to all employees and other
17 agents, such as by requiring participation in
18 training programs or by disseminating publica-
19 tions that explain in a practical manner what is
20 required.

21 “(E) The organization must have taken
22 reasonable steps to achieve compliance with its
23 standards, such as by utilizing monitoring and
24 auditing systems reasonably designed to detect
25 criminal, civil, and administrative violations

1 under this Act by its employees and other
2 agents and by having in place and publicizing
3 a reporting system whereby employees and
4 other agents could report violations by others
5 within the organization without fear of retribu-
6 tion.

7 “(F) The standards must have been con-
8 sistently enforced through appropriate discipli-
9 nary mechanisms, including, as appropriate,
10 discipline of individuals responsible for the fail-
11 ure to detect an offense.

12 “(G) After an offense has been detected,
13 the organization must have taken all reasonable
14 steps to respond appropriately to the offense
15 and to prevent further similar offenses, includ-
16 ing any necessary modification to its program
17 to prevent and detect criminal, civil, and admin-
18 istrative violations under this Act.

19 “(H) The organization must periodically
20 undertake reassessment of its compliance pro-
21 gram to identify changes necessary to reflect
22 changes within the organization and its facili-
23 ties.

24 “(c) QUALITY ASSURANCE AND PERFORMANCE IM-
25 PROVEMENT PROGRAM.—

1 “(1) IN GENERAL.—Not later than December
2 31, 2011, the Secretary shall establish and imple-
3 ment a quality assurance and performance improve-
4 ment program (in this subparagraph referred to as
5 the ‘QAPI program’) for facilities, including multi
6 unit chains of facilities. Under the QAPI program,
7 the Secretary shall establish standards relating to
8 quality assurance and performance improvement
9 with respect to facilities and provide technical assist-
10 ance to facilities on the development of best prac-
11 tices in order to meet such standards. Not later than
12 1 year after the date on which the regulations are
13 promulgated under paragraph (2), a facility must
14 submit to the Secretary a plan for the facility to
15 meet such standards and implement such best prac-
16 tices, including how to coordinate the implementa-
17 tion of such plan with quality assessment and assur-
18 ance activities conducted under sections
19 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

20 “(2) REGULATIONS.—The Secretary shall pro-
21 mulgate regulations to carry out this subsection.”.

22 **SEC. 4203. NURSING HOME COMPARE MEDICARE WEBSITE.**

23 (a) **SKILLED NURSING FACILITIES.**—

24 (1) IN GENERAL.—Section 1819 of the Social
25 Security Act (42 U.S.C. 1395i–3) is amended—

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1 (A) by redesignating subsection (i) as sub-
2 section (j); and

3 (B) by inserting after subsection (h) the
4 following new subsection:

5 “(i) NURSING HOME COMPARE WEBSITE.—

6 “(1) INCLUSION OF ADDITIONAL INFORMA-
7 TION.—

8 “(A) IN GENERAL.—The Secretary shall
9 ensure that the Department of Health and
10 Human Services includes, as part of the infor-
11 mation provided for comparison of nursing
12 homes on the official Internet website of the
13 Federal Government for Medicare beneficiaries
14 (commonly referred to as the ‘Nursing Home
15 Compare’ Medicare website) (or a successor
16 website), the following information in a manner
17 that is prominent, easily accessible, readily un-
18 derstandable to consumers of long-term care
19 services, and searchable:

20 “(i) Information that is reported to
21 the Secretary under section 1124(c)(3).

22 “(ii) Information on the ‘Special
23 Focus Facility program’ (or a successor
24 program) established by the Centers for
25 Medicare and Medicaid Services, according

1 to procedures established by the Secretary.
2 Such procedures shall provide for the in-
3 clusion of information with respect to, and
4 the names and locations of, those facilities
5 that, since the previous quarter—

6 “(I) were newly enrolled in the
7 program;

8 “(II) are enrolled in the program
9 and have failed to significantly im-
10 prove;

11 “(III) are enrolled in the pro-
12 gram and have significantly improved;

13 “(IV) have graduated from the
14 program; and

15 “(V) have closed voluntarily or
16 no longer participate under this title.

17 “(iii) Staffing data for each facility
18 (including resident census data and data
19 on the hours of care provided per resident
20 per day) based on data submitted under
21 section 1128I(g), including information on
22 staffing turnover and tenure, in a format
23 that is clearly understandable to con-
24 sumers of long-term care services and al-
25 lows such consumers to compare dif-

1 ferences in staffing between facilities and
2 State and national averages for the facili-
3 ties. Such format shall include—

4 “**(I)** concise explanations of how
5 to interpret the data (such as a plain
6 English explanation of data reflecting
7 ‘nursing home staff hours per resident
8 day’);

9 “**(II)** differences in types of staff
10 (such as training associated with dif-
11 ferent categories of staff);

12 “**(III)** the relationship between
13 nurse staffing levels and quality of
14 care; and

15 “**(IV)** an explanation that appro-
16 priate staffing levels vary based on
17 patient case mix.

18 “(iv) Links to State Internet websites
19 with information regarding State survey
20 and certification programs, links to Form
21 2567 State inspection reports (or a suc-
22 cessor form) on such websites, information
23 to guide consumers in how to interpret and
24 understand such reports, and the facility

1 plan of correction or other response to
2 such report.

3 “(v) The standardized complaint form
4 developed under section 1128I(f), including
5 explanatory material on what complaint
6 forms are, how they are used, and how to
7 file a complaint with the State survey and
8 certification program and the State long-
9 term care ombudsman program.

10 “(vi) Summary information on the
11 number, type, severity, and outcome of
12 substantiated complaints.

13 “(vii) The number of adjudicated in-
14 stances of criminal violations by a facility
15 or the employees of a facility—

16 “(I) that were committed inside
17 the facility;

18 “(II) with respect to such in-
19 stances of violations or crimes com-
20 mitted inside of the facility that were
21 the violations or crimes of abuse, ne-
22 glect, and exploitation, criminal sexual
23 abuse, or other violations or crimes
24 that resulted in serious bodily injury;
25 and

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1 “(III) the number of civil mone-
2 tary penalties levied against the facil-
3 ity, employees, contractors, and other
4 agents.

5 “(B) DEADLINE FOR PROVISION OF INFOR-
6 MATION.—

7 “(i) IN GENERAL.—Except as pro-
8 vided in clause (ii), the Secretary shall en-
9 sure that the information described in sub-
10 paragraph (A) is included on such website
11 (or a successor website) not later than 1
12 year after the date of the enactment of this
13 subsection.

14 “(ii) EXCEPTION.—The Secretary
15 shall ensure that the information described
16 in subparagraph (A)(i) and (A)(iii) is in-
17 cluded on such website (or a successor
18 website) not later than the date on which
19 the requirements under section 1124(e)(3)
20 and section 1128I(g) are implemented.

21 “(2) REVIEW AND MODIFICATION OF
22 WEBSITE.—

23 “(A) IN GENERAL.—The Secretary shall
24 establish a process—

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1 “(i) to review the accuracy, clarity of
2 presentation, timeliness, and comprehen-
3 siveness of information reported on such
4 website as of the day before the date of the
5 enactment of this subsection; and

6 “(ii) not later than 1 year after the
7 date of the enactment of this subsection, to
8 modify or revamp such website in accord-
9 ance with the review conducted under
10 clause (i).

11 “(B) CONSULTATION.—In conducting the
12 review under subparagraph (A)(i), the Sec-
13 retary shall consult with—

14 “(i) State long-term care ombudsman
15 programs;

16 “(ii) consumer advocacy groups;

17 “(iii) provider stakeholder groups; and

18 “(iv) any other representatives of pro-
19 grams or groups the Secretary determines
20 appropriate.”.

21 (2) TIMELINESS OF SUBMISSION OF SURVEY
22 AND CERTIFICATION INFORMATION.—

23 (A) IN GENERAL.—Section 1819(g)(5) of
24 the Social Security Act (42 U.S.C. 1395i-

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1 3(g)(5)) is amended by adding at the end the
2 following new subparagraph:

3 “(E) SUBMISSION OF SURVEY AND CER-
4 TIFICATION INFORMATION TO THE SEC-
5 RETARY.—In order to improve the timeliness of
6 information made available to the public under
7 subparagraph (A) and provided on the Nursing
8 Home Compare Medicare website under sub-
9 section (i), each State shall submit information
10 respecting any survey or certification made re-
11 specting a skilled nursing facility (including any
12 enforcement actions taken by the State) to the
13 Secretary not later than the date on which the
14 State sends such information to the facility.
15 The Secretary shall use the information sub-
16 mitted under the preceding sentence to update
17 the information provided on the Nursing Home
18 Compare Medicare website as expeditiously as
19 practicable but not less frequently than quar-
20 terly.”.

21 (B) EFFECTIVE DATE.—The amendment
22 made by this paragraph shall take effect 1 year
23 after the date of the enactment of this Act.

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1 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
2 tion 1819(f) of such Act is amended by adding at
3 the end the following new paragraph:

4 “(8) SPECIAL FOCUS FACILITY PROGRAM.—

5 “(A) IN GENERAL.—The Secretary shall
6 conduct a special focus facility program for en-
7 forcement of requirements for skilled nursing
8 facilities that the Secretary has identified as
9 having substantially failed to meet applicable
10 requirement of this Act.

11 “(B) PERIODIC SURVEYS.—Under such
12 program the Secretary shall conduct surveys of
13 each facility in the program not less than once
14 every 6 months.”.

15 (b) NURSING FACILITIES.—

16 (1) IN GENERAL.—Section 1919 of the Social
17 Security Act (42 U.S.C. 1396r) is amended—

18 (A) by redesignating subsection (i) as sub-
19 section (j); and

20 (B) by inserting after subsection (h) the
21 following new subsection:

22 “(i) NURSING HOME COMPARE WEBSITE.—

23 “(1) INCLUSION OF ADDITIONAL INFORMA-
24 TION.—

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1 “(A) IN GENERAL.—The Secretary shall
2 ensure that the Department of Health and
3 Human Services includes, as part of the infor-
4 mation provided for comparison of nursing
5 homes on the official Internet website of the
6 Federal Government for Medicare beneficiaries
7 (commonly referred to as the ‘Nursing Home
8 Compare’ Medicare website) (or a successor
9 website), the following information in a manner
10 that is prominent, easily accessible, readily un-
11 derstandable to consumers of long-term care
12 services, and searchable:

13 “(i) Staffing data for each facility (in-
14 cluding resident census data and data on
15 the hours of care provided per resident per
16 day) based on data submitted under sec-
17 tion 1128I(g), including information on
18 staffing turnover and tenure, in a format
19 that is clearly understandable to con-
20 sumers of long-term care services and al-
21 lows such consumers to compare dif-
22 ferences in staffing between facilities and
23 State and national averages for the facili-
24 ties. Such format shall include—

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1 “(I) concise explanations of how
2 to interpret the data (such as plain
3 English explanation of data reflecting
4 ‘nursing home staff hours per resident
5 day’);

6 “(II) differences in types of staff
7 (such as training associated with dif-
8 ferent categories of staff);

9 “(III) the relationship between
10 nurse staffing levels and quality of
11 care; and

12 “(IV) an explanation that appro-
13 priate staffing levels vary based on
14 patient case mix.

15 “(ii) Links to State Internet websites
16 with information regarding State survey
17 and certification programs, links to Form
18 2567 State inspection reports (or a suc-
19 cessor form) on such websites, information
20 to guide consumers in how to interpret and
21 understand such reports, and the facility
22 plan of correction or other response to
23 such report.

24 “(iii) The standardized complaint
25 form developed under section 1128I(f), in-

1 including explanatory material on what com-
2 plaint forms are, how they are used, and
3 how to file a complaint with the State sur-
4 vey and certification program and the
5 State long-term care ombudsman program.

6 “(iv) Summary information on the
7 number, type, severity, and outcome of
8 substantiated complaints.

9 “(v) The number of adjudicated in-
10 stances of criminal violations by a facility
11 or the employees of a facility—

12 “(I) that were committed inside
13 of the facility; and

14 “(II) with respect to such in-
15 stances of violations or crimes com-
16 mitted outside of the facility, that
17 were violations or crimes that resulted
18 in the serious bodily injury of an
19 elder.

20 “(B) DEADLINE FOR PROVISION OF INFOR-
21 MATION.—

22 “(i) IN GENERAL.—Except as pro-
23 vided in clause (ii), the Secretary shall en-
24 sure that the information described in sub-
25 paragraph (A) is included on such website

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1 (or a successor website) not later than 1
2 year after the date of the enactment of this
3 subsection.

4 “(ii) EXCEPTION.—The Secretary
5 shall ensure that the information described
6 in subparagraph (A)(i) is included on such
7 website (or a successor website) not later
8 than the date on which the requirements
9 under section 1128I(g) are implemented.

10 “(2) REVIEW AND MODIFICATION OF
11 WEBSITE.—

12 “(A) IN GENERAL.—The Secretary shall
13 establish a process—

14 “(i) to review the accuracy, clarity of
15 presentation, timeliness, and comprehen-
16 siveness of information reported on such
17 website as of the day before the date of the
18 enactment of this subsection; and

19 “(ii) not later than 1 year after the
20 date of the enactment of this subsection, to
21 modify or revamp such website in accord-
22 ance with the review conducted under
23 clause (i).

1 “(B) CONSULTATION.—In conducting the
2 review under subparagraph (A)(i), the Sec-
3 retary shall consult with—

4 “(i) State long-term care ombudsman
5 programs;

6 “(ii) consumer advocacy groups;

7 “(iii) provider stakeholder groups;

8 “(iv) skilled nursing facility employees
9 and their representatives; and

10 “(v) any other representatives of pro-
11 grams or groups the Secretary determines
12 appropriate.”.

13 (2) TIMELINESS OF SUBMISSION OF SURVEY
14 AND CERTIFICATION INFORMATION.—

15 (A) IN GENERAL.—Section 1919(g)(5) of
16 the Social Security Act (42 U.S.C. 1396r(g)(5))
17 is amended by adding at the end the following
18 new subparagraph:

19 “(E) SUBMISSION OF SURVEY AND CER-
20 TIFICATION INFORMATION TO THE SEC-
21 RETARY.—In order to improve the timeliness of
22 information made available to the public under
23 subparagraph (A) and provided on the Nursing
24 Home Compare Medicare website under sub-
25 section (i), each State shall submit information

1 respecting any survey or certification made re-
2 specting a nursing facility (including any en-
3 forcement actions taken by the State) to the
4 Secretary not later than the date on which the
5 State sends such information to the facility.
6 The Secretary shall use the information sub-
7 mitted under the preceding sentence to update
8 the information provided on the Nursing Home
9 Compare Medicare website as expeditiously as
10 practicable but not less frequently than quar-
11 terly.”.

12 (B) EFFECTIVE DATE.—The amendment
13 made by this paragraph shall take effect 1 year
14 after the date of the enactment of this Act.

15 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
16 tion 1919(f) of such Act is amended by adding at
17 the end of the following new paragraph:

18 “(10) SPECIAL FOCUS FACILITY PROGRAM.—

19 “(A) IN GENERAL.—The Secretary shall
20 conduct a special focus facility program for en-
21 forcement of requirements for nursing facilities
22 that the Secretary has identified as having sub-
23 stantially failed to meet applicable requirements
24 of this Act.

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1 “(B) PERIODIC SURVEYS.—Under such
2 program the Secretary shall conduct surveys of
3 each facility in the program not less often than
4 once every 6 months.”.

5 (c) AVAILABILITY OF REPORTS ON SURVEYS, CER-
6 TIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

7 (1) SKILLED NURSING FACILITIES.—Section
8 1819(d)(1) of the Social Security Act (42 U.S.C.
9 1395i–3(d)(1)), as amended by section 4201, is
10 amended by adding at the end the following new
11 subparagraph:

12 “(C) AVAILABILITY OF SURVEY, CERTIFI-
13 CATION, AND COMPLAINT INVESTIGATION RE-
14 PORTS.—A skilled nursing facility must—

15 “(i) have reports with respect to any
16 surveys, certifications, and complaint in-
17 vestigations made respecting the facility
18 during the 3 preceding years available for
19 any individual to review upon request; and

20 “(ii) post notice of the availability of
21 such reports in areas of the facility that
22 are prominent and accessible to the public.

23 The facility shall not make available under
24 clause (i) identifying information about com-
25 plainants or residents.”.

1 (2) NURSING FACILITIES.—Section 1919(d)(1)
2 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
3 as amended by section 4201, is amended by adding
4 at the end the following new subparagraph:

5 “(V) AVAILABILITY OF SURVEY, CERTIFI-
6 CATION, AND COMPLAINT INVESTIGATION RE-
7 PORTS.—A nursing facility must—

8 “(i) have reports with respect to any
9 surveys, certifications, and complaint in-
10 vestigations made respecting the facility
11 during the 3 preceding years available for
12 any individual to review upon request; and

13 “(ii) post notice of the availability of
14 such reports in areas of the facility that
15 are prominent and accessible to the public.

16 The facility shall not make available under
17 clause (i) identifying information about com-
18 plainants or residents.”.

19 (3) EFFECTIVE DATE.—The amendments made
20 by this subsection shall take effect 1 year after the
21 date of the enactment of this Act.

22 (d) GUIDANCE TO STATES ON FORM 2567 STATE IN-
23 SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-
24 PORTS.—

1 (1) GUIDANCE.—The Secretary of Health and
2 Human Services (in this subtitle referred to as the
3 “Secretary”) shall provide guidance to States on
4 how States can establish electronic links to Form
5 2567 State inspection reports (or a successor form),
6 complaint investigation reports, and a facility’s plan
7 of correction or other response to such Form 2567
8 State inspection reports (or a successor form) on the
9 Internet website of the State that provides informa-
10 tion on skilled nursing facilities and nursing facili-
11 ties and the Secretary shall, if possible, include such
12 information on Nursing Home Compare.

13 (2) REQUIREMENT.—Section 1902(a)(9) of the
14 Social Security Act (42 U.S.C. 1396a(a)(9)) is
15 amended—

16 (A) by striking “and” at the end of sub-
17 paragraph (B);

18 (B) by striking the semicolon at the end of
19 subparagraph (C) and inserting “, and”; and

20 (C) by adding at the end the following new
21 subparagraph:

22 “(D) that the State maintain a consumer-
23 oriented website providing useful information to
24 consumers regarding all skilled nursing facili-
25 ties and all nursing facilities in the State, in-

1 including for each facility, Form 2567 State in-
2 spection reports (or a successor form), com-
3 plaint investigation reports, the facility's plan of
4 correction, and such other information that the
5 State or the Secretary considers useful in as-
6 sisting the public to assess the quality of long
7 term care options and the quality of care pro-
8 vided by individual facilities;”.

9 (3) DEFINITIONS.—In this subsection:

10 (A) NURSING FACILITY.—The term “nurs-
11 ing facility” has the meaning given such term
12 in section 1919(a) of the Social Security Act
13 (42 U.S.C. 1396r(a)).

14 (B) SECRETARY.—The term “Secretary”
15 means the Secretary of Health and Human
16 Services.

17 (C) SKILLED NURSING FACILITY.—The
18 term “skilled nursing facility” has the meaning
19 given such term in section 1819(a) of the Social
20 Security Act (42 U.S.C. 1395i-3(a)).

21 (e) DEVELOPMENT OF CONSUMER RIGHTS INFORMA-
22 TION PAGE ON NURSING HOME COMPARE WEBSITE.—
23 Not later than 1 year after the date of enactment of this
24 Act, the Secretary shall ensure that the Department of
25 Health and Human Services, as part of the information

1 provided for comparison of nursing facilities on the Nurs-
2 ing Home Compare Medicare website develops and in-
3 cludes a consumer rights information page that contains
4 links to descriptions of, and information with respect to,
5 the following:

6 (1) The documentation on nursing facilities
7 that is available to the public.

8 (2) General information and tips on choosing a
9 nursing facility that meets the needs of the indi-
10 vidual.

11 (3) General information on consumer rights
12 with respect to nursing facilities.

13 (4) The nursing facility survey process (on a
14 national and State-specific basis).

15 (5) On a State-specific basis, the services avail-
16 able through the State long-term care ombudsman
17 for such State.

18 **SEC. 4204. REPORTING OF EXPENDITURES.**

19 Section 1888 of the Social Security Act (42 U.S.C.
20 1395yy) is amended by adding at the end the following
21 new subsection:

22 “(f) REPORTING OF DIRECT CARE EXPENDI-
23 TURES.—

24 “(1) IN GENERAL.—For cost reports submitted
25 under this title for cost reporting periods beginning

1 on or after the date that is 2 years after the date
2 of the enactment of this subsection, skilled nursing
3 facilities shall separately report expenditures for
4 wages and benefits for direct care staff (breaking
5 out (at a minimum) registered nurses, licensed pro-
6 fessional nurses, certified nurse assistants, and other
7 medical and therapy staff).

8 “(2) MODIFICATION OF FORM.—The Secretary,
9 in consultation with private sector accountants expe-
10 rienced with Medicare and Medicaid nursing facility
11 home cost reports, shall redesign such reports to
12 meet the requirement of paragraph (1) not later
13 than 1 year after the date of the enactment of this
14 subsection.

15 “(3) CATEGORIZATION BY FUNCTIONAL AC-
16 COUNTS.—Not later than 30 months after the date
17 of the enactment of this subsection, the Secretary,
18 working in consultation with the Medicare Payment
19 Advisory Commission, the Medicaid and CHIP Pay-
20 ment and Access Commission, the Inspector General
21 of the Department of Health and Human Services,
22 and other expert parties the Secretary determines
23 appropriate, shall take the expenditures listed on
24 cost reports, as modified under paragraph (1), sub-
25 mitted by skilled nursing facilities and categorize

1 such expenditures, regardless of any source of pay-
2 ment for such expenditures, for each skilled nursing
3 facility into the following functional accounts on an
4 annual basis:

5 “(A) Spending on direct care services (in-
6 cluding nursing, therapy, and medical services).

7 “(B) Spending on indirect care (including
8 housekeeping and dietary services).

9 “(C) Capital assets (including building and
10 land costs).

11 “(D) Administrative services costs.

12 “(4) AVAILABILITY OF INFORMATION SUB-
13 MITTED.—The Secretary shall establish procedures
14 to make information on expenditures submitted
15 under this subsection readily available to interested
16 parties upon request, subject to such requirements
17 as the Secretary may specify under the procedures
18 established under this paragraph.”.

19 **SEC. 4205. STANDARDIZED COMPLAINT FORM.**

20 (a) IN GENERAL.—Section 1128I of the Social Secu-
21 rity Act, as added and amended by this Act, is amended
22 by adding at the end the following new subsection:

23 “(f) STANDARDIZED COMPLAINT FORM.—

24 “(1) DEVELOPMENT BY THE SECRETARY.—The
25 Secretary shall develop a standardized complaint

1 form for use by a resident (or a person acting on the
2 resident's behalf) in filing a complaint with a State
3 survey and certification agency and a State long-
4 term care ombudsman program with respect to a fa-
5 cility.

6 “(2) COMPLAINT FORMS AND RESOLUTION
7 PROCESSES.—

8 “(A) COMPLAINT FORMS.—The State must
9 make the standardized complaint form devel-
10 oped under paragraph (1) available upon re-
11 quest to—

12 “(i) a resident of a facility; and

13 “(ii) any person acting on the resi-
14 dent's behalf.

15 “(B) COMPLAINT RESOLUTION PROCESS.—

16 The State must establish a complaint resolution
17 process in order to ensure that the legal rep-
18 resentative of a resident of a facility or other
19 responsible party is not denied access to such
20 resident or otherwise retaliated against if they
21 have complained about the quality of care pro-
22 vided by the facility or other issues relating to
23 the facility. Such complaint resolution process
24 shall include—

1 “(i) procedures to assure accurate
2 tracking of complaints received, including
3 notification to the complainant that a com-
4 plaint has been received;

5 “(ii) procedures to determine the like-
6 ly severity of a complaint and for the in-
7 vestigation of the complaint; and

8 “(iii) deadlines for responding to a
9 complaint and for notifying the complain-
10 ant of the outcome of the investigation.

11 “(3) RULE OF CONSTRUCTION.—Nothing in
12 this subsection shall be construed as preventing a
13 resident of a facility (or a person acting on the resi-
14 dent’s behalf) from submitting a complaint in a
15 manner or format other than by using the standard-
16 ized complaint form developed under paragraph (1)
17 (including submitting a complaint orally).”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 this section shall take effect 1 year after the date of the
20 enactment of this Act.

21 **SEC. 4206. ENSURING STAFFING ACCOUNTABILITY.**

22 Section 1128I of the Social Security Act, as added
23 and amended by this Act, is amended by adding at the
24 end the following new subsection:

1 “(g) SUBMISSION OF STAFFING INFORMATION
2 BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Be-
3 ginning not later than 2 years after the date of the enact-
4 ment of this subsection, and after consulting with State
5 long-term care ombudsman programs, consumer advocacy
6 groups, provider stakeholder groups, employees and their
7 representatives, and other parties the Secretary deems ap-
8 propriate, the Secretary shall require a facility to elec-
9 tronically submit to the Secretary direct care staffing in-
10 formation (including information with respect to agency
11 and contract staff) based on payroll and other verifiable
12 and auditable data in a uniform format (according to spec-
13 ifications established by the Secretary in consultation with
14 such programs, groups, and parties). Such specifications
15 shall require that the information submitted under the
16 preceding sentence—

17 “(1) specify the category of work a certified em-
18 ployee performs (such as whether the employee is a
19 registered nurse, licensed practical nurse, licensed
20 vocational nurse, certified nursing assistant, thera-
21 pist, or other medical personnel);

22 “(2) include resident census data and informa-
23 tion on resident case mix;

24 “(3) include a regular reporting schedule; and

1 “(4) include information on employee turnover
2 and tenure and on the hours of care provided by
3 each category of certified employees referenced in
4 paragraph (1) per resident per day.

5 Nothing in this subsection shall be construed as pre-
6 venting the Secretary from requiring submission of such
7 information with respect to specific categories, such as
8 nursing staff, before other categories of certified employ-
9 ees. Information under this subsection with respect to
10 agency and contract staff shall be kept separate from in-
11 formation on employee staffing.”.

12 **SEC. 4207. GAO STUDY AND REPORT ON FIVE-STAR QUAL-**
13 **ITY RATING SYSTEM.**

14 (a) STUDY.—The Comptroller General of the United
15 States (in this section referred to as the “Comptroller
16 General”) shall conduct a study on the Five-Star Quality
17 Rating System for nursing homes of the Centers for Medi-
18 care & Medicaid Services. Such study shall include an
19 analysis of—

20 (1) how such system is being implemented;

21 (2) any problems associated with such system
22 or its implementation; and

23 (3) how such system could be improved.

24 (b) REPORT.—Not later than 2 years after the date
25 of enactment of this Act, the Comptroller General shall

1 submit to Congress a report containing the results of the
2 study conducted under subsection (a), together with rec-
3 ommendations for such legislation and administrative ac-
4 tion as the Comptroller General determines appropriate.

5 **PART II—TARGETING ENFORCEMENT**

6 **SEC. 4211. CIVIL MONEY PENALTIES.**

7 (a) SKILLED NURSING FACILITIES.—

8 (1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of
9 the Social Security Act (42 U.S.C. 1395i-
10 3(h)(2)(B)(ii)) is amended—

11 (A) by striking “PENALTIES.—The Sec-
12 retary” and inserting “PENALTIES.—

13 “(I) IN GENERAL.—Subject to
14 subclause (II), the Secretary”; and

15 (B) by adding at the end the following new
16 subclauses:

17 “(II) REDUCTION OF CIVIL
18 MONEY PENALTIES IN CERTAIN CIR-
19 CUMSTANCES.—Subject to subclause
20 (III), in the case where a facility self-
21 reports and promptly corrects a defi-
22 ciency for which a penalty was im-
23 posed under this clause not later than
24 10 calendar days after the date of
25 such imposition, the Secretary may

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1 reduce the amount of the penalty im-
2 posed by not more than 50 percent.

3 “(III) PROHIBITIONS ON REDUC-
4 TION FOR CERTAIN DEFICIENCIES.—

5 “(aa) REPEAT DEFICI-
6 CIENCIES.—The Secretary may
7 not reduce the amount of a pen-
8 alty under subclause (II) if the
9 Secretary had reduced a penalty
10 imposed on the facility in the
11 preceding year under such sub-
12 clause with respect to a repeat
13 deficiency.

14 “(bb) CERTAIN OTHER DE-
15 FICIENCIES.—The Secretary may
16 not reduce the amount of a pen-
17 alty under subclause (II) if the
18 penalty is imposed on the facility
19 for a deficiency that is found to
20 result in a pattern of harm or
21 widespread harm, immediately
22 jeopardizes the health or safety
23 of a resident or residents of the
24 facility, or results in the death of
25 a resident of the facility.

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1 “(IV) COLLECTION OF CIVIL
2 MONEY PENALTIES.—In the case of a
3 civil money penalty imposed under
4 this clause, the Secretary shall issue
5 regulations that—

6 “(aa) subject to item (cc),
7 not later than 30 days after the
8 imposition of the penalty, provide
9 for the facility to have the oppor-
10 tunity to participate in an inde-
11 pendent informal dispute resolu-
12 tion process which generates a
13 written record prior to the collec-
14 tion of such penalty;

15 “(bb) in the case where the
16 penalty is imposed for each day
17 of noncompliance, provide that a
18 penalty may not be imposed for
19 any day during the period begin-
20 ning on the initial day of the im-
21 position of the penalty and end-
22 ing on the day on which the in-
23 formal dispute resolution process
24 under item (aa) is completed;

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1 “(cc) may provide for the
2 collection of such civil money
3 penalty and the placement of
4 such amounts collected in an es-
5 crow account under the direction
6 of the Secretary on the earlier of
7 the date on which the informal
8 dispute resolution process under
9 item (aa) is completed or the
10 date that is 90 days after the
11 date of the imposition of the pen-
12 alty;

13 “(dd) may provide that such
14 amounts collected are kept in
15 such account pending the resolu-
16 tion of any subsequent appeals;

17 “(ee) in the case where the
18 facility successfully appeals the
19 penalty, may provide for the re-
20 turn of such amounts collected
21 (plus interest) to the facility; and

22 “(ff) in the case where all
23 such appeals are unsuccessful,
24 may provide that some portion of
25 such amounts collected may be

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1 used to support activities that
2 benefit residents, including as-
3 sistance to support and protect
4 residents of a facility that closes
5 (voluntarily or involuntarily) or is
6 decertified (including offsetting
7 costs of relocating residents to
8 home and community-based set-
9 tings or another facility), projects
10 that support resident and family
11 councils and other consumer in-
12 volvement in assuring quality
13 care in facilities, and facility im-
14 provement initiatives approved by
15 the Secretary (including joint
16 training of facility staff and sur-
17 veyors, technical assistance for
18 facilities implementing quality as-
19 surance programs, the appoint-
20 ment of temporary management
21 firms, and other activities ap-
22 proved by the Secretary).”.

23 (2) CONFORMING AMENDMENT.—The second
24 sentence of section 1819(h)(5) of the Social Security

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1 Act (42 U.S.C. 1395i-3(h)(5)) is amended by insert-
2 ing “(ii)(IV),” after “(i),”.

3 (b) NURSING FACILITIES.—

4 (1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of
5 the Social Security Act (42 U.S.C. 1396r(h)(3)(C))
6 is amended—

7 (A) by striking “PENALTIES.—The Sec-
8 retary” and inserting “PENALTIES.—

9 “(I) IN GENERAL.—Subject to
10 subclause (II), the Secretary”; and

11 (B) by adding at the end the following new
12 subclauses:

13 “(II) REDUCTION OF CIVIL
14 MONEY PENALTIES IN CERTAIN CIR-
15 CUMSTANCES.—Subject to subclause
16 (III), in the case where a facility self-
17 reports and promptly corrects a defi-
18 ciency for which a penalty was im-
19 posed under this clause not later than
20 10 calendar days after the date of
21 such imposition, the Secretary may
22 reduce the amount of the penalty im-
23 posed by not more than 50 percent.

24 “(III) PROHIBITIONS ON REDUC-
25 TION FOR CERTAIN DEFICIENCIES.—

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1 “(aa) REPEAT DEFI-
2 CIENCIES.—The Secretary may
3 not reduce the amount of a pen-
4 alty under subclause (II) if the
5 Secretary had reduced a penalty
6 imposed on the facility in the
7 preceding year under such sub-
8 clause with respect to a repeat
9 deficiency.

10 “(bb) CERTAIN OTHER DE-
11 FICIENCIES.—The Secretary may
12 not reduce the amount of a pen-
13 alty under subclause (II) if the
14 penalty is imposed on the facility
15 for a deficiency that is found to
16 result in a pattern of harm or
17 widespread harm, immediately
18 jeopardizes the health or safety
19 of a resident or residents of the
20 facility, or results in the death of
21 a resident of the facility.

22 “(IV) COLLECTION OF CIVIL
23 MONEY PENALTIES.—In the case of a
24 civil money penalty imposed under

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1 this clause, the Secretary shall issue
2 regulations that—

3 “(aa) subject to item (cc),
4 not later than 30 days after the
5 imposition of the penalty, provide
6 for the facility to have the oppor-
7 tunity to participate in an inde-
8 pendent informal dispute resolu-
9 tion 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
14 of noncompliance, provide that a
15 penalty may not be imposed for
16 any day during the period begin-
17 ning on the initial day of the im-
18 position of the penalty and end-
19 ing on the day on which the in-
20 formal dispute resolution process
21 under item (aa) is completed;

22 “(cc) may provide for the
23 collection of such civil money
24 penalty and the placement of
25 such amounts collected in an es-

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1 crow account under the direction
2 of the Secretary on the earlier of
3 the date on which the informal
4 dispute resolution process under
5 item (aa) is completed or the
6 date that is 90 days after the
7 date of the imposition of the pen-
8 alty;

9 “(dd) may provide that such
10 amounts collected are kept in
11 such account pending the resolu-
12 tion of any subsequent appeals;

13 “(ee) in the case where the
14 facility successfully appeals the
15 penalty, may provide for the re-
16 turn of such amounts collected
17 (plus interest) to the facility; and

18 “(ff) in the case where all
19 such appeals are unsuccessful,
20 may provide that some portion of
21 such amounts collected may be
22 used to support activities that
23 benefit residents, including as-
24 sistance to support and protect
25 residents of a facility that closes

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1 (voluntarily or involuntarily) or is
2 decertified (including offsetting
3 costs of relocating residents to
4 home and community-based set-
5 tings or another facility), projects
6 that support resident and family
7 councils and other consumer in-
8 volvement in assuring quality
9 care in facilities, and facility im-
10 provement initiatives approved by
11 the Secretary (including joint
12 training of facility staff and sur-
13 veyors, technical assistance for
14 facilities implementing quality as-
15 surance programs, the appoint-
16 ment of temporary management
17 firms, and other activities ap-
18 proved by the Secretary).”.

19 (2) CONFORMING AMENDMENT.—Section
20 1919(h)(5)(8) of the Social Security Act (42 U.S.C.
21 1396r(h)(5)(8)) is amended by inserting “(ii)(IV),”
22 after “(i),”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect 1 year after the date of the
25 enactment of this Act.

1 **SEC. 4212. NATIONAL INDEPENDENT MONITOR PILOT PRO-**
2 **GRAM.**

3 (a) ESTABLISHMENT.—

4 (1) IN GENERAL.—The Secretary shall establish
5 a pilot program to develop, test, and implement an
6 independent monitor program to oversee interstate
7 and large intrastate chains of skilled nursing facili-
8 ties and nursing facilities.

9 (2) SELECTION.—The Secretary shall select
10 chains of skilled nursing facilities and nursing facili-
11 ties described in paragraph (1) to participate in the
12 pilot program under this section from among those
13 chains that submit an application to the Secretary at
14 such time, in such manner, and containing such in-
15 formation as the Secretary may require.

16 (3) DURATION.—The Secretary shall conduct
17 the pilot program under this section for a 2-year pe-
18 riod.

19 (4) IMPLEMENTATION.—The Secretary shall
20 implement the pilot program under this section not
21 later than 1 year after the date of the enactment of
22 this Act.

23 (b) REQUIREMENTS.—The Secretary shall evaluate
24 chains selected to participate in the pilot program under
25 this section based on criteria selected by the Secretary,
26 including where evidence suggests that 1 or more facilities

1 of the chain are experiencing serious safety and quality
2 of care problems. Such criteria may include the evaluation
3 of a chain that includes 1 or more facilities participating
4 in the “Special Focus Facility” program (or a successor
5 program) or 1 or more facilities with a record of repeated
6 serious safety and quality of care deficiencies.

7 (c) RESPONSIBILITIES.—An independent monitor
8 that enters into a contract with the Secretary to partici-
9 pate in the conduct of the pilot program under this section
10 shall—

11 (1) conduct periodic reviews and prepare root-
12 cause quality and deficiency analyses of a chain to
13 assess if facilities of the chain are in compliance
14 with State and Federal laws and regulations applica-
15 ble to the facilities;

16 (2) undertake sustained oversight of the chain,
17 whether publicly or privately held, to involve the
18 owners of, and any additional disclosable party with
19 respect to a facility of, the chain in facilitating com-
20 pliance by facilities of the chain with State and Fed-
21 eral laws and regulations applicable to the facilities;

22 (3) analyze the management structure, distribu-
23 tion of expenditures, and nurse staffing levels of fa-
24 cilities of the chain in relation to resident census,
25 staff turnover rates, and tenure;

1 (4) report findings and recommendations with
2 respect to such reviews, analyses, and oversight to
3 the chain and facilities of the chain, to the Sec-
4 retary, and to relevant States; and

5 (5) publish the results of such reviews, anal-
6 yses, and oversight.

7 (d) IMPLEMENTATION OF RECOMMENDATIONS.—

8 (1) RECEIPT OF FINDING BY CHAIN.—Not later
9 than 10 days after receipt of a finding of an inde-
10 pendent monitor under subsection (c)(4), a chain
11 participating in the pilot program shall submit to
12 the independent monitor a report—

13 (A) outlining corrective actions the chain
14 will take to implement the recommendations in
15 such report; or

16 (B) indicating that the chain will not im-
17 plement such recommendations, and why it will
18 not do so.

19 (2) RECEIPT OF REPORT BY INDEPENDENT
20 MONITOR.—Not later than 10 days after receipt of
21 a report submitted by a chain under paragraph (1),
22 an independent monitor shall finalize its rec-
23 ommendations and submit a report to the chain and
24 facilities of the chain, the Secretary, and the State

1 or States, as appropriate, containing such final rec-
2 ommendations.

3 (e) COST OF APPOINTMENT.—A chain shall be re-
4 sponsible for a portion of the costs associated with the
5 appointment of independent monitors under the pilot pro-
6 gram under this section. The chain shall pay such portion
7 to the Secretary (in an amount and in accordance with
8 procedures established by the Secretary).

9 (f) WAIVER AUTHORITY.—The Secretary may waive
10 such requirements of titles XVIII and XIX of the Social
11 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
12 may be necessary for the purpose of carrying out the pilot
13 program under this section.

14 (g) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated such sums as may be
16 necessary to carry out this section.

17 (h) DEFINITIONS.—In this section:

18 (1) ADDITIONAL DISCLOSABLE PARTY.—The
19 term “additional disclosable party” has the meaning
20 given such term in section 1124(c)(5)(A) of the So-
21 cial Security Act, as added by section 4201(a).

22 (2) FACILITY.—The term “facility” means a
23 skilled nursing facility or a nursing facility.

24 (3) NURSING FACILITY.—The term “nursing
25 facility” has the meaning given such term in section

1 1919(a) of the Social Security Act (42 U.S.C.
2 1396r(a)).

3 (4) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services, acting
5 through the Assistant Secretary for Planning and
6 Evaluation.

7 (5) SKILLED NURSING FACILITY.—The term
8 “skilled nursing facility” has the meaning given such
9 term in section 1819(a) of the Social Security Act
10 (42 U.S.C. 1395(a)).

11 (i) EVALUATION AND REPORT.—

12 (1) EVALUATION.—The Inspector General of
13 the Department of Health and Human Services shall
14 evaluate the pilot program conducted under this sub-
15 section.

16 (2) REPORT.—Not later than 180 days after
17 the completion of the pilot program under this sec-
18 tion, the Inspector General shall submit to Congress
19 and the Secretary a report containing the results of
20 the evaluation conducted under paragraph (1), to-
21 gether with recommendations—

22 (A) as to whether the independent monitor
23 program should be established on a permanent
24 basis;

1 (B) if the Inspector General recommends
2 that such program be so established, on appro-
3 priate procedures and mechanisms for such es-
4 tablishment; and

5 (C) for such legislation and administrative
6 action as the Inspector General determines ap-
7 propriate.

8 **SEC. 4213. NOTIFICATION OF FACILITY CLOSURE.**

9 (a) IN GENERAL.—Section 1128I of the Social Secu-
10 rity Act, as added and amended by this Act, is amended
11 by adding at the end the following new subsection:

12 “(h) NOTIFICATION OF FACILITY CLOSURE.—

13 “(1) IN GENERAL.—Any individual who is the
14 administrator of a facility must—

15 “(A) submit to the Secretary, the State
16 long-term care ombudsman, residents of the fa-
17 cility, and the legal representatives of such resi-
18 dents or other responsible parties, written noti-
19 fication of an impending closure—

20 “(i) subject to clause (ii), not later
21 than the date that is 60 days prior to the
22 date of such closure; and

23 “(ii) in the case of a facility where the
24 Secretary terminates the facility’s partici-
25 pation under this title, not later than the

1 date that the Secretary determines appro-
2 priate;

3 “(B) ensure that the facility does not
4 admit any new residents on or after the date on
5 which such written notification is submitted;
6 and

7 “(C) include in the notice a plan for the
8 transfer and adequate relocation of the resi-
9 dents of the facility by a specified date prior to
10 closure that has been approved by the State, in-
11 cluding assurances that the residents will be
12 transferred to the most appropriate facility or
13 other setting in terms of quality, services, and
14 location, taking into consideration the needs,
15 choice, and best interests of each resident.

16 “(2) RELOCATION.—

17 “(A) IN GENERAL.—The State shall ensure
18 that, before a facility closes, all residents of the
19 facility have been successfully relocated to an-
20 other facility or an alternative home and com-
21 munity-based setting.

22 “(B) CONTINUATION OF PAYMENTS UNTIL
23 RESIDENTS RELOCATED.—The Secretary may,
24 as the Secretary determines appropriate, con-
25 tinue to make payments under this title with re-

1 spect to residents of a facility that has sub-
2 mitted a notification under paragraph (1) dur-
3 ing the period beginning on the date such noti-
4 fication is submitted and ending on the date on
5 which the resident is successfully relocated.

6 “(3) SANCTIONS.—Any individual who is the
7 administrator of a facility that fails to comply with
8 the requirements of paragraph (1)—

9 “(A) shall be subject to a civil monetary
10 penalty of up to \$1,000,000;

11 “(B) may be subject to exclusion from par-
12 ticipation in any Federal health care program
13 (as defined in section 1128B(f)); and

14 “(C) shall be subject to any other penalties
15 that may be prescribed by law.

16 “(4) PROCEDURE.—The provisions of section
17 1128A (other than subsections (a) and (b) and the
18 second sentence of subsection (f)) shall apply to a
19 civil money penalty or exclusion under paragraph (3)
20 in the same manner as such provisions apply to a
21 penalty or proceeding under section 1128A(a).”.

22 (b) CONFORMING AMENDMENTS.—Section
23 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i-
24 3(h)(4)) is amended—

1 (1) in the first sentence, by striking “the Sec-
2 retary shall terminate” and inserting “the Secretary,
3 subject to section 1128I(h), shall terminate”; and

4 (2) in the second sentence, by striking “sub-
5 section (c)(2)” and inserting “subsection (c)(2) and
6 section 1128I(h)”.

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall take effect 1 year after the date of the
9 enactment of this Act.

10 **SEC. 4214. NATIONAL DEMONSTRATION PROJECTS ON CUL-**
11 **TURE CHANGE AND USE OF INFORMATION**
12 **TECHNOLOGY IN NURSING HOMES.**

13 (a) IN GENERAL.—The Secretary shall conduct 2
14 demonstration projects, 1 for the development of best
15 practices in skilled nursing facilities and nursing facilities
16 that are involved in the culture change movement (includ-
17 ing the development of resources for facilities to find and
18 access funding in order to undertake culture change) and
19 1 for the development of best practices in skilled nursing
20 facilities and nursing facilities for the use of information
21 technology to improve resident care.

22 (b) CONDUCT OF DEMONSTRATION PROJECTS.—

23 (1) GRANT AWARD.—Under each demonstration
24 project conducted under this section, the Secretary
25 shall award 1 or more grants to facility-based set-

1 tings for the development of best practices described
2 in subsection (a) with respect to the demonstration
3 project involved. Such award shall be made on a
4 competitive basis and may be allocated in 1 lump-
5 sum payment.

6 (2) CONSIDERATION OF SPECIAL NEEDS OF
7 RESIDENTS.—Each demonstration project conducted
8 under this section shall take into consideration the
9 special needs of residents of skilled nursing facilities
10 and nursing facilities who have cognitive impair-
11 ment, including dementia.

12 (c) DURATION AND IMPLEMENTATION.—

13 (1) DURATION.—The demonstration projects
14 shall each be conducted for a period not to exceed
15 3 years.

16 (2) IMPLEMENTATION.—The demonstration
17 projects shall each be implemented not later than 1
18 year after the date of the enactment of this Act.

19 (d) DEFINITIONS.—In this section:

20 (1) NURSING FACILITY.—The term “nursing
21 facility” has the meaning given such term in section
22 1919(a) of the Social Security Act (42 U.S.C.
23 1396r(a)).

24 (2) SECRETARY.—The term “Secretary” means
25 the Secretary of Health and Human Services.

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1 (3) SKILLED NURSING FACILITY.—The term
2 “skilled nursing facility” has the meaning given such
3 term in section 1819(a) of the Social Security Act
4 (42 U.S.C. 1395(a)).

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated such sums as may be
7 necessary to carry out this section.

8 (f) REPORT.—Not later than 9 months after the com-
9 pletion of the demonstration project, the Secretary shall
10 submit to Congress a report on such project, together with
11 recommendations for such legislation and administrative
12 action as the Secretary determines appropriate.

13 **PART III—IMPROVING STAFF TRAINING**

14 **SEC. 4221. DEMENTIA AND ABUSE PREVENTION TRAINING.**

15 (a) SKILLED NURSING FACILITIES.—

16 (1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I)
17 of the Social Security Act (42 U.S.C. 1395i-
18 3(f)(2)(A)(i)(I)) is amended by inserting “(includ-
19 ing, in the case of initial training and, if the Sec-
20 retary determines appropriate, in the case of ongo-
21 ing training, dementia management training, and
22 patient abuse prevention training” before “, (II)”.

23 (2) CLARIFICATION OF DEFINITION OF NURSE
24 AIDE.—Section 1819(b)(5)(F) of the Social Security

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1 Act (42 U.S.C. 1395i-3(b)(5)(F)) is amended by
2 adding at the end the following flush sentence:

3 “Such term includes an individual who provides
4 such services through an agency or under a
5 contract with the facility.”.

6 (b) NURSING FACILITIES.—

7 (1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I)
8 of the Social Security Act (42 U.S.C.
9 1396r(f)(2)(A)(i)(I)) is amended by inserting “(in-
10 cluding, in the case of initial training and, if the
11 Secretary determines appropriate, in the case of on-
12 going training, dementia management training, and
13 patient abuse prevention training” before “, (II)”.

14 (2) CLARIFICATION OF DEFINITION OF NURSE
15 AIDE.—Section 1919(b)(5)(F) of the Social Security
16 Act (42 U.S.C. 1396r(b)(5)(F)) is amended by add-
17 ing at the end the following flush sentence:

18 “Such term includes an individual who provides
19 such services through an agency or under a
20 contract with the facility.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect 1 year after the date of the
23 enactment of this Act.

1 **Subtitle D—Nationwide Program**
2 **for National and State Back-**
3 **ground Checks on Direct Pa-**
4 **tient Access Employees of Long-**
5 **term Care Facilities and Pro-**
6 **viders**

7 **SEC. 4301. NATIONWIDE PROGRAM FOR NATIONAL AND**
8 **STATE BACKGROUND CHECKS ON DIRECT PA-**
9 **TIENT ACCESS EMPLOYEES OF LONG-TERM**
10 **CARE FACILITIES AND PROVIDERS.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (in this section referred to as the “Sec-
13 retary”), shall establish a program to identify efficient, ef-
14 fective, and economical procedures for long term care fa-
15 cilities or providers to conduct background checks on pro-
16 spective direct patient access employees on a nationwide
17 basis (in this subsection, such program shall be referred
18 to as the “nationwide program”). Except for the following
19 modifications, the Secretary shall carry out the nationwide
20 program under similar terms and conditions as the pilot
21 program under section 307 of the Medicare Prescription
22 Drug, Improvement, and Modernization Act of 2003 (Pub-
23 lic Law 108–173; 117 Stat. 2257), including the prohibi-
24 tion on hiring abusive workers and the authorization of
25 the imposition of penalties by a participating State under

1 subsection (b)(3)(A) and (b)(6), respectively, of such sec-
2 tion 307:

3 (1) AGREEMENTS.—

4 (A) NEWLY PARTICIPATING STATES.—The
5 Secretary shall enter into agreements with each
6 State—

7 (i) that the Secretary has not entered
8 into an agreement with under subsection
9 (c)(1) of such section 307;

10 (ii) that agrees to conduct background
11 checks under the nationwide program on a
12 Statewide basis; and

13 (iii) that submits an application to the
14 Secretary containing such information and
15 at such time as the Secretary may specify.

16 (B) CERTAIN PREVIOUSLY PARTICIPATING
17 STATES.—The Secretary shall enter into agree-
18 ments with each State—

19 (i) that the Secretary has entered into
20 an agreement with under such subsection
21 (c)(1), but only in the case where such
22 agreement did not require the State to
23 conduct background checks under the pro-
24 gram established under subsection (a) of
25 such section 307 on a Statewide basis;

1 (ii) that agrees to conduct background
2 checks under the nationwide program on a
3 Statewide basis; and

4 (iii) that submits an application to the
5 Secretary containing such information and
6 at such time as the Secretary may specify.

7 (2) NONAPPLICATION OF SELECTION CRI-
8 TERIA.—The selection criteria required under sub-
9 section (c)(3)(B) of such section 307 shall not apply.

10 (3) REQUIRED FINGERPRINT CHECK AS PART
11 OF CRIMINAL HISTORY BACKGROUND CHECK.—The
12 procedures established under subsection (b)(1) of
13 such section 307 shall—

14 (A) require that the long-term care facility
15 or provider (or the designated agent of the
16 long-term care facility or provider) obtain State
17 and national criminal history background
18 checks on the prospective employee through
19 such means as the Secretary determines appro-
20 priate, efficient, and effective that utilize a
21 search of State-based abuse and neglect reg-
22 istries and databases, including the abuse and
23 neglect registries of another State in the case
24 where a prospective employee previously resided
25 in that State, State criminal history records,

1 the records of any proceedings in the State that
2 may contain disqualifying information about
3 prospective employees (such as proceedings con-
4 ducted by State professional licensing and dis-
5 ciplinary boards and State Medicaid Fraud
6 Control Units), and Federal criminal history
7 records, including a fingerprint check using the
8 Integrated Automated Fingerprint Identifica-
9 tion System of the Federal Bureau of Investiga-
10 tion;

11 (B) require States to describe and test
12 methods that reduce duplicative fingerprinting,
13 including providing for the development of “rap
14 back” capability by the State such that, if a di-
15 rect patient access employee of a long-term care
16 facility or provider is convicted of a crime fol-
17 lowing the initial criminal history background
18 check conducted with respect to such employee,
19 and the employee’s fingerprints match the
20 prints on file with the State law enforcement
21 department, the department will immediately
22 inform the State and the State will immediately
23 inform the long-term care facility or provider
24 which employs the direct patient access em-
25 ployee of such conviction; and

1 (C) require that criminal history back-
2 ground checks conducted under the nationwide
3 program remain valid for a period of time speci-
4 fied by the Secretary.

5 (4) STATE REQUIREMENTS.—An agreement en-
6 tered into under paragraph (1) shall require that a
7 participating State—

8 (A) be responsible for monitoring compli-
9 ance with the requirements of the nationwide
10 program;

11 (B) have procedures in place to—

12 (i) conduct screening and criminal his-
13 tory background checks under the nation-
14 wide program in accordance with the re-
15 quirements of this section;

16 (ii) monitor compliance by long-term
17 care facilities and providers with the proce-
18 dures and requirements of the nationwide
19 program;

20 (iii) as appropriate, provide for a pro-
21 visional period of employment by a long-
22 term care facility or provider of a direct
23 patient access employee, not to exceed 60
24 days, pending completion of the required
25 criminal history background check and, in

1 the case where the employee has appealed
2 the results of such background check,
3 pending completion of the appeals process,
4 during which the employee shall be subject
5 to direct on-site supervision (in accordance
6 with procedures established by the State to
7 ensure that a long-term care facility or
8 provider furnishes such direct on-site su-
9 pervision);

10 (iv) provide an independent process by
11 which a provisional employee or an em-
12 ployee may appeal or dispute the accuracy
13 of the information obtained in a back-
14 ground check performed under the nation-
15 wide program, including the specification
16 of criteria for appeals for direct patient ac-
17 cess employees found to have disqualifying
18 information which shall include consider-
19 ation of the passage of time, extenuating
20 circumstances, demonstration of rehabilita-
21 tion, and relevancy of the particular dis-
22 qualifying information with respect to the
23 current employment of the individual;

24 (v) provide for the designation of a
25 single State agency as responsible for—

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1 (I) overseeing the coordination of
2 any State and national criminal his-
3 tory background checks requested by
4 a long-term care facility or provider
5 (or the designated agent of the long-
6 term care facility or provider) utilizing
7 a search of State and Federal crimi-
8 nal history records, including a finger-
9 print check of such records;

10 (II) overseeing the design of ap-
11 propriate privacy and security safe-
12 guards for use in the review of the re-
13 sults of any State or national criminal
14 history background checks conducted
15 regarding a prospective direct patient
16 access employee to determine whether
17 the employee has any conviction for a
18 relevant crime;

19 (III) immediately reporting to
20 the long-term care facility or provider
21 that requested the criminal history
22 background check the results of such
23 review; and

24 (IV) in the case of an employee
25 with a conviction for a relevant crime

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1 that is subject to reporting under sec-
2 tion 1128E of the Social Security Act
3 (42 U.S.C. 1320a-7e), reporting the
4 existence of such conviction to the
5 database established under that sec-
6 tion;

7 (vi) determine which individuals are
8 direct patient access employees (as defined
9 in paragraph (6)(B)) for purposes of the
10 nationwide program;

11 (vii) as appropriate, specify offenses,
12 including convictions for violent crimes, for
13 purposes of the nationwide program; and

14 (viii) describe and test methods that
15 reduce duplicative fingerprinting, including
16 providing for the development of “rap
17 back” capability such that, if a direct pa-
18 tient access employee of a long-term care
19 facility or provider is convicted of a crime
20 following the initial criminal history back-
21 ground check conducted with respect to
22 such employee, and the employee’s finger-
23 prints match the prints on file with the
24 State law enforcement department—

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1 (I) the department will imme-
2 diately inform the State agency des-
3 igned under clause (v) and such
4 agency will immediately inform the fa-
5 cility or provider which employs the
6 direct patient access employee of such
7 conviction; and

8 (II) the State will provide, or will
9 require the facility to provide, to the
10 employee a copy of the results of the
11 criminal history background check
12 conducted with respect to the em-
13 ployee at no charge in the case where
14 the individual requests such a copy.

15 (5) PAYMENTS.—

16 (A) NEWLY PARTICIPATING STATES.—

17 (i) IN GENERAL.—As part of the ap-
18 plication submitted by a State under para-
19 graph (1)(A)(iii), the State shall guar-
20 antee, with respect to the costs to be in-
21 curred by the State in carrying out the na-
22 tionwide program, that the State will make
23 available (directly or through donations
24 from public or private entities) a particular
25 amount of non-Federal contributions, as a

1 condition of receiving the Federal match
2 under clause (ii).

3 (ii) FEDERAL MATCH.—The payment
4 amount to each State that the Secretary
5 enters into an agreement with under para-
6 graph (1)(A) shall be 3 times the amount
7 that the State guarantees to make avail-
8 able under clause (i), except that in no
9 case may the payment amount exceed
10 \$3,000,000.

11 (B) PREVIOUSLY PARTICIPATING
12 STATES.—

13 (i) IN GENERAL.—As part of the ap-
14 plication submitted by a State under para-
15 graph (1)(B)(iii), the State shall guar-
16 antee, with respect to the costs to be in-
17 curred by the State in carrying out the na-
18 tionwide program, that the State will make
19 available (directly or through donations
20 from public or private entities) a particular
21 amount of non-Federal contributions, as a
22 condition of receiving the Federal match
23 under clause (ii).

24 (ii) FEDERAL MATCH.—The payment
25 amount to each State that the Secretary

1 enters into an agreement with under para-
2 graph (1)(B) shall be 3 times the amount
3 that the State guarantees to make avail-
4 able under clause (i), except that in no
5 case may the payment amount exceed
6 \$1,500,000.

7 (6) DEFINITIONS.—Under the nationwide pro-
8 gram:

9 (A) CONVICTION FOR A RELEVANT
10 CRIME.—The term “conviction for a relevant
11 crime” means any Federal or State criminal
12 conviction for—

13 (i) any offense described in section
14 1128(a) of the Social Security Act (42
15 U.S.C. 1320a–7); or

16 (ii) such other types of offenses as a
17 participating State may specify for pur-
18 poses of conducting the program in such
19 State.

20 (B) DISQUALIFYING INFORMATION.—The
21 term “disqualifying information” means a con-
22 viction for a relevant crime or a finding of pa-
23 tient or resident abuse.

24 (C) FINDING OF PATIENT OR RESIDENT
25 ABUSE.—The term “finding of patient or resi-

1 dent abuse” means any substantiated finding
2 by a State agency under section 1819(g)(1)(C)
3 or 1919(g)(1)(C) of the Social Security Act (42
4 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a
5 Federal agency that a direct patient access em-
6 ployee has committed—

7 (i) an act of patient or resident abuse
8 or neglect or a misappropriation of patient
9 or resident property; or

10 (ii) such other types of acts as a par-
11 ticipating State may specify for purposes
12 of conducting the program in such State.

13 (D) DIRECT PATIENT ACCESS EM-
14 PLOYEE.—The term “direct patient access em-
15 ployee” means any individual who has access to
16 a patient or resident of a long-term care facility
17 or provider through employment or through a
18 contract with such facility or provider and has
19 duties that involve (or may involve) one-on-one
20 contact with a patient or resident of the facility
21 or provider, as determined by the State for pur-
22 poses of the nationwide program. Such term
23 does not include a volunteer unless the volun-
24 teer has duties that are equivalent to the duties
25 of a direct patient access employee and those

1 duties involve (or may involve) one-on-one con-
2 tact with a patient or resident of the long-term
3 care facility or provider.

4 (E) LONG-TERM CARE FACILITY OR PRO-
5 VIDER.—The term “long-term care facility or
6 provider” means the following facilities or pro-
7 viders which receive payment for services under
8 title XVIII or XIX of the Social Security Act:

9 (i) A skilled nursing facility (as de-
10 fined in section 1819(a) of the Social Secu-
11 rity Act (42 U.S.C. 1395i–3(a))).

12 (ii) A nursing facility (as defined in
13 section 1919(a) of such Act (42 U.S.C.
14 1396r(a))).

15 (iii) A home health agency.

16 (iv) A provider of hospice care (as de-
17 fined in section 1861(dd)(1) of such Act
18 (42 U.S.C. 1395x(dd)(1))).

19 (v) A long-term care hospital (as de-
20 scribed in section 1886(d)(1)(B)(iv) of
21 such Act (42 U.S.C.
22 1395ww(d)(1)(B)(iv))).

23 (vi) A provider of personal care serv-
24 ices.

25 (vii) A provider of adult day care.

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1 (viii) A residential care provider that
2 arranges for, or directly provides, long-
3 term care services, including an assisted
4 living facility that provides a level of care
5 established by the Secretary.

6 (ix) An intermediate care facility for
7 the mentally retarded (as defined in sec-
8 tion 1905(d) of such Act (42 U.S.C.
9 1396d(d))).

10 (x) Any other facility or provider of
11 long-term care services under such titles as
12 the participating State determines appro-
13 priate.

14 (7) EVALUATION AND REPORT.—

15 (A) EVALUATION.—

16 (i) IN GENERAL.—The Inspector Gen-
17 eral of the Department of Health and
18 Human Services shall conduct an evalua-
19 tion of the nationwide program.

20 (ii) INCLUSION OF SPECIFIC TOP-
21 ICS.—The evaluation conducted under
22 clause (i) shall include the following:

23 (I) A review of the various proce-
24 dures implemented by participating
25 States for long-term care facilities or

1 providers, including staffing agencies,
2 to conduct background checks of di-
3 rect patient access employees under
4 the nationwide program and identi-
5 fication of the most appropriate, effi-
6 cient, and effective procedures for
7 conducting such background checks.

8 (II) An assessment of the costs
9 of conducting such background checks
10 (including start up and administrative
11 costs).

12 (III) A determination of the ex-
13 tent to which conducting such back-
14 ground checks leads to any unin-
15 tended consequences, including a re-
16 duction in the available workforce for
17 long-term care facilities or providers.

18 (IV) An assessment of the impact
19 of the nationwide program on reduc-
20 ing the number of incidents of neglect,
21 abuse, and misappropriation of resi-
22 dent property to the extent prac-
23 ticable.

24 (V) An evaluation of other as-
25 pects of the nationwide program, as

1 determined appropriate by the Sec-
2 retary.

3 (B) REPORT.—Not later than 180 days
4 after the completion of the nationwide program,
5 the Inspector General of the Department of
6 Health and Human Services shall submit a re-
7 port to Congress containing the results of the
8 evaluation conducted under subparagraph (A).

9 (b) FUNDING.—

10 (1) NOTIFICATION.—The Secretary of Health
11 and Human Services shall notify the Secretary of
12 the Treasury of the amount necessary to carry out
13 the nationwide program under this section for the
14 period of fiscal years 2010 through 2012, except
15 that in no case shall such amount exceed
16 \$160,000,000.

17 (2) TRANSFER OF FUNDS.—

18 (A) IN GENERAL.—Out of any funds in the
19 Treasury not otherwise appropriated, the Sec-
20 retary of the Treasury shall provide for the
21 transfer to the Secretary of Health and Human
22 Services of the amount specified as necessary to
23 carry out the nationwide program under para-
24 graph (1). Such amount shall remain available
25 until expended.

1 (B) RESERVATION OF FUNDS FOR CON-
2 DUCT OF EVALUATION.—The Secretary may re-
3 serve not more than \$3,000,000 of the amount
4 transferred under subparagraph (A) to provide
5 for the conduct of the evaluation under sub-
6 section (a)(7)(A).

7 **Subtitle E—Pharmacy Benefit** 8 **Managers**

9 **SEC. 4401. PHARMACY BENEFIT MANAGERS TRANS-**
10 **PARENCY REQUIREMENTS.**

11 Title XI of the Social Security Act (42 U.S.C. 1301
12 et seq.), as amended by sections 1611(c) and 1923, is
13 amended by inserting after section 1150B the following
14 new section:

15 **“SEC. 1150C. PHARMACY BENEFIT MANAGERS TRANS-**
16 **PARENCY REQUIREMENTS.**

17 “(a) PROVISION OF INFORMATION.—A health bene-
18 fits plan or any entity that provides pharmacy benefits
19 management services on behalf of a health benefits plan
20 (in this section referred to as a ‘PBM’) that manages pre-
21 scription drug coverage under a contract with—

22 “(1) a PDP sponsor of a prescription drug plan
23 or an MA organization offering an MA–PD plan
24 under part D of title XVIII; or

1 “(2) a qualified health benefits plan offered
2 through an exchange established by a State under
3 title XXII,
4 shall provide the information described in subsection (b)
5 to the Secretary and, in the case of a PBM, to the plan
6 with which the PBM is under contract with, at such times,
7 and in such form and manner, as the Secretary shall speci-
8 fy.

9 “(b) INFORMATION DESCRIBED.—The information
10 described in this subsection is the following with respect
11 to services provided by a health benefits plan or PBM for
12 a contract year:

13 “(1) The percentage of all prescriptions that
14 were provided through retail pharmacies compared
15 to mail order pharmacies, and the percentage of pre-
16 scriptions for which a generic drug was available and
17 dispensed (generic dispensing rate), by pharmacy
18 type (which includes an independent pharmacy,
19 chain pharmacy, supermarket pharmacy, or mass
20 merchandiser pharmacy that is licensed as a phar-
21 macy by the State and that dispenses medication to
22 the general public), that is paid by the health bene-
23 fits plan or PBM under the contract.

24 “(2) The aggregate amount, and the type of re-
25 bates, discounts, or price concessions (excluding

1 bona fide service fees, which include but are not lim-
2 ited to distribution service fees, inventory manage-
3 ment fees, product stocking allowances, and fees as-
4 sociated with administrative services agreements and
5 patient care programs (such as medication compli-
6 ance programs and patient education programs))that
7 the PBM negotiates that are attributable to patient
8 utilization under the plan, and the aggregate amount
9 of the rebates, discounts, or price concessions that
10 are passed through to the plan sponsor, and the
11 total number of prescriptions that were dispensed.

12 “(3) The aggregate amount of the difference
13 between the amount the health benefits plan pays
14 the PBM and the amount that the PBM pays retail
15 pharmacies, and mail order pharmacies, and the
16 total number of prescriptions that were dispensed.

17 “(c) CONFIDENTIALITY.—Information disclosed by a
18 health benefits plan or PBM under this section is con-
19 fidential and shall not be disclosed by the Secretary or
20 by a plan receiving the information, except that the Sec-
21 retary may disclose the information in a form which does
22 not disclose the identity of a specific PBM, plan, or prices
23 charged for drugs, for the following purposes:

1 “(1) As the Secretary determines to be nec-
2 essary to carry out this section or part D of title
3 XVIII.

4 “(2) To permit the Comptroller General to re-
5 view the information provided.

6 “(3) To permit the Director of the Congres-
7 sional Budget Office to review the information pro-
8 vided.

9 “(4) To States to carry out title XXII.

10 “(d) PENALTIES.—The provisions of subsection
11 (b)(3)(C) of section 1927 shall apply to a health benefits
12 plan or PBM that fails to provide information required
13 under subsection (a) on a timely basis or that knowingly
14 provides false information in the same manner as such
15 provisions apply to a manufacturer with an agreement
16 under that section.”.

17 **TITLE V—FRAUD, WASTE, AND**
18 **ABUSE**

19 **Subtitle A—Medicare, Medicaid,**
20 **and CHIP**

21 **SEC. 5001. PROVIDER SCREENING AND OTHER ENROLL-**
22 **MENT REQUIREMENTS UNDER MEDICARE,**
23 **MEDICAID, AND CHIP.**

24 (a) MEDICARE.—Section 1866(j) of the Social Secu-
25 rity Act (42 U.S.C. 1395cc(j)) is amended—

1 “(B) LEVEL OF SCREENING.—The Sec-
2 retary shall determine the level of screening
3 conducted under this paragraph according to
4 the risk of fraud, waste, and abuse, as deter-
5 mined by the Secretary, with respect to the cat-
6 egory of provider of medical or other items or
7 services or supplier. Such screening—

8 “(i) shall include a licensure check,
9 which may include such checks across
10 States; and

11 “(ii) may, as the Secretary determines
12 appropriate based on the risk of fraud,
13 waste, and abuse described in the pre-
14 ceding sentence, include—

15 “(I) a criminal background
16 check;

17 “(II) fingerprinting;

18 “(III) unscheduled and unan-
19 nounced site visits, including
20 preenrollment site visits;

21 “(IV) database checks (including
22 such checks across States); and

23 “(V) such other screening as the
24 Secretary determines appropriate.

25 “(C) APPLICATION FEES.—

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1 “(i) IN GENERAL.—Except as pro-
2 vided in clause (ii) or (iii), the Secretary
3 shall impose a fee on each provider of med-
4 ical or other items or services or supplier
5 with respect to which screening is con-
6 ducted under this paragraph in an amount
7 equal to—

8 “(I) for 2010, \$350; and

9 “(II) for 2011 and each subse-
10 quent year, the amount determined
11 under this clause for the preceding
12 year, adjusted by the percentage
13 change in the consumer price index
14 for all urban consumers (all items;
15 United States city average) for the
16 12-month period ending with June of
17 the previous year.

18 “(ii) TEMPORARY REDUCED FEE FOR
19 CURRENT PROVIDERS OF SERVICES AND
20 SUPPLIERS.—In the case of a provider of
21 medical or other items or services or sup-
22 plier who is enrolled in the program under
23 this title, title XIX, or title XXI as of the
24 date of enactment of this paragraph, dur-
25 ing the period beginning on such date of

1 enactment and ending on the date that is
2 1 year after such date, the amount of the
3 fee imposed under this subparagraph shall
4 be equal to \$250. Such fee shall be im-
5 posed with respect to all providers of med-
6 ical or other items and services and sup-
7 pliers described in the preceding sentence,
8 regardless of whether the provider or sup-
9 plier is due for revalidation of enrollment
10 in the program during such period.

11 “(iii) **HARDSHIP EXCEPTION; WAIVER**
12 **FOR CERTAIN MEDICAID PROVIDERS.**—The
13 Secretary may, on a case-by-case basis, ex-
14 empt a provider of medical or other items
15 or services or supplier from the imposition
16 of an application fee under this subpara-
17 graph if the Secretary determines that the
18 imposition of the application fee would re-
19 sult in a hardship. The Secretary may
20 waive the application fee under this sub-
21 paragraph for providers enrolled in a State
22 Medicaid program for whom the State
23 demonstrates that imposition of the fee
24 would impede beneficiary access to care.

1 “(iv) USE OF FUNDS.—Amounts col-
2 lected as a result of the imposition of a fee
3 under this subparagraph shall be used by
4 the Secretary for program integrity efforts,
5 including to cover the costs of conducting
6 screening under this paragraph and to
7 carry out this subsection and section
8 1128J.

9 “(D) APPLICATION AND ENFORCEMENT.—

10 “(i) NEW PROVIDERS OF SERVICES
11 AND SUPPLIERS.—The screening under
12 this paragraph shall apply, in the case of
13 a provider of medical or other items or
14 services or supplier who is not enrolled in
15 the program under this title, title XIX , or
16 title XXI as of the date of enactment of
17 this paragraph, on or after the date that is
18 1 year after such date of enactment.

19 “(ii) CURRENT PROVIDERS OF SERV-
20 ICES AND SUPPLIERS.—The screening
21 under this paragraph shall apply, in the
22 case of a provider of medical or other
23 items or services or supplier who is en-
24 rolled in the program under this title, title
25 XIX, or title XXI as of such date of enact-

1 ment, on or after the date that is 2 years
2 after such date of enactment.

3 “(iii) REVALIDATION OF ENROLL-
4 MENT.—Effective beginning on the date
5 that is 180 days after such date of enact-
6 ment, the screening under this paragraph
7 shall apply with respect to the revalidation
8 of enrollment of a provider of medical or
9 other items or services or supplier in the
10 program under this title, title XIX, or title
11 XXI.

12 “(iv) LIMITATION ON ENROLLMENT
13 AND REVALIDATION OF ENROLLMENT.—In
14 no case may a provider of medical or other
15 items or services or supplier who has not
16 been screened under this paragraph be ini-
17 tially enrolled or reenrolled in the program
18 under this title, title XIX, or title XXI on
19 or after the date that is 3 years after such
20 date of enactment.

21 “(E) EXPEDITED RULEMAKING.—The Sec-
22 retary may promulgate an interim final rule to
23 carry out this paragraph.

1 “(3) PROVISIONAL PERIOD OF ENHANCED
2 OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND
3 SUPPLIERS.—

4 “(A) IN GENERAL.—The Secretary shall
5 establish procedures to provide for a provisional
6 period of not less than 30 days and not more
7 than 1 year during which new providers of med-
8 ical or other items or services and suppliers, as
9 the Secretary determines appropriate, including
10 categories of providers or suppliers, would be
11 subject to enhanced oversight, such as prepay-
12 ment review and payment caps, under the pro-
13 gram under this title, the Medicaid program
14 under title XIX, and the CHIP program under
15 title XXI.

16 “(B) IMPLEMENTATION.—The Secretary
17 may establish by program instruction or other-
18 wise the procedures under this paragraph.

19 “(4) INCREASED DISCLOSURE REQUIRE-
20 MENTS.—

21 “(A) DISCLOSURE.—A provider of medical
22 or other items or services or supplier who sub-
23 mits an application for enrollment or revalida-
24 tion of enrollment in the program under this
25 title , title XIX, or title XXI on or after the

1 date that is 1 year after the date of enactment
2 of this paragraph shall disclose (in a form and
3 manner and at such time as determined by the
4 Secretary) any current or previous affiliation
5 (directly or indirectly) with a provider of med-
6 ical or other items or services or supplier that
7 has uncollected debt, has been or is subject to
8 a payment suspension under a Federal health
9 care program (as defined in section 1128B(f)),
10 has been excluded from participation under the
11 program under this title, the Medicaid program
12 under title XIX, or the CHIP program under
13 title XXI, or has had its billing privileges de-
14 nied or revoked.

15 “(B) AUTHORITY TO DENY ENROLL-
16 MENT.—If the Secretary determines that such
17 previous affiliation poses an undue risk of
18 fraud, waste, or abuse, the Secretary may deny
19 such application. Such a denial shall be subject
20 to appeal in accordance with paragraph (7).

21 “(5) AUTHORITY TO ADJUST PAYMENTS OF
22 PROVIDERS OF SERVICES AND SUPPLIERS WITH THE
23 SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE
24 OBLIGATIONS.—

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1 “(A) IN GENERAL.—Notwithstanding any
2 other provision of this title, in the case of an
3 applicable provider of services or supplier, the
4 Secretary may make any necessary adjustments
5 to payments to the applicable provider of serv-
6 ices or supplier under the program under this
7 title in order to satisfy any past-due obligations
8 described in subparagraph (B)(ii) of an obli-
9 gated provider of services or supplier.

10 “(B) DEFINITIONS.—In this paragraph:

11 “(i) IN GENERAL.—The term ‘applica-
12 ble provider of services or supplier’ means
13 a provider of services or supplier that has
14 the same taxpayer identification number
15 assigned under section 6109 of the Inter-
16 nal Revenue Code of 1986 as is assigned
17 to the obligated provider of services or sup-
18 plier under such section, regardless of
19 whether the applicable provider of services
20 or supplier is assigned a different billing
21 number or national provider identification
22 number under the program under this title
23 than is assigned to the obligated provider
24 of services or supplier.

1 “(ii) OBLIGATED PROVIDER OF SERV-
2 ICES OR SUPPLIER.—The term ‘obligated
3 provider of services or supplier’ means a
4 provider of services or supplier that owes a
5 past-due obligation under the program
6 under this title (as determined by the Sec-
7 retary).

8 “(6) TEMPORARY MORATORIUM ON ENROLL-
9 MENT OF NEW PROVIDERS.—

10 “(A) IN GENERAL.—The Secretary may
11 impose a temporary moratorium on the enroll-
12 ment of new providers of services and suppliers,
13 including categories of providers of services and
14 suppliers, in the program under this title, under
15 the Medicaid program under title XIX, or
16 under the CHIP program under title XXI if the
17 Secretary determines such moratorium is nec-
18 essary to prevent or combat fraud, waste, or
19 abuse under either such program.

20 “(B) LIMITATION ON REVIEW.—There
21 shall be no judicial review under section 1869,
22 section 1878, or otherwise, of a temporary mor-
23 atorium imposed under subparagraph (A).

24 “(7) COMPLIANCE PROGRAMS.—

1 “(A) IN GENERAL.—On or after the date
2 of implementation determined by the Secretary
3 under subparagraph (C), a provider of medical
4 or other items or services or supplier within a
5 particular industry sector or category shall, as
6 a condition of enrollment in the program under
7 this title, title XIX, or title XXI, establish a
8 compliance program that contains the core ele-
9 ments established under subparagraph (B) with
10 respect to that provider or supplier and indus-
11 try or category.

12 “(B) ESTABLISHMENT OF CORE ELE-
13 MENTS.—The Secretary, in consultation with
14 the Inspector General of the Department of
15 Health and Human Services, shall establish
16 core elements for a compliance program under
17 subparagraph (A) for providers or suppliers
18 within a particular industry or category.

19 “(C) TIMELINE FOR IMPLEMENTATION.—
20 The Secretary shall determine the timeline for
21 the establishment of the core elements under
22 subparagraph (B) and the date of the imple-
23 mentation of subparagraph (A) for providers or
24 suppliers within a particular industry or cat-
25 egory. The Secretary shall, in determining such

1 date of implementation, consider the extent to
2 which the adoption of compliance programs by
3 a provider of medical or other items or services
4 or supplier is widespread in a particular indus-
5 try sector or with respect to a particular pro-
6 vider or supplier category.”.

7 (b) MEDICAID.—

8 (1) STATE PLAN AMENDMENT.—Section
9 1902(a) of the Social Security Act (42 U.S.C.
10 1396a(a)), as amended by sections 1601(d) and
11 1640, is amended—

12 (A) in subsection (a)—

13 (i) by striking “and” at the end of
14 paragraph (74);

15 (ii) by striking the period at the end
16 of paragraph (75) and inserting a semi-
17 colon; and

18 (iii) by inserting after paragraph (75)
19 the following:

20 “(76) provide that the State shall comply with
21 provider and supplier screening, oversight, and re-
22 porting requirements in accordance with subsection
23 (ii);”; and

24 (B) by adding at the end the following:

1 “(ii) PROVIDER AND SUPPLIER SCREENING, OVER-
2 SIGHT, AND REPORTING REQUIREMENTS.—For purposes
3 of subsection (a)(75), the requirements of this subsection
4 are the following:

5 “(1) SCREENING.—The State complies with the
6 process for screening providers and suppliers under
7 this title, as established by the Secretary under sec-
8 tion 1886(j)(2).

9 “(2) PROVISIONAL PERIOD OF ENHANCED
10 OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—
11 The State complies with procedures to provide for a
12 provisional period of enhanced oversight for new pro-
13 viders and suppliers under this title, as established
14 by the Secretary under section 1886(j)(3).

15 “(3) DISCLOSURE REQUIREMENTS.—The State
16 requires providers and suppliers under the State
17 plan or under a waiver of the plan to comply with
18 the disclosure requirements established by the Sec-
19 retary under section 1886(j)(4).

20 “(4) TEMPORARY MORATORIUM ON ENROLL-
21 MENT OF NEW PROVIDERS OR SUPPLIERS.—

22 “(A) TEMPORARY MORATORIUM IMPOSED
23 BY THE SECRETARY.—

24 “(i) IN GENERAL.—Subject to clause
25 (ii), the State complies with any temporary

1 moratorium on the enrollment of new pro-
2 viders or suppliers imposed by the Sec-
3 retary under section 1886(j)(6).

4 “(ii) EXCEPTION.—A State shall not
5 be required to comply with a temporary
6 moratorium described in clause (i) if the
7 State determines that the imposition of
8 such temporary moratorium would ad-
9 versely impact beneficiaries’ access to med-
10 ical assistance.

11 “(B) MORATORIUM ON ENROLLMENT OF
12 PROVIDERS AND SUPPLIERS.—At the option of
13 the State, the State imposes, for purposes of
14 entering into participation agreements with pro-
15 viders or suppliers under the State plan or
16 under a waiver of the plan, periods of enroll-
17 ment moratoria, or numerical caps or other lim-
18 its, for providers or suppliers identified by the
19 Secretary as being at high-risk for fraud, waste,
20 or abuse as necessary to combat fraud, waste,
21 or abuse, but only if the State determines that
22 the imposition of any such period, cap, or other
23 limits would not adversely impact beneficiaries’
24 access to medical assistance.

1 “(5) COMPLIANCE PROGRAMS.—The State re-
2 quires providers and suppliers under the State plan
3 or under a waiver of the plan to establish, in accord-
4 ance with the requirements of section 1866(j)(7), a
5 compliance program that contains the core elements
6 established under subparagraph (B) of that section
7 1866(j)(7) for providers or suppliers within a par-
8 ticular industry or category.

9 “(6) REPORTING OF ADVERSE PROVIDER AC-
10 TIONS.—The State complies with the national sys-
11 tem for reporting criminal and civil convictions,
12 sanctions, negative licensure actions, and other ad-
13 verse provider actions to the Secretary, through the
14 Administrator of the Centers for Medicare & Med-
15 icaid Services, in accordance with regulations of the
16 Secretary.

17 “(7) ENROLLMENT AND NPI OF ORDERING OR
18 REFERRING PROVIDERS.—The State requires—

19 “(A) all ordering or referring physicians or
20 other professionals to be enrolled under the
21 State plan or under a waiver of the plan as a
22 participating provider; and

23 “(B) the national provider identifier of any
24 ordering or referring physician or other profes-
25 sional to be specified on any claim for payment

1 that is based on an order or referral of the phy-
2 sician or other professional.

3 “(8) OTHER STATE OVERSIGHT.—Nothing in
4 this subsection shall be interpreted to preclude or
5 limit the ability of a State to engage in provider and
6 supplier screening or enhanced provider and supplier
7 oversight activities beyond those required by the Sec-
8 retary.”.

9 (2) DISCLOSURE OF MEDICARE TERMINATED
10 PROVIDERS AND SUPPLIERS TO STATES.—The Ad-
11 ministrators of the Centers for Medicare & Medicaid
12 Services shall establish a process for making avail-
13 able to the each State agency with responsibility for
14 administering a State Medicaid plan (or a waiver of
15 such plan) under title XIX of the Social Security
16 Act or a child health plan under title XXI the name,
17 national provider identifier, and other identifying in-
18 formation for any provider of medical or other items
19 or services or supplier under the Medicare program
20 under title XVIII or under the CHIP program under
21 title XXI that is terminated from participation
22 under that program within 30 days of the termi-
23 nation (and, with respect to all such providers or
24 suppliers who are terminated from the Medicare pro-

1 gram on the date of enactment of this Act, within
2 90 days of such date).

3 (3) CONFORMING AMENDMENT.—Section
4 1902(a)(23) of the Social Security Act (42 U.S.C.
5 1396a), is amended by inserting before the semi-
6 colon at the end the following: “or by a provider or
7 supplier to which a moratorium under subsection
8 (ii)(4) is applied during the period of such morato-
9 rium”.

10 (c) CHIP.—Section 2107(e)(1) of the Social Security
11 Act (42 U.S.C. 1397gg(e)(1)), as amended by section
12 1611(d), is amended—

13 (1) by redesignating subparagraphs (D)
14 through (M) as subparagraphs (E) through (N), re-
15 spectively; and

16 (2) by inserting after subparagraph (C), the fol-
17 lowing:

18 “(D) Subsections (a)(76) and (ii) of sec-
19 tion 1902 (relating to provider and supplier
20 screening, oversight, and reporting require-
21 ments).”.

22 **SEC. 5002. ENHANCED MEDICARE AND MEDICAID PRO-**
23 **GRAM INTEGRITY PROVISIONS.**

24 (a) IN GENERAL.—Part A of title XI of the Social
25 Security Act (42 U.S.C. 1301 et seq.), as amended by sec-

1 tion 4202, is amended by inserting after section 1128I the
2 following new section:

3 **“SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEG-**
4 **RITY PROVISIONS.**

5 “(a) DATA MATCHING.—

6 “(1) INTEGRATED DATA REPOSITORY.—

7 “(A) INCLUSION OF CERTAIN DATA.—

8 “(i) IN GENERAL.—The Integrated
9 Data Repository of the Centers for Medi-
10 care & Medicaid Services shall include, at
11 a minimum, claims and payment data from
12 the following:

13 “(I) The programs under titles
14 XVIII and XIX (including parts A, B,
15 C, and D of title XVIII).

16 “(II) The program under title
17 XXI.

18 “(III) Health-related programs
19 administered by the Secretary of Vet-
20 erans Affairs.

21 “(IV) Health-related programs
22 administered by the Secretary of De-
23 fense.

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1 “(V) The program of old-age,
2 survivors, and disability insurance
3 benefits established under title II.

4 “(VI) The Indian Health Service
5 and the Contract Health Service pro-
6 gram.

7 “(ii) PRIORITY FOR INCLUSION OF
8 CERTAIN DATA.—Inclusion of the data de-
9 scribed in subclause (I) of such clause in
10 the Integrated Data Repository shall be a
11 priority. Data described in subclauses (II)
12 through (VI) of such clause shall be in-
13 cluded in the Integrated Data Repository
14 as appropriate.

15 “(B) DATA SHARING AND MATCHING.—

16 “(i) IN GENERAL.—The Secretary
17 shall enter into agreements with the indi-
18 viduals described in clause (ii) under which
19 such individuals share and match data in
20 the system of records of the respective
21 agencies of such individuals with data in
22 the system of records of the Department of
23 Health and Human Services for the pur-
24 pose of identifying potential fraud, waste,

1 and abuse under the programs under titles
2 XVIII and XIX.

3 “(ii) INDIVIDUALS DESCRIBED.—The
4 following individuals are described in this
5 clause:

6 “(I) The Commissioner of Social
7 Security.

8 “(II) The Secretary of Veterans
9 Affairs.

10 “(III) The Secretary of Defense.

11 “(IV) The Director of the Indian
12 Health Service.

13 “(iii) DEFINITION OF SYSTEM OF
14 RECORDS.—For purposes of this para-
15 graph, the term ‘system of records’ has the
16 meaning given such term in section
17 552a(a)(5) of title 5, United States Code.

18 “(2) ACCESS TO CLAIMS AND PAYMENT DATA-
19 BASES.—For purposes of conducting law enforce-
20 ment and oversight activities and to the extent con-
21 sistent with applicable information, privacy, security,
22 and disclosure laws, including the regulations pro-
23 mulgated under the Health Insurance Portability
24 and Accountability Act of 1996 and section 552a of
25 title 5, United States Code, and subject to any infor-

1 mation systems security requirements under such
2 laws or otherwise required by the Secretary, the In-
3 spector General of the Department of Health and
4 Human Services and the Attorney General shall
5 have access to claims and payment data of the De-
6 partment of Health and Human Services and its
7 contractors related to titles XVIII, XIX, and XXI.

8 “(b) **OIG AUTHORITY TO OBTAIN INFORMATION.**—

9 “(1) **IN GENERAL.**—Notwithstanding and in ad-
10 dition to any other provision of law, the Inspector
11 General of the Department of Health and Human
12 Services may, for purposes of protecting the integ-
13 rity of the programs under titles XVIII and XIX,
14 obtain information from any individual (including a
15 beneficiary provided all applicable privacy protec-
16 tions are followed) or entity that—

17 “(A) is a provider of medical or other
18 items or services, supplier, grant recipient, con-
19 tractor, or subcontractor; or

20 “(B) directly or indirectly provides, orders,
21 manufactures, distributes, arranges for, pre-
22 scribes, supplies, or receives medical or other
23 items or services payable by any Federal health
24 care program (as defined in section 1128B(f))

1 regardless of how the item or service is paid
2 for, or to whom such payment is made.

3 “(2) INCLUSION OF CERTAIN INFORMATION.—
4 Information which the Inspector General may obtain
5 under paragraph (1) includes any supporting docu-
6 mentation necessary to validate claims for payment
7 or payments under title XVIII or XIX, including a
8 prescribing physician’s medical records for an indi-
9 vidual who is prescribed an item or service which is
10 covered under part B of title XVIII, a covered part
11 D drug (as defined in section 1860D–2(e)) for which
12 payment is made under an MA–PD plan under part
13 C of such title, or a prescription drug plan under
14 part D of such title, and any records necessary for
15 evaluation of the economy, efficiency, and effective-
16 ness of the programs under titles XVIII and XIX.

17 “(c) ADMINISTRATIVE REMEDY FOR KNOWING PAR-
18 TICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD
19 SCHEME.—

20 “(1) IN GENERAL.—In addition to any other
21 applicable remedies, if an applicable individual has
22 knowingly participated in a Federal health care
23 fraud offense or a conspiracy to commit a Federal
24 health care fraud offense, the Secretary shall impose

1 an appropriate administrative penalty commensurate
2 with the offense or conspiracy.

3 “(2) APPLICABLE INDIVIDUAL.—For purposes
4 of paragraph (1), the term ‘applicable individual’
5 means an individual—

6 “(A) entitled to, or enrolled for, benefits
7 under part A of title XVIII or enrolled under
8 part B of such title;

9 “(B) eligible for medical assistance under
10 a State plan under title XIX or under a waiver
11 of such plan; or

12 “(C) eligible for child health assistance
13 under a child health plan under title XXI.

14 “(d) REPORTING AND RETURNING OF OVERPAY-
15 MENTS.—

16 “(1) IN GENERAL.—If a person has received an
17 overpayment, the person shall—

18 “(A) report and return the overpayment to
19 the Secretary, the State, an intermediary, a
20 carrier, or a contractor, as appropriate, at the
21 correct address; and

22 “(B) notify the Secretary, State, inter-
23 mediary, carrier, or contractor to whom the
24 overpayment was returned in writing of the rea-
25 son for the overpayment.

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1 “(2) DEADLINE FOR REPORTING AND RETURN-
2 ING OVERPAYMENTS.—An overpayment must be re-
3 ported and returned under paragraph (1) by the
4 later of—

5 “(A) the date which is 60 days after the
6 date on which the overpayment was identified;
7 or

8 “(B) the date any corresponding cost re-
9 port is due, if applicable.

10 “(3) ENFORCEMENT.—Any overpayment re-
11 tained by a person after the deadline for reporting
12 and returning the overpayment under paragraph (2)
13 is an obligation (as defined in section 3729(b)(3) of
14 title 31, United States Code) for purposes of section
15 3729 of such title.

16 “(4) DEFINITIONS.—In this subsection:

17 “(A) KNOWING AND KNOWINGLY.—The
18 terms ‘knowing’ and ‘knowingly’ have the mean-
19 ing given those terms in section 3729(b) of title
20 31, United States Code.

21 “(B) OVERPAYMENT.—The term “overpay-
22 ment” means any funds that a person receives
23 or retains under title XVIII or XIX to which
24 the person, after applicable reconciliation, is not
25 entitled under such title.

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1 “(C) PERSON.—

2 “(i) IN GENERAL.—The term ‘person’
3 means a provider of services, supplier,
4 medicaid managed care organization (as
5 defined in section 1903(m)(1)(A)), Medi-
6 care Advantage organization (as defined in
7 section 1859(a)(1)), or PDP sponsor (as
8 defined in section 1860D–41(a)(13)).

9 “(ii) EXCLUSION.—Such term does
10 not include a beneficiary.

11 “(e) INCLUSION OF NATIONAL PROVIDER IDENTI-
12 FIER ON ALL APPLICATIONS AND CLAIMS.—The Sec-
13 retary shall promulgate a regulation that requires, not
14 later than January 1, 2011, all providers of medical or
15 other items or services and suppliers under the programs
16 under titles XVIII and XIX that qualify for a national
17 provider identifier to include their national provider identi-
18 fier on all applications to enroll in such programs and on
19 all claims for payment submitted under such programs.”.

20 (b) ACCESS TO DATA.—

21 (1) MEDICARE PART D.—Section 1860D–
22 15(f)(2) of the Social Security Act (42 U.S.C.
23 1395w–116(f)(2)) is amended by striking “may be
24 used by” and all that follows through the period at
25 the end and inserting “may be used—

1 “(A) by officers, employees, and contrac-
2 tors of the Department of Health and Human
3 Services for the purposes of, and to the extent
4 necessary in—

5 “(i) carrying out this section; and

6 “(ii) conducting oversight, evaluation,
7 and enforcement under this title; and

8 “(B) by the Attorney General and the
9 Comptroller General of the United States for
10 the purposes of, and to the extent necessary in,
11 carrying out health oversight activities.”.

12 (2) DATA MATCHING.—Section 552a(a)(8)(B)
13 of title 5, United States Code, is amended—

14 (A) in clause (vii), by striking “or” at the
15 end;

16 (B) in clause (viii), by inserting “or” after
17 the semicolon; and

18 (C) by adding at the end the following new
19 clause:

20 “(ix) matches performed by the Sec-
21 retary of Health and Human Services or
22 the Inspector General of the Department
23 of Health and Human Services with re-
24 spect to potential fraud, waste, and abuse,

1 including matches of a system of records
2 with non-Federal records;”.

3 (3) MATCHING AGREEMENTS WITH THE COM-
4 MISSIONER OF SOCIAL SECURITY.—Section 205(r) of
5 the Social Security Act (42 U.S.C. 405(r)) is amend-
6 ed by adding at the end the following new para-
7 graph:

8 “(9)(A) The Commissioner of Social Security
9 shall, upon the request of the Secretary or the In-
10 spector General of the Department of Health and
11 Human Services—

12 “(i) enter into an agreement with the Sec-
13 retary or such Inspector General for the pur-
14 pose of matching data in the system of records
15 of the Social Security Administration and the
16 system of records of the Department of Health
17 and Human Services; and

18 “(ii) include in such agreement safeguards
19 to assure the maintenance of the confidentiality
20 of any information disclosed.

21 “(B) For purposes of this paragraph, the term
22 ‘system of records’ has the meaning given such term
23 in section 552a(a)(5) of title 5, United States
24 Code.”.

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1 (c) WITHHOLDING OF FEDERAL MATCHING PAY-
2 MENTS FOR STATES THAT FAIL TO REPORT ENROLLEE
3 ENCOUNTER DATA IN THE MEDICAID STATISTICAL IN-
4 FORMATION SYSTEM.—Section 1903(i) of the Social Secu-
5 rity Act (42 U.S.C. 1396b(i)) is amended—

6 (1) in paragraph (23), by striking “or” at the
7 end;

8 (2) in paragraph (24), by striking the period at
9 the end and inserting “; or”; and

10 (3) by adding at the end the following new
11 paragraph:

12 “(25) with respect to any amounts expended for
13 medical assistance for individuals for whom the
14 State does not report enrollee encounter data (as de-
15 fined by the Secretary) to the Medicaid Statistical
16 Information System (MSIS) in a timely manner (as
17 determined by the Secretary).”.

18 (d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY
19 PENALTIES.—

20 (1) PERMISSIVE EXCLUSIONS.—Section 1128(b)
21 of the Social Security Act (42 U.S.C. 1320a–7(b))
22 is amended by adding at the end the following new
23 paragraph:

24 “(16) MAKING FALSE STATEMENTS OR MIS-
25 REPRESENTATION OF MATERIAL FACTS.—Any indi-

1 vidual or entity that knowingly makes or causes to
2 be made any false statement, omission, or misrepre-
3 sentation of a material fact in any application,
4 agreement, bid, or contract to participate or enroll
5 as a provider of services or supplier under a Federal
6 health care program (as defined in section
7 1128B(f)), including Medicare Advantage organiza-
8 tions under part C of title XVIII, prescription drug
9 plan sponsors under part D of title XVIII, medicaid
10 managed care organizations under title XIX, and en-
11 tities that apply to participate as providers of serv-
12 ices or suppliers in such managed care organizations
13 and such plans.”.

14 (2) CIVIL MONETARY PENALTIES.—

15 (A) IN GENERAL.—Section 1128A(a) of
16 the Social Security Act (42 U.S.C. 1320a-
17 7a(a)) is amended—

18 (i) in paragraph (1)(D), by striking
19 “was excluded” and all that follows
20 through the period at the end and insert-
21 ing “was excluded from the Federal health
22 care program (as defined in section
23 1128B(f)) under which the claim was
24 made pursuant to Federal law.”;

1 (ii) in paragraph (6), by striking “or”
2 at the end;

3 (iii) by inserting after paragraph (7),
4 the following new paragraphs:

5 “(8) orders or prescribes a medical or other
6 item or service during a period in which the person
7 was excluded from a Federal health care program
8 (as so defined), in the case where the person knows
9 or should know that a claim for such medical or
10 other item or service will be made under such a pro-
11 gram;

12 “(9) knowingly makes or causes to be made any
13 false statement, omission, or misrepresentation of a
14 material fact in any application, bid, or contract to
15 participate or enroll as a provider of services or a
16 supplier under a Federal health care program (as so
17 defined), including Medicare Advantage organiza-
18 tions under part C of title XVIII, prescription drug
19 plan sponsors under part D of title XVIII, medicaid
20 managed care organizations under title XIX, and en-
21 tities that apply to participate as providers of serv-
22 ices or suppliers in such managed care organizations
23 and such plans;

24 “(10) knows of an overpayment (as defined in
25 paragraph (4) of section 1128J(d)) and does not re-

1 port and return the overpayment in accordance with
2 such section;”;

3 (iv) in the first sentence—

4 (I) by striking the “or” after
5 “prohibited relationship occurs;”; and

6 (II) by striking “act)” and in-
7 serting “act; or in cases under para-
8 graph (9), \$50,000 for each false
9 statement or misrepresentation of a
10 material fact)”;

11 (v) in the second sentence, by striking
12 “purpose)” and inserting “purpose; or in
13 cases under paragraph (9), an assessment
14 of not more than 3 times the total amount
15 claimed for each item or service for which
16 payment was made based upon the applica-
17 tion containing the false statement or mis-
18 representation of a material fact)”.

19 (B) CLARIFICATION OF TREATMENT OF
20 CERTAIN CHARITABLE AND OTHER INNOCUOUS
21 PROGRAMS.—Section 1128A(i)(6) of the Social
22 Security Act (42 U.S.C. 1320a–7a(i)(6)) is
23 amended—

24 (i) in subparagraph (C), by striking
25 “or” at the end;

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1 (ii) in subparagraph (D), as redesignig-
2 nated by section 4331(e) of the Balanced
3 Budget Act of 1997 (Public Law 105–33),
4 by striking the period at the end and in-
5 serting a semicolon;

6 (iii) by redesignating subparagraph
7 (D), as added by section 4523(c) of such
8 Act, as subparagraph (E) and striking the
9 period at the end and inserting “; or”; and

10 (iv) by adding at the end the following
11 new subparagraphs:

12 “(F) any other remuneration which pro-
13 motes access to care and poses a low risk of
14 harm to patients and Federal health care pro-
15 grams (as defined in section 1128B(f) and des-
16 ignated by the Secretary under regulations);

17 “(G) the offer or transfer of items or serv-
18 ices for free or less than fair market value by
19 a person, if—

20 “(i) the items or services consist of
21 coupons, rebates, or other rewards from a
22 retailer;

23 “(ii) the items or services are offered
24 or transferred on equal terms available to

1 the general public, regardless of health in-
2 surance status; and

3 “(iii) the offer or transfer of the items
4 or services is not tied to the provision of
5 other items or services reimbursed in whole
6 or in part by the program under title
7 XVIII or a State health care program (as
8 defined in section 1128(h));

9 “(H) the offer or transfer of items or serv-
10 ices for free or less than fair market value by
11 a person, if—

12 “(i) the items or services are not of-
13 fered as part of any advertisement or solici-
14 tation;

15 “(ii) the items or services are not tied
16 to the provision of other services reim-
17 bursed in whole or in part by the program
18 under title XVIII or a State health care
19 program (as so defined);

20 “(iii) there is a reasonable connection
21 between the items or services and the med-
22 ical care of the individual; and

23 “(iv) the person provides the items or
24 services after determining in good faith
25 that the individual is in financial need; or

1 “(I) effective on a date specified by the
2 Secretary (but not earlier than January 1,
3 2011), the waiver by a PDP sponsor of a pre-
4 scription drug plan under part D of title XVIII
5 or an MA organization offering an MA–PD
6 plan under part C of such title of any copay-
7 ment for the first fill of a covered part D drug
8 (as defined in section 1860D–2(e)) that is a ge-
9 neric drug for individuals enrolled in the pre-
10 scription drug plan or MA–PD plan, respec-
11 tively.”.

12 (e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLU-
13 SION-ONLY CASES.—Section 1128(f) of the Social Secu-
14 rity Act (42 U.S.C. 1320a–7(f)) is amended by adding at
15 the end the following new paragraph:

16 “(4) The provisions of subsections (d) and (e)
17 of section 205 shall apply with respect to this sec-
18 tion to the same extent as they are applicable with
19 respect to title II. The Secretary may delegate the
20 authority granted by section 205(d) (as made appli-
21 cable to this section) to the Inspector General of the
22 Department of Health and Human Services for pur-
23 poses of any investigation under this section.”.

24 (f) REVISING THE INTENT REQUIREMENT FOR
25 HEALTH CARE FRAUD.—Section 1128B of the Social Se-

1 curity Act (42 U.S.C. 1320a–7b) is amended by adding
2 at the end the following new subsection:

3 “(g) With respect to violations of this section, a per-
4 son need not have actual knowledge of this section or spe-
5 cific intent to commit a violation of this section.”.

6 (g) SURETY BOND REQUIREMENTS.—

7 (1) DURABLE MEDICAL EQUIPMENT.—Section
8 1834(a)(16)(B) of the Social Security Act (42
9 U.S.C. 1395m(a)(16)(B)) is amended by inserting
10 “that the Secretary determines is commensurate
11 with the volume of the billing of the supplier” before
12 the period at the end.

13 (2) HOME HEALTH AGENCIES.—Section
14 1861(o)(7)(C) of the Social Security Act (42 U.S.C.
15 1395x(o)(7)(C)) is amended by inserting “that the
16 Secretary determines is commensurate with the vol-
17 ume of the billing of the home health agency” before
18 the semicolon at the end.

19 (3) REQUIREMENTS FOR CERTAIN OTHER PRO-
20 VIDERS OF SERVICES AND SUPPLIERS.—Section
21 1862 of the Social Security Act (42 U.S.C. 1395y)
22 is amended by adding at the end the following new
23 subsection:

24 “(n) REQUIREMENT OF A SURETY BOND FOR CER-
25 TAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

1 “(1) IN GENERAL.—The Secretary may require
2 a provider of services or supplier described in para-
3 graph (2) to provide the Secretary on a continuing
4 basis with a surety bond in a form specified by the
5 Secretary in an amount (not less than \$50,000) that
6 the Secretary determines is commensurate with the
7 volume of the billing of the provider of services or
8 supplier. The Secretary may waive the requirement
9 of a bond under the preceding sentence in the case
10 of a provider of services or supplier that provides a
11 comparable surety bond under State law.

12 “(2) PROVIDER OF SERVICES OR SUPPLIER DE-
13 SCRIBED.—A provider of services or supplier de-
14 scribed in this paragraph is a provider of services or
15 supplier the Secretary determines appropriate based
16 on the level of risk involved with respect to the pro-
17 vider of services or supplier, and consistent with the
18 surety bond requirements under sections
19 1834(a)(16)(B) and 1861(o)(7)(C).”.

20 (h) SUSPENSION OF MEDICARE AND MEDICAID PAY-
21 MENTS PENDING INVESTIGATION OF CREDIBLE ALLEGA-
22 TIONS OF FRAUD.—

23 (1) MEDICARE.—Section 1862 of the Social Se-
24 curity Act (42 U.S.C. 1395y), as amended by sub-

1 section (g)(3), is amended by adding at the end the
2 following new subsection:

3 “(o) SUSPENSION OF PAYMENTS PENDING INVES-
4 TIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

5 “(1) IN GENERAL.—The Secretary may suspend
6 payments to a provider of services or supplier under
7 this title pending an investigation of a credible alle-
8 gation of fraud against the provider of services or
9 supplier, unless the Secretary determines there is
10 good cause not to suspend such payments.

11 “(2) CONSULTATION.—The Secretary shall con-
12 sult with the Inspector General of the Department
13 of Health and Human Services in determining
14 whether there is a credible allegation of fraud
15 against a provider of services or supplier.

16 “(3) PROMULGATION OF REGULATIONS.—The
17 Secretary shall promulgate regulations to carry out
18 this subsection and section 1903(i)(2)(C).”.

19 (2) MEDICAID.—Section 1903(i)(2) of such Act
20 (42 U.S.C. 1396b(i)(2)) is amended—

21 (A) in subparagraph (A), by striking “or”
22 at the end; and

23 (B) by inserting after subparagraph (B),
24 the following:

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1 “(C) by any individual or entity to whom
2 the State has failed to suspend payments under
3 the plan during any period when there is pend-
4 ing an investigation of a credible allegation of
5 fraud against the individual or entity, as deter-
6 mined by the State in accordance with regula-
7 tions promulgated by the Secretary for pur-
8 poses of section 1862(o) and this subparagraph,
9 unless the State determines in accordance with
10 such regulations there is good cause not to sus-
11 pend such payments; or”.

12 (i) INCREASED FUNDING TO FIGHT FRAUD AND
13 ABUSE.—

14 (1) IN GENERAL.—Section 1817(k) of the So-
15 cial Security Act (42 U.S.C. 1395i(k)) is amended—

16 (A) by adding at the end the following new
17 paragraph:

18 “(7) ADDITIONAL FUNDING.—In addition to the
19 funds otherwise appropriated to the Account from
20 the Trust Fund under paragraphs (3) and (4) and
21 for purposes described in paragraphs (3)(C) and
22 (4)(A), there are hereby appropriated an additional
23 \$10,000,000 to such Account from such Trust Fund
24 for each of fiscal years 2011 through 2020. The
25 funds appropriated under this paragraph shall be al-

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1 located in the same proportion as the total funding
2 appropriated with respect to paragraphs (3)(A) and
3 (4)(A) was allocated with respect to fiscal year
4 2010, and shall be available without further appro-
5 priation until expended.”; and

6 (B) in paragraph (4)(A), by inserting
7 “until expended” after “appropriation”.

8 (2) INDEXING OF AMOUNTS APPROPRIATED.—

9 (A) DEPARTMENTS OF HEALTH AND
10 HUMAN SERVICES AND JUSTICE.—Section
11 1817(k)(3)(A)(i) of the Social Security Act (42
12 U.S.C. 1395i(k)(3)(A)(i)) is amended—

13 (i) in subclause (III), by inserting
14 “and” at the end;

15 (ii) in subclause (IV)—

16 (I) by striking “for each of fiscal
17 years 2007, 2008, 2009, and 2010”
18 and inserting “for each fiscal year
19 after fiscal year 2006”; and

20 (II) by striking “; and” and in-
21 serting a period; and

22 (iii) by striking subclause (V).

23 (B) OFFICE OF THE INSPECTOR GENERAL
24 OF THE DEPARTMENT OF HEALTH AND HUMAN
25 SERVICES.—Section 1817(k)(3)(A)(ii) of such

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1 Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amend-
2 ed—

3 (i) in subclause (VIII), by inserting
4 “and” at the end;

5 (ii) in subclause (IX)—

6 (I) by striking “for each of fiscal
7 years 2008, 2009, and 2010” and in-
8 serting “for each fiscal year after fis-
9 cal year 2007”; and

10 (II) by striking “; and” and in-
11 serting a period; and

12 (iii) by striking subclause (X).

13 (C) FEDERAL BUREAU OF INVESTIGA-
14 TION.—Section 1817(k)(3)(B) of the Social Se-
15 curity Act (42 U.S.C. 1395i(k)(3)(B)) is
16 amended—

17 (i) in clause (vii), by inserting “and”
18 at the end;

19 (ii) in clause (viii)—

20 (I) by striking “for each of fiscal
21 years 2007, 2008, 2009, and 2010”
22 and inserting “for each fiscal year
23 after fiscal year 2006”; and

24 (II) by striking “; and” and in-
25 serting a period; and

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1 (iii) by striking clause (ix).

2 (D) MEDICARE INTEGRITY PROGRAM.—

3 Section 1817(k)(4)(C) of the Social Security
4 Act (42 U.S.C. 1395i(k)(4)(C)) is amended by
5 adding at the end the following new clause:

6 “(ii) For each fiscal year after 2010,
7 by the percentage increase in the consumer
8 price index for all urban consumers (all
9 items; United States city average) over the
10 previous year.”.

11 (j) MEDICARE INTEGRITY PROGRAM AND MEDICAID
12 INTEGRITY PROGRAM.—

13 (1) MEDICARE INTEGRITY PROGRAM.—

14 (A) REQUIREMENT TO PROVIDE PERFORM-
15 ANCE STATISTICS.—Section 1893(c) of the So-
16 cial Security Act (42 U.S.C. 1395ddd(e)) is
17 amended—

18 (i) in paragraph (3), by striking
19 “and” at the end;

20 (ii) by redesignating paragraph (4) as
21 paragraph (5); and

22 (iii) by inserting after paragraph (3)
23 the following new paragraph:

24 “(4) the entity agrees to provide the Secretary
25 and the Inspector General of the Department of

1 Health and Human Services with such performance
2 statistics (including the number and amount of over-
3 payments recovered, the number of fraud referrals,
4 and the return on investment of such activities by
5 the entity) as the Secretary or the Inspector General
6 may request; and”.

7 (B) EVALUATIONS AND ANNUAL RE-
8 PORT.—Section 1893 of the Social Security Act
9 (42 U.S.C. 1395ddd) is amended by adding at
10 the end the following new subsection:

11 “(i) EVALUATIONS AND ANNUAL REPORT.—

12 “(1) EVALUATIONS.—The Secretary shall con-
13 duct evaluations of eligible entities which the Sec-
14 retary contracts with under the Program not less
15 frequently than every 3 years.

16 “(2) ANNUAL REPORT.—Not later than 180
17 days after the end of each fiscal year (beginning
18 with fiscal year 2011), the Secretary shall submit a
19 report to Congress which identifies—

20 “(A) the use of funds, including funds
21 transferred from the Federal Hospital Insur-
22 ance Trust Fund under section 1817 and the
23 Federal Supplementary Insurance Trust Fund
24 under section 1841, to carry out this section;
25 and

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1 “(B) the effectiveness of the use of such
2 funds.”.

3 (C) FLEXIBILITY IN PURSUING FRAUD
4 AND ABUSE.—Section 1893(a) of the Social Se-
5 curity Act (42 U.S.C. 1395ddd(a)) is amended
6 by inserting “, or otherwise,” after “entities”.

7 (2) MEDICAID INTEGRITY PROGRAM.—

8 (A) REQUIREMENT TO PROVIDE PERFORM-
9 ANCE STATISTICS.—Section 1936(c)(2) of the
10 Social Security Act (42 U.S.C. 1396u–6(c)(2))
11 is amended—

12 (i) by redesignating subparagraph (D)
13 as subparagraph (E); and

14 (ii) by inserting after subparagraph
15 (C) the following new subparagraph:

16 “(D) The entity agrees to provide the Sec-
17 retary and the Inspector General of the Depart-
18 ment of Health and Human Services with such
19 performance statistics (including the number
20 and amount of overpayments recovered, the
21 number of fraud referrals, and the return on in-
22 vestment of such activities by the entity) as the
23 Secretary or the Inspector General may re-
24 quest.”.

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1 (B) EVALUATIONS AND ANNUAL RE-
2 PORT.—Section 1936(e) of the Social Security
3 Act (42 U.S.C. 1396u–7(e)) is amended—

4 (i) by redesignating paragraph (4) as
5 paragraph (5); and

6 (ii) by inserting after paragraph (3)
7 the following new paragraph:

8 “(4) EVALUATIONS.—The Secretary shall con-
9 duct evaluations of eligible entities which the Sec-
10 retary contracts with under the Program not less
11 frequently than every 3 years.”.

12 (k) EXPANDED APPLICATION OF HARDSHIP WAIV-
13 ERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the So-
14 cial Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amend-
15 ed by striking “individuals entitled to benefits under part
16 A of title XVIII or enrolled under part B of such title,
17 or both” and inserting “beneficiaries (as defined in section
18 1128A(i)(5)) of that program”.

19 **SEC. 5003. ELIMINATION OF DUPLICATION BETWEEN THE**
20 **HEALTHCARE INTEGRITY AND PROTECTION**
21 **DATA BANK AND THE NATIONAL PRACTI-**
22 **TIONER DATA BANK.**

23 (a) INFORMATION REPORTED BY FEDERAL AGEN-
24 CIES AND HEALTH PLANS.—Section 1128E of the Social
25 Security Act (42 U.S.C. 1320a–7e) is amended—

1 (1) by striking subsection (a) and inserting the
2 following:

3 “(a) IN GENERAL.—The Secretary shall maintain a
4 national health care fraud and abuse data collection pro-
5 gram under this section for the reporting of certain final
6 adverse actions (not including settlements in which no
7 findings of liability have been made) against health care
8 providers, suppliers, or practitioners as required by sub-
9 section (b), with access as set forth in subsection (d), and
10 shall furnish the information collected under this section
11 to the National Practitioner Data Bank established pursu-
12 ant to the Health Care Quality Improvement Act of 1986
13 (42 U.S.C. 11101 et seq.).”;

14 (2) by striking subsection (d) and inserting the
15 following:

16 “(d) ACCESS TO REPORTED INFORMATION.—

17 “(1) AVAILABILITY.—The information collected
18 under this section shall be available from the Na-
19 tional Practitioner Data Bank to the agencies, au-
20 thorities, and officials which are provided under sec-
21 tion 1921(b) information reported under section
22 1921(a).

23 “(2) FEES FOR DISCLOSURE.—The Secretary
24 may establish or approve reasonable fees for the dis-
25 closure of information under this section. The

1 amount of such a fee may not exceed the costs of
2 processing the requests for disclosure and of pro-
3 viding such information. Such fees shall be available
4 to the Secretary to cover such costs.”;

5 (3) by striking subsection (f) and inserting the
6 following:

7 “(f) APPROPRIATE COORDINATION.—In imple-
8 menting this section, the Secretary shall provide for the
9 maximum appropriate coordination with part B of the
10 Health Care Quality Improvement Act of 1986 (42 U.S.C.
11 11131 et seq.) and section 1921.”; and

12 (4) in subsection (g)—

13 (A) in paragraph (1)(A)—

14 (i) in clause (iii)—

15 (I) by striking “or State” each
16 place it appears;

17 (II) by redesignating subclauses
18 (II) and (III) as subclauses (III) and
19 (IV), respectively; and

20 (III) by inserting after subclause
21 (I) the following new subclause:

22 “(II) any dismissal or closure of
23 the proceedings by reason of the pro-
24 vider, supplier, or practitioner surren-

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1 dering their license or leaving the
2 State or jurisdiction”; and

3 (ii) by striking clause (iv) and insert-
4 ing the following:

5 “(iv) Exclusion from participation in a
6 Federal health care program (as defined in
7 section 1128B(f)).”;

8 (B) in paragraph (3)—

9 (i) by striking subparagraphs (D) and
10 (E); and

11 (ii) by redesignating subparagraph
12 (F) as subparagraph (D); and

13 (C) in subparagraph (D) (as so redesign-
14 ated), by striking “or State”.

15 (b) INFORMATION REPORTED BY STATE LAW OR
16 FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the
17 Social Security Act (42 U.S.C. 1396r-2) is amended—

18 (1) in subsection (a)—

19 (A) in paragraph (1)—

20 (i) by striking “SYSTEM.—The State”
21 and all that follows through the semicolon
22 and inserting SYSTEM.—

23 “(A) LICENSING OR CERTIFICATION AC-
24 TIONS.—The State must have in effect a system
25 of reporting the following information with re-

1 spect to formal proceedings (as defined by the
2 Secretary in regulations) concluded against a
3 health care practitioner or entity by a State li-
4 censing or certification agency.”;

5 (ii) by redesignating subparagraphs
6 (A) through (D) as clauses (i) through
7 (iv), respectively, and indenting appro-
8 priately;

9 (iii) in subparagraph (A)(iii) (as so
10 redesignated)—

11 (I) by striking “the license of”
12 and inserting “license or the right to
13 apply for, or renew, a license by”; and

14 (II) by inserting “nonrenew-
15 ability,” after “voluntary surrender,”;
16 and

17 (iv) by adding at the end the following
18 new subparagraph:

19 “(B) OTHER FINAL ADVERSE ACTIONS.—
20 The State must have in effect a system of re-
21 porting information with respect to any final
22 adverse action (not including settlements in
23 which no findings of liability have been made)
24 taken against a health care provider, supplier,

1 or practitioner by a State law or fraud enforce-
2 ment agency.”; and

3 (B) in paragraph (2), by striking “the au-
4 thority described in paragraph (1)” and insert-
5 ing “a State licensing or certification agency or
6 State law or fraud enforcement agency”;

7 (2) in subsection (b)—

8 (A) by striking paragraph (2) and insert-
9 ing the following:

10 “(2) to State licensing or certification agencies
11 and Federal agencies responsible for the licensing
12 and certification of health care providers, suppliers,
13 and licensed health care practitioners;”;

14 (B) in each of paragraphs (4) and (6), by
15 inserting “, but only with respect to information
16 provided pursuant to subsection (a)(1)(A)” be-
17 fore the comma at the end;

18 (C) by striking paragraph (5) and insert-
19 ing the following:

20 “(5) to State law or fraud enforcement agen-
21 cies;”;

22 (D) by redesignating paragraphs (7) and
23 (8) as paragraphs (8) and (9), respectively; and

24 (E) by inserting after paragraph (6) the
25 following new paragraph:

1 “(7) to health plans (as defined in section
2 1128C(c));”;

3 (3) by redesignating subsection (d) as sub-
4 section (h), and by inserting after subsection (e) the
5 following new subsections:

6 “(d) DISCLOSURE AND CORRECTION OF INFORMA-
7 TION.—

8 “(1) DISCLOSURE.—With respect to informa-
9 tion reported pursuant to subsection (a)(1), the Sec-
10 retary shall—

11 “(A) provide for disclosure of the informa-
12 tion, upon request, to the health care practi-
13 tioner who, or the entity that, is the subject of
14 the information reported; and

15 “(B) establish procedures for the case
16 where the health care practitioner or entity dis-
17 putes the accuracy of the information reported.

18 “(2) CORRECTIONS.—Each State licensing or
19 certification agency and State law or fraud enforce-
20 ment agency shall report corrections of information
21 already reported about any formal proceeding or
22 final adverse action described in subsection (a), in
23 such form and manner as the Secretary prescribes
24 by regulation.

1 “(e) FEES FOR DISCLOSURE.—The Secretary may
2 establish or approve reasonable fees for the disclosure of
3 information under this section. The amount of such a fee
4 may not exceed the costs of processing the requests for
5 disclosure and of providing such information. Such fees
6 shall be available to the Secretary to cover such costs.

7 “(f) PROTECTION FROM LIABILITY FOR REPORT-
8 ING.—No person or entity, including any agency des-
9 ignated by the Secretary in subsection (b), shall be held
10 liable in any civil action with respect to any reporting of
11 information as required under this section, without knowl-
12 edge of the falsity of the information contained in the re-
13 port.

14 “(g) REFERENCES.—For purposes of this section:

15 “(1) STATE LICENSING OR CERTIFICATION
16 AGENCY.—The term ‘State licensing or certification
17 agency’ includes any authority of a State (or of a
18 political subdivision thereof) responsible for the li-
19 censing of health care practitioners (or any peer re-
20 view organization or private accreditation entity re-
21 viewing the services provided by health care practi-
22 tioners) or entities.

23 “(2) STATE LAW OR FRAUD ENFORCEMENT
24 AGENCY.—The term ‘State law or fraud enforcement
25 agency’ includes—

1 “(A) a State law enforcement agency; and

2 “(B) a State medicaid fraud control unit

3 (as defined in section 1903(q)).

4 “(3) FINAL ADVERSE ACTION.—

5 “(A) IN GENERAL.—Subject to subpara-

6 graph (B), the term ‘final adverse action’ in-

7 cludes—

8 “(i) civil judgments against a health
9 care provider, supplier, or practitioner in
10 State court related to the delivery of a
11 health care item or service;

12 “(ii) State criminal convictions related
13 to the delivery of a health care item or
14 service;

15 “(iii) exclusion from participation in
16 State health care programs (as defined in
17 section 1128(h));

18 “(iv) any licensing or certification ac-
19 tion described in subsection (a)(1)(A)
20 taken against a supplier by a State licens-
21 ing or certification agency; and

22 “(v) any other adjudicated actions or
23 decisions that the Secretary shall establish
24 by regulation.

1 “(B) EXCEPTION.—Such term does not in-
2 clude any action with respect to a malpractice
3 claim.”; and

4 (4) in subsection (h), as so redesignated, by
5 striking “The Secretary” and all that follows
6 through the period at the end and inserting “In im-
7 plementing this section, the Secretary shall provide
8 for the maximum appropriate coordination with part
9 B of the Health Care Quality Improvement Act of
10 1986 (42 U.S.C. 11131 et seq.) and section
11 1128E.”.

12 (c) CONFORMING AMENDMENT.—Section
13 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-
14 7c(a)(1)) is amended—

15 (1) in subparagraph (C), by adding “and” after
16 the comma at the end;

17 (2) in subparagraph (D), by striking “, and”
18 and inserting a period; and

19 (3) by striking subparagraph (E).

20 (d) TRANSITION PROCESS; EFFECTIVE DATE.—

21 (1) IN GENERAL.—Effective on the date of en-
22 actment of this Act, the Secretary of Health and
23 Human Services (in this section referred to as the
24 “Secretary”) shall implement a transition process
25 under which, by not later than the end of the transi-

1 tion period described in paragraph (5), the Secretary
2 shall cease operating the Healthcare Integrity and
3 Protection Data Bank established under section
4 1128E of the Social Security Act (as in effect before
5 the effective date specified in paragraph (6)) and
6 shall transfer all data collected in the Healthcare In-
7 tegrity and Protection Data Bank to the National
8 Practitioner Data Bank established pursuant to the
9 Health Care Quality Improvement Act of 1986 (42
10 U.S.C. 11101 et seq.). During such transition proc-
11 ess, the Secretary shall have in effect appropriate
12 procedures to ensure that data collection and access
13 to the Healthcare Integrity and Protection Data
14 Bank and the National Practitioner Data Bank are
15 not disrupted.

16 (2) REGULATIONS.—The Secretary shall pro-
17 mulgate regulations to carry out the amendments
18 made by subsections (a) and (b).

19 (3) FUNDING.—

20 (A) AVAILABILITY OF FEES.—Fees col-
21 lected pursuant to section 1128E(d)(2) of the
22 Social Security Act prior to the effective date
23 specified in paragraph (6) for the disclosure of
24 information in the Healthcare Integrity and
25 Protection Data Bank shall be available to the

1 Secretary, without fiscal year limitation, for
2 payment of costs related to the transition pro-
3 cess described in paragraph (1). Any such fees
4 remaining after the transition period is com-
5 plete shall be available to the Secretary, without
6 fiscal year limitation, for payment of the costs
7 of operating the National Practitioner Data
8 Bank.

9 (B) AVAILABILITY OF ADDITIONAL
10 FUNDS.—In addition to the fees described in
11 subparagraph (A), any funds available to the
12 Secretary or to the Inspector General of the
13 Department of Health and Human Services for
14 a purpose related to combating health care
15 fraud, waste, or abuse shall be available to the
16 extent necessary for operating the Healthcare
17 Integrity and Protection Data Bank during the
18 transition period, including systems testing and
19 other activities necessary to ensure that infor-
20 mation formerly reported to the Healthcare In-
21 tegrity and Protection Data Bank will be acces-
22 sible through the National Practitioner Data
23 Bank after the end of such transition period.

1 (4) SPECIAL PROVISION FOR ACCESS TO THE
2 NATIONAL PRACTITIONER DATA BANK BY THE DE-
3 PARTMENT OF VETERANS AFFAIRS.—

4 (A) IN GENERAL.—Notwithstanding any
5 other provision of law, during the 1-year period
6 that begins on the effective date specified in
7 paragraph (6), the information described in
8 subparagraph (B) shall be available from the
9 National Practitioner Data Bank to the Sec-
10 retary of Veterans Affairs without charge.

11 (B) INFORMATION DESCRIBED.—For pur-
12 poses of subparagraph (A), the information de-
13 scribed in this subparagraph is the information
14 that would, but for the amendments made by
15 this section, have been available to the Sec-
16 retary of Veterans Affairs from the Healthcare
17 Integrity and Protection Data Bank.

18 (5) TRANSITION PERIOD DEFINED.—For pur-
19 poses of this subsection, the term “transition pe-
20 riod” means the period that begins on the date of
21 enactment of this Act and ends on the later of—

22 (A) the date that is 1 year after such date
23 of enactment; or

24 (B) the effective date of the regulations
25 promulgated under paragraph (2).

1 (6) EFFECTIVE DATE.—The amendments made
2 by subsections (a), (b), and (c) shall take effect on
3 the first day after the final day of the transition pe-
4 riod.

5 **SEC. 5004. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-**
6 **CARE CLAIMS REDUCED TO NOT MORE THAN**
7 **12 MONTHS.**

8 (a) REDUCING MAXIMUM PERIOD FOR SUBMIS-
9 SION.—

10 (1) PART A.—Section 1814(a) of the Social Se-
11 curity Act (42 U.S.C. 1395f(a)(1)) is amended—

12 (A) in paragraph (1), by striking “period
13 of 3 calendar years” and all that follows
14 through the semicolon and inserting “period
15 ending 1 calendar year after the date of serv-
16 ice;”; and

17 (B) by adding at the end the following new
18 sentence: “In applying paragraph (1), the Sec-
19 retary may specify exceptions to the 1 calendar
20 year period specified in such paragraph.”

21 (2) PART B.—

22 (A) Section 1842(b)(3) of such Act (42
23 U.S.C. 1395u(b)(3)(B)) is amended—

24 (i) in subparagraph (B), in the flush
25 language following clause (ii), by striking

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1 “close of the calendar year following the
2 year in which such service is furnished
3 (deeming any service furnished in the last
4 3 months of any calendar year to have
5 been furnished in the succeeding calendar
6 year)” and inserting “period ending 1 cal-
7 endar year after the date of service”; and

8 (ii) by adding at the end the following
9 new sentence: “In applying subparagraph
10 (B), the Secretary may specify exceptions
11 to the 1 calendar year period specified in
12 such subparagraph.”

13 (B) Section 1835(a) of such Act (42
14 U.S.C. 1395n(a)) is amended—

15 (i) in paragraph (1), by striking “pe-
16 riod of 3 calendar years” and all that fol-
17 lows through the semicolon and inserting
18 “period ending 1 calendar year after the
19 date of service;”; and

20 (ii) by adding at the end the following
21 new sentence: “In applying paragraph (1),
22 the Secretary may specify exceptions to the
23 1 calendar year period specified in such
24 paragraph.”

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 subsection (a) shall apply to services furnished on or
3 after January 1, 2010.

4 (2) SERVICES FURNISHED BEFORE 2010.—In
5 the case of services furnished before January 1,
6 2010, a bill or request for payment under section
7 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed
8 not later than December 31, 2010.

9 **SEC. 5005. PHYSICIANS WHO ORDER ITEMS OR SERVICES**
10 **REQUIRED TO BE MEDICARE ENROLLED PHY-**
11 **SICIANS OR ELIGIBLE PROFESSIONALS.**

12 (a) DME.—Section 1834(a)(11)(B) of the Social Se-
13 curity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
14 striking “physician” and inserting “physician enrolled
15 under section 1866(j) or an eligible professional under sec-
16 tion 1848(k)(3)(B) that is enrolled under section
17 1866(j)”.

18 (b) HOME HEALTH SERVICES.—

19 (1) PART A.—Section 1814(a)(2) of such Act
20 (42 U.S.C. 1395(a)(2)) is amended in the matter
21 preceding subparagraph (A) by inserting “in the
22 case of services described in subparagraph (C), a
23 physician enrolled under section 1866(j) or an eligi-
24 ble professional under section 1848(k)(3)(B),” be-
25 fore “or, in the case of services”.

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1 (2) PART B.—Section 1835(a)(2) of such Act
2 (42 U.S.C. 1395n(a)(2)) is amended in the matter
3 preceding subparagraph (A) by inserting “, or in the
4 case of services described in subparagraph (A), a
5 physician enrolled under section 1866(j) or an eligi-
6 ble professional under section 1848(k)(3)(B),” after
7 “a physician”.

8 (c) APPLICATION TO OTHER ITEMS OR SERVICES.—
9 The Secretary may extend the requirement applied by the
10 amendments made by subsections (a) and (b) to durable
11 medical equipment and home health services (relating to
12 requiring certifications and written orders to be made by
13 enrolled physicians and health professions) to all other
14 categories of items or services under title XVIII of the
15 Social Security Act (42 U.S.C. 1395 et seq.), including
16 covered part D drugs as defined in section 1860D–2(e)
17 of such Act (42 U.S.C. 1395w–102), that are ordered, pre-
18 scribed, or referred by a physician enrolled under section
19 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible
20 professional under section 1848(k)(3)(B) of such Act (42
21 U.S.C. 1395w–4(k)(3)(B)).

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to written orders and certifications
24 made on or after July 1, 2010.

1 **SEC. 5006. REQUIREMENT FOR PHYSICIANS TO PROVIDE**
2 **DOCUMENTATION ON REFERRALS TO PRO-**
3 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

4 (a) PHYSICIANS AND OTHER SUPPLIERS.—Section
5 1842(h) of the Social Security Act (42 U.S.C. 1395u(h))
6 is amended by adding at the end the following new para-
7 graph

8 “(9) The Secretary may revoke enrollment, for a pe-
9 riod of not more than one year for each act, for a physi-
10 cian or supplier under section 1866(j) if such physician
11 or supplier fails to maintain and, upon request of the Sec-
12 retary, provide access to documentation relating to written
13 orders or requests for payment for durable medical equip-
14 ment, certifications for home health services, or referrals
15 for other items or services written or ordered by such phy-
16 sician or supplier under this title, as specified by the Sec-
17 retary.”.

18 (b) PROVIDERS OF SERVICES.—Section 1866(a)(1)
19 of such Act (42 U.S.C. 1395cc) is further amended—

20 (1) in subparagraph (U), by striking at the end
21 “and”;

22 (2) in subparagraph (V), by striking the period
23 at the end and adding “; and”; and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 (A) by striking “and such services” and in-
2 serting “such services”; and

3 (B) by inserting after “care of a physi-
4 cian” the following: “, and, in the case of a cer-
5 tification made by a physician after January 1,
6 2010, prior to making such certification the
7 physician must document that the physician
8 himself or herself has had a face-to-face en-
9 counter (including through use of telehealth,
10 subject to the requirements in section 1834(m),
11 and other than with respect to encounters that
12 are incident to services involved) with the indi-
13 vidual within a reasonable timeframe as deter-
14 mined by the Secretary”.

15 (2) PART B.—Section 1835(a)(2)(A) of the So-
16 cial Security Act is amended—

17 (A) by striking “and” before “(iii)”; and

18 (B) by inserting after “care of a physi-
19 cian” the following: “, and (iv) in the case of
20 a certification after January 1, 2010, prior to
21 making such certification the physician must
22 document that the physician has had a face-to-
23 face encounter (including through use of tele-
24 health and other than with respect to encoun-
25 ters that are incident to services involved) with

1 the individual during the 6-month period pre-
2 ceding such certification, or other reasonable
3 timeframe as determined by the Secretary”.

4 (b) CONDITION OF PAYMENT FOR DURABLE MED-
5 ICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social
6 Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
7 adding at the end the following: “and shall require that
8 such an order be written pursuant to the physician docu-
9 menting that the physician has had a face-to-face encoun-
10 ter (including through use of telehealth and other than
11 with respect to encounters that are incident to services in-
12 volved) with the individual involved during the 6-month
13 period preceding such written order, or other reasonable
14 timeframe as determined by the Secretary”.

15 (c) APPLICATION TO OTHER AREAS UNDER MEDI-
16 CARE.—The Secretary may apply the face-to-face encoun-
17 ter requirement described in the amendments made by
18 subsections (a) and (b) to other items and services for
19 which payment is provided under title XVIII of the Social
20 Security Act based upon a finding that such an decision
21 would reduce the risk of waste, fraud, or abuse.

22 (d) APPLICATION TO MEDICAID.—The requirements
23 pursuant to the amendments made by subsections (a) and
24 (b) shall apply in the case of physicians making certifi-
25 cations for home health services under title XIX of the

1 Social Security Act in the same manner and to the same
2 extent as such requirements apply in the case of physi-
3 cians making such certifications under title XVIII of such
4 Act.

5 **SEC. 5008. ENHANCED PENALTIES.**

6 (a) CIVIL MONETARY PENALTIES FOR FALSE STATE-
7 MENTS OR DELAYING INSPECTIONS.—Section 1128A(a)
8 of the Social Security Act (42 U.S.C. 1320a–7a(a)), as
9 amended by section 5002(d)(2)(A), is amended—

10 (1) by inserting after paragraph (10) the fol-
11 lowing new paragraphs:

12 “(11) knowingly makes, uses, or causes to be
13 made or used, a false record or statement material
14 to a false or fraudulent claim for payment for items
15 and services furnished under a Federal health care
16 program; or

17 “(12) fails to grant timely access, upon reason-
18 able request (as defined by the Secretary in regula-
19 tions), to the Inspector General of the Department
20 of Health and Human Services, for the purpose of
21 audits, investigations, evaluations, or other statutory
22 functions of the Inspector General of the Depart-
23 ment of Health and Human Services;” and

24 (2) in the first sentence (as so amended)—

1 (A) by striking “or in cases under para-
2 graph (9)” and inserting “in cases under para-
3 graph (9)”; and

4 (B) by striking “a material fact)” and in-
5 serting “a material fact, in cases under para-
6 graph (11), \$50,000 for each false record or
7 statement, or in cases under paragraph (12),
8 \$15,000 for each day of the failure described in
9 such paragraph)”.

10 (b) MEDICARE ADVANTAGE AND PART D PLANS.—

11 (1) ENSURING TIMELY INSPECTIONS RELATING
12 TO CONTRACTS WITH MA ORGANIZATIONS.—Section
13 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2))
14 is amended—

15 (A) in subparagraph (A), by inserting
16 “timely” before “inspect”; and

17 (B) in subparagraph (B), by inserting
18 “timely” before “audit and inspect”.

19 (2) MARKETING VIOLATIONS.—Section
20 1857(g)(1) of the Social Security Act (42 U.S.C.
21 1395w—27(g)(1)) is amended—

22 (A) in subparagraph (F), by striking “or”
23 at the end;

24 (B) by inserting after subparagraph (G)
25 the following new subparagraphs:

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1 “(H) except as provided under subpara-
2 graph (C) or (D) of section 1860D–1(b)(1), en-
3 rolls an individual in any plan under this part
4 without the prior consent of the individual or
5 the designee of the individual;

6 “(I) transfers an individual enrolled under
7 this part from one plan to another without the
8 prior consent of the individual or the designee
9 of the individual or solely for the purpose of
10 earning a commission;

11 “(J) fails to comply with marketing re-
12 strictions described in subsections (h) and (j) of
13 section 1851 or applicable implementing regula-
14 tions or guidance; or

15 “(K) employs or contracts with any indi-
16 vidual or entity who engages in the conduct de-
17 scribed in subparagraphs (A) through (J) of
18 this paragraph;” and

19 (C) by adding at the end the following new
20 sentence: “The Secretary may provide, in addi-
21 tion to any other remedies authorized by law,
22 for any of the remedies described in paragraph
23 (2), if the Secretary determines that any em-
24 ployee or agent of such organization, or any
25 provider or supplier who contracts with such or-

1 ganization, has engaged in any conduct de-
2 scribed in subparagraphs (A) through (K) of
3 this paragraph.”.

4 (3) PROVISION OF FALSE INFORMATION.—Sec-
5 tion 1857(g)(2)(A) of the Social Security Act (42
6 U.S.C. 1395w—27(g)(2)(A)) is amended by insert-
7 ing “except with respect to a determination under
8 subparagraph (E), an assessment of not more than
9 the amount claimed by such plan or plan sponsor
10 based upon the misrepresentation or falsified infor-
11 mation involved,” after “for each such determina-
12 tion,”.

13 (c) OBSTRUCTION OF PROGRAM AUDITS.—Section
14 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a-
15 7(b)(2)) is amended—

16 (1) in the heading, by inserting “OR AUDIT”
17 after “INVESTIGATION”; and

18 (2) by striking “investigation into” and all that
19 follows through the period and inserting “investiga-
20 tion or audit related to—”

21 “(i) any offense described in para-
22 graph (1) or in subsection (a); or

23 “(ii) the use of funds received, directly
24 or indirectly, from any Federal health care

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1 program (as defined in section
2 1128B(f)).”.

3 (d) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by this section
6 shall apply to acts committed on or after January 1,
7 2010.

8 (2) EXCEPTION.—The amendments made by
9 subsection (b)(1) take effect on the date of enact-
10 ment of this Act.

11 **SEC. 5009. MEDICARE SELF-REFERRAL DISCLOSURE PRO-**
12 **TOCOL.**

13 (a) DEVELOPMENT OF SELF-REFERRAL DISCLO-
14 SURE PROTOCOL.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services, in cooperation with the Inspector
17 General of the Department of Health and Human
18 Services, shall establish, not later than 6 months
19 after the date of the enactment of this Act, a pro-
20 tocol to enable health care providers of services and
21 suppliers to disclose an actual or potential violation
22 of section 1877 of the Social Security Act (42
23 U.S.C. 1395nn) pursuant to a self-referral disclosure
24 protocol (in this section referred to as an “SRDP”).

1 The SRDP shall include direction to health care pro-
2 viders of services and suppliers on—

3 (A) a specific person, official, or office to
4 whom such disclosures shall be made; and

5 (B) instruction on the implication of the
6 SRDP on corporate integrity agreements and
7 corporate compliance agreements.

8 (2) PUBLICATION ON INTERNET WEBSITE OF
9 SRDP INFORMATION.—The Secretary of Health and
10 Human Services shall post information on the public
11 Internet website of the Centers for Medicare & Med-
12 icaid Services to inform relevant stakeholders of how
13 to disclose actual or potential violations pursuant to
14 an SRDP.

15 (3) RELATION TO ADVISORY OPINIONS.—The
16 SRDP shall be separate from the advisory opinion
17 process set forth in regulations implementing section
18 1877(g) of the Social Security Act.

19 (b) REDUCTION IN AMOUNTS OWED.—The Secretary
20 of Health and Human Services is authorized to reduce the
21 amount due and owing for all violations under section
22 1877 of the Social Security Act to an amount less than
23 that specified in subsection (g) of such section. In estab-
24 lishing such amount for a violation, the Secretary may
25 consider the following factors:

1 (1) The nature and extent of the improper or
2 illegal practice.

3 (2) The timeliness of such self-disclosure.

4 (3) The cooperation in providing additional in-
5 formation related to the disclosure.

6 (4) Such other factors as the Secretary con-
7 siders appropriate.

8 (c) REPORT.—Not later than 18 months after the
9 date on which the SRDP protocol is established under sub-
10 section (a)(1), the Secretary shall submit to Congress a
11 report on the implementation of this section. Such report
12 shall include—

13 (1) the number of health care providers of serv-
14 ices and suppliers making disclosures pursuant to
15 the SRDP;

16 (2) the amounts collected pursuant to the
17 SRDP;

18 (3) the types of violations reported under the
19 SRDP; and

20 (4) such other information as may be necessary
21 to evaluate the impact of this section.

1 **SEC. 5010. ADJUSTMENTS TO THE MEDICARE DURABLE**
2 **MEDICAL EQUIPMENT, PROSTHETICS,**
3 **ORTHOTICS, AND SUPPLIES COMPETITIVE**
4 **ACQUISITION PROGRAM.**

5 (a) EXPANSION OF ROUND 2 OF THE DME COM-
6 PETITIVE BIDDING PROGRAM.—Section 1847(a)(1) of the
7 Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amend-
8 ed—

9 (1) in subparagraph (B)(i)(II), by striking “70”
10 and inserting “91”; and

11 (2) in subparagraph (D)(ii)—

12 (A) in subclause (I), by striking “and” at
13 the end;

14 (B) by redesignating subclause (II) as sub-
15 clause (III); and

16 (C) by inserting after subclause (I) the fol-
17 lowing new subclause:

18 “(II) the Secretary shall include
19 the next 21 largest metropolitan sta-
20 tistical areas by total population
21 (after those selected under subclause
22 (I)) for such round; and”.

23 (b) REQUIREMENT TO EITHER COMPETITIVELY BID
24 AREAS OR USE COMPETITIVE BID PRICES BY 2016.—
25 Section 1834(a)(1)(F) of the Social Security Act (42
26 U.S.C. 1395m(a)(1)(F)) is amended—

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

2 (2) in clause (ii)—

3 (A) by inserting “(and, in the case of cov-
4 ered items furnished on or after January 1,
5 2016, subject to clause (iii), shall)” after
6 “may”; and

7 (B) by striking the period at the end and
8 inserting “; and”; and

9 (3) by adding at the end the following new
10 clause:

11 “(iii) in the case of covered items fur-
12 nished on or after January 1, 2016, the
13 Secretary may continue to make such ad-
14 justments described in clause (ii) as, under
15 such competitive acquisition programs, ad-
16 ditional covered items are phased in or in-
17 formation is updated as contracts under
18 section 1847 are recompeted in accordance
19 with section 1847(b)(3)(B).”.

20 **SEC. 5011. EXPANSION OF THE RECOVERY AUDIT CON-**
21 **TRACTOR (RAC) PROGRAM.**

22 (a) EXPANSION TO MEDICAID.—

23 (1) STATE PLAN AMENDMENT.—Section
24 1902(a)(42) of the Social Security Act (42 U.S.C.
25 1396a(a)(42)) is amended—

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1 (A) by striking “that the records” and in-
2 serting “that—

3 “(A) the records”;

4 (B) by inserting “and” after the semicolon;
5 and

6 (C) by adding at the end the following:

7 “(B) not later than December 31, 2010,
8 the State shall—

9 “(i) establish a program under which
10 the State contracts (consistent with State
11 law and in the same manner as the Sec-
12 retary enters into contracts with recovery
13 audit contractors under section 1893(h),
14 subject to such exceptions or requirements
15 as the Secretary may require for purposes
16 of this title or a particular State) with 1
17 or more recovery audit contractors for the
18 purpose of identifying underpayments and
19 overpayments and recouping overpayments
20 under the State plan and under any waiver
21 of the State plan with respect to all serv-
22 ices for which payment is made to any en-
23 tity under such plan or waiver; and

24 “(ii) provide assurances satisfactory
25 to the Secretary that—

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1 “(I) under such contracts, pay-
2 ment shall be made to such a con-
3 tractor only from amounts recovered;

4 “(II) from such amounts recov-
5 ered, payment—

6 “(aa) shall be made on a
7 contingent basis for collecting
8 overpayments; and

9 “(bb) may be made in such
10 amounts as the State may specify
11 for identifying underpayments;

12 “(III) the State has an adequate
13 process for entities to appeal any ad-
14 verse determination made by such
15 contractors; and

16 “(IV) such program is carried
17 out in accordance with such require-
18 ments as the Secretary shall specify,
19 including—

20 “(aa) for purposes of section
21 1903(a)(7), that amounts ex-
22 pended by the State to carry out
23 the program shall be considered
24 amounts expended as necessary
25 for the proper and efficient ad-

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1 ministration of the State plan or
2 a waiver of the plan;

3 “(bb) that section 1903(d)
4 shall apply to amounts recovered
5 under the program; and

6 “(cc) that the State and any
7 such contractors under contract
8 with the State shall coordinate
9 such recovery audit efforts with
10 other contractors or entities per-
11 forming audits of entities receiv-
12 ing payments under the State
13 plan or waiver in the State, in-
14 cluding efforts with Federal and
15 State law enforcement with re-
16 spect to the Department of Jus-
17 tice, including the Federal Bu-
18 reau of Investigations, the In-
19 spector General of the Depart-
20 ment of Health and Human
21 Services, and the State medicaid
22 fraud control unit; and”.

23 (2) COORDINATION; REGULATIONS.—

24 (A) IN GENERAL.—The Secretary of
25 Health and Human Services, acting through the

1 Administrator of the Centers for Medicare &
2 Medicaid Services, shall coordinate the expan-
3 sion of the Recovery Audit Contractor program
4 to Medicaid with States, particularly with re-
5 spect to each State that enters into a contract
6 with a recovery audit contractor for purposes of
7 the State's Medicaid program prior to Decem-
8 ber 31, 2010.

9 (B) REGULATIONS.—The Secretary of
10 Health and Human Services shall promulgate
11 regulations to carry out this subsection and the
12 amendments made by this subsection, including
13 with respect to conditions of Federal financial
14 participation, as specified by the Secretary.

15 (b) EXPANSION TO MEDICARE PARTS C AND D.—
16 Section 1893(h) of the Social Security Act (42 U.S.C.
17 1395ddd(h)) is amended—

18 (1) in paragraph (1), in the matter preceding
19 subparagraph (A), by striking “part A or B” and in-
20 serting “this title”;

21 (2) in paragraph (2), by striking “parts A and
22 B” and inserting “this title”;

23 (3) in paragraph (3), by inserting “(not later
24 than December 31, 2010, in the case of contracts re-

1 relating to payments made under part C or D)” after
2 “2010”;

3 (4) in paragraph (4), in the matter preceding
4 subparagraph (A), by striking “part A or B” and in-
5 serting “this title”; and

6 (5) by adding at the end the following:

7 “(9) SPECIAL RULES RELATING TO PARTS C
8 AND D.—The Secretary shall enter into contracts
9 under paragraph (1) to require recovery audit con-
10 tractors to—

11 “(A) ensure that each MA plan under part
12 C has an anti- fraud plan in effect and to re-
13 view the effectiveness of each such anti-fraud
14 plan;

15 “(B) ensure that each prescription drug
16 plan under part D has an anti- fraud plan in
17 effect and to review the effectiveness of each
18 such anti-fraud plan;

19 “(C) examine claims for reinsurance pay-
20 ments under section 1860D–15(b) to determine
21 whether prescription drug plans submitting
22 such claims incurred costs in excess of the al-
23 lowable reinsurance costs permitted under para-
24 graph (2) of that section; and

1 pation of such individual or entity is terminated under title
2 XVIII or any other State plan under this title.”.

3 **SEC. 5102. MEDICAID EXCLUSION FROM PARTICIPATION**
4 **RELATING TO CERTAIN OWNERSHIP, CON-**
5 **TROL, AND MANAGEMENT AFFILIATIONS.**

6 Section 1902(a) of the Social Security Act (42 U.S.C.
7 1396a(a)), as amended by section 5001(b), is amended by
8 inserting after paragraph (75) the following:

9 “(76) provide that the State agency described
10 in paragraph (9) exclude, with respect to a period,
11 any individual or entity from participation in the
12 program under the State plan if such individual or
13 entity owns, controls, or manages an entity that (or
14 if such entity is owned, controlled, or managed by an
15 individual or entity that)—

16 “(A) has unpaid overpayments (as defined
17 by the Secretary) under this title during such
18 period determined by the Secretary or the State
19 agency to be delinquent;

20 “(B) is suspended or excluded from par-
21 ticipation under or whose participation is termi-
22 nated under this title during such period; or

23 “(C) is affiliated with an individual or enti-
24 ty that has been suspended or excluded from
25 participation under this title or whose participa-

1 tion is terminated under this title during such
2 period;”.

3 **SEC. 5103. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**
4 **ALTERNATE PAYEES REQUIRED TO REG-**
5 **ISTER UNDER MEDICAID.**

6 (a) IN GENERAL.—Section 1902(a) of the Social Se-
7 curity Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended
8 by section 5102(a), is amended by inserting after para-
9 graph (76), the following:

10 “(77) provide that any agent, clearinghouse, or
11 other alternate payee (as defined by the Secretary)
12 that submits claims on behalf of a health care pro-
13 vider must register with the State and the Secretary
14 in a form and manner specified by the Secretary;
15 and”.

16 **SEC. 5104. REQUIREMENT TO REPORT EXPANDED SET OF**
17 **DATA ELEMENTS UNDER MMIS TO DETECT**
18 **FRAUD AND ABUSE.**

19 (a) IN GENERAL.—Section 1903(r)(1)(F) of the So-
20 cial Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended
21 by inserting after “necessary” the following: “and includ-
22 ing, for data submitted to the Secretary on or after Janu-
23 ary 1, 2010, data elements from the automated data sys-
24 tem that the Secretary determines to be necessary for pro-

1 gram integrity, program oversight, and administration, at
2 such frequency as the Secretary shall determine”.

3 (b) **MANAGED CARE ORGANIZATIONS.**—

4 (1) **IN GENERAL.**—Section 1903(m)(2)(A)(xi)
5 of the Social Security Act (42 U.S.C.
6 1396b(m)(2)(A)(xi)) is amended by inserting “and
7 for the provision of such data to the State at a fre-
8 quency and level of detail to be specified by the Sec-
9 retary” after “patients”.

10 (2) **EFFECTIVE DATE.**—The amendment made
11 by paragraph (1) shall apply with respect to contract
12 years beginning on or after January 1, 2010.

13 **SEC. 5105. PROHIBITION ON PAYMENTS TO INSTITUTIONS**
14 **OR ENTITIES LOCATED OUTSIDE OF THE**
15 **UNITED STATES.**

16 Section 1902(a) of the Social Security Act (42 U.S.C.
17 1396b(a)), as amended by section 5103, is amended by
18 inserting after paragraph (77) the following new para-
19 graph:

20 “(78) provide that the State shall not provide
21 any payments for items or services provided under
22 the State plan or under a waiver to any financial in-
23 stitution or entity located outside of the United
24 States.”.

1 **SEC. 5106. OVERPAYMENTS.**

2 (a) EXTENSION OF PERIOD FOR COLLECTION OF
3 OVERPAYMENTS DUE TO FRAUD.—

4 (1) IN GENERAL.—Section 1903(d)(2) of the
5 Social Security Act (42 U.S.C. 1396b(d)(2)) is
6 amended—

7 (A) in subparagraph (C)—

8 (i) in the first sentence, by striking
9 “60 days” and inserting “1 year”; and

10 (ii) in the second sentence, by striking
11 “60 days” and inserting “1-year period”;
12 and

13 (B) in subparagraph (D)—

14 (i) in inserting “(i)” after “(D)”; and

15 (ii) by adding at the end the fol-
16 lowing:

17 “(ii) In any case where the State is unable to recover
18 a debt which represents an overpayment (or any portion
19 thereof) made to a person or other entity due to fraud
20 within 1 year of discovery because there is not a final de-
21 termination of the amount of the overpayment under an
22 administrative or judicial process (as applicable), includ-
23 ing as a result of a judgment being under appeal, no ad-
24 justment shall be made in the Federal payment to such
25 State on account of such overpayment (or portion thereof)
26 before the date that is 30 days after the date on which

1 a final judgment (including, if applicable, a final deter-
2 mination on an appeal) is made.”.

3 (2) **EFFECTIVE DATE.**—The amendments made
4 by this subsection take effect on the date of enact-
5 ment of this Act and apply to overpayments discov-
6 ered on or after that date.

7 (b) **CORRECTIVE ACTION.**—The Secretary shall pro-
8 mulgate regulations that require States to correct Feder-
9 ally identified claims overpayments, of an ongoing or re-
10 curring nature, with new Medicaid Management Informa-
11 tion System (MMIS) edits, audits, or other appropriate
12 corrective action.

13 **SEC. 5107. MANDATORY STATE USE OF NATIONAL CORRECT**
14 **CODING INITIATIVE.**

15 Section 1903(r) of the Social Security Act (42 U.S.C.
16 1396b(r)) is amended—

17 (1) in paragraph (1)(B)—

18 (A) in clause (ii), by striking “and” at the
19 end;

20 (B) in clause (iii), by adding “and” after
21 the semi-colon; and

22 (C) by adding at the end the following new
23 clause:

24 “(iv) effective for claims filed on or
25 after October 1, 2010, incorporate compat-

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1 ible methodologies of the National Correct
2 Coding Initiative administered by the Sec-
3 retary (or any successor initiative to pro-
4 mote correct coding and to control im-
5 proper coding leading to inappropriate pay-
6 ment) and such other methodologies of
7 that Initiative (or such other national cor-
8 rect coding methodologies) as the Sec-
9 retary identifies in accordance with para-
10 graph (4);” and

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

13 “(4) For purposes of paragraph (1)(B)(iv), the Sec-
14 retary shall do the following:

15 “(A) Not later than September 1, 2010:

16 “(i) Identify those methodologies of the
17 National Correct Coding Initiative administered
18 by the Secretary (or any successor initiative to
19 promote correct coding and to control improper
20 coding leading to inappropriate payment) which
21 are compatible to claims filed under this title.

22 “(ii) Identify those methodologies of such
23 Initiative (or such other national correct coding
24 methodologies) that should be incorporated into
25 claims filed under this title with respect to

1 items or services for which States provide med-
2 ical assistance under this title and no national
3 correct coding methodologies have been estab-
4 lished under such Initiative with respect to title
5 XVIII.

6 “(iii) Notify States of—

7 “(I) the methodologies identified
8 under subparagraphs (A) and (B) (and of
9 any other national correct coding meth-
10 odologies identified under subparagraph
11 (B)); and

12 “(II) how States are to incorporate
13 such methodologies into claims filed under
14 this title.

15 “(B) Not later than March 1, 2011, submit a
16 report to Congress that includes the notice to States
17 under clause (iii) of subparagraph (A) and an anal-
18 ysis supporting the identification of the methodolo-
19 gies made under clauses (i) and (ii) of subparagraph
20 (A).”.

21 **SEC. 5108. GENERAL EFFECTIVE DATE.**

22 (a) IN GENERAL.—Except as otherwise provided in
23 this subtitle, this subtitle and the amendments made by
24 this subtitle take effect on January 1, 2011, without re-

1 gard to whether final regulations to carry out such amend-
2 ments and subtitle have been promulgated by that date.

3 (b) DELAY IF STATE LEGISLATION REQUIRED.—In
4 the case of a State plan for medical assistance under title
5 XIX of the Social Security Act or a child health plan
6 under title XXI of such Act which the Secretary of Health
7 and Human Services determines requires State legislation
8 (other than legislation appropriating funds) in order for
9 the plan to meet the additional requirement imposed by
10 the amendments made by this subtitle, the State plan or
11 child health plan shall not be regarded as failing to comply
12 with the requirements of such title solely on the basis of
13 its failure to meet this additional requirement before the
14 first day of the first calendar quarter beginning after the
15 close of the first regular session of the State legislature
16 that begins after the date of the enactment of this Act.
17 For purposes of the previous sentence, in the case of a
18 State that has a 2-year legislative session, each year of
19 such session shall be deemed to be a separate regular ses-
20 sion of the State legislature.

1 **TITLE VI—REVENUE**
2 **PROVISIONS**
3 **Subtitle A—Revenue Offset**
4 **Provisions**

5 **SEC. 6001. EXCISE TAX ON HIGH COST EMPLOYER-SPON-**
6 **SORED HEALTH COVERAGE.**

7 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
8 enue Code of 1986, as amended by section 1306, is
9 amended by adding at the end the following:

10 **“SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPON-**
11 **SORED HEALTH COVERAGE.**

12 “(a) IMPOSITION OF TAX.—If—

13 “(1) an employee is covered under any applica-
14 ble employer-sponsored coverage of an employer at
15 any time during a taxable period, and

16 “(2) there is any excess benefit with respect to
17 the coverage,

18 there is hereby imposed a tax equal to 40 percent of the
19 excess benefit.

20 “(b) EXCESS BENEFIT.—For purposes of this sec-
21 tion—

22 “(1) IN GENERAL.—The term ‘excess benefit’
23 means, with respect to any applicable employer-spon-
24 sored coverage made available by an employer to an
25 employee during any taxable period, the sum of the

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1 excess amounts determined under paragraph (2) for
2 months during the taxable period.

3 “(2) MONTHLY EXCESS AMOUNT.—The excess
4 amount determined under this paragraph for any
5 month is the excess (if any) of—

6 “(A) the aggregate cost of the applicable
7 employer-sponsored coverage of the employee
8 for the month, over

9 “(B) an amount equal to $\frac{1}{12}$ of the annual
10 limitation under paragraph (3) for the calendar
11 year in which the month occurs.

12 “(3) ANNUAL LIMITATION.—For purposes of
13 this subsection—

14 “(A) IN GENERAL.—The annual limitation
15 under this paragraph for any calendar year is
16 the dollar limit determined under subparagraph
17 (C) for the calendar year.

18 “(B) APPLICABLE ANNUAL LIMITATION.—
19 The annual limitation which applies for any
20 month shall be determined on the basis of the
21 type of coverage (as determined under sub-
22 section (f)(1)) provided to the employee by the
23 employer as of the beginning of the month.

24 “(C) APPLICABLE DOLLAR LIMIT.—Except
25 as provided in subparagraph (D)—

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1 “(i) 2013.—In the case of 2013, the
2 dollar limit under this subparagraph is—

3 “(I) in the case of an employee
4 with self-only coverage, \$8,000, and

5 “(II) in the case of an employee
6 with coverage other than self-only cov-
7 erage, \$21,000.

8 “(ii) EXCEPTION FOR CERTAIN RE-
9 TIRED EMPLOYEES AND EMPLOYEES EN-
10 GAGED IN HIGH-RISK PROFESSIONS.—In
11 the case of an individual receiving retiree
12 coverage who has attained age 55, and an
13 employee (other than such an individual)
14 who participates in a plan which covers
15 employees engaged in a high-risk profes-
16 sion—

17 “(I) the dollar amount in clause
18 (i)(I) (determined after the applica-
19 tion of subparagraph (D)) shall be in-
20 creased by \$1,850, and

21 “(II) the dollar amount in clause
22 (i)(II) (determined after the applica-
23 tion of such subparagraph) shall be
24 increased by \$5,000.

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1 “(iii) SUBSEQUENT YEARS.—In the
2 case of any calendar year after 2013, the
3 dollar limit under this subparagraph is an
4 amount equal to the sum of the applicable
5 dollar amount in effect for the calendar
6 year preceding such year under clause (i)
7 and the dollar amount of any increase
8 under clause (ii) as in effect for the cal-
9 endar year preceding such year, except
10 that each such amount shall be increased
11 by an amount equal to the product of—

12 “(I) such amount, multiplied by
13 “(II) the cost-of-living adjust-
14 ment determined under section 1(f)(3)
15 for such year (determined by
16 substituting the calendar year that
17 is 2 years before such year for ‘1992’
18 in subparagraph (B) thereof), in-
19 creased by 1 percentage point.

20 If the amount determined under this
21 clause is not a multiple of \$50, such
22 amount shall be rounded to the nearest
23 multiple of \$50.

24 “(D) TRANSITION RULE FOR STATES WITH
25 HIGHEST COVERAGE COSTS.—

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1 “(i) IN GENERAL.—If an employee is
2 a resident of a high cost State on the first
3 day of any month beginning in 2013,
4 2014, or 2015, the annual limitation under
5 this paragraph for such month with re-
6 spect to such employee shall be an amount
7 equal to the applicable percentage of the
8 annual limitation (determined without re-
9 gard to this subparagraph or subparagraph
10 (C)(ii)).

11 “(ii) APPLICABLE PERCENTAGE.—The
12 applicable percentage is 120 percent for
13 2013, 110 percent for 2014, and 105 per-
14 cent for 2015.

15 “(iii) HIGH COST STATE.—The term
16 ‘high cost State’ means each of the 17
17 States which the Secretary of Health and
18 Human Services, in consultation with the
19 Secretary, estimates had the highest aver-
20 age cost during 2012 for employer-spon-
21 sored coverage under health plans. The
22 Secretary’s estimate shall be made on the
23 basis of aggregate premiums paid in the
24 State for such health plans, determined

1 using the most recent data available as of
2 August 31, 2012.

3 “(c) LIABILITY TO PAY TAX.—

4 “(1) IN GENERAL.—Each coverage provider
5 shall pay the tax imposed by subsection (a) on its
6 applicable share of the excess benefit with respect to
7 an employee for any taxable period.

8 “(2) COVERAGE PROVIDER.—For purposes of
9 this subsection, the term ‘coverage provider’ means
10 each of the following:

11 “(A) HEALTH INSURANCE COVERAGE.—If
12 the applicable employer-sponsored coverage con-
13 sists of coverage under a group health plan
14 which provides health insurance coverage, the
15 health insurance issuer.

16 “(B) HSA CONTRIBUTIONS.—If the appli-
17 cable employer-sponsored coverage consists of
18 coverage under an arrangement under which
19 the employer makes contributions described in
20 subsection (b) or (d) of section 106, the em-
21 ployer.

22 “(C) OTHER COVERAGE.—In the case of
23 any other applicable employer-sponsored cov-
24 erage, the person that administers the plan ben-
25 efits.

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1 “(3) APPLICABLE SHARE.—For purposes of
2 this subsection, a coverage provider’s applicable
3 share of an excess benefit for any taxable period is
4 the amount which bears the same ratio to the
5 amount of such excess benefit as—

6 “(A) the cost of the applicable employer-
7 sponsored coverage provided by the provider to
8 the employee during such period, bears to

9 “(B) the aggregate cost of all applicable
10 employer-sponsored coverage provided to the
11 employee by all coverage providers during such
12 period.

13 “(4) RESPONSIBILITY TO CALCULATE TAX AND
14 APPLICABLE SHARES.—

15 “(A) IN GENERAL.—Each employer shall—

16 “(i) calculate for each taxable period
17 the amount of the excess benefit subject to
18 the tax imposed by subsection (a) and the
19 applicable share of such excess benefit for
20 each coverage provider, and

21 “(ii) notify, at such time and in such
22 manner as the Secretary may prescribe,
23 the Secretary and each coverage provider
24 of the amount so determined for the pro-
25 vider.

1 “(B) SPECIAL RULE FOR MULTIEMPLOYER
2 PLANS.—In the case of applicable employer-
3 sponsored coverage made available to employees
4 through a multiemployer plan (as defined in
5 section 414(f)), the plan sponsor shall make the
6 calculations, and provide the notice, required
7 under subparagraph (A).

8 “(d) APPLICABLE EMPLOYER-SPONSORED COV-
9 ERAGE; COST.—For purposes of this section—

10 “(1) APPLICABLE EMPLOYER-SPONSORED COV-
11 ERAGE.—

12 “(A) IN GENERAL.—The term ‘applicable
13 employer-sponsored coverage’ means, with re-
14 spect to any employee, coverage under any
15 group health plan made available to the em-
16 ployee by an employer which is excludable from
17 the employee’s gross income under section 106,
18 or would be so excludable if it were employer-
19 provided coverage (within the meaning of such
20 section 106).

21 “(B) EXCEPTIONS.—The term ‘applicable
22 employer-sponsored coverage’ shall not in-
23 clude—

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1 “(i) any coverage (whether through
2 insurance or otherwise) for disability or
3 long-term care, or

4 “(ii) any coverage described in section
5 9832(c)(3) the payment for which is not
6 excludable from gross income and for
7 which a deduction under section 162(l) is
8 not allowable.

9 “(C) COVERAGE INCLUDES EMPLOYEE
10 PAID PORTION.—Coverage shall be treated as
11 applicable employer-sponsored coverage without
12 regard to whether the employer or employee
13 pays for the coverage.

14 “(D) SELF-EMPLOYED INDIVIDUAL.—In
15 the case of an individual who is an employee
16 within the meaning of section 401(c)(1), cov-
17 erage under any group health plan providing
18 health insurance coverage shall be treated as
19 applicable employer-sponsored coverage if a de-
20 duction is allowable under section 162(l) with
21 respect to all or any portion the cost of the cov-
22 erage.

23 “(E) GOVERNMENTAL PLANS INCLUDED.—
24 Applicable employer-sponsored coverage shall
25 include coverage under any group health plan

1 established and maintained for its civilian em-
2 ployees by the Government of the United
3 States, by the government of any State or polit-
4 ical subdivision thereof, or by any agency or in-
5 strumentality of any such government.

6 “(2) DETERMINATION OF COST.—

7 “(A) IN GENERAL.—The cost of applicable
8 employer-sponsored coverage shall be deter-
9 mined under rules similar to the rules of section
10 4980B(f)(4), except that in determining such
11 cost, any portion of the cost of such coverage
12 which is attributable to the tax imposed under
13 this section shall not be taken into account. In
14 the case of such coverage which provides cov-
15 erage to retired employees, the employer may
16 elect to treat a retired employee who has not at-
17 tained the age of 65 and a retired employee
18 who has attained the age of 65 as similarly sit-
19 uated beneficiaries.

20 “(B) HEALTH FSAS.—In the case of appli-
21 cable employer-sponsored coverage consisting of
22 coverage under a flexible spending arrangement
23 (as defined in section 106(c)(2)), the cost of the
24 coverage shall be equal to the sum of—

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1 “(i) the amount of employer contribu-
2 tions under any salary reduction election
3 under the arrangement, plus

4 “(ii) the amount determined under
5 subparagraph (A) with respect to any re-
6 imbursement under the arrangement in ex-
7 cess of the contributions described in
8 clause (i).

9 “(C) HSAS.—In the case of applicable em-
10 ployer-sponsored coverage consisting of cov-
11 erage under an arrangement under which the
12 employer makes contributions described in sub-
13 section (b) or (d) of section 106, the cost of the
14 coverage shall be equal to the amount of em-
15 ployer contributions under the arrangement.

16 “(D) ALLOCATION ON A MONTHLY
17 BASIS.—If cost is determined on other than a
18 monthly basis, the cost shall be allocated to
19 months in a taxable period on such basis as the
20 Secretary may prescribe.

21 “(e) PENALTY FOR FAILURE TO PROPERLY CAL-
22 CULATE EXCESS BENEFIT.—

23 “(1) IN GENERAL.—If, for any taxable period,
24 the tax imposed by subsection (a) exceeds the tax
25 determined under such subsection with respect to

1 the total excess benefit calculated by the employer or
2 plan sponsor under subsection (c)(4)—

3 “(A) each coverage provider shall pay the
4 tax on its applicable share (determined in the
5 same manner as under subsection (c)(4)) of the
6 excess, but no penalty shall be imposed on the
7 provider with respect to such amount, and

8 “(B) the employer or plan sponsor shall, in
9 addition to any tax imposed by subsection (a),
10 pay a penalty in an amount equal to such ex-
11 cess, plus interest at the underpayment rate de-
12 termined under section 6621 for the period be-
13 ginning on the due date for the payment of tax
14 imposed by subsection (a) to which the excess
15 relates and ending on the date of payment of
16 the penalty.

17 “(2) LIMITATIONS ON PENALTY.—

18 “(A) PENALTY NOT TO APPLY WHERE
19 FAILURE NOT DISCOVERED EXERCISING REA-
20 SONABLE DILIGENCE.—No penalty shall be im-
21 posed by paragraph (1)(B) on any failure to
22 properly calculate the excess benefit during any
23 period for which it is established to the satisfac-
24 tion of the Secretary that the employer or plan
25 sponsor neither knew, nor exercising reasonable

1 diligence would have known, that such failure
2 existed.

3 “(B) PENALTY NOT TO APPLY TO FAIL-
4 URES CORRECTED WITHIN 30 DAYS.—No pen-
5 alty shall be imposed by paragraph (1)(B) on
6 any such failure if—

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

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

14 “(C) WAIVER BY SECRETARY.—In the case
15 of any such failure which is due to reasonable
16 cause and not to willful neglect, the Secretary
17 may waive part or all of the penalty imposed by
18 paragraph (1), to the extent that the payment
19 of such penalty would be excessive or otherwise
20 inequitable relative to the failure involved.

21 “(f) OTHER DEFINITIONS AND SPECIAL RULES.—
22 For purposes of this section—

23 “(1) COVERAGE DETERMINATIONS.—

24 “(A) IN GENERAL.—Except as provided in
25 subparagraph (B), an employee shall be treated

1 as having self-only coverage with respect any
2 applicable employer-sponsored coverage of an
3 employer.

4 “(B) COVERAGE UNDER ESSENTIAL BENE-
5 FITS PACKAGE.—An employee shall be treated
6 as having coverage other than self-only coverage
7 only if the employee is enrolled in coverage
8 other than self-only coverage in a group health
9 plan which provides at least an essential bene-
10 fits package (as defined in section 2242 of the
11 Social Security Act).

12 “(2) EMPLOYEES ENGAGED IN HIGH-RISK PRO-
13 FESSION.—The term ‘employees engaged in a high-
14 risk profession’ means law enforcement officers, fire-
15 fighters, members of a rescue squad or ambulance
16 crew, and individuals engaged in the construction,
17 mining, agriculture (not including food processing),
18 forestry, and fishing industries.

19 “(3) GROUP HEALTH PLAN.—The term ‘group
20 health plan’ has the meaning given such term by
21 section 5000(b)(1).

22 “(4) HEALTH INSURANCE COVERAGE; HEALTH
23 INSURANCE ISSUER.—

24 “(A) HEALTH INSURANCE COVERAGE.—
25 The term ‘health insurance coverage’ has the

1 meaning given such term by section 9832(b)(1)
2 (applied without regard to subparagraph (B)
3 thereof, except as provided by the Secretary in
4 regulations).

5 “(B) HEALTH INSURANCE ISSUER.—The
6 term ‘health insurance issuer’ has the meaning
7 given such term by section 9832(b)(2).

8 “(5) PERSON THAT ADMINISTERS THE PLAN
9 BENEFITS.—The term ‘person that administers the
10 plan benefits’ shall include the plan sponsor if the
11 plan sponsor administers benefits under the plan.

12 “(6) PLAN SPONSOR.—The term ‘plan sponsor’
13 has the meaning given such term in section 3(16)(B)
14 of the Employee Retirement Income Security Act of
15 1974.

16 “(7) TAXABLE PERIOD.—The term ‘taxable pe-
17 riod’ means the calendar year or such shorter period
18 as the Secretary may prescribe. The Secretary may
19 have different taxable periods for employers of vary-
20 ing sizes.

21 “(8) AGGREGATION RULES.—All employers
22 treated as a single employer under subsection (b),
23 (c), (m), or (o) of section 414 shall be treated as a
24 single employer.

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1 “(9) DENIAL OF DEDUCTION.—For denial of
2 deduction for the tax imposed by this section, see
3 section 275(a)(6).

4 “(g) REGULATIONS.—The Secretary shall prescribe
5 such regulations as may be necessary to carry out this
6 section.”.

7 (b) CLERICAL AMENDMENT.—The table of sections
8 for chapter 43 of such Code, as amended by section 1306,
9 is amended by adding at the end the following new item:

 “Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.”.

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 2012.

13 **SEC. 6002. INCLUSION OF COST OF EMPLOYER-SPONSORED**
14 **HEALTH COVERAGE ON W-2.**

15 (a) IN GENERAL.—Section 6051(a) of the Internal
16 Revenue Code of 1986 (relating to receipts for employees)
17 is amended by striking “and” at the end of paragraph
18 (12), by striking the period at the end of paragraph (13)
19 and inserting “, and”, and by adding after paragraph (13)
20 the following new paragraph:

21 “(14) the aggregate cost (determined under
22 rules similar to the rules of section 4980B(f)(4)) of
23 applicable employer-sponsored coverage (as defined
24 in section 4980I(d)(1)), except that this paragraph
25 shall not apply to—

1 “(A) coverage to which paragraphs (11)
2 and (12) apply, or

3 “(B) the amount of any salary reduction
4 contributions to a flexible spending arrange-
5 ment (within the meaning of section 125).”.

6 (b) **EFFECTIVE DATE.**—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 2009.

9 **SEC. 6003. DISTRIBUTIONS FOR MEDICINE QUALIFIED**
10 **ONLY IF FOR PRESCRIBED DRUG OR INSU-**
11 **LIN.**

12 (a) **HSAs.**—Subparagraph (A) of section 223(d)(2)
13 of the Internal Revenue Code of 1986 is amended by add-
14 ing at the end the following: “Such term shall include an
15 amount paid for medicine or a drug only if such medicine
16 or drug is a prescribed drug (determined without regard
17 to whether such drug is available without a prescription)
18 or is insulin.”.

19 (b) **ARCHER MSAs.**—Subparagraph (A) of section
20 220(d)(2) of the Internal Revenue Code of 1986 is amend-
21 ed by adding at the end the following: “Such term shall
22 include an amount paid for medicine or a drug only if such
23 medicine or drug is a prescribed drug (determined without
24 regard to whether such drug is available without a pre-
25 scription) or is insulin.”.

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1 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
2 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-
3 tion 106 of the Internal Revenue Code of 1986 is amended
4 by adding at the end the following new subsection:

5 “(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED
6 TO PRESCRIBED DRUGS AND INSULIN.—For purposes of
7 this section and section 105, reimbursement for expenses
8 incurred for a medicine or a drug shall be treated as a
9 reimbursement for medical expenses only if such medicine
10 or drug is a prescribed drug (determined without regard
11 to whether such drug is available without a prescription)
12 or is insulin.”.

13 (d) EFFECTIVE DATES.—

14 (1) DISTRIBUTIONS FROM SAVINGS AC-
15 COUNTS.—The amendments made by subsections (a)
16 and (b) shall apply to amounts paid with respect to
17 taxable years beginning after December 31, 2009.

18 (2) REIMBURSEMENTS.—The amendment made
19 by subsection (c) shall apply to expenses incurred
20 with respect to taxable years beginning after Decem-
21 ber 31, 2009.

1 **SEC. 6004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTU-**
2 **TIONS FROM HSAS NOT USED FOR QUALIFIED**
3 **MEDICAL EXPENSES.**

4 (a) IN GENERAL.—Section 223(f)(4)(A) of the Inter-
5 nal Revenue Code of 1986 is amended by striking “10 per-
6 cent” and inserting “20 percent”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall apply to distributions made after Decem-
9 ber 31, 2010.

10 **SEC. 6005. LIMITATION ON HEALTH FLEXIBLE SPENDING**
11 **ARRANGEMENTS UNDER CAFETERIA PLANS.**

12 (a) IN GENERAL.—Section 125 of the Internal Rev-
13 enue Code of 1986 is amended—

14 (1) by redesignating subsections (i) and (j) as
15 subsections (j) and (k), respectively, and

16 (2) by inserting after subsection (h) the fol-
17 lowing new subsection:

18 “(i) LIMITATION ON HEALTH FLEXIBLE SPENDING
19 ARRANGEMENTS.—For purposes of this section, if a ben-
20 efit is provided under a cafeteria plan through employer
21 contributions to a health flexible spending arrangement,
22 such benefit shall not be treated as a qualified benefit un-
23 less the cafeteria plan provides that an employee may not
24 elect for any taxable year to have salary reduction con-
25 tributions in excess of \$2,500 made to such arrange-
26 ment.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2010.

4 **SEC. 6006. EXPANSION OF INFORMATION REPORTING RE-**
5 **QUIREMENTS.**

6 (a) IN GENERAL.—Section 6041 of the Internal Rev-
7 enue Code of 1986 is amended by adding at the end the
8 following new subsections:

9 “(h) APPLICATION TO CORPORATIONS.—Notwith-
10 standing any regulation prescribed by the Secretary before
11 the date of the enactment of this subsection, for purposes
12 of this section the term ‘person’ includes any corporation
13 that is not an organization exempt from tax under section
14 501(a).

15 “(i) REGULATIONS.—The Secretary may prescribe
16 such regulations and other guidance as may be appro-
17 priate or necessary to carry out the purposes of this sec-
18 tion, including rules to prevent duplicative reporting of
19 transactions.”.

20 (b) PAYMENTS FOR PROPERTY AND OTHER GROSS
21 PROCEEDS.—Subsection (a) of section 6041 of the Inter-
22 nal Revenue Code of 1986 is amended—

23 (1) by inserting “amounts in consideration for
24 property,” after “wages,”

1 (2) by inserting “gross proceeds,” after “emolu-
2 ments, or other”, and

3 (3) by inserting “gross proceeds,” after “setting
4 forth the amount of such”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to payments made after December
7 31, 2011.

8 **SEC. 6007. ADDITIONAL REQUIREMENTS FOR CHARITABLE**
9 **HOSPITALS.**

10 (a) REQUIREMENTS TO QUALIFY AS SECTION
11 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Sec-
12 tion 501 of the Internal Revenue Code of 1986 (relating
13 to exemption from tax on corporations, certain trusts, etc.)
14 is amended by redesignating subsection (r) as subsection
15 (s) and by inserting after subsection (q) the following new
16 subsection:

17 “(r) ADDITIONAL REQUIREMENTS FOR CERTAIN
18 HOSPITALS.—

19 “(1) IN GENERAL.—A hospital organization to
20 which this subsection applies shall not be treated as
21 described in subsection (c)(3) unless the organiza-
22 tion—

23 “(A) meets the community health needs
24 assessment requirements described in para-
25 graph (3),

1 “(B) meets the financial assistance policy
2 requirements described in paragraph (4),

3 “(C) meets the requirements on charges
4 described in paragraph (5), and

5 “(D) meets the billing and collection re-
6 quirement described in paragraph (6).

7 “(2) HOSPITAL ORGANIZATIONS TO WHICH
8 SUBSECTION APPLIES.—

9 “(A) IN GENERAL.—This subsection shall
10 apply to—

11 “(i) an organization which operates a
12 facility which is required by a State to be
13 licensed, registered, or similarly recognized
14 as a hospital, and

15 “(ii) any other organization which the
16 Secretary determines has the provision of
17 hospital care as its principal function or
18 purpose constituting the basis for its ex-
19 emption under subsection (c)(3) (deter-
20 mined without regard to this subsection).

21 “(B) ORGANIZATIONS WITH MORE THAN 1
22 HOSPITAL FACILITY.—If a hospital organization
23 operates more than 1 hospital facility—

1 “(i) the organization shall meet the
2 requirements of this subsection separately
3 with respect to each such facility, and

4 “(ii) shall not be treated as described
5 in subsection (c)(3) with respect to any
6 such facility for which such requirements
7 are not separately met.

8 “(3) COMMUNITY HEALTH NEEDS ASSESS-
9 MENTS.—

10 “(A) IN GENERAL.—An organization meets
11 the requirements of this paragraph with respect
12 to any taxable year only if the organization—

13 “(i) has conducted a community
14 health needs assessment which meets the
15 requirements of subparagraph (B) in such
16 taxable year or in either of the 2 taxable
17 years immediately preceding such taxable
18 year,

19 “(ii) has adopted an implementation
20 strategy to meet the community health
21 needs identified through such assessment.

22 “(B) COMMUNITY HEALTH NEEDS ASSESS-
23 MENT.—A community health needs assessment
24 meets the requirements of this paragraph if
25 such community health needs assessment—

1 “(i) takes into account input from
2 persons who represent the broad interests
3 of the community served by the hospital
4 facility, including those with special knowl-
5 edge of or expertise in public health, and

6 “(ii) is made widely available to the
7 public.

8 “(4) FINANCIAL ASSISTANCE POLICY.—An or-
9 ganization meets the requirements of this paragraph
10 if the organization establishes the following policies:

11 “(A) FINANCIAL ASSISTANCE POLICY.—A
12 written financial assistance policy which in-
13 cludes—

14 “(i) eligibility criteria for financial as-
15 sistance, and whether such assistance in-
16 cludes free or discounted care,

17 “(ii) the basis for calculating amounts
18 charged to patients,

19 “(iii) the method for applying for fi-
20 nancial assistance,

21 “(iv) in the case of an organization
22 which does not have a separate billing and
23 collections policy, the actions the organiza-
24 tion may take in the event of non-payment,

1 including collections action and reporting
2 to credit agencies, and

3 “(v) measures to widely publicize the
4 policy within the community to be served
5 by the organization.

6 “(B) POLICY RELATING TO EMERGENCY
7 MEDICAL CARE.—A written policy requiring the
8 organization to provide, without discrimination,
9 care for emergency medical conditions (within
10 the meaning of section 1867 of the Social Secu-
11 rity Act (42 U.S.C. 1395dd)), or other medi-
12 cally necessary care, to individuals regardless of
13 their eligibility under the financial assistance
14 policy described in subparagraph (A).

15 “(5) LIMITATION ON CHARGES.—An organiza-
16 tion meets the requirements of this paragraph if the
17 organization—

18 “(A) limits amounts charged for emer-
19 gency or other medically necessary care pro-
20 vided to individuals eligible for assistance under
21 the financial assistance policy described in para-
22 graph (4)(A) to not more than the lowest
23 amounts charged to individuals who have insur-
24 ance covering such care, and

25 “(B) prohibits the use of gross charges.

1 “(6) BILLING AND COLLECTION REQUIRE-
2 MENTS.—An organization meets the requirement of
3 this paragraph only if the organization does not en-
4 gage in extraordinary collection actions before the
5 organization has made reasonable efforts to deter-
6 mine whether the individual is eligible for assistance
7 under the financial assistance policy described in
8 paragraph (4)(A).

9 “(7) REGULATORY AUTHORITY.—The Secretary
10 shall issue such regulations and guidance as may be
11 necessary to carry out the provisions of this sub-
12 section, including guidance relating to what con-
13 stitutes reasonable efforts to determine the eligibility
14 of a patient under a financial assistance policy for
15 purposes of paragraph (6).”.

16 (b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL
17 EXEMPTION REQUIREMENTS.—

18 (1) IN GENERAL.—Subchapter D of chapter 42
19 of the Internal Revenue Code of 1986 (relating to
20 failure by certain charitable organizations to meet
21 certain qualification requirements) is amended by
22 adding at the end the following new section:

1 **“SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZA-**
2 **TIONS.**

3 “If a hospital organization to which section 501(r)
4 applies fails to meet the requirement of section 501(r)(3)
5 for any taxable year, there is imposed on the organization
6 a tax equal to \$50,000.”.

7 (2) CONFORMING AMENDMENT.—The table of
8 sections for subchapter D of chapter 42 of such
9 Code is amended by adding at the end the following
10 new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

11 (c) MANDATORY REVIEW OF TAX EXEMPTION FOR
12 HOSPITALS.—The Secretary of the Treasury or the Sec-
13 retary’s delegate shall review at least once every 3 years
14 the community benefit activities of each hospital organiza-
15 tion to which section 501(r) of the Internal Revenue Code
16 of 1986 (as added by this section) applies.

17 (d) ADDITIONAL REPORTING REQUIREMENTS.—

18 (1) COMMUNITY HEALTH NEEDS ASSESSMENTS
19 AND AUDITED FINANCIAL STATEMENTS.—Section
20 6033(b) of the Internal Revenue Code of 1986 (re-
21 lating to certain organizations described in section
22 501(c)(3)) is amended by striking “and” at the end
23 of paragraph (14), by redesignating paragraph (15)
24 as paragraph (16), and by inserting after paragraph
25 (14) the following new paragraph:

1 “(15) in the case of an organization to which
2 the requirements of section 501(r) apply for the tax-
3 able year—

4 “(A) a description of how the organization
5 is addressing the needs identified in each com-
6 munity health needs assessment conducted
7 under section 501(r)(3) and a description of
8 any such needs that are not being addressed to-
9 gether with the reasons why such needs are not
10 being addressed, and

11 “(B) the audited financial statements of
12 such organization (or, in the case of an organi-
13 zation the financial statements of which are in-
14 cluded in a consolidated financial statement
15 with other organizations, such consolidated fi-
16 nancial statement).”.

17 (2) TAXES.—Section 6033(b)(10) of such Code
18 is amended by striking “and” at the end of subpara-
19 graph (B), by inserting “and” at the end of sub-
20 paragraph (C), and by adding at the end the fol-
21 lowing new subparagraph:

22 “(D) section 4959 (relating to taxes on
23 failures by hospital organizations),”.

24 (e) REPORTS.—

1 (1) REPORT ON LEVELS OF CHARITY CARE.—

2 The Secretary of the Treasury, in consultation with
3 the Secretary of Health and Human Services, shall
4 submit to the Committees on Ways and Means,
5 Education and Labor, and Energy and Commerce of
6 the House of Representatives and to the Committees
7 on Finance and Health, Education, Labor, and Pen-
8 sions of the Senate an annual report on the fol-
9 lowing:

10 (A) Information with respect to private
11 tax-exempt, taxable, and government-owned
12 hospitals regarding—

13 (i) levels of charity care provided,

14 (ii) bad debt expenses,

15 (iii) unreimbursed costs for services
16 provided with respect to means-tested gov-
17 ernment programs, and

18 (iv) unreimbursed costs for services
19 provided with respect to non-means tested
20 government programs.

21 (B) Information with respect to private
22 tax-exempt hospitals regarding costs incurred
23 for community benefit activities.

24 (2) REPORT ON TRENDS.—

1 (A) STUDY.—The Secretary of the Treas-
2 ury, in consultation with the Secretary of
3 Health and Human Services, shall conduct a
4 study on trends in the information required to
5 be reported under paragraph (1).

6 (B) REPORT.—Not later than 5 years after
7 the date of the enactment of this Act, the Sec-
8 retary of the Treasury, in consultation with the
9 Secretary of Health and Human Services, shall
10 submit a report on the study conducted under
11 subparagraph (A) to the Committees on Ways
12 and Means, Education and Labor, and Energy
13 and Commerce of the House of Representatives
14 and to the Committees on Finance and Health,
15 Education, Labor, and Pensions of the Senate.

16 (f) EFFECTIVE DATES.—

17 (1) IN GENERAL.—Except as provided in para-
18 graphs (2) and (3), the amendments made by this
19 section shall apply to taxable years beginning after
20 the date of the enactment of this Act.

21 (2) COMMUNITY HEALTH NEEDS ASSESS-
22 MENT.—The requirements of section 501(r)(3) of
23 the Internal Revenue Code of 1986, as added by
24 subsection (a), shall apply to taxable years beginning

1 after the date which is 2 years after the date of the
2 enactment of this Act.

3 (3) EXCISE TAX.—The amendments made by
4 subsection (b) shall apply to failures occurring after
5 the date of the enactment of this Act.

6 **SEC. 6008. IMPOSITION OF ANNUAL FEE ON BRANDED PRE-**
7 **SCRIPTION PHARMACEUTICAL MANUFAC-**
8 **TURERS AND IMPORTERS.**

9 (a) IMPOSITION OF FEE.—

10 (1) IN GENERAL.—Each covered entity engaged
11 in the business of manufacturing or importing
12 branded prescription drugs shall pay to the Sec-
13 retary of the Treasury not later than the annual
14 payment date of each calendar year beginning after
15 2009 a fee in an amount determined under sub-
16 section (b).

17 (2) ANNUAL PAYMENT DATE.—For purposes of
18 this section, the term “annual payment date” means
19 with respect to any calendar year the date deter-
20 mined by the Secretary, but in no event later than
21 September 30 of such calendar year.

22 (b) DETERMINATION OF FEE AMOUNT.—

23 (1) IN GENERAL.—With respect to each covered
24 entity, the fee under this section for any calendar

1 year shall be equal to an amount that bears the
 2 same ratio to \$2,300,000,000 as—

3 (A) the covered entity's branded prescrip-
 4 tion drug sales taken into account during the
 5 preceding calendar year, bear to

6 (B) the aggregate branded prescription
 7 drug sales of all covered entities taken into ac-
 8 count during such preceding calendar year.

9 (2) SALES TAKEN INTO ACCOUNT.—For pur-
 10 poses of paragraph (1), the branded prescription
 11 drug sales taken into account during any calendar
 12 year with respect to any covered entity shall be de-
 13 termined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$125,000,000.	10 percent
More than \$125,000,000 but not more than \$225,000,000.	40 percent
More than \$225,000,000 but not more than \$400,000,000.	75 percent
More than \$400,000,000	100 percent.

14 (3) SECRETARIAL DETERMINATION.—The Sec-
 15 retary of the Treasury shall calculate the amount of
 16 each covered entity's fee for any calendar year under
 17 paragraph (1). In calculating such amount, the Sec-
 18 retary of the Treasury shall determine such covered
 19 entity's branded prescription drug sales on the basis

1 of reports submitted under subsection (g) and
2 through the use of any other source of information
3 available to the Secretary of the Treasury.

4 (c) TRANSFER OF FEES TO MEDICARE PART B
5 TRUST FUND.—There is hereby appropriated to the Fed-
6 eral Supplementary Medical Insurance Trust Fund estab-
7 lished under section 1841 of the Social Security Act an
8 amount equal to the fees received by the Secretary of the
9 Treasury under subsection (a).

10 (d) COVERED ENTITY.—

11 (1) IN GENERAL.—For purposes of this section,
12 the term “covered entity” means any manufacturer
13 or importer with gross receipts from branded pre-
14 scription drug sales.

15 (2) CONTROLLED GROUPS.—

16 (A) IN GENERAL.—For purposes of this
17 subsection, all persons treated as a single em-
18 ployer under subsection (a) or (b) of section 52
19 of the Internal Revenue Code of 1986 or sub-
20 section (m) or (o) of section 414 of such Code
21 shall be treated as a single covered entity.

22 (B) INCLUSION OF FOREIGN CORPORA-
23 TIONS.—For purposes of subparagraph (A), in
24 applying subsections (a) and (b) of section 52
25 of such Code to this section, section 1563 of

1 such Code shall be applied without regard to
2 subsection (b)(2)(C) thereof.

3 (e) **BRANDED PRESCRIPTION DRUG SALES.**—For
4 purposes of this section—

5 (1) **IN GENERAL.**—The term “branded prescrip-
6 tion drug sales” means sales of branded prescription
7 drugs to any specified government program or pur-
8 suant to coverage under any such program.

9 (2) **BRANDED PRESCRIPTION DRUGS.**—

10 (A) **IN GENERAL.**—The term “branded
11 prescription drug” means—

12 (i) any prescription drug the applica-
13 tion for which was submitted under section
14 505(b) of the Federal Food, Drug, and
15 Cosmetic Act (21 U.S.C. 355(b)), or

16 (ii) any biological product the license
17 for which was submitted under section
18 351(a) of the Public Health Service Act
19 (42 U.S.C. 262(a)).

20 (B) **PRESCRIPTION DRUG.**—For purposes
21 of subparagraph (A)(i), the term “prescription
22 drug” means any drug which is subject to sec-
23 tion 503(b) of the Federal Food, Drug, and
24 Cosmetic Act (21 U.S.C. 353(b)).

1 (3) EXCLUSION OF ORPHAN DRUG SALES.—The
2 term “branded prescription drug sales” shall not in-
3 clude sales of any drug or biological product with re-
4 spect to which a credit was allowed for any taxable
5 year under section 45C of the Internal Revenue
6 Code of 1986. The preceding sentence shall not
7 apply with respect to any such drug or biological
8 product after the date on which such drug or bio-
9 logical product is approved by the Food and Drug
10 Administration for marketing for any indication
11 other than the treatment of the rare disease or con-
12 dition with respect to which such credit was allowed.

13 (4) SPECIFIED GOVERNMENT PROGRAM.—The
14 term “specified government program” means—

15 (A) the Medicare Part D program under
16 part D of title XVIII of the Social Security Act,

17 (B) the Medicare Part B program under
18 part B of title XVIII of the Social Security Act,

19 (C) the Medicaid program under title XIX
20 of the Social Security Act,

21 (D) any program under which branded
22 prescription drugs are procured by the Depart-
23 ment of Veterans Affairs,

1 (E) any program under which branded pre-
2 scription drugs are procured by the Department
3 of Defense, or

4 (F) the TRICARE retail pharmacy pro-
5 gram under section 1074g of title 10, United
6 States Code.

7 (f) TAX TREATMENT OF FEES.—The fees imposed
8 by this section—

9 (1) for purposes of subtitle F of the Internal
10 Revenue Code of 1986, shall be treated as excise
11 taxes with respect to which only civil actions for re-
12 fund under procedures of such subtitle shall apply,
13 and

14 (2) for purposes of section 275 of such Code
15 shall be considered to be a tax described in section
16 275(a)(6).

17 (g) REPORTING REQUIREMENT.—Not later than the
18 date determined by the Secretary of the Treasury fol-
19 lowing the end of any calendar year, the Secretary of
20 Health and Human Services, the Secretary of Veterans
21 Affairs, and the Secretary of Defense shall report to the
22 Secretary of the Treasury, in such manner as the Sec-
23 retary of the Treasury prescribes, the total branded pre-
24 scription drug sales for each covered entity with respect

1 to each specified government program under such Sec-
2 retary's jurisdiction using the following methodology:

3 (1) MEDICARE PART D PROGRAM.—The Sec-
4 retary of Health and Human Services shall report,
5 for each covered entity and for each branded pre-
6 scription drug of the covered entity covered by the
7 Medicare Part D program, the product of—

8 (A) the per-unit ingredient cost, as re-
9 ported to the Secretary of Health and Human
10 Services by prescription drug plans and Medi-
11 care Advantage prescription drug plans, minus
12 any per-unit rebate, discount, or other price
13 concession provided by the covered entity, as re-
14 ported to the Secretary of Health and Human
15 Services by the prescription drug plans and
16 Medicare Advantage prescription drug plans,
17 and

18 (B) the number of units of the branded
19 prescription drug paid for under the Medicare
20 Part D program.

21 (2) MEDICARE PART B PROGRAM.—The Sec-
22 retary of Health and Human Services shall report,
23 for each covered entity and for each branded pre-
24 scription drug of the covered entity covered by the

1 Medicare Part B program under section 1862(a) of
2 the Social Security Act, the product of—

3 (A) the per-unit average sales price (as de-
4 fined in section 1847A(e) of the Social Security
5 Act) or the per-unit Part B payment rate for
6 a separately paid branded prescription drug
7 without a reported average sales price, and

8 (B) the number of units of the branded
9 prescription drug paid for under the Medicare
10 Part B program.

11 The Centers for Medicare and Medicaid Services
12 shall establish a process for determining the units
13 and the allocated price for purposes of this section
14 for those branded prescription drugs that are not
15 separately payable or for which National Drug
16 Codes are not reported.

17 (3) MEDICAID PROGRAM.—The Secretary of
18 Health and Human Services shall report, for each
19 covered entity and for each branded prescription
20 drug of the covered entity covered under the Med-
21 icaid program, the product of—

22 (A) the per-unit ingredient cost paid to
23 pharmacies by States for the branded prescrip-
24 tion drug dispensed to Medicaid beneficiaries,
25 minus any per-unit rebate paid by the covered

1 entity under section 1927 of the Social Security
2 Act and any State supplemental rebate, and

3 (B) the number of units of the branded
4 prescription drug paid for under the Medicaid
5 program.

6 (4) DEPARTMENT OF VETERANS AFFAIRS PRO-
7 GRAMS.—The Secretary of Veterans Affairs shall re-
8 port, for each covered entity and for each branded
9 prescription drug of the covered entity the total
10 amount paid for each such branded prescription
11 drug procured by the Department of Veterans Af-
12 fairs for its beneficiaries.

13 (5) DEPARTMENT OF DEFENSE PROGRAMS AND
14 TRICARE.—The Secretary of Defense shall report,
15 for each covered entity and for each branded pre-
16 scription drug of the covered entity, the sum of—

17 (A) the total amount paid for each such
18 branded prescription drug procured by the De-
19 partment of Defense for its beneficiaries, and

20 (B) for each such branded prescription
21 drug dispensed under the TRICARE retail
22 pharmacy program, the product of—

23 (i) the per-unit ingredient cost, minus
24 any per-unit rebate paid by the covered en-
25 tity, and

1 (ii) the number of units of the brand-
2 ed prescription drug dispensed under such
3 program.

4 (h) SECRETARY.—For purposes of this section, the
5 term “Secretary” includes the Secretary’s delegate.

6 (i) GUIDANCE.—The Secretary of the Treasury shall
7 publish guidance necessary to carry out the purposes of
8 this section.

9 (j) APPLICATION OF SECTION.—This section shall
10 apply to any branded prescription drug sales after Decem-
11 ber 31, 2008.

12 (k) CONFORMING AMENDMENT.—Section 1841(a) of
13 the Social Security Act is amended by inserting “or sec-
14 tion 6008(c) of the America’s Healthy Future Act of
15 2009” after “this part”.

16 **SEC. 6009. IMPOSITION OF ANNUAL FEE ON MEDICAL DE-**
17 **VICE MANUFACTURERS AND IMPORTERS.**

18 (a) IMPOSITION OF FEE.—

19 (1) IN GENERAL.—Each covered entity engaged
20 in the business of manufacturing or importing med-
21 ical devices shall pay to the Secretary not later than
22 the annual payment date of each calendar year be-
23 ginning after 2009 a fee in an amount determined
24 under subsection (b).

1 (2) ANNUAL PAYMENT DATE.—For purposes of
 2 this section, the term “annual payment date” means
 3 with respect to any calendar year the date deter-
 4 mined by the Secretary, but in no event later than
 5 September 30 of such calendar year.

6 (b) DETERMINATION OF FEE AMOUNT.—

7 (1) IN GENERAL.—With respect to each covered
 8 entity, the fee under this section for any calendar
 9 year shall be equal to an amount that bears the
 10 same ratio to \$4,000,000,000 as—

11 (A) the covered entity’s gross receipts from
 12 medical device sales taken into account during
 13 the preceding calendar year, bear to

14 (B) the aggregate gross receipts of all cov-
 15 ered entities from medical device sales taken
 16 into account during such preceding calendar
 17 year.

18 (2) GROSS RECEIPTS FROM SALES TAKEN INTO
 19 ACCOUNT.—For purposes of paragraph (1), the
 20 gross receipts from medical device sales taken into
 21 account during any calendar year with respect to
 22 any covered entity shall be determined in accordance
 23 with the following table:

With respect to a covered entity’s aggregate gross re- cepts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than \$5,000,000	0 percent

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
More than \$5,000,000 but not more than \$25,000,000.	50 percent
More than \$25,000,000	100 percent.

1 (3) SECRETARIAL DETERMINATION.—The Sec-
2 retary shall calculate the amount of each covered en-
3 tity's fee for any calendar year under paragraph (1).
4 In calculating such amount, the Secretary shall de-
5 termine such covered entity's gross receipts from
6 medical device sales on the basis of reports sub-
7 mitted by the covered entity under subsection (f)
8 and through the use of any other source of informa-
9 tion available to the Secretary.

10 (c) COVERED ENTITY.—

11 (1) IN GENERAL.—For purposes of this section,
12 the term “covered entity” means any manufacturer
13 or importer with gross receipts from medical device
14 sales.

15 (2) CONTROLLED GROUPS.—

16 (A) IN GENERAL.—For purposes of this
17 subsection, all persons treated as a single em-
18 ployer under subsection (a) or (b) of section 52
19 of the Internal Revenue Code of 1986 or sub-
20 section (m) or (o) of section 414 of such Code
21 shall be treated as a single covered entity.

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1 (B) INCLUSION OF FOREIGN CORPORA-
2 TIONS.—For purposes of subparagraph (A), in
3 applying subsections (a) and (b) of section 52
4 of such Code to this section, section 1563 of
5 such Code shall be applied without regard to
6 subsection (b)(2)(C) thereof.

7 (d) MEDICAL DEVICE SALES.—For purposes of this
8 section—

9 (1) IN GENERAL.—The term “medical device
10 sales” means sales for use in the United States of
11 any medical device, other than the sales of a medical
12 device that—

13 (A) has been classified in class II under
14 section 513 of the Federal Food, Drug, and
15 Cosmetic Act (21 U.S.C. 360c) and is primarily
16 sold to consumers at retail for not more than
17 \$100 per unit, or

18 (B) has been classified in class I under
19 such section.

20 (2) UNITED STATES.—For purposes of para-
21 graph (1), the term “United States” means the sev-
22 eral States, the District of Columbia, the Common-
23 wealth of Puerto Rico, and the possessions of the
24 United States.

1 (3) MEDICAL DEVICE.—For purposes of para-
2 graph (1), the term “medical device” means any de-
3 vice (as defined in section 201(h) of the Federal
4 Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)))
5 intended for humans.

6 (e) TAX TREATMENT OF FEES.—The fees imposed
7 by this section—

8 (1) for purposes of subtitle F of the Internal
9 Revenue Code of 1986, shall be treated as excise
10 taxes with respect to which only civil actions for re-
11 fund under procedures of such subtitle shall apply,
12 and

13 (2) for purposes of section 275 of such Code
14 shall be considered to be a tax described in section
15 275(a)(6).

16 (f) REPORTING REQUIREMENT.—Not later than the
17 date determined by the Secretary following the end of any
18 calendar year, each covered entity shall report to the Sec-
19 retary, in such manner as the Secretary prescribes, the
20 gross receipts from medical device sales of such covered
21 entity during such calendar year.

22 (g) SECRETARY.—For purposes of this section, the
23 term “Secretary” means the Secretary of the Treasury or
24 the Secretary’s delegate.

1 (h) GUIDANCE.—The Secretary shall publish guid-
2 ance necessary to carry out the purposes of this section,
3 including identification of medical devices described in
4 subsection (d)(1)(A) and with respect to the treatment of
5 gross receipts from sales of medical devices to another cov-
6 ered entity.

7 (i) APPLICATION OF SECTION.—This section shall
8 apply to any medical device sales after December 31,
9 2008.

10 **SEC. 6010. IMPOSITION OF ANNUAL FEE ON HEALTH INSUR-**
11 **ANCE PROVIDERS.**

12 (a) IMPOSITION OF FEE.—

13 (1) IN GENERAL.—Each covered entity engaged
14 in the business of providing health insurance shall
15 pay to the Secretary not later than the annual pay-
16 ment date of each calendar year beginning after
17 2009 a fee in an amount determined under sub-
18 section (b).

19 (2) ANNUAL PAYMENT DATE.—For purposes of
20 this section, the term “annual payment date” means
21 with respect to any calendar year the date deter-
22 mined by the Secretary, but in no event later than
23 September 30 of such calendar year.

24 (b) DETERMINATION OF FEE AMOUNT.—

1 (1) IN GENERAL.—With respect to each covered
2 entity, the fee under this section for any calendar
3 year shall be equal to an amount that bears the
4 same ratio to \$6,700,000,000 as—

5 (A) the covered entity’s net premiums writ-
6 ten during the preceding calendar year with re-
7 spect to health insurance for any United States
8 health risk, bear to

9 (B) the aggregate net premiums of all cov-
10 ered entities written during such preceding cal-
11 endar year with respect to such health insur-
12 ance.

13 (2) SECRETARIAL DETERMINATION.—The Sec-
14 retary shall calculate the amount of each covered en-
15 tity’s fee for any calendar year under paragraph (1).
16 In calculating such amount, the Secretary shall de-
17 termine such covered entity’s net premiums written
18 with respect to any United States health risk on the
19 basis of reports submitted by the covered entity
20 under subsection (f) and through the use of any
21 other source of information available to the Sec-
22 retary.

23 (c) COVERED ENTITY.—

24 (1) IN GENERAL.—For purposes of this section,
25 the term “covered entity” means any entity which

1 provides health insurance for any United States
2 health risk.

3 (2) EXCLUSION.—Such term does not include—

4 (A) any employer to the extent that such
5 employer self-insures its employees' health
6 risks, or

7 (B) any governmental entity.

8 (3) CONTROLLED GROUPS.—

9 (A) IN GENERAL.—For purposes of this
10 subsection, all persons treated as a single em-
11 ployer under subsection (a) or (b) of section 52
12 of the Internal Revenue Code of 1986 or sub-
13 section (m) or (o) of section 414 of such Code
14 shall be treated as a single covered entity (or
15 employer for purposes of paragraph (2)).

16 (B) INCLUSION OF FOREIGN CORPORA-
17 TIONS.—For purposes of subparagraph (A), in
18 applying subsections (a) and (b) of section 52
19 of such Code to this section, section 1563 of
20 such Code shall be applied without regard to
21 subsection (b)(2)(C) thereof.

22 (d) UNITED STATES HEALTH RISK.—For purposes
23 of this section, the term “United States health risk”
24 means the health risk of any individual who is—

25 (1) a United States citizen,

1 (2) a resident of the United States (within the
2 meaning of section 7701(b)(1)(A) of the Internal
3 Revenue Code of 1986), or

4 (3) located in the United States, with respect to
5 the period such individual is so located.

6 (e) TAX TREATMENT OF FEES.—The fees imposed
7 by this section—

8 (1) for purposes of subtitle F of the Internal
9 Revenue Code of 1986, shall be treated as excise
10 taxes with respect to which only civil actions for re-
11 fund under procedures of such subtitle shall apply,
12 and

13 (2) for purposes of section 275 of such Code
14 shall be considered to be a tax described in section
15 275(a)(6).

16 (f) REPORTING REQUIREMENT.—Not later than the
17 date determined by the Secretary following the end of any
18 calendar year, each covered entity shall report to the Sec-
19 retary, in such manner as the Secretary prescribes, the
20 covered entity's net premiums written during such cal-
21 endar year with respect to health insurance for any United
22 States health risk.

23 (g) ADDITIONAL DEFINITIONS.—For purposes of this
24 section—

1 (1) SECRETARY.—The term “Secretary” means
2 the Secretary of the Treasury or the Secretary’s del-
3 egate.

4 (2) UNITED STATES.—The term “United
5 States” means the several States, the District of Co-
6 lumbia, the Commonwealth of Puerto Rico, and the
7 possessions of the United States.

8 (h) GUIDANCE.—The Secretary shall publish guid-
9 ance necessary to carry out the purposes of this section.

10 (i) APPLICATION OF SECTION.—This section shall
11 apply to any net premiums written after December 31,
12 2008, with respect to health insurance for any United
13 States health risk.

14 **SEC. 6011. STUDY AND REPORT OF EFFECT ON VETERANS**
15 **HEALTH CARE.**

16 (a) IN GENERAL.—The Secretary of Veterans Affairs
17 shall conduct a study on the effect (if any) of the provi-
18 sions of sections 6008, 6009, and 6010 on—

19 (1) the cost of medical care provided to vet-
20 erans, and

21 (2) veterans’ access to medical devices and
22 branded prescription drugs.

23 (b) REPORT.—The Secretary of Veterans Affairs
24 shall report the results of the study under subsection (a)
25 to the Committee on Ways and Means of the House of

1 Representatives and to the Committee on Finance of the
2 Senate not later than December 31, 2012.

3 **SEC. 6012. ELIMINATION OF DEDUCTION FOR EXPENSES**
4 **ALLOCABLE TO MEDICARE PART D SUBSIDY.**

5 (a) IN GENERAL.—Section 139A of the Internal Rev-
6 enue Code of 1986 is amended by striking the second sen-
7 tence.

8 (b) EFFECTIVE DATE.—The amendment made by
9 this section shall apply to taxable years beginning after
10 December 31, 2010.

11 **SEC. 6013. MODIFICATION OF ITEMIZED DEDUCTION FOR**
12 **MEDICAL EXPENSES.**

13 (a) IN GENERAL.—Subsection (a) of section 213 of
14 the Internal Revenue Code of 1986 is amended by striking
15 “7.5 percent” and inserting “10 percent”.

16 (b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN
17 SENIORS.—Section 213 of the Internal Revenue Code of
18 1986 is amended by adding at the end the following new
19 subsection:

20 “(f) SPECIAL RULE FOR 2013, 2014, 2015, AND
21 2016.—In the case of a taxable year beginning after De-
22 cember 31, 2012, and ending before January 1, 2017, sub-
23 section (a) shall be applied with respect to a taxpayer by
24 substituting ‘7.5 percent’ for ‘10 percent’ if such taxpayer

1 or such taxpayer's spouse has attained age 65 before the
2 close of such taxable year.”.

3 (c) CONFORMING AMENDMENT.—Section
4 56(b)(1)(B) of the Internal Revenue Code of 1986 is
5 amended by striking “by substituting ‘10 percent’ for ‘7.5
6 percent’” and inserting “without regard to subsection (f)
7 of such section”.

8 (d) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable year beginning after De-
10 cember 31, 2012.

11 **SEC. 6014. LIMITATION ON EXCESSIVE REMUNERATION**
12 **PAID BY CERTAIN HEALTH INSURANCE PRO-**
13 **VIDERS.**

14 (a) IN GENERAL.—Section 162(m) of the Internal
15 Revenue Code of 1986 is amended by adding at the end
16 the following new subparagraph:

17 “(6) SPECIAL RULE FOR APPLICATION TO CER-
18 TAIN HEALTH INSURANCE PROVIDERS.—

19 “(A) IN GENERAL.—No deduction shall be
20 allowed under this chapter—

21 “(i) in the case of applicable indi-
22 vidual remuneration which is for any dis-
23 qualified taxable year beginning after De-
24 cember 31, 2012, and which is attributable
25 to services performed by an applicable indi-

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1 vidual during such taxable year, to the ex-
2 tent that the amount of such remuneration
3 exceeds \$500,000, or

4 “(ii) in the case of deferred deduction
5 remuneration for any taxable year begin-
6 ning after December 31, 2012, for services
7 performed by an applicable individual dur-
8 ing any disqualified taxable year beginning
9 after December 31, 2009, to the extent
10 that the amount of such remuneration ex-
11 ceeds \$500,000 reduced (but not below
12 zero) by the sum of—

13 “(I) the applicable individual re-
14 muneration for such taxable year, plus

15 “(II) the portion of the deferred
16 deduction remuneration for such serv-
17 ices which was taken into account
18 under this clause in a preceding tax-
19 able year.

20 “(B) DISQUALIFIED TAXABLE YEAR.—For
21 purposes of this paragraph, the term ‘disquali-
22 fied taxable year’ means, with respect to any
23 employer, any taxable year for which such em-
24 ployer is a covered health insurance provider.

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1 “(C) COVERED HEALTH INSURANCE PRO-
2 VIDER.—For purposes of this paragraph—

3 “(i) IN GENERAL.—The term ‘covered
4 health insurance provider’ means—

5 “(I) with respect to taxable years
6 beginning after December 31, 2009,
7 and before January 1, 2013, any em-
8 ployer which is a health insurance
9 issuer (as defined in section
10 9832(b)(2)) and which receives pre-
11 miums from providing health insur-
12 ance coverage (as defined in section
13 9832(b)(1)), and

14 “(II) with respect to taxable
15 years beginning after December 31,
16 2012, any employer which is a health
17 insurance issuer (as defined in section
18 9832(b)(2)) and with respect to which
19 not less than 25 percent of the gross
20 premiums received from providing
21 health insurance coverage (as defined
22 in section 9832(b)(1)) is from essen-
23 tial health benefits coverage (as de-
24 fined in section 5000A(f)(1)).

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1 “(ii) AGGREGATION RULES.—Two or
2 more persons who are treated as a single
3 employer under subsection (b), (c), (m), or
4 (o) of section 414 shall be treated as a sin-
5 gle employer, except that in applying sec-
6 tion 1563(a) for purposes of any such sub-
7 section, paragraphs (2) and (3) thereof
8 shall be disregarded.

9 “(D) APPLICABLE INDIVIDUAL REMUNERA-
10 TION.—For purposes of this paragraph, the
11 term ‘applicable individual remuneration’
12 means, with respect to any applicable individual
13 for any disqualified taxable year, the aggregate
14 amount allowable as a deduction under this
15 chapter for such taxable year (determined with-
16 out regard to this subsection) for remuneration
17 (as defined in paragraph (4)(D)) for services
18 performed by such individual (whether or not
19 during the taxable year). Such term shall not
20 include any deferred deduction remuneration
21 with respect to services performed during the
22 disqualified taxable year.

23 “(E) DEFERRED DEDUCTION REMUNERA-
24 TION.—For purposes of this paragraph, the
25 term and ‘deferred deduction remuneration’

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1 means remuneration which would be applicable
2 individual remuneration for services performed
3 in a disqualified taxable year but for the fact
4 that the deduction under this chapter (deter-
5 mined without regard to this paragraph) for
6 such remuneration is allowable in a subsequent
7 taxable year.

8 “(F) APPLICABLE INDIVIDUAL.—For pur-
9 poses of this paragraph, the term ‘applicable in-
10 dividual’ means, with respect to any covered
11 health insurance provider for any disqualified
12 taxable year, any individual—

13 “(i) who is an officer, director, or em-
14 ployee in such taxable year, or

15 “(ii) who provides services for or on
16 behalf of such covered health insurance
17 provider during such taxable year.

18 “(G) COORDINATION.—Rules similar to
19 the rules of subparagraphs (F) and (G) of para-
20 graph (4) shall apply for purposes of this para-
21 graph.

22 “(H) REGULATORY AUTHORITY.—The Sec-
23 retary may prescribe such guidance, rules, or
24 regulations as are necessary to carry out the
25 purposes of this paragraph.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to taxable years beginning after
3 December 31, 2009, with respect to services performed
4 after such date.

5 **Subtitle B—Other Provisions**

6 **SEC. 6021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY** 7 **INDIAN TRIBAL GOVERNMENTS.**

8 (a) IN GENERAL.—Part III of subchapter B of chap-
9 ter 1 of the Internal Revenue Code of 1986 is amended
10 by inserting after section 139C the following new section:

11 **“SEC. 139D. INDIAN HEALTH CARE BENEFITS.**

12 “(a) GENERAL RULE.—Except as otherwise provided
13 in this section, gross income does not include the value
14 of any qualified Indian health care benefit.

15 “(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—
16 For purposes of this section, the term ‘qualified Indian
17 health care benefit’ means—

18 “(1) any health service or benefit provided or
19 purchased, directly or indirectly, by the Indian
20 Health Service through a grant to or a contract or
21 compact with an Indian tribe or tribal organization,
22 or through a third-party program funded by the In-
23 dian Health Service,

24 “(2) medical care provided or purchased by, or
25 amounts to reimburse for such medical care provided

1 by, an Indian tribe or tribal organization for, or to,
2 a member of an Indian tribe, including a spouse or
3 dependent of such a member,

4 “(3) coverage under accident or health insur-
5 ance (or an arrangement having the effect of acci-
6 dent or health insurance), or an accident or health
7 plan, provided by an Indian tribe or tribal organiza-
8 tion for medical care to a member of an Indian
9 tribe, include a spouse or dependent of such a mem-
10 ber, and

11 “(4) any other medical care provided by an In-
12 dian tribe or tribal organization that supplements,
13 replaces, or substitutes for a program or service re-
14 lating to medical care provided by the Federal gov-
15 ernment to Indian tribes or members of such a tribe.

16 “(c) DEFINITIONS.—For purposes of this section—

17 “(1) INDIAN TRIBE.—The term ‘Indian tribe’
18 has the meaning given such term by section
19 45A(c)(6).

20 “(2) TRIBAL ORGANIZATION.—The term ‘tribal
21 organization’ has the meaning given such term by
22 section 4(l) of the Indian Self-Determination and
23 Education Assistance Act.

24 “(3) MEDICAL CARE.—The term ‘medical care’
25 has the same meaning as when used in section 213.

1 “(4) ACCIDENT OR HEALTH INSURANCE; ACCI-
2 DENT OR HEALTH PLAN.—The terms ‘accident or
3 health insurance’ and ‘accident or health plan’ have
4 the same meaning as when used in section 105.

5 “(5) DEPENDENT.—The term ‘dependent’ has
6 the meaning given such term by section 152, deter-
7 mined without regard to subsections (b)(1), (b)(2),
8 and (d)(1)(B) thereof.

9 “(d) DENIAL OF DOUBLE BENEFIT.—Gross income
10 of a beneficiary of any qualified Indian health care benefit
11 shall include the amount of any such benefit which is not
12 includible in gross income of such beneficiary, or for which
13 a deduction is allowable to such beneficiary, under any
14 other provision of this chapter.”.

15 (b) CLERICAL AMENDMENT.—The table of sections
16 for part III of subchapter B of chapter 1 of the Internal
17 Revenue Code of 1986 is amended by inserting after the
18 item relating to section 139C the following new item:

 “Sec. 139D. Indian health care benefits.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to benefits and coverage provided
21 after the date of the enactment of this Act.

22 (d) NO INFERENCE.—Nothing in the amendments
23 made by this section shall be construed to create an infer-
24 ence with respect to the exclusion from gross income of—

1 (1) benefits provided by an Indian tribe or trib-
2 al organization that are not within the scope of this
3 section, and

4 (2) benefits provided prior to the date of the
5 enactment of this Act.

6 **SEC. 6022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS**
7 **FOR SMALL BUSINESSES.**

8 (a) IN GENERAL.—Section 125 of the Internal Rev-
9 enue Code of 1986 (relating to cafeteria plans), as amend-
10 ed by this Act, is amended by redesignating subsections
11 (j) and (k) as subsections (k) and (l), respectively, and
12 by inserting after subsection (i) the following new sub-
13 section:

14 “(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSI-
15 NESSES.—

16 “(1) IN GENERAL.—An eligible employer main-
17 taining a simple cafeteria plan with respect to which
18 the requirements of this subsection are met for any
19 year shall be treated as meeting any applicable non-
20 discrimination requirement during such year.

21 “(2) SIMPLE CAFETERIA PLAN.—For purposes
22 of this subsection, the term ‘simple cafeteria plan’
23 means a cafeteria plan—

24 “(A) which is established and maintained
25 by an eligible employer, and

1 “(B) with respect to which the contribution
2 requirements of paragraph (3), and the eligi-
3 bility and participation requirements of para-
4 graph (4), are met.

5 “(3) CONTRIBUTIONS REQUIREMENTS.—

6 “(A) IN GENERAL.—The requirements of
7 this paragraph are met if, under the plan the
8 employer is required, without regard to whether
9 a qualified employee makes any salary reduc-
10 tion contribution, to make a contribution to
11 provide qualified benefits under the plan on be-
12 half of each qualified employee in an amount
13 equal to—

14 “(i) a uniform percentage (not less
15 than 2 percent) of the employee’s com-
16 pensation for the plan year, or

17 “(ii) an amount which is not less than
18 the lesser of—

19 “(I) 6 percent of the employee’s
20 compensation for the plan year, or

21 “(II) twice the amount of the sal-
22 ary reduction contributions of each
23 qualified employee.

24 “(B) MATCHING CONTRIBUTIONS ON BE-
25 HALF OF HIGHLY COMPENSATED AND KEY EM-

1 PLOYEES.—The requirements of subparagraph
2 (A)(ii) shall not be treated as met if, under the
3 plan, the rate of contributions with respect to
4 any salary reduction contribution of a highly
5 compensated or key employee at any rate of
6 contribution is greater than that with respect to
7 an employee who is not a highly compensated or
8 key employee.

9 “(C) ADDITIONAL CONTRIBUTIONS.—Sub-
10 subject to subparagraph (B), nothing in this para-
11 graph shall be treated as prohibiting an em-
12 ployer from making contributions to provide
13 qualified benefits under the plan in addition to
14 contributions required under subparagraph (A).

15 “(D) DEFINITIONS.—For purposes of this
16 paragraph—

17 “(i) SALARY REDUCTION CONTRIBU-
18 TION.—The term ‘salary reduction con-
19 tribution’ means, with respect to a cafe-
20 teria plan, any amount which is contrib-
21 uted to the plan at the election of the em-
22 ployee and which is not includible in gross
23 income by reason of this section.

24 “(ii) QUALIFIED EMPLOYEE.—The
25 term ‘qualified employee’ means, with re-

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1 spect to a cafeteria plan, any employee who
2 is not a highly compensated or key em-
3 ployee and who is eligible to participate in
4 the plan.

5 “(iii) HIGHLY COMPENSATED EM-
6 PLOYEE.—The term ‘highly compensated
7 employee’ has the meaning given such term
8 by section 414(q).

9 “(iv) KEY EMPLOYEE.—The term ‘key
10 employee’ has the meaning given such term
11 by section 416(i).

12 “(4) MINIMUM ELIGIBILITY AND PARTICIPA-
13 TION REQUIREMENTS.—

14 “(A) IN GENERAL.—The requirements of
15 this paragraph shall be treated as met with re-
16 spect to any year if, under the plan—

17 “(i) all employees who had at least
18 1,000 hours of service for the preceding
19 plan year are eligible to participate, and

20 “(ii) each employee eligible to partici-
21 pate in the plan may, subject to terms and
22 conditions applicable to all participants,
23 elect any benefit available under the plan.

24 “(B) CERTAIN EMPLOYEES MAY BE EX-
25 CLUDED.—For purposes of subparagraph

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1 (A)(i), an employer may elect to exclude under
2 the plan employees—

3 “(i) who have not attained the age of
4 21 before the close of a plan year,

5 “(ii) who have less than 1 year of
6 service with the employer as of any day
7 during the plan year,

8 “(iii) who are covered under an agree-
9 ment which the Secretary of Labor finds to
10 be a collective bargaining agreement if
11 there is evidence that the benefits covered
12 under the cafeteria plan were the subject
13 of good faith bargaining between employee
14 representatives and the employer, or

15 “(iv) who are described in section
16 410(b)(3)(C) (relating to nonresident
17 aliens working outside the United States).

18 A plan may provide a shorter period of service
19 or younger age for purposes of clause (i) or (ii).

20 “(5) ELIGIBLE EMPLOYER.—For purposes of
21 this subsection—

22 “(A) IN GENERAL.—The term ‘eligible em-
23 ployer’ means, with respect to any year, any
24 employer if such employer employed an average
25 of 100 or fewer employees on business days

1 during either of the 2 preceding years. For pur-
2 poses of this subparagraph, a year may only be
3 taken into account if the employer was in exist-
4 ence throughout the year.

5 “(B) EMPLOYERS NOT IN EXISTENCE DUR-
6 ING PRECEDING YEAR.—If an employer was not
7 in existence throughout the preceding year, the
8 determination under subparagraph (A) shall be
9 based on the average number of employees that
10 it is reasonably expected such employer will em-
11 ploy on business days in the current year.

12 “(C) GROWING EMPLOYERS RETAIN
13 TREATMENT AS SMALL EMPLOYER.—

14 “(i) IN GENERAL.—If—

15 “(I) an employer was an eligible
16 employer for any year (a ‘qualified
17 year’), and

18 “(II) such employer establishes a
19 simple cafeteria plan for its employees
20 for such year,

21 then, notwithstanding the fact the em-
22 ployer fails to meet the requirements of
23 subparagraph (A) for any subsequent year,
24 such employer shall be treated as an eligi-
25 ble employer for such subsequent year with

1 respect to employees (whether or not em-
2 ployees during a qualified year) of any
3 trade or business which was covered by the
4 plan during any qualified year.

5 “(ii) EXCEPTION.—This subpara-
6 graph shall cease to apply if the employer
7 employs an average of 200 or more em-
8 ployees on business days during any year
9 preceding any such subsequent year.

10 “(D) SPECIAL RULES.—

11 “(i) PREDECESSORS.—Any reference
12 in this paragraph to an employer shall in-
13 clude a reference to any predecessor of
14 such employer.

15 “(ii) AGGREGATION RULES.—All per-
16 sons treated as a single employer under
17 subsection (a) or (b) of section 52, or sub-
18 section (n) or (o) of section 414, shall be
19 treated as one person.

20 “(6) APPLICABLE NONDISCRIMINATION RE-
21 QUIREMENT.—For purposes of this subsection, the
22 term ‘applicable nondiscrimination requirement’
23 means any requirement under subsection (b) of this
24 section, section 79(d), section 105(h), or paragraph
25 (2), (3), (4), or (8) of section 129(d).

1 “(7) COMPENSATION.—The term ‘compensa-
2 tion’ has the meaning given such term by section
3 414(s).”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to years beginning after December
6 31, 2010.

7 **SEC. 6023. QUALIFYING THERAPEUTIC DISCOVERY**
8 **PROJECT CREDIT.**

9 (a) IN GENERAL.—Subpart E of part IV of sub-
10 chapter A of chapter 1 of the Internal Revenue Code of
11 1986 is amended by inserting after section 48C the fol-
12 lowing new section:

13 **“SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY**
14 **PROJECT CREDIT.**

15 “(a) IN GENERAL.—For purposes of section 46, the
16 qualifying therapeutic discovery project credit for any tax-
17 able year is an amount equal to 50 percent of the qualified
18 investment for such taxable year with respect to any quali-
19 fying therapeutic discovery project of an eligible taxpayer.

20 “(b) QUALIFIED INVESTMENT.—

21 “(1) IN GENERAL.—For purposes of subsection
22 (a), the qualified investment for any taxable year is
23 the aggregate amount of the costs paid or incurred
24 in such taxable year for expenses necessary for and

1 directly related to the conduct of a qualifying thera-
2 peutic discovery project.

3 “(2) LIMITATION.—The amount which is treat-
4 ed as qualified investment for all taxable years with
5 respect to any qualifying therapeutic discovery
6 project shall not exceed the amount certified by the
7 Secretary as eligible for the credit under this sec-
8 tion.

9 “(3) EXCLUSIONS.—The qualified investment
10 for any taxable year with respect to any qualifying
11 therapeutic discovery project shall not take into ac-
12 count any cost—

13 “(A) for remuneration for an employee de-
14 scribed in section 162(m)(3),

15 “(B) for interest expenses,

16 “(C) for facility maintenance expenses,

17 “(D) which is identified as a service cost
18 under section 1.263A-1(e)(4) of title 26, Code
19 of Federal Regulations, or

20 “(E) for any other expense as determined
21 by the Secretary as appropriate to carry out the
22 purposes of this section.

23 “(4) CERTAIN PROGRESS EXPENDITURE RULES
24 MADE APPLICABLE.—In the case of costs described
25 in paragraph (1) that are paid for property of a

1 character subject to an allowance for depreciation,
2 rules similar to the rules of subsections (c)(4) and
3 (d) of section 46 (as in effect on the day before the
4 date of the enactment of the Revenue Reconciliation
5 Act of 1990) shall apply for purposes of this section.

6 “(5) APPLICATION OF SUBSECTION.—An invest-
7 ment shall be considered a qualified investment
8 under this subsection only if such investment is
9 made in a taxable year beginning in 2009 or 2010.

10 “(c) DEFINITIONS.—

11 “(1) QUALIFYING THERAPEUTIC DISCOVERY
12 PROJECT.—The term ‘qualifying therapeutic dis-
13 covery project’ means a project which is designed—

14 “(A) to treat or prevent diseases or condi-
15 tions by conducting pre-clinical activities, clin-
16 ical trials, and clinical studies, or carrying out
17 research protocols, for the purpose of securing
18 approval of a product under section 505(b) of
19 the Federal Food, Drug, and Cosmetic Act or
20 section 351(a) of the Public Health Service Act,

21 “(B) to diagnose diseases or conditions or
22 to determine molecular factors related to dis-
23 eases or conditions by developing molecular
24 diagnostics to guide therapeutic decisions, or

1 “(C) to develop a product, process, or tech-
2 nology to further the delivery or administration
3 of therapeutics.

4 “(2) ELIGIBLE TAXPAYER.—

5 “(A) IN GENERAL.—The term ‘eligible tax-
6 payer’ means a taxpayer which employs not
7 more than 250 employees in all businesses of
8 the taxpayer at the time of the submission of
9 the application under subsection (d)(2).

10 “(B) AGGREGATION RULES.—All persons
11 treated as a single employer under subsection
12 (a) or (b) of section 52, or subsection (m) or
13 (o) of section 414, shall be so treated for pur-
14 poses of this paragraph.

15 “(3) FACILITY MAINTENANCE EXPENSES.—The
16 term ‘facility maintenance expenses’ means costs
17 paid or incurred to maintain a facility, including—

18 “(A) mortgage or rent payments,

19 “(B) insurance payments,

20 “(C) utility and maintenance costs, and

21 “(D) costs of employment of maintenance
22 personnel.

23 “(d) QUALIFYING THERAPEUTIC DISCOVERY
24 PROJECT PROGRAM.—

25 “(1) ESTABLISHMENT.—

1 “(A) IN GENERAL.—Not later than 60
2 days after the date of the enactment of this sec-
3 tion, the Secretary, in consultation with the
4 Secretary of Health and Human Services, shall
5 establish a qualifying therapeutic discovery
6 project program to consider and award certifi-
7 cations for qualified investments eligible for
8 credits under this section to qualifying thera-
9 peutic discovery project sponsors.

10 “(B) LIMITATION.—The total amount of
11 credits that may be allocated under the pro-
12 gram shall not exceed \$1,000,000,000 for the
13 2-year period beginning with 2009.

14 “(2) CERTIFICATION.—

15 “(A) APPLICATION PERIOD.—Each appli-
16 cant for certification under this paragraph shall
17 submit an application containing such informa-
18 tion as the Secretary may require during the
19 period beginning on the date the Secretary es-
20 tablishes the program under paragraph (1).

21 “(B) TIME FOR REVIEW OF APPLICA-
22 TIONS.—The Secretary shall take action to ap-
23 prove or deny any application under subpara-
24 graph (A) within 30 days of the submission of
25 such application.

1 “(C) MULTI-YEAR APPLICATIONS.—An ap-
2 plication for certification under subparagraph
3 (A) may include a request for an allocation of
4 credits for more than 1 of the years described
5 in paragraph (1)(B).

6 “(3) SELECTION CRITERIA.—In determining
7 the qualifying therapeutic discovery projects with re-
8 spect to which qualified investments may be certified
9 under this section, the Secretary—

10 “(A) shall take into consideration only
11 those projects that show reasonable potential—

12 “(i) to result in new therapies—

13 “(I) to treat areas of unmet med-
14 ical need, or

15 “(II) to prevent, detect, or treat
16 chronic or acute diseases and condi-
17 tions,

18 “(ii) to reduce long-term health care
19 costs in the United States, or

20 “(iii) to significantly advance the goal
21 of curing cancer within the 30-year period
22 beginning on the date the Secretary estab-
23 lishes the program under paragraph (1),
24 and

1 “(B) shall take into consideration which
2 projects have the greatest potential—

3 “(i) to create and sustain (directly or
4 indirectly) high quality, high-paying jobs in
5 the United States, and

6 “(ii) to advance United States com-
7 petitiveness in the fields of life, biological,
8 and medical sciences.

9 “(4) DISCLOSURE OF ALLOCATIONS.—The Sec-
10 retary shall, upon making a certification under this
11 subsection, publicly disclose the identity of the appli-
12 cant and the amount of the credit with respect to
13 such applicant.

14 “(e) SPECIAL RULES.—

15 “(1) BASIS ADJUSTMENT.—For purposes of
16 this subtitle, if a credit is allowed under this section
17 for an expenditure related to property of a character
18 subject to an allowance for depreciation, the basis of
19 such property shall be reduced by the amount of
20 such credit.

21 “(2) DENIAL OF DOUBLE BENEFIT.—

22 “(A) BONUS DEPRECIATION.—A credit
23 shall not be allowed under this section for any
24 investment for which bonus depreciation is al-

1 lowed under section 168(k), 1400L(b)(1), or
2 1400N(d)(1).

3 “(B) DEDUCTIONS.—No deduction under
4 this subtitle shall be allowed for the portion of
5 the expenses otherwise allowable as a deduction
6 taken into account in determining the credit
7 under this section for the taxable year which is
8 equal to the amount of the credit determined
9 for such taxable year under subsection (a) at-
10 tributable to such portion. This subparagraph
11 shall not apply to expenses related to property
12 of a character subject to an allowance for de-
13 preciation the basis of which is reduced under
14 paragraph (1), or which are described in section
15 280C(g).

16 “(C) CREDIT FOR RESEARCH ACTIVI-
17 TIES.—

18 “(i) IN GENERAL.—Except as pro-
19 vided in clause (ii), any expenses taken
20 into account under this section for a tax-
21 able year shall not be taken into account
22 for purposes of determining the credit al-
23 lowable under section 41 or 45C for such
24 taxable year.

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1 “(ii) EXPENSES INCLUDED IN DETER-
2 MINING BASE PERIOD RESEARCH EX-
3 PENSES.—Any expenses for any taxable
4 year which are qualified research expenses
5 (within the meaning of section 41(b)) shall
6 be taken into account in determining base
7 period research expenses for purposes of
8 applying section 41 to subsequent taxable
9 years.

10 “(f) COORDINATION WITH DEPARTMENT OF TREAS-
11 URY LOANS.—In the case of any investment with respect
12 to which the Secretary makes a loan under section 6023(e)
13 of the America’s Healthy Future Act of 2009—

14 “(1) DENIAL OF CREDIT.—No credit shall be
15 determined under this section with respect to such
16 investment for the taxable year in which such loan
17 is made or any subsequent taxable year.

18 “(2) RECAPTURE OF CREDITS FOR PROGRESS
19 EXPENDITURES MADE BEFORE LOAN.—If a credit
20 was determined under this section with respect to
21 such investment for any taxable year ending before
22 such loan is made—

23 “(A) the tax imposed under subtitle A on
24 the taxpayer for the taxable year in which such

1 loan is made shall be increased by so much of
2 such credit as was allowed under section 38,

3 “(B) the general business carryforwards
4 under section 39 shall be adjusted so as to re-
5 capture the portion of such credit which was
6 not so allowed, and

7 “(C) the amount of such loan shall be de-
8 termined without regard to any reduction in the
9 basis of any property of a character subject to
10 an allowance for depreciation by reason of such
11 credit.”.

12 (b) INCLUSION AS PART OF INVESTMENT CREDIT.—
13 Section 46 of the Internal Revenue Code of 1986 is
14 amended—

15 (1) by adding a comma at the end of paragraph

16 (2),

17 (2) by striking the period at the end of para-
18 graph (5) and inserting “, and”, and

19 (3) by adding at the end the following new
20 paragraph:

21 “(6) the qualifying therapeutic discovery project
22 credit.”.

23 (c) CONFORMING AMENDMENTS.—

24 (1) Section 49(a)(1)(C) of the Internal Revenue
25 Code of 1986 is amended—

1 (A) by striking “and” at the end of clause
2 (iv),

3 (B) by striking the period at the end of
4 clause (v) and inserting “, and”, and

5 (C) by adding at the end the following new
6 clause:

7 “(vi) the basis of any property to
8 which paragraph (1) of section 48D(e) ap-
9 plies which is part of a qualifying thera-
10 peutic discovery project under such section
11 48D.”.

12 (2) Section 280C of such Code is amended by
13 adding at the end the following new subsection:

14 “(g) QUALIFYING THERAPEUTIC DISCOVERY
15 PROJECT CREDIT.—

16 “(1) IN GENERAL.—No deduction shall be al-
17 lowed for that portion of the qualified investment (as
18 defined in section 48D(b)) otherwise allowable as a
19 deduction for the taxable year which—

20 “(A) would be qualified research expenses
21 (as defined in section 41(b)), basic research ex-
22 penses (as defined in section 41(e)(2)), or quali-
23 fied clinical testing expenses (as defined in sec-
24 tion 45C(b)) if the credit under section 41 or

1 section 45C were allowed with respect to such
2 expenses for such taxable year, and

3 “(B) is equal to the amount of the credit
4 determined for such taxable year under section
5 48D(a), reduced by—

6 “(i) the amount disallowed as a de-
7 duction by reason of section 48D(e)(2)(B),
8 and

9 “(ii) the amount of any basis reduc-
10 tion under section 48D(e)(1).

11 “(2) SIMILAR RULE WHERE TAXPAYER CAP-
12 ITALIZES RATHER THAN DEDUCTS EXPENSES.—In
13 the case of expenses described in paragraph (1)(A)
14 taken into account in determining the credit under
15 section 48D for the taxable year, if—

16 “(A) the amount of the portion of the
17 credit determined under such section with re-
18 spect to such expenses, exceeds

19 “(B) the amount allowable as a deduction
20 for such taxable year for such expenses (deter-
21 mined without regard to paragraph (1)),
22 the amount chargeable to capital account for the
23 taxable year for such expenses shall be reduced by
24 the amount of such excess.

1 “(3) CONTROLLED GROUPS.—Paragraph (3) of
2 subsection (b) shall apply for purposes of this sub-
3 section.”.

4 (d) CLERICAL AMENDMENT.—The table of sections
5 for subpart E of part IV of subchapter A of chapter 1
6 of the Internal Revenue Code of 1986 is amended by in-
7 serting after the item relating to section 48C the following
8 new item:

 “Sec. 48D. Qualifying therapeutic discovery project credit.”.

9 (e) LOANS FOR QUALIFIED INVESTMENTS IN THERA-
10 PEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CRED-
11 ITS.—

12 (1) IN GENERAL.—Upon application, the Sec-
13 retary of the Treasury shall, subject to the require-
14 ments of this subsection, provide a loan to each per-
15 son who makes a qualified investment in a qualifying
16 therapeutic discovery project in the amount of 50
17 percent of such investment. No loan shall be made
18 under this subsection with respect to any investment
19 unless such investment is made during a taxable
20 year beginning in 2009 or 2010. The Secretary of
21 the Treasury may by regulations prescribe terms for
22 any loan made under this paragraph.

23 (2) APPLICATION.—

24 (A) IN GENERAL.—At the stated election
25 of the applicant, an application for certification

1 under section 48D(d)(2) of the Internal Rev-
2 enue Code of 1986 for a credit under such sec-
3 tion for the taxable year of the applicant which
4 begins in 2009 shall be considered to be an ap-
5 plication for a loan under paragraph (1) for
6 such taxable year.

7 (B) TAXABLE YEARS BEGINNING IN
8 2010.—An application for a loan under para-
9 graph (1) for a taxable year beginning in 2010
10 shall be submitted—

11 (i) not earlier than the day after the
12 last day of such taxable year, and

13 (ii) not later than the due date (in-
14 cluding extensions) for filing the return of
15 tax for such taxable year.

16 (C) INFORMATION TO BE SUBMITTED.—An
17 application for a loan under paragraph (1) shall
18 include such information and be in such form
19 as the Secretary may require to state the
20 amount of the credit allowable (but for the re-
21 ceipt of a loan under this subsection) under sec-
22 tion 48D for the taxable year for the qualified
23 investment with respect to which such applica-
24 tion is made.

25 (3) TIME FOR PAYMENT OF LOAN PROCEEDS.—

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1 (A) IN GENERAL.—The Secretary of the
2 Treasury shall make payment of the amount of
3 any loan under paragraph (1) during the 30-
4 day period beginning on the later of—

5 (i) the date of the application for such
6 loan, or

7 (ii) the date the qualified investment
8 for which the loan is being made is made.

9 (B) REGULATIONS.—In the case of invest-
10 ments of an ongoing nature, the Secretary shall
11 issue regulations to determine the date on
12 which a qualified investment shall be deemed to
13 have been made for purposes of this paragraph.

14 (4) QUALIFIED INVESTMENT.—For purposes of
15 this subsection, the term “qualified investment”
16 means a qualified investment that is certified under
17 section 48D(d) of the Internal Revenue Code of
18 1986 for purposes of the credit under such section
19 48D.

20 (5) APPLICATION OF CERTAIN RULES.—

21 (A) IN GENERAL.—In making loans under
22 this subsection, the Secretary of the Treasury
23 shall apply rules similar to the rules of section
24 50 of the Internal Revenue Code of 1986. In
25 applying such rules, any increase in tax under

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1 chapter 1 of such Code by reason of an invest-
2 ment ceasing to be a qualified investment shall
3 be imposed on the person to whom the loan was
4 made.

5 (B) SPECIAL RULES.—

6 (i) RECAPTURE OF EXCESSIVE LOAN
7 AMOUNTS.—If the amount of a loan made
8 under this subsection exceeds the amount
9 allowable as a loan under this subsection,
10 such excess shall be recaptured under sub-
11 paragraph (A) as if the investment to
12 which such excess portion of the loan re-
13 lates had ceased to be a qualified invest-
14 ment immediately after such loan was
15 made.

16 (ii) LOAN INFORMATION NOT TREAT-
17 ED AS RETURN INFORMATION.—In no
18 event shall the amount of a loan made
19 under paragraph (1), the identity of the
20 person to whom such loan was made, or a
21 description of the investment with respect
22 to which such loan was made be treated as
23 return information for purposes of section
24 6103 of the Internal Revenue Code of
25 1986.

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1 (6) EXCEPTION FOR CERTAIN NON-TAX-
2 PAYERS.—The Secretary of the Treasury shall not
3 make any loan under this subsection to—

4 (A) any Federal, State, or local govern-
5 ment (or any political subdivision, agency, or
6 instrumentality thereof),

7 (B) any organization described in section
8 501(c) of the Internal Revenue Code of 1986
9 and exempt from tax under section 501(a) of
10 such Code,

11 (C) any entity referred to in paragraph (4)
12 of section 54(j) of such Code, or

13 (D) any partnership or other pass-thru en-
14 tity any partner (or other holder of an equity
15 or profits interest) of which is described in sub-
16 paragraph (A), (B) or (C).

17 In the case of a partnership or other pass-thru enti-
18 ty described in subparagraph (D), partners and
19 other holders of any equity or profits interest shall
20 provide to such partnership or entity such informa-
21 tion as the Secretary of the Treasury may require to
22 carry out the purposes of this paragraph.

23 (7) SECRETARY.—Any reference in this sub-
24 section to the Secretary of the Treasury shall be
25 treated as including the Secretary's delegate.

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1 (8) OTHER TERMS.—Any term used in this sub-
2 section which is also used in section 48D of the In-
3 ternal Revenue Code of 1986 shall have the same
4 meaning for purposes of this subsection as when
5 used in such section.

6 (9) DENIAL OF DOUBLE BENEFIT.—No credit
7 shall be allowed under section 46(6) of the Internal
8 Revenue Code of 1986 by reason of section 48D of
9 such Code for any investment for which a loan is
10 awarded under this subsection.

11 (10) APPROPRIATIONS.—There is hereby appro-
12 priated to the Secretary of the Treasury such sums
13 as may be necessary to carry out this subsection.

14 (11) TERMINATION.—The Secretary of the
15 Treasury shall not make any loan to any person
16 under this subsection unless the application of such
17 person for such loan is received before January 1,
18 2013.

19 (f) EFFECTIVE DATE.—The amendments made by
20 subsections (a) through (d) of this section shall apply to
21 amounts paid or incurred after December 31, 2008, in
22 taxable years beginning after such date.