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(Original Signature of Member)

111TH CONGRESS
1ST SESSION

H. R.

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

IN THE HOUSE OF REPRESENTATIVES

Mr. DINGELL (for himself, Mr. RANGEL, Mr. WAXMAN, Mr. GEORGE MILLER of California, Mr. STARK, Mr. PALLONE, and Mr. ANDREWS) introduced the following bill; which was referred to the Committee on

A BILL

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

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

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

5 (a) SHORT TITLE.—This Act may be cited as the
6 “Affordable Health Care for America Act”.

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

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—IMMEDIATE REFORMS

TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED
HEALTH BENEFITS PLANS

Subtitle A—General Standards

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Subtitle D—Additional Consumer Protections

Subtitle E—Governance

Subtitle F—Relation to Other Requirements; Miscellaneous

TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVI-
SIONS

Subtitle A—Health Insurance Exchange

Subtitle B—Public Health Insurance Option

Subtitle C—Individual Affordability Credits

TITLE IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Subtitle B—Employer Responsibility

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

Subtitle C—Disclosures To Carry Out Health Insurance Exchange Subsidies

Subtitle D—Other Revenue Provisions

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions related to Medicare part A

Subtitle B—Provisions Related to Part B

Subtitle C—Provisions Related to Medicare Parts A and B

Subtitle D—Medicare Advantage Reforms

Subtitle E—Improvements to Medicare Part D

Subtitle F—Medicare Rural Access Protections

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

Subtitle B—Reducing Health Disparities

Subtitle C—Miscellaneous Improvements

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERV-
ICES, AND COORDINATED CARE

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Subtitle B—Nursing Home Transparency

Subtitle C—Quality Measurements

Subtitle D—Physician Payments Sunshine Provision

Subtitle E—Public Reporting on Health Care-Associated Infections

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased funding to fight waste, fraud, and abuse
 Subtitle B—Enhanced penalties for fraud and abuse
 Subtitle C—Enhanced Program and Provider Protections
 Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse
TITLE VII—MEDICAID AND CHIP
 Subtitle A—Medicaid and Health Reform
 Subtitle B—Prevention
 Subtitle C—Access
 Subtitle D—Coverage
 Subtitle E—Financing
 Subtitle F—Waste, Fraud, and Abuse
 Subtitle G—Puerto Rico and the Territories
 Subtitle H—Miscellaneous
TITLE VIII—REVENUE-RELATED PROVISIONS
TITLE IX—MISCELLANEOUS PROVISIONS

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

TITLE I—COMMUNITY HEALTH CENTERS
TITLE II—WORKFORCE
 Subtitle A—Primary Care Workforce
 Subtitle B—Nursing Workforce
 Subtitle C—Public Health Workforce
 Subtitle D—Adapting Workforce to Evolving Health System Needs
TITLE III—PREVENTION AND WELLNESS
TITLE IV—QUALITY AND SURVEILLANCE
TITLE V—OTHER PROVISIONS
 Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity
 Subtitle B—Programs
 Subtitle C—Food and Drug Administration
 Subtitle D—Community Living Assistance Services and Supports
 Subtitle E—Miscellaneous

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

TITLE I—AMENDMENTS TO INDIAN LAWS
TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

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

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

5 (a) PURPOSE.—

6 (1) IN GENERAL.—The purpose of this division
 7 is to provide affordable, quality health care for all

1 Americans and reduce the growth in health care
2 spending.

3 (2) BUILDING ON CURRENT SYSTEM.—This di-
4 vision achieves this purpose by building on what
5 works in today’s health care system, while repairing
6 the aspects that are broken.

7 (3) INSURANCE REFORMS.—This division—

8 (A) enacts strong insurance market re-
9 forms;

10 (B) creates a new Health Insurance Ex-
11 change, with a public health insurance option
12 alongside private plans;

13 (C) includes sliding scale affordability
14 credits; and

15 (D) initiates shared responsibility among
16 workers, employers, and the Government;

17 so that all Americans have coverage of essential
18 health benefits.

19 (4) HEALTH DELIVERY REFORM.—This division
20 institutes health delivery system reforms both to in-
21 crease quality and to reduce growth in health spend-
22 ing so that health care becomes more affordable for
23 businesses, families, and Government.

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

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

TITLE I—IMMEDIATE REFORMS

- Sec. 101. National high-risk pool program.
- Sec. 102. Ensuring value and lower premiums.
- Sec. 103. Ending health insurance rescission abuse.
- Sec. 104. Sunshine on price gouging by health insurance issuers.
- Sec. 105. Requiring the option of extension of dependent coverage for uninsured young adults.
- Sec. 106. Limitations on preexisting condition exclusions in group health plans in advance of applicability of new prohibition of preexisting condition exclusions.
- Sec. 107. Prohibiting acts of domestic violence from being treated as preexisting conditions.
- Sec. 108. Ending health insurance denials and delays of necessary treatment for children with deformities.
- Sec. 109. Elimination of lifetime limits.
- Sec. 110. Prohibition against postretirement reductions of retiree health benefits by group health plans.
- Sec. 111. Reinsurance program for retirees.
- Sec. 112. Wellness program grants.
- Sec. 113. Extension of COBRA continuation coverage.
- Sec. 114. State Health Access Program grants.
- Sec. 115. Administrative simplification.

TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

- Sec. 201. Requirements reforming health insurance marketplace.
- Sec. 202. Protecting the choice to keep current coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

- Sec. 211. Prohibiting preexisting condition exclusions.
- Sec. 212. Guaranteed issue and renewal for insured plans and prohibiting rescissions.
- Sec. 213. Insurance rating rules.
- Sec. 214. Nondiscrimination in benefits; parity in mental health and substance abuse disorder benefits.
- Sec. 215. Ensuring adequacy of provider networks.
- Sec. 216. Requiring the option of extension of dependent coverage for uninsured young adults.
- Sec. 217. Consistency of costs and coverage under qualified health benefits plans during plan year.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

- Sec. 221. Coverage of essential benefits package.
- Sec. 222. Essential benefits package defined.
- Sec. 223. Health Benefits Advisory Committee.
- Sec. 224. Process for adoption of recommendations; adoption of benefit standards.

Subtitle D—Additional Consumer Protections

- Sec. 231. Requiring fair marketing practices by health insurers.

- Sec. 232. Requiring fair grievance and appeals mechanisms.
- Sec. 233. Requiring information transparency and plan disclosure.
- Sec. 234. Application to qualified health benefits plans not offered through the Health Insurance Exchange.
- Sec. 235. Timely payment of claims.
- Sec. 236. Standardized rules for coordination and subrogation of benefits.
- Sec. 237. Application of administrative simplification.
- Sec. 238. State prohibitions on discrimination against health care providers.
- Sec. 239. Protection of physician prescriber information.
- Sec. 240. Dissemination of advance care planning information.

Subtitle E—Governance

- Sec. 241. Health Choices Administration; Health Choices Commissioner.
- Sec. 242. Duties and authority of Commissioner.
- Sec. 243. Consultation and coordination.
- Sec. 244. Health Insurance Ombudsman.

Subtitle F—Relation to Other Requirements; Miscellaneous

- Sec. 251. Relation to other requirements.
- Sec. 252. Prohibiting discrimination in health care.
- Sec. 253. Whistleblower protection.
- Sec. 254. Construction regarding collective bargaining.
- Sec. 255. Severability.
- Sec. 256. Treatment of Hawaii Prepaid Health Care Act.
- Sec. 257. Actions by State attorneys general.
- Sec. 258. Application of State and Federal laws regarding abortion.
- Sec. 259. Nondiscrimination on abortion and respect for rights of conscience.
- Sec. 260. Authority of Federal Trade Commission.
- Sec. 261. Construction regarding standard of care.
- Sec. 262. Restoring application of antitrust laws to health sector insurers.
- Sec. 263. Study and report on methods to increase EHR use by small health care providers.

TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

- Sec. 301. Establishment of Health Insurance Exchange; outline of duties; definitions.
- Sec. 302. Exchange-eligible individuals and employers.
- Sec. 303. Benefits package levels.
- Sec. 304. Contracts for the offering of Exchange-participating health benefits plans.
- Sec. 305. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.
- Sec. 306. Other functions.
- Sec. 307. Health Insurance Exchange Trust Fund.
- Sec. 308. Optional operation of State-based health insurance exchanges.
- Sec. 309. Interstate health insurance compacts.
- Sec. 310. Health insurance cooperatives.
- Sec. 311. Retention of DOD and VA authority.

Subtitle B—Public Health Insurance Option

- Sec. 321. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan.
- Sec. 322. Premiums and financing.
- Sec. 323. Payment rates for items and services.
- Sec. 324. Modernized payment initiatives and delivery system reform.
- Sec. 325. Provider participation.
- Sec. 326. Application of fraud and abuse provisions.
- Sec. 327. Application of HIPAA insurance requirements.
- Sec. 328. Application of health information privacy, security, and electronic transaction requirements.
- Sec. 329. Enrollment in public health insurance option is voluntary.
- Sec. 330. Enrollment in public health insurance option by Members of Congress.
- Sec. 331. Reimbursement of Secretary of Veterans Affairs.

Subtitle C—Individual Affordability Credits

- Sec. 341. Availability through Health Insurance Exchange.
- Sec. 342. Affordable credit eligible individual.
- Sec. 343. Affordability premium credit.
- Sec. 344. Affordability cost-sharing credit.
- Sec. 345. Income determinations.
- Sec. 346. Special rules for application to territories.
- Sec. 347. No Federal payment for undocumented aliens.

TITLE IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

- Sec. 401. Individual responsibility.

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

- Sec. 411. Health coverage participation requirements.
- Sec. 412. Employer responsibility to contribute toward employee and dependent coverage.
- Sec. 413. Employer contributions in lieu of coverage.
- Sec. 414. Authority related to improper steering.
- Sec. 415. Impact study on employer responsibility requirements.
- Sec. 416. Study on employer hardship exemption.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

- Sec. 421. Satisfaction of health coverage participation requirements under the Employee Retirement Income Security Act of 1974.
- Sec. 422. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986.
- Sec. 423. Satisfaction of health coverage participation requirements under the Public Health Service Act.
- Sec. 424. Additional rules relating to health coverage participation requirements.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

SUBPART A—INDIVIDUAL RESPONSIBILITY

Sec. 501. Tax on individuals without acceptable health care coverage.

SUBPART B—EMPLOYER RESPONSIBILITY

Sec. 511. Election to satisfy health coverage participation requirements.

Sec. 512. Health care contributions of nonelecting employers.

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

Sec. 521. Credit for small business employee health coverage expenses.

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

Sec. 531. Distributions for medicine qualified only if for prescribed drug or insulin.

Sec. 532. Limitation on health flexible spending arrangements under cafeteria plans.

Sec. 533. Increase in penalty for nonqualified distributions from health savings accounts.

Sec. 534. Denial of deduction for federal subsidies for prescription drug plans which have been excluded from gross income.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

Sec. 541. Disclosures to carry out health insurance exchange subsidies.

Sec. 542. Offering of exchange-participating health benefits plans through cafeteria plans.

Sec. 543. Exclusion from gross income of payments made under reinsurance program for retirees.

Sec. 544. CLASS program treated in same manner as long-term care insurance.

Sec. 545. Exclusion from gross income for medical care provided for Indians.

Subtitle B—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

Sec. 551. Surcharge on high income individuals.

Sec. 552. Excise tax on medical devices.

Sec. 553. Expansion of information reporting requirements.

Sec. 554. Delay in application of worldwide allocation of interest.

PART 2—PREVENTION OF TAX AVOIDANCE

Sec. 561. Limitation on treaty benefits for certain deductible payments.

Sec. 562. Codification of economic substance doctrine; penalties.

Sec. 563. Certain large or publicly traded persons made subject to a more likely than not standard for avoiding penalties on underpayments.

PART 3—PARITY IN HEALTH BENEFITS

Sec. 571. Certain health related benefits applicable to spouses and dependents extended to eligible beneficiaries.

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

3 (1) ACCEPTABLE COVERAGE.—The term “ac-
4 ceptable coverage” has the meaning given such term
5 in section 302(d)(2).

6 (2) BASIC PLAN.—The term “basic plan” has
7 the meaning given such term in section 303(c).

8 (3) COMMISSIONER.—The term “Commis-
9 sioner” means the Health Choices Commissioner es-
10 tablished under section 241.

11 (4) COST-SHARING.—The term “cost-sharing”
12 includes deductibles, coinsurance, copayments, and
13 similar charges, but does not include premiums, bal-
14 ance billing amounts for non-network providers, or
15 spending for non-covered services.

16 (5) DEPENDENT.—The term “dependent” has
17 the meaning given such term by the Commissioner
18 and includes a spouse.

19 (6) EMPLOYMENT-BASED HEALTH PLAN.—The
20 term “employment-based health plan”—

21 (A) means a group health plan (as defined
22 in section 733(a)(1) of the Employee Retirement
23 Income Security Act of 1974);

24 (B) includes such a plan that is the fol-
25 lowing:

1 (i) FEDERAL, STATE, AND TRIBAL
2 GOVERNMENTAL PLANS.—A governmental
3 plan (as defined in section 3(32) of the
4 Employee Retirement Income Security Act
5 of 1974), including a health benefits plan
6 offered under chapter 89 of title 5, United
7 States Code.

8 (ii) CHURCH PLANS.—A church plan
9 (as defined in section 3(33) of the Em-
10 ployee Retirement Income Security Act of
11 1974); and

12 (C) excludes coverage described in section
13 302(d)(2)(E) (relating to TRICARE).

14 (7) ENHANCED PLAN.—The term “enhanced
15 plan” has the meaning given such term in section
16 303(c).

17 (8) ESSENTIAL BENEFITS PACKAGE.—The term
18 “essential benefits package” is defined in section
19 222(a).

20 (9) EXCHANGE-PARTICIPATING HEALTH BENE-
21 FITS PLAN.—The term “Exchange-participating
22 health benefits plan” means a qualified health bene-
23 fits plan that is offered through the Health Insur-
24 ance Exchange and may be purchased directly from

1 the entity offering the plan or through enrollment
2 agents and brokers.

3 (10) FAMILY.—The term “family” means an
4 individual and includes the individual’s dependents.

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

11 (12) HEALTH BENEFITS PLAN.—The term
12 “health benefits plan” means health insurance cov-
13 erage and an employment-based health plan and in-
14 cludes the public health insurance option.

15 (13) HEALTH INSURANCE COVERAGE.—The
16 term “health insurance coverage” has the meaning
17 given such term in section 2791 of the Public
18 Health Service Act, but does not include coverage in
19 relation to its provision of excepted benefits—

20 (A) described in paragraph (1) of sub-
21 section (c) of such section; or

22 (B) described in paragraph (2), (3), or (4)
23 of such subsection if the benefits are provided
24 under a separate policy, certificate, or contract
25 of insurance.

1 (14) HEALTH INSURANCE ISSUER.—The term
2 “health insurance issuer” has the meaning given
3 such term in section 2791(b)(2) of the Public Health
4 Service Act.

5 (15) HEALTH INSURANCE EXCHANGE.—The
6 term “Health Insurance Exchange” means the
7 Health Insurance Exchange established under sec-
8 tion 301.

9 (16) INDIAN.—The term “Indian” has the
10 meaning given such term in section 4 of the Indian
11 Health Care Improvement Act (24 U.S.C. 1603).

12 (17) INDIAN HEALTH CARE PROVIDER.—The
13 term “Indian health care provider” means a health
14 care program operated by the Indian Health Service,
15 an Indian tribe, tribal organization, or urban Indian
16 organization as such terms are defined in section 4
17 of the Indian Health Care Improvement Act (25
18 U.S.C. 1603).

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

23 (19) MEDICAID ELIGIBLE INDIVIDUAL.—The
24 term “Medicaid eligible individual” means an indi-

1 vidual who is eligible for medical assistance under
2 Medicaid.

3 (20) MEDICARE.—The term “Medicare” means
4 the health insurance programs under title XVIII of
5 the Social Security Act.

6 (21) PLAN SPONSOR.—The term “plan spon-
7 sor” has the meaning given such term in section
8 3(16)(B) of the Employee Retirement Income Secu-
9 rity Act of 1974.

10 (22) PLAN YEAR.—The term “plan year”
11 means—

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

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

19 (23) PREMIUM PLAN; PREMIUM-PLUS PLAN.—
20 The terms “premium plan” and “premium-plus
21 plan” have the meanings given such terms in section
22 303(c).

23 (24) QHBP OFFERING ENTITY.—The terms
24 “QHBP offering entity” means, with respect to a
25 health benefits plan that is—

1 (A) a group health plan (as defined, sub-
2 ject to subsection (d), in section 733(a)(1) of
3 the Employee Retirement Income Security Act
4 of 1974), the plan sponsor in relation to such
5 group health plan, except that, in the case of a
6 plan maintained jointly by 1 or more employers
7 and 1 or more employee organizations and with
8 respect to which an employer is the primary
9 source of financing, such term means such em-
10 ployer;

11 (B) health insurance coverage, the health
12 insurance issuer offering the coverage;

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

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

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

1 (25) QUALIFIED HEALTH BENEFITS PLAN.—

2 The term “qualified health benefits plan” means a
3 health benefits plan that—

4 (A) meets the requirements for such a plan
5 under title II and includes the public health in-
6 surance option; and

7 (B) is offered by a QHBP offering entity
8 that meets the applicable requirements of such
9 title with respect to such plan.

10 (26) PUBLIC HEALTH INSURANCE OPTION.—

11 The term “public health insurance option” means
12 the public health insurance option as provided under
13 subtitle B of title III.

14 (27) SERVICE AREA; PREMIUM RATING AREA.—

15 The terms “service area” and “premium rating
16 area” mean with respect to health insurance cov-
17 erage—

18 (A) offered other than through the Health
19 Insurance Exchange, such an area as estab-
20 lished by the QHBP offering entity of such cov-
21 erage in accordance with applicable State law;
22 and

23 (B) offered through the Health Insurance
24 Exchange, such an area as established by such
25 entity in accordance with applicable State law

1 and applicable rules of the Commissioner for
2 Exchange-participating health benefits plans.

3 (28) STATE.—The term “State” means the 50
4 States and the District of Columbia and includes—

5 (A) for purposes of title I, Puerto Rico, the
6 Virgin Islands, Guam, American Samoa, and
7 the Northern Mariana Islands; and

8 (B) for purposes of titles II and III, as
9 elected under and subject to section 346, Puer-
10 to Rico, the Virgin Islands, Guam, American
11 Samoa, and the Northern Mariana Islands.

12 (29) STATE MEDICAID AGENCY.—The term
13 “State Medicaid agency” means, with respect to a
14 Medicaid plan, the single State agency responsible
15 for administering such plan under title XIX of the
16 Social Security Act.

17 (30) Y1, Y2, ETC.—The terms “Y1”, “Y2”,
18 “Y3”, “Y4”, “Y5”, and similar subsequently num-
19 bered terms, mean 2013 and subsequent years, re-
20 spectively.

21 **TITLE I—IMMEDIATE REFORMS**

22 **SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services (in this section referred to as the “Sec-
25 retary”) shall establish a temporary national high-risk

1 pool program (in this section referred to as the “pro-
2 gram”) to provide health benefits to eligible individuals
3 during the period beginning on January 1, 2010, and, sub-
4 ject to subsection (h)(3)(B), ending on the date on which
5 the Health Insurance Exchange is established.

6 (b) ADMINISTRATION.—The Secretary may carry out
7 this section directly or, pursuant to agreements, grants,
8 or contracts with States, through State high-risk pool pro-
9 grams provided that the requirements of this section are
10 met.

11 (c) ELIGIBILITY.—For purposes of this section, the
12 term “eligible individual” means an individual—

13 (1) who—

14 (A) is not eligible for—

15 (i) benefits under title XVIII, XIX, or
16 XXI of the Social Security Act; or

17 (ii) coverage under an employment-
18 based health plan (not including coverage
19 under a COBRA continuation provision, as
20 defined in section 107(d)(1)); and

21 (B) who—

22 (i) is an eligible individual under sec-
23 tion 2741(b) of the Public Health Service
24 Act; or

1 (ii) is medically eligible for the pro-
2 gram by virtue of being an individual de-
3 scribed in subsection (d) at any time dur-
4 ing the 6-month period ending on the date
5 the individual applies for high-risk pool
6 coverage under this section;

7 (2) who is the spouse or dependent of an indi-
8 vidual who is described in paragraph (1); or

9 (3) who has not had health insurance coverage
10 or coverage under an employment-based health plan
11 for at least the 6-month period immediately pre-
12 ceding the date of the individual's application for
13 high-risk pool coverage under this section.

14 For purposes of paragraph (1)(A)(ii), a person who is in
15 a waiting period as defined in section 2701(b)(4) of the
16 Public Health Service Act shall not be considered to be
17 eligible for coverage under an employment-based health
18 plan.

19 (d) **MEDICALLY ELIGIBLE REQUIREMENTS.**—For
20 purposes of subsection (c)(1)(B)(ii), an individual de-
21 scribed in this subsection is an individual—

22 (1) who, during the 6-month period ending on
23 the date the individual applies for high-risk pool cov-
24 erage under this section applied for individual health
25 insurance coverage and—

1 (A) was denied such coverage because of a
2 preexisting condition or health status; or

3 (B) was offered such coverage—

4 (i) under terms that limit the cov-
5 erage for such a preexisting condition; or

6 (ii) at a premium rate that is above
7 the premium rate for high risk pool cov-
8 erage under this section; or

9 (2) who has an eligible medical condition as de-
10 fined by the Secretary.

11 In making a determination under paragraph (1) of wheth-
12 er an individual was offered individual coverage at a pre-
13 mium rate above the premium rate for high risk pool cov-
14 erage, the Secretary shall make adjustments to offset dif-
15 ferences in premium rating that are attributable solely to
16 differences in age rating.

17 (e) ENROLLMENT.—To enroll in coverage in the pro-
18 gram, an individual shall—

19 (1) submit to the Secretary an application for
20 participation in the program, at such time, in such
21 manner, and containing such information as the Sec-
22 retary shall require;

23 (2) attest that the individual is an eligible indi-
24 vidual and is a resident of one of the 50 States or
25 the District of Columbia; and

1 (3) if the individual had other prior health in-
2 surance coverage or coverage under an employment-
3 based health plan during the previous 6 months,
4 provide information as to the nature and source of
5 such coverage and reasons for its discontinuance.

6 (f) PROTECTION AGAINST DUMPING RISKS BY IN-
7 SURERS.—

8 (1) IN GENERAL.—The Secretary shall establish
9 criteria for determining whether health insurance
10 issuers and employment-based health plans have dis-
11 couraged an individual from remaining enrolled in
12 prior coverage based on that individual's health sta-
13 tus.

14 (2) SANCTIONS.—An issuer or employment-
15 based health plan shall be responsible for reimburs-
16 ing the program for the medical expenses incurred
17 by the program for an individual who, based on cri-
18 teria established by the Secretary, the Secretary
19 finds was encouraged by the issuer to disenroll from
20 health benefits coverage prior to enrolling in the pro-
21 gram. The criteria shall include at least the fol-
22 lowing circumstances:

23 (A) In the case of prior coverage obtained
24 through an employer, the provision by the em-
25 ployer, group health plan, or the issuer of

1 money or other financial consideration for
2 disenrolling from the coverage.

3 (B) In the case of prior coverage obtained
4 directly from an issuer or under an employ-
5 ment-based health plan—

6 (i) the provision by the issuer or plan
7 of money or other financial consideration
8 for disenrolling from the coverage; or

9 (ii) in the case of an individual whose
10 premium for the prior coverage exceeded
11 the premium required by the program (ad-
12 justed based on the age factors applied to
13 the prior coverage)—

14 (I) the prior coverage is a policy
15 that is no longer being actively mar-
16 keted (as defined by the Secretary) by
17 the issuer; or

18 (II) the prior coverage is a policy
19 for which duration of coverage form
20 issue or health status are factors that
21 can be considered in determining pre-
22 miums at renewal.

23 (3) CONSTRUCTION.—Nothing in this sub-
24 section shall be construed as constituting exclusive
25 remedies for violations of criteria established under

1 paragraph (1) or as preventing States from applying
2 or enforcing such paragraph or other provisions
3 under law with respect to health insurance issuers.

4 (g) COVERED BENEFITS, COST-SHARING, PREMIUMS,
5 AND CONSUMER PROTECTIONS.—

6 (1) PREMIUM.—The monthly premium charged
7 to eligible individuals for coverage under the pro-
8 gram—

9 (A) may vary by age so long as the ratio
10 of the highest such premium to the lowest such
11 premium does not exceed the ratio of 2 to 1;

12 (B) shall be set at a level that does not ex-
13 ceed 125 percent of the prevailing standard rate
14 for comparable coverage in the individual mar-
15 ket; and

16 (C) shall be adjusted for geographic vari-
17 ation in costs.

18 Health insurance issuers shall provide such informa-
19 tion as the Secretary may require to determine pre-
20 vailing standard rates under this paragraph. The
21 Secretary shall establish standard rates in consulta-
22 tion with the National Association of Insurance
23 Commissioners.

24 (2) COVERED BENEFITS.—Covered benefits
25 under the program shall be determined by the Sec-

1 retary and shall be consistent with the basic cat-
2 egories in the essential benefits package described in
3 section 222. Under such benefits package—

4 (A) the annual deductible for such benefits
5 may not be higher than \$1,500 for an indi-
6 vidual or such higher amount for a family as
7 determined by the Secretary;

8 (B) there may not be annual or lifetime
9 limits; and

10 (C) the maximum cost-sharing with respect
11 to an individual (or family) for a year shall not
12 exceed \$5,000 for an individual (or \$10,000 for
13 a family).

14 (3) NO PREEXISTING CONDITION EXCLUSION
15 PERIODS.—No preexisting condition exclusion period
16 shall be imposed on coverage under the program.

17 (4) APPEALS.—The Secretary shall establish an
18 appeals process for individuals to appeal a deter-
19 mination of the Secretary—

20 (A) with respect to claims submitted under
21 this section; and

22 (B) with respect to eligibility determina-
23 tions made by the Secretary under this section.

24 (5) STATE CONTRIBUTION, MAINTENANCE OF
25 EFFORT.—As a condition of providing health bene-

1 fits under this section to eligible individual residing
2 in a State—

3 (A) in the case of a State in which a quali-
4 fied high-risk pool (as defined under section
5 2744(c)(2) of the Public Health Service Act)
6 was in effect as of July 1, 2009, the Secretary
7 shall require the State make a maintenance of
8 effort payment each year that the high-risk pool
9 is in effect equal to an amount not less than the
10 amount of all sources of funding for high-risk
11 pool coverage made by that State in the year
12 ending July 1, 2009; and

13 (B) in the case of a State which required
14 health insurance issuers to contribute to a State
15 high-risk pool or similar arrangement for the
16 assessment against such issuers for pool losses,
17 the State shall maintain such a contribution ar-
18 rangement among such issuers.

19 (6) LIMITING PROGRAM EXPENDITURES.—The
20 Secretary shall, with respect to the program—

21 (A) establish procedures to protect against
22 fraud, waste, and abuse under the program;
23 and

24 (B) provide for other program integrity
25 methods.

1 (7) TREATMENT AS CREDITABLE COVERAGE.—

2 Coverage under the program shall be treated, for
3 purposes of applying the definition of “creditable
4 coverage” under the provisions of title XXVII of the
5 Public Health Service Act, part 6 of subtitle B of
6 title I of Employee Retirement Income Security Act
7 of 1974, and chapter 100 of the Internal Revenue
8 Code of 1986 (and any other provision of law that
9 references such provisions) in the same manner as
10 if it were coverage under a State health benefits risk
11 pool described in section 2701(c)(1)(G) of the Public
12 Health Service Act.

13 (h) FUNDING; TERMINATION OF AUTHORITY.—

14 (1) IN GENERAL.—There is appropriated to the
15 Secretary, out of any moneys in the Treasury not
16 otherwise appropriated, \$5,000,000,000 to pay
17 claims against (and administrative costs of) the
18 high-risk pool under this section in excess of the pre-
19 miums collected with respect to eligible individuals
20 enrolled in the high-risk pool. Such funds shall be
21 available without fiscal year limitation.

22 (2) INSUFFICIENT FUNDS.—If the Secretary es-
23 timates for any fiscal year that the aggregate
24 amounts available for payment of expenses of the
25 high-risk pool will be less than the amount of the ex-

1 penses, the Secretary shall make such adjustments
2 as are necessary to eliminate such deficit, including
3 reducing benefits, increasing premiums, or estab-
4 lishing waiting lists.

5 (3) TERMINATION OF AUTHORITY.—

6 (A) IN GENERAL.—Except as provided in
7 subparagraph (B), coverage of eligible individ-
8 uals under a high-risk pool shall terminate as
9 of the date on which the Health Insurance Ex-
10 change is established.

11 (B) TRANSITION TO EXCHANGE.—The
12 Secretary shall develop procedures to provide
13 for the transition of eligible individuals who are
14 enrolled in health insurance coverage offered
15 through a high-risk pool established under this
16 section to be enrolled in acceptable coverage.
17 Such procedures shall ensure that there is no
18 lapse in coverage with respect to the individual
19 and may extend coverage offered through such
20 a high-risk pool beyond 2012 if the Secretary
21 determines necessary to avoid such a lapse.

22 **SEC. 102. ENSURING VALUE AND LOWER PREMIUMS.**

23 (a) GROUP HEALTH INSURANCE COVERAGE.—Title
24 XXVII of the Public Health Service Act is amended by
25 inserting after section 2713 the following new section:

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

2 “(a) IN GENERAL.—Each health insurance issuer
3 that offers health insurance coverage in the small or large
4 group market shall provide that for any plan year in which
5 the coverage has a medical loss ratio below a level specified
6 by the Secretary (but not less than 85 percent), the issuer
7 shall provide in a manner specified by the Secretary for
8 rebates to enrollees of the amount by which the issuer’s
9 medical loss ratio is less than the level so specified.

10 “(b) IMPLEMENTATION.—The Secretary shall estab-
11 lish a uniform definition of medical loss ratio and method-
12 ology for determining how to calculate it based on the av-
13 erage medical loss ratio in a health insurance issuer’s book
14 of business for the small and large group market. Such
15 methodology shall be designed to take into account the
16 special circumstances of smaller plans, different types of
17 plans, and newer plans. In determining the medical loss
18 ratio, the Secretary shall exclude State taxes and licensing
19 or regulatory fees. Such methodology shall be designed
20 and exceptions shall be established to ensure adequate
21 participation by health insurance issuers, competition in
22 the health insurance market, and value for consumers so
23 that their premiums are used for services.

24 “(c) SUNSET.—Subsections (a) and (b) shall not
25 apply to health insurance coverage on and after the first

1 date that health insurance coverage is offered through the
2 Health Insurance Exchange.”.

3 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—

4 Such title is further amended by inserting after section
5 2753 the following new section:

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

7 “The provisions of section 2714 shall apply to health
8 insurance coverage offered in the individual market in the
9 same manner as such provisions apply to health insurance
10 coverage offered in the small or large group market except
11 to the extent the Secretary determines that the application
12 of such section may destabilize the existing individual
13 market.”.

14 (c) IMMEDIATE IMPLEMENTATION.—The amend-
15 ments made by this section shall apply in the group and
16 individual market for plan years beginning on or after
17 January 1, 2010, or as soon as practicable after such date.

18 **SEC. 103. ENDING HEALTH INSURANCE RESCISSION ABUSE.**

19 (a) CLARIFICATION REGARDING APPLICATION OF
20 GUARANTEED RENEWABILITY OF INDIVIDUAL AND
21 GROUP HEALTH INSURANCE COVERAGE.—Sections 2712
22 and 2742 of the Public Health Service Act (42 U.S.C.
23 300gg–12, 300gg–42) are each amended—

24 (1) in its heading, by inserting **“AND CON-**
25 **TINUATION IN FORCE, INCLUDING PROHIBI-**

1 **TION OF RESCISSION,**” after **“GUARANTEED RE-**
2 **NEWABILITY”**; and

3 (2) in subsection (a), by inserting “, including
4 without rescission,” after “continue in force”.

5 (b) **SECRETARIAL GUIDANCE REGARDING RESCIS-**
6 **SIONS.—**

7 (1) **GROUP HEALTH INSURANCE MARKET.—**Sec-
8 tion 2712 of such Act (42 U.S.C. 300gg–12) is
9 amended by adding at the end the following:

10 “(f) **RESCISSION.—**A health insurance issuer may re-
11 scind group health insurance coverage only upon clear and
12 convincing evidence of fraud described in subsection
13 (b)(2), under procedures that provide for independent, ex-
14 ternal third-party review.”.

15 (2) **INDIVIDUAL HEALTH MARKET.—**Section
16 2742 of such Act (42 U.S.C. 300gg–42) is amended
17 by adding at the end the following:

18 “(f) **RESCISSION.—**A health insurance issuer may re-
19 scind individual health insurance coverage only upon clear
20 and convincing evidence of fraud described in subsection
21 (b)(2), under procedures that provide for independent, ex-
22 ternal third-party review.”.

23 (3) **GUIDANCE.—**The Secretary of Health and
24 Human Services, no later than 90 days after the
25 date of the enactment of this Act, shall issue guid-

1 ance implementing the amendments made by para-
2 graphs (1) and (2), including procedures for inde-
3 pendent, external third-party review.

4 (c) OPPORTUNITY FOR INDEPENDENT, EXTERNAL
5 THIRD-PARTY REVIEW IN CERTAIN CASES.—

6 (1) INDIVIDUAL MARKET.—Subpart 1 of part B
7 of title XXVII of such Act (42 U.S.C. 300gg–41 et
8 seq.) is amended by adding at the end the following:

9 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
10 **THIRD-PARTY REVIEW IN CASES OF RESCIS-**
11 **SION.**

12 “(a) NOTICE AND REVIEW RIGHT.—If a health in-
13 surance issuer determines to rescind health insurance cov-
14 erage for an individual in the individual market, before
15 such rescission may take effect the issuer shall provide the
16 individual with notice of such proposed rescission and an
17 opportunity for a review of such determination by an inde-
18 pendent, external third-party under procedures specified
19 by the Secretary under section 2742(f).

20 “(b) INDEPENDENT DETERMINATION.—If the indi-
21 vidual requests such review by an independent, external
22 third-party of a rescission of health insurance coverage,
23 the coverage shall remain in effect until such third party
24 determines that the coverage may be rescinded under the
25 guidance issued by the Secretary under section 2742(f).”.

1 (2) APPLICATION TO GROUP HEALTH INSUR-
2 ANCE.—Such title is further amended by adding
3 after section 2702 the following new section:

4 **“SEC. 2703. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
5 **THIRD-PARTY REVIEW IN CASES OF RESCIS-**
6 **SION.**

7 “The provisions of section 2746 shall apply to group
8 health insurance coverage in the same manner as such
9 provisions apply to individual health insurance coverage,
10 except that any reference to section 2742(f) is deemed a
11 reference to section 2712(f).”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall take effect on the date of the enactment
14 of this Act and shall apply to rescissions occurring on and
15 after July 1, 2010, with respect to health insurance cov-
16 erage issued before, on, or after such date.

17 **SEC. 104. SUNSHINE ON PRICE GOUGING BY HEALTH IN-**
18 **SURANCE ISSUERS.**

19 The Secretary of Health and Human Services, in con-
20 junction with States, shall establish a process for the an-
21 nual review of increases in premiums for health insurance
22 coverage. Such process shall require health insurance
23 issuers to submit a justification for any premium increases
24 prior to implementation of the increase.

1 **SEC. 105. REQUIRING THE OPTION OF EXTENSION OF DE-**
2 **PENDENT COVERAGE FOR UNINSURED**
3 **YOUNG ADULTS.**

4 (a) UNDER GROUP HEALTH PLANS.—

5 (1) PHSA.—Title XXVII of the Public Health
6 Service Act is amended by inserting after section
7 2702 the following new section:

8 **“SEC. 2703. REQUIRING THE OPTION OF EXTENSION OF DE-**
9 **PENDENT COVERAGE FOR UNINSURED**
10 **YOUNG ADULTS.**

11 “(a) IN GENERAL.—A group health plan and a health
12 insurance issuer offering health insurance coverage in con-
13 nection with a group health plan that provides coverage
14 for dependent children shall make available such coverage,
15 at the option of the participant involved, for one or more
16 qualified children (as defined in subsection (b)) of the par-
17 ticipant.

18 “(b) QUALIFIED CHILD DEFINED.—In this section,
19 the term ‘qualified child’ means, with respect to a partici-
20 pant in a group health plan or group health insurance cov-
21 erage, an individual who (but for age) would be treated
22 as a dependent child of the participant under such plan
23 or coverage and who—

24 “(1) is under 27 years of age; and

25 “(2) is not enrolled as a participant, bene-
26 ficiary, or enrollee (other than under this section,

1 section 2746, or section 704 of the Employee Retirement
2 Income Security Act of 1974) under any
3 health insurance coverage or group health plan.

4 “(c) PREMIUMS.—Nothing in this section shall be
5 construed as preventing a group health plan or health in-
6 surance issuer with respect to group health insurance cov-
7 erage from increasing the premiums otherwise required for
8 coverage provided under this section consistent with
9 standards established by the Secretary based upon family
10 size.”.

11 (2) EMPLOYEE RETIREMENT INCOME SECURITY
12 ACT OF 1974.—

13 (A) IN GENERAL.—Part 7 of subtitle B of
14 title I of the Employee Retirement Income Se-
15 curity Act of 1974 is amended by inserting
16 after section 703 the following new section:

17 **“SEC. 704. REQUIRING THE OPTION OF EXTENSION OF DE-**
18 **PENDENT COVERAGE FOR UNINSURED**
19 **YOUNG ADULTS.**

20 “(a) IN GENERAL.—A group health plan and a health
21 insurance issuer offering health insurance coverage in con-
22 nection with a group health plan that provides coverage
23 for dependent children shall make available such coverage,
24 at the option of the participant involved, for one or more

1 qualified children (as defined in subsection (b)) of the par-
2 ticipant.

3 “(b) QUALIFIED CHILD DEFINED.—In this section,
4 the term ‘qualified child’ means, with respect to a partici-
5 pant in a group health plan or group health insurance cov-
6 erage, an individual who (but for age) would be treated
7 as a dependent child of the participant under such plan
8 or coverage and who—

9 “(1) is under 27 years of age; and

10 “(2) is not enrolled as a participant, bene-
11 ficiary, or enrollee (other than under this section)
12 under any health insurance coverage or group health
13 plan.

14 “(c) PREMIUMS.—Nothing in this section shall be
15 construed as preventing a group health plan or health in-
16 surance issuer with respect to group health insurance cov-
17 erage from increasing the premiums otherwise required for
18 coverage provided under this section consistent with
19 standards established by the Secretary based upon family
20 size.”.

21 (B) CLERICAL AMENDMENT.—The table of
22 contents of such Act is amended by inserting
23 after the item relating to section 703 the fol-
24 lowing new item:

“Sec. 704. Requiring the option of extension of dependent coverage for unin-
sured young adults.”.

1 (3) IRC.—

2 (A) IN GENERAL.—Subchapter A of chap-
3 ter 100 of the Internal Revenue Code of 1986
4 is amended by adding at the end the following
5 new section:

6 **“SEC. 9804. REQUIRING THE OPTION OF EXTENSION OF DE-**
7 **PENDENT COVERAGE FOR UNINSURED**
8 **YOUNG ADULTS.**

9 “(a) IN GENERAL.—A group health plan that pro-
10 vides coverage for dependent children shall make available
11 such coverage, at the option of the participant involved,
12 for one or more qualified children (as defined in subsection
13 (b)) of the participant.

14 “(b) QUALIFIED CHILD DEFINED.—In this section,
15 the term ‘qualified child’ means, with respect to a partici-
16 pant in a group health plan, an individual who (but for
17 age) would be treated as a dependent child of the partici-
18 pant under such plan and who—

19 “(1) is under 27 years of age; and

20 “(2) is not enrolled as a participant, bene-
21 ficiary, or enrollee (other than under this section,
22 section 704 of the Employee Retirement Income Se-
23 curity Act of 1974, or section 2704 or 2746 of the
24 Public Health Service Act) under any health insur-
25 ance coverage or group health plan.

1 plans for plan years beginning on or after January
2 1, 2010.

3 (2) INDIVIDUAL HEALTH INSURANCE COV-
4 ERAGE.—Section 2746 of the Public Health Service
5 Act, as inserted by subsection (b), shall apply with
6 respect to health insurance coverage offered, sold,
7 issued, renewed, in effect, or operated in the indi-
8 vidual market on or after January 1, 2010.

9 **SEC. 106. LIMITATIONS ON PREEXISTING CONDITION EX-**
10 **CLUSIONS IN GROUP HEALTH PLANS IN AD-**
11 **VANCE OF APPLICABILITY OF NEW PROHIBI-**
12 **TION OF PREEXISTING CONDITION EXCLU-**
13 **SIONS.**

14 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
15 INCOME SECURITY ACT OF 1974.—

16 (1) REDUCTION IN LOOK-BACK PERIOD.—Sec-
17 tion 701(a)(1) of the Employee Retirement Income
18 Security Act of 1974 (29 U.S.C. 1181(a)(1)) is
19 amended by striking “6-month period” and inserting
20 “30-day period”.

21 (2) REDUCTION IN PERMITTED PREEXISTING
22 CONDITION LIMITATION PERIOD.—Section 701(a)(2)
23 of such Act (29 U.S.C. 1181(a)(2)) is amended by
24 striking “12 months” and inserting “3 months”,

1 and by striking “18 months” and inserting “9
2 months”.

3 (3) SUNSET OF INTERIM LIMITATION.—Section
4 701 of such Act (29 U.S.C. 1181) is amended by
5 adding at the end the following new subsection:

6 “(h) TERMINATION.—This section shall cease to
7 apply to any group health plan as of the date that such
8 plan becomes subject to the requirements of section 211
9 of the (relating to prohibiting preexisting condition exclu-
10 sions).”.

11 (b) AMENDMENTS TO THE INTERNAL REVENUE
12 CODE OF 1986.—

13 (1) REDUCTION IN LOOK-BACK PERIOD.—Sec-
14 tion 9801(a)(1) of the Internal Revenue Code of
15 1986 is amended by striking “6-month period” and
16 inserting “30-day period”.

17 (2) REDUCTION IN PERMITTED PREEXISTING
18 CONDITION LIMITATION PERIOD.—Section
19 9801(a)(2) of such Code is amended by striking “12
20 months” and inserting “3 months”, and by striking
21 “18 months” and inserting “9 months”.

22 (3) SUNSET OF INTERIM LIMITATION.—Section
23 9801 of such Code is amended by adding at the end
24 the following new subsection:

1 “(g) TERMINATION.—This section shall cease to
2 apply to any group health plan as of the date that such
3 plan becomes subject to the requirements of section 211
4 of the (relating to prohibiting preexisting condition exclu-
5 sions).”.

6 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE
7 ACT.—

8 (1) REDUCTION IN LOOK-BACK PERIOD.—Sec-
9 tion 2701(a)(1) of the Public Health Service Act (42
10 U.S.C. 300gg(a)(1)) is amended by striking “6-
11 month period” and inserting “30-day period”.

12 (2) REDUCTION IN PERMITTED PREEXISTING
13 CONDITION LIMITATION PERIOD.—Section
14 2701(a)(2) of such Act (42 U.S.C. 300gg(a)(2)) is
15 amended by striking “12 months” and inserting “3
16 months”, and by striking “18 months” and inserting
17 “9 months”.

18 (3) SUNSET OF INTERIM LIMITATION.—Section
19 2701 of such Act (42 U.S.C. 300gg) is amended by
20 adding at the end the following new subsection:

21 “(h) TERMINATION.—This section shall cease to
22 apply to any group health plan as of the date that such
23 plan becomes subject to the requirements of section 211
24 of the (relating to prohibiting preexisting condition exclu-
25 sions).”.

1 (4) MISCELLANEOUS TECHNICAL AMEND-
2 MENT.—Section 2702(a)(2) of such Act (42 U.S.C.
3 300gg-1) is amended by striking “701” and insert-
4 ing “2701”.

5 (d) EFFECTIVE DATE.—

6 (1) IN GENERAL.—Except as provided in para-
7 graph (2), the amendments made by this section
8 shall apply with respect to group health plans for
9 plan years beginning on or after January 1, 2010.

10 (2) SPECIAL RULE FOR COLLECTIVE BAR-
11 GAINING AGREEMENTS.—In the case of a group
12 health plan maintained pursuant to 1 or more collec-
13 tive bargaining agreements between employee rep-
14 resentatives and 1 or more employers ratified before
15 the date of the enactment of this Act, the amend-
16 ments made by this section shall not apply to plan
17 years beginning before the earlier of—

18 (A) the date on which the last of the col-
19 lective bargaining agreements relating to the
20 plan terminates (determined without regard to
21 any extension thereof agreed to after the date
22 of the enactment of this Act);

23 (B) 3 years after the date of the enact-
24 ment of this Act.

1 **SEC. 107. PROHIBITING ACTS OF DOMESTIC VIOLENCE**
2 **FROM BEING TREATED AS PREEXISTING CON-**
3 **DITIONS.**

4 (a) ERISA.—Section 701(d)(3) of the Employee Re-
5 tirement Income Security Act of 1974 (29 U.S.C.) is
6 amended—

7 (1) in the heading, by inserting “OR DOMESTIC
8 VIOLENCE” after “PREGNANCY”; and

9 (2) by inserting “or domestic violence” after
10 “relating to pregnancy”.

11 (b) PHSA.—

12 (1) GROUP MARKET.—Section 2701(d)(3) of
13 the Public Health Service Act (42 U.S.C.
14 300gg(d)(3)) is amended—

15 (A) in the heading, by inserting “OR DO-
16 MESTIC VIOLENCE” after “PREGNANCY”; and

17 (B) by inserting “or domestic violence”
18 after “relating to pregnancy”.

19 (2) INDIVIDUAL MARKET.—Title XXVII of such
20 Act is amended by inserting after section 2753 the
21 following new section:

22 **“SEC. 2754. PROHIBITION ON DOMESTIC VIOLENCE AS PRE-**
23 **EXISTING CONDITION.**

24 “A health insurance issuer offering health insurance
25 coverage in the individual market may not, on the basis
26 of domestic violence, impose any preexisting condition ex-

1 clusion (as defined in section 2701(b)(1)(A)) with respect
2 to such coverage.”.

3 (c) IRC.—Section 9801(d)(3) of the Internal Rev-
4 enue Code of 1986 is amended—

5 (1) in the heading, by inserting “OR DOMESTIC
6 VIOLENCE” after “PREGNANCY”; and

7 (2) by inserting “or domestic violence” after
8 “relating to pregnancy”.

9 (d) EFFECTIVE DATES.—

10 (1) Except as otherwise provided in this sub-
11 section, the amendments made by this section shall
12 apply with respect to group health plans (and health
13 insurance issuers offering group health insurance
14 coverage) for plan years beginning on or after Janu-
15 ary 1, 2010.

16 (2) The amendment made by subsection (b)(2)
17 shall apply with respect to health insurance coverage
18 offered, sold, issued, renewed, in effect, or operated
19 in the individual market on or after such date.

20 **SEC. 108. ENDING HEALTH INSURANCE DENIALS AND**
21 **DELAYS OF NECESSARY TREATMENT FOR**
22 **CHILDREN WITH DEFORMITIES.**

23 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
24 INCOME SECURITY ACT OF 1974.—

1 (1) IN GENERAL.—Subpart B of part 7 of sub-
2 title B of title I of the Employee Retirement Income
3 Security Act of 1974 is amended by adding at the
4 end the following new section:

5 **“SEC. 715. STANDARDS RELATING TO BENEFITS FOR MINOR**
6 **CHILD’S CONGENITAL OR DEVELOPMENTAL**
7 **DEFORMITY OR DISORDER.**

8 “(a) REQUIREMENTS FOR TREATMENT FOR CHIL-
9 DREN WITH DEFORMITIES.—

10 “(1) IN GENERAL.—A group health plan, and a
11 health insurance issuer offering group health insur-
12 ance coverage, that provides coverage for surgical
13 benefits shall provide coverage for outpatient and in-
14 patient diagnosis and treatment of a minor child’s
15 congenital or developmental deformity, disease, or
16 injury. A minor child shall include any individual
17 who is 21 years of age or younger.

18 “(2) TREATMENT DEFINED.—

19 “(A) IN GENERAL.—In this section, the
20 term ‘treatment’ includes reconstructive sur-
21 gical procedures (procedures that are generally
22 performed to improve function, but may also be
23 performed to approximate a normal appear-
24 ance) that are performed on abnormal struc-
25 tures of the body caused by congenital defects,

1 developmental abnormalities, trauma, infection,
2 tumors, or disease, including—

3 “(i) procedures that do not materially
4 affect the function of the body part being
5 treated; and

6 “(ii) procedures for secondary condi-
7 tions and follow-up treatment.

8 “(B) EXCEPTION.—Such term does not in-
9 clude cosmetic surgery performed to reshape
10 normal structures of the body to improve ap-
11 pearance or self-esteem.

12 “(b) NOTICE.—A group health plan under this part
13 shall comply with the notice requirement under section
14 713(b) (other than paragraph (3)) with respect to the re-
15 quirements of this section.”.

16 (2) CONFORMING AMENDMENT.—

17 (A) Subsection (c) of section 731 of such
18 Act is amended by striking “section 711” and
19 inserting “sections 711 and 715”.

20 (B) The table of contents in section 1 of
21 such Act is amended by inserting after the item
22 relating to section 714 the following new item:

“Sec. 715. Standards relating to benefits for minor child’s congenital or devel-
opmental deformity or disorder.”.

23 (b) AMENDMENTS TO THE INTERNAL REVENUE
24 CODE OF 1986.—

1 (1) IN GENERAL.—Subchapter B of chapter
2 100 of the Internal Revenue Code of 1986 is amend-
3 ed by adding at the end the following new section:

4 **“SEC. 9814. STANDARDS RELATING TO BENEFITS FOR**
5 **MINOR CHILD’S CONGENITAL OR DEVELOP-**
6 **MENTAL DEFORMITY OR DISORDER.**

7 “(a) REQUIREMENTS FOR TREATMENT FOR CHIL-
8 DREN WITH DEFORMITIES.—A group health plan that
9 provides coverage for surgical benefits shall provide cov-
10 erage for outpatient and inpatient diagnosis and treat-
11 ment of a minor child’s congenital or developmental de-
12 formity, disease, or injury. A minor child shall include any
13 individual who is 21 years of age or younger.

14 “(b) TREATMENT DEFINED.—

15 “(1) IN GENERAL.—In this section, the term
16 ‘treatment’ includes reconstructive surgical proce-
17 dures (procedures that are generally performed to
18 improve function, but may also be performed to ap-
19 proximate a normal appearance) that are performed
20 on abnormal structures of the body caused by con-
21 genital defects, developmental abnormalities, trau-
22 ma, infection, tumors, or disease, including—

23 “(A) procedures that do not materially af-
24 fect the function of the body part being treated,
25 and

1 “(B) procedures for secondary conditions
2 and follow-up treatment.

3 “(2) EXCEPTION.—Such term does not include
4 cosmetic surgery performed to reshape normal struc-
5 tures of the body to improve appearance or self-es-
6 teem.”.

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for subchapter B of chapter 100 of such Code
9 is amended by adding at the end the following new
10 item:

 “Sec. 9814. Standards relating to benefits for minor child’s congenital or devel-
 opmental deformity or disorder.”.

11 (c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE
12 ACT.—

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

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

19 “(a) REQUIREMENTS FOR TREATMENT FOR CHIL-
20 DREN WITH DEFORMITIES.—

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

1 patient diagnosis and treatment of a minor child's
2 congenital or developmental deformity, disease, or
3 injury. A minor child shall include any individual
4 who is 21 years of age or younger.

5 “(2) TREATMENT DEFINED.—

6 “(A) IN GENERAL.—In this section, the
7 term ‘treatment’ includes reconstructive sur-
8 gical procedures (procedures that are generally
9 performed to improve function, but may also be
10 performed to approximate a normal appear-
11 ance) that are performed on abnormal struc-
12 tures of the body caused by congenital defects,
13 developmental abnormalities, trauma, infection,
14 tumors, or disease, including—

15 “(i) procedures that do not materially
16 affect the function of the body part being
17 treated; and

18 “(ii) procedures for secondary condi-
19 tions and follow-up treatment.

20 “(B) EXCEPTION.—Such term does not in-
21 clude cosmetic surgery performed to reshape
22 normal structures of the body to improve ap-
23 pearance or self-esteem.

24 “(b) NOTICE.—A group health plan under this part
25 shall comply with the notice requirement under section

1 715(b) of the Employee Retirement Income Security Act
2 of 1974 with respect to the requirements of this section
3 as if such section applied to such plan.”.

4 (2) INDIVIDUAL HEALTH INSURANCE.—Subpart
5 2 of part B of title XXVII of the Public Health
6 Service Act, as amended by section 161(b), is fur-
7 ther amended by adding at the end the following
8 new section:

9 **“SEC. 2755. STANDARDS RELATING TO BENEFITS FOR**
10 **MINOR CHILD’S CONGENITAL OR DEVELOP-**
11 **MENTAL DEFORMITY OR DISORDER.**

12 “The provisions of section 2708 shall apply to health
13 insurance coverage offered by a health insurance issuer
14 in the individual market in the same manner as such pro-
15 visions apply to health insurance coverage offered by a
16 health insurance issuer in connection with a group health
17 plan in the small or large group market.”.

18 (3) CONFORMING AMENDMENTS.—

19 (A) Section 2723(c) of such Act (42
20 U.S.C. 300gg–23(c)) is amended by striking
21 “section 2704” and inserting “sections 2704
22 and 2708”.

23 (B) Section 2762(b)(2) of such Act (42
24 U.S.C. 300gg–62(b)(2)) is amended by striking

1 “section 2751” and inserting “sections 2751
2 and 2755”.

3 (d) EFFECTIVE DATES.—

4 (1) The amendments made by this section shall
5 apply with respect to group health plans (and health
6 insurance issuers offering group health insurance
7 coverage) for plan years beginning on or after Janu-
8 ary 1, 2010.

9 (2) The amendment made by subsection (c)(2)
10 shall apply with respect to health insurance coverage
11 offered, sold, issued, renewed, in effect, or operated
12 in the individual market on or after such date.

13 (e) COORDINATION.—Section 104(1) of the Health
14 Insurance Portability and Accountability Act of 1996 is
15 amended by striking “(and the amendments made by this
16 subtitle and section 401)” and inserting “, part 7 of sub-
17 title B of title I of the Employee Retirement Income Secu-
18 rity Act of 1974, parts A and C of title XXVII of the
19 Public Health Service Act, and chapter 100 of the Internal
20 Revenue Code of 1986”.

21 **SEC. 109. ELIMINATION OF LIFETIME LIMITS.**

22 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
23 INCOME SECURITY ACT OF 1974.—

24 (1) IN GENERAL.—Subpart B of part 7 of sub-
25 title B of title I of the Employee Retirement Income

1 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
2 amended by section 108, is amended by adding at
3 the end the following:

4 **“SEC. 716. ELIMINATION OF LIFETIME AGGREGATE LIMITS.**

5 “(a) IN GENERAL.—A group health plan and a health
6 insurance issuer providing health insurance coverage in
7 connection with a group health plan, may not impose an
8 aggregate dollar lifetime limit with respect to benefits pay-
9 able under the plan or coverage.

10 “(b) DEFINITION.—In this section, the term ‘aggre-
11 gate dollar lifetime limit’ means, with respect to benefits
12 under a group health plan or health insurance coverage
13 offered in connection with a group health plan, a dollar
14 limitation on the total amount that may be paid with re-
15 spect to such benefits under the plan or health insurance
16 coverage with respect to an individual or other coverage
17 unit on a lifetime basis.”.

18 (2) CLERICAL AMENDMENT.—The table of con-
19 tents in section 1 of such Act, is amended by insert-
20 ing after the item relating to section 715 the fol-
21 lowing new item:

“Sec. 716. Elimination of lifetime aggregate limits.”.

22 (b) AMENDMENTS TO THE INTERNAL REVENUE
23 CODE OF 1986.—

24 (1) IN GENERAL.—Subchapter B of chapter
25 100 of the Internal Revenue Code of 1986, as

1 amended by section 108(b), is amended by adding at
2 the end the following new section:

3 **“SEC. 9815. ELIMINATION OF LIFETIME AGGREGATE LIM-**
4 **ITS.**

5 “(a) IN GENERAL.—A group health plan may not im-
6 pose an aggregate dollar lifetime limit with respect to ben-
7 efits payable under the plan.

8 “(b) DEFINITION.—In this section, the term ‘aggre-
9 gate dollar lifetime limit’ means, with respect to benefits
10 under a group health plan a dollar limitation on the total
11 amount that may be paid with respect to such benefits
12 under the plan with respect to an individual or other cov-
13 erage unit on a lifetime basis.”.

14 (2) CLERICAL AMENDMENT.—The table of sec-
15 tions for subchapter B of chapter 100 of such Code,
16 as amended by section 108(b), is amended by adding
17 at the end the following new item:

“Sec. 9854. Standards relating to benefits for minor child’s congenital or devel-
opmental deformity or disorder.”.

18 (c) AMENDMENT TO THE PUBLIC HEALTH SERVICE
19 ACT RELATING TO THE GROUP MARKET.—

20 (1) IN GENERAL.—Subpart 2 of part A of title
21 XXVII of the Public Health Service Act (42 U.S.C.
22 300gg–4 et seq.) as amended by section 108(c)(1),
23 is amended by adding at the end the following:

1 **“SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIM-**
2 **ITS.**

3 “(a) IN GENERAL.—A group health plan and a health
4 insurance issuer providing health insurance coverage in
5 connection with a group health plan, may not impose an
6 aggregate dollar lifetime limit with respect to benefits pay-
7 able under the plan or coverage.

8 “(b) DEFINITION.—In this section, the term ‘aggre-
9 gate dollar lifetime limit’ means, with respect to benefits
10 under a group health plan or health insurance coverage,
11 a dollar limitation on the total amount that may be paid
12 with respect to such benefits under the plan or health in-
13 surance coverage with respect to an individual or other
14 coverage unit on a lifetime basis.”.

15 (2) INDIVIDUAL MARKET.—Subpart 2 of part B
16 of title XXVII of the Public Health Service Act (42
17 U.S.C. 300gg–51 et seq.), as amended by section
18 108(c)(2), is amended by adding at the end the fol-
19 lowing:

20 **“SEC. 2756. ELIMINATION OF ANNUAL OR LIFETIME AGGRE-**
21 **GATE LIMITS.**

22 “The provisions of section 2709 shall apply to health
23 insurance coverage offered by a health insurance issuer
24 in the individual market in the same manner as they apply
25 to health insurance coverage offered by a health insurance

1 issuer in connection with a group health plan in the small
2 or large group market.”.

3 (d) EFFECTIVE DATES.—

4 (1) The amendments made by this section shall
5 apply with respect to group health plans (and health
6 insurance issuers offering group health insurance
7 coverage) for plan years beginning on or after Janu-
8 ary 1, 2010.

9 (2) The amendment made by subsection (c)(2)
10 shall apply with respect to health insurance coverage
11 offered, sold, issued, renewed, in effect, or operated
12 in the individual market on or after such date.

13 **SEC. 110. PROHIBITION AGAINST POSTRETIREMENT RE-**
14 **DUCTIONS OF RETIREE HEALTH BENEFITS**
15 **BY GROUP HEALTH PLANS.**

16 (a) IN GENERAL.—Part 7 of subtitle B of title I of
17 the Employee Retirement Income Security Act of 1974,
18 as amended by sections 108 and 109, is amended by in-
19 serting after section 716 the following new section:

20 **“SEC. 717. PROTECTION AGAINST POSTRETIREMENT RE-**
21 **DUCTION OF RETIREE HEALTH BENEFITS.**

22 “(a) IN GENERAL.—Every group health plan shall
23 contain a provision which expressly bars the plan, or any
24 fiduciary of the plan, from reducing the benefits provided
25 under the plan to a retired participant, or beneficiary of

1 such participant, if such reduction affects the benefits pro-
2 vided to the participant or beneficiary as of the date the
3 participant retired for purposes of the plan and such re-
4 duction occurs after the participant's retirement unless
5 such reduction is also made with respect to active partici-
6 pants. Nothing in this section shall prohibit a plan from
7 enforcing a total aggregate cap on amounts paid for re-
8 tiree health coverage that is part of the plan at the time
9 of retirement.

10 “(b) NO REDUCTION.—Notwithstanding that a group
11 health plan may contain a provision reserving the general
12 power to amend or terminate the plan or a provision spe-
13 cifically authorizing the plan to make post-retirement re-
14 ductions in retiree health benefits, it shall be prohibited
15 for any group health plan, whether through amendment
16 or otherwise, to reduce the benefits provided to a retired
17 participant or the participant's beneficiary under the
18 terms of the plan if such reduction of benefits occurs after
19 the date the participant retired for purposes of the plan
20 and reduces benefits that were provided to the participant,
21 or the participant's beneficiary, as of the date the partici-
22 pant retired unless such reduction is also made with re-
23 spect to active participants.

24 “(c) REDUCTION DESCRIBED.— For purposes of this
25 section, a reduction in benefits—

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect on the date of the enactment
3 of this Act.

4 **SEC. 111. REINSURANCE PROGRAM FOR RETIREES.**

5 (a) ESTABLISHMENT.—

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

15 (2) DEFINITIONS.—For purposes of this sec-
16 tion:

17 (A) The term “eligible employment-based
18 plan” means a group health plan or employ-
19 ment-based health plan that—

20 (i) is —

21 (I) maintained by one or more
22 employers (including without limita-
23 tion any State or political subdivision
24 thereof, or any agency or instrumen-
25 tality of any of the foregoing), former

1 employers or employee organizations
2 or associations, or a voluntary employ-
3 ees' beneficiary association, or a com-
4 mittee or board of individuals ap-
5 pointed to administer such plan; or

6 (II) a multiemployer plan (as de-
7 fined in section 3(37) of the Employee
8 Retirement Income Security Act of
9 1974); and

10 (ii) provides health benefits to retir-
11 ees.

12 (B) The term "health benefits" means
13 medical, surgical, hospital, prescription drug,
14 and such other benefits as shall be determined
15 by the Secretary, whether self-funded or deliv-
16 ered through the purchase of insurance or oth-
17 erwise.

18 (C) The term "participating employment-
19 based plan" means an eligible employment-
20 based plan that is participating in the reinsur-
21 ance program.

22 (D) The term "retiree" means, with re-
23 spect to a participating employment-benefit
24 plan, an individual who—

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

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

3 (iii) is not an active employee of an
4 employer maintaining the plan or of any
5 employer that makes or has made substan-
6 tial contributions to fund such plan.

7 (E) The term “Secretary” means Sec-
8 retary of Health and Human Services.

9 (b) PARTICIPATION.—To be eligible to participate in
10 the reinsurance program, an eligible employment-based
11 plan shall submit to the Secretary an application for par-
12 ticipation in the program, at such time, in such manner,
13 and containing such information as the Secretary shall re-
14 quire.

15 (c) PAYMENT.—

16 (1) SUBMISSION OF CLAIMS.—

17 (A) IN GENERAL.—Under the reinsurance
18 program, a participating employment-based
19 plan shall submit claims for reimbursement to
20 the Secretary which shall contain documenta-
21 tion of the actual costs of the items and serv-
22 ices for which each claim is being submitted.

23 (B) BASIS FOR CLAIMS.—Each claim sub-
24 mitted under subparagraph (A) shall be based
25 on 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 to
4 the spouse, surviving spouse, or dependent of a
5 retiree. In determining the amount of any claim
6 for purposes of this subsection, the partici-
7 pating employment-based plan shall take into
8 account any negotiated price concessions (such
9 as discounts, direct or indirect subsidies, re-
10 bates, and direct or indirect remunerations) ob-
11 tained by such plan with respect to such health
12 benefits. For purposes of calculating the
13 amount of any claim, the costs paid by the re-
14 tiree or by the spouse, surviving spouse, or de-
15 pendent of the retiree in the form of
16 deductibles, copayments, and coinsurance shall
17 be included along with the amounts paid by the
18 participating employment-based plan.

19 (2) PROGRAM PAYMENTS AND LIMIT.—If the
20 Secretary determines that a participating employ-
21 ment-based plan has submitted a valid claim under
22 paragraph (1), the Secretary shall reimburse such
23 plan for 80 percent of that portion of the costs at-
24 tributable to such claim that exceeds \$15,000, but is
25 less than \$90,000. Such amounts shall be adjusted

1 each year based on the percentage increase in the
2 medical care component of the Consumer Price
3 Index (rounded to the nearest multiple of \$1,000)
4 for the year involved.

5 (3) USE OF PAYMENTS.—Amounts paid to a
6 participating employment-based plan under this sub-
7 section shall only be used to reduce the costs of
8 health care provided by the plan by reducing pre-
9 mium costs for the employer or employee association
10 maintaining the plan, and reducing premium con-
11 tributions, deductibles, copayments, coinsurance, or
12 other out-of-pocket costs for plan participants and
13 beneficiaries. Where the benefits are provided by an
14 employer to members of a represented bargaining
15 unit, the allocation of payments among these pur-
16 poses shall be subject to collective bargaining.
17 Amounts paid to the plan under this subsection shall
18 not be used as general revenues by the employer or
19 employee association maintaining the plan or for any
20 other purposes. The Secretary shall develop a mech-
21 anism to monitor the appropriate use of such pay-
22 ments by such plans.

23 (4) APPEALS AND PROGRAM PROTECTIONS.—
24 The Secretary shall establish—

1 (A) an appeals process to permit partici-
2 pating employment-based plans to appeal a de-
3 termination of the Secretary with respect to
4 claims submitted under this section; and

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

7 (5) AUDITS.—The Secretary shall conduct an-
8 nual audits of claims data submitted by partici-
9 pating employment-based plans under this section to
10 ensure that they are in compliance with the require-
11 ments of this section.

12 (d) RETIREE RESERVE TRUST FUND.—

13 (1) ESTABLISHMENT.—

14 (A) IN GENERAL.—There is established in
15 the Treasury of the United States a trust fund
16 to be known as the “Retiree Reserve Trust
17 Fund” (referred to in this section as the “Trust
18 Fund”), that shall consist of such amounts as
19 may be appropriated or credited to the Trust
20 Fund as provided for in this subsection to en-
21 able the Secretary to carry out the reinsurance
22 program. Such amounts shall remain available
23 until expended.

24 (B) FUNDING.—There are hereby appro-
25 priated to the Trust Fund, out of any moneys

1 in the Treasury not otherwise appropriated, an
2 amount requested by the Secretary as necessary
3 to carry out this section, except that the total
4 of all such amounts requested shall not exceed
5 \$10,000,000,000.

6 (C) APPROPRIATIONS FROM THE TRUST
7 FUND.—

8 (i) IN GENERAL.—Amounts in the
9 Trust Fund are appropriated to provide
10 funding to carry out the reinsurance pro-
11 gram and shall be used to carry out such
12 program.

13 (ii) LIMITATION TO AVAILABLE
14 FUNDS.—The Secretary has the authority
15 to stop taking applications for participa-
16 tion in the program or take such other
17 steps in reducing expenditures under the
18 reinsurance program in order to ensure
19 that expenditures under the reinsurance
20 program do not exceed the funds available
21 under this subsection.

22 **SEC. 112. WELLNESS PROGRAM GRANTS.**

23 (a) ALLOWANCE OF GRANT.—

24 (1) IN GENERAL.—For purposes of this section,
25 the Secretaries of Health and Human Services and

1 Labor shall jointly award wellness grants as deter-
2 mined under this section. Wellness program grants
3 shall be awarded to small employers (as defined by
4 the Secretary) for any plan year in an amount equal
5 to 50 percent of the costs paid or incurred by such
6 employers in connection with a qualified wellness
7 program during the plan year. For purposes of the
8 preceding sentence, in the case of any qualified
9 wellness program offered as part of an employment-
10 based health plan, only costs attributable to the
11 qualified wellness program and not to the health
12 plan, or health insurance coverage offered in connec-
13 tion with such a plan, may be taken into account.

14 (2) LIMITATIONS.—

15 (A) PERIOD.—A wellness grant awarded to
16 an employer under this section shall be for up
17 to 3 years.

18 (B) AMOUNT.—The amount of the grant
19 under paragraph (1) for an employer shall not
20 exceed—

21 (i) the product of \$150 and the num-
22 ber of employees of the employer for any
23 plan year; and

24 (ii) \$50,000 for the entire period of
25 the grant.

1 (b) QUALIFIED WELLNESS PROGRAM.—For purposes
2 of this section:

3 (1) QUALIFIED WELLNESS PROGRAM.—The
4 term “qualified wellness program” means a program
5 that —

6 (A) includes any 3 wellness components de-
7 scribed in subsection (c); and

8 (B) is to be certified jointly by the Sec-
9 retary of Health and Human Services and the
10 Secretary of Labor, in coordination with the Di-
11 rector of the Centers for Disease Control and
12 Prevention, as a qualified wellness program
13 under this section.

14 (2) PROGRAMS MUST BE CONSISTENT WITH RE-
15 SEARCH AND BEST PRACTICES.—

16 (A) IN GENERAL.—The Secretary of
17 Health and Human Services and the Secretary
18 of Labor shall not certify a program as a quali-
19 fied wellness program unless the program—

20 (i) is consistent with evidence-based
21 research and best practices, as identified
22 by persons with expertise in employer
23 health promotion and wellness programs;

24 (ii) includes multiple, evidence-based
25 strategies which are based on the existing

1 and emerging research and careful sci-
2 entific reviews, including the Guide to
3 Community Preventative Services, the
4 Guide to Clinical Preventative Services,
5 and the National Registry for Effective
6 Programs, and

7 (iii) includes strategies which focus on
8 prevention and support for employee popu-
9 lations at risk of poor health outcomes.

10 (B) PERIODIC UPDATING AND REVIEW.—

11 The Secretaries of Health and Human Services
12 and Labor, in consultation with other appro-
13 priate agencies shall jointly establish procedures
14 for periodic review, evaluation, and update of
15 the programs under this subsection.

16 (3) HEALTH LITERACY AND ACCESSIBILITY.—

17 The Secretaries of Health and Human Services and
18 Labor shall jointly, as part of the certification proc-
19 ess—

20 (A) ensure that employers make the pro-
21 grams culturally competent, physically and pro-
22 grammatically accessible (including for individ-
23 uals with disabilities), and appropriate to the
24 health literacy needs of the employees covered
25 by the programs;

1 (B) require a health literacy component to
2 provide special assistance and materials to em-
3 ployees with low literacy skills, limited English
4 and from underserved populations; and

5 (C) require the Secretaries to compile and
6 disseminate to employer health plans informa-
7 tion on model health literacy curricula, instruc-
8 tional programs, and effective intervention
9 strategies.

10 (c) WELLNESS PROGRAM COMPONENTS.—For pur-
11 poses of this section, the wellness program components de-
12 scribed in this subsection are the following:

13 (1) HEALTH AWARENESS COMPONENT.—A
14 health awareness component which provides for the
15 following:

16 (A) HEALTH EDUCATION.—The dissemina-
17 tion of health information which addresses the
18 specific needs and health risks of employees.

19 (B) HEALTH SCREENINGS.—The oppor-
20 tunity for periodic screenings for health prob-
21 lems and referrals for appropriate follow-up
22 measures.

23 (2) EMPLOYEE ENGAGEMENT COMPONENT.—
24 An employee engagement component which provides
25 for the active engagement of employees in worksite

1 wellness programs through worksite assessments and
2 program planning, onsite delivery, evaluation, and
3 improvement efforts.

4 (3) BEHAVIORAL CHANGE COMPONENT.—A be-
5 havioral change component which encourages
6 healthy living through counseling, seminars, on-line
7 programs, self-help materials, or other programs
8 which provide technical assistance and problem solv-
9 ing skills. Such component may include programs re-
10 lating to—

- 11 (A) tobacco use;
- 12 (B) obesity;
- 13 (C) stress management;
- 14 (D) physical fitness;
- 15 (E) nutrition;
- 16 (F) substance abuse;
- 17 (G) depression; and
- 18 (H) mental health promotion.

19 (4) SUPPORTIVE ENVIRONMENT COMPONENT.—
20 A supportive environment component which includes
21 the following:

22 (A) ON-SITE POLICIES.—Policies and serv-
23 ices at the worksite which promote a healthy
24 lifestyle, including policies relating to—

- 25 (i) tobacco use at the worksite;

1 (ii) the nutrition of food available at
2 the worksite through cafeterias and vend-
3 ing options;

4 (iii) minimizing stress and promoting
5 positive mental health in the workplace;
6 and

7 (iv) the encouragement of physical ac-
8 tivity before, during, and after work hours.

9 (d) PARTICIPATION REQUIREMENT.—No grant shall
10 be allowed under subsection (a) unless the Secretaries of
11 Health and Human Services and Labor, in consultation
12 with other appropriate agencies, jointly certify, as a part
13 of any certification described in subsection (b), that each
14 wellness program component of the qualified wellness pro-
15 gram—

16 (1) shall be available to all employees of the
17 employer;

18 (2) shall not mandate participation by employ-
19 ees; and

20 (3) may provide a financial reward for partici-
21 pation of an individual in such program so long as
22 such reward is not tied to the premium or cost-shar-
23 ing of the individual under the health benefits plan.

24 (e) PRIVACY PROTECTIONS.—Data gathered for pur-
25 poses of the employer wellness program may be used solely

1 for the purposes of administering the program. The Secre-
2 taries of Health and Human Services and Labor shall de-
3 velop standards to ensure such data remain confidential
4 and are not used for purposes beyond those for admin-
5 istering the program.

6 (f) CERTAIN COSTS NOT INCLUDED.—For purposes
7 of this section, costs paid or incurred by an employer for
8 food or health insurance shall not be taken into account
9 under subsection (a).

10 (g) OUTREACH.—The Secretaries of Health and
11 Human Services and Labor, in conjunction with other ap-
12 propriate agencies and members of the business commu-
13 nity, shall jointly institute an outreach program to inform
14 businesses about the availability of the wellness program
15 grant as well as to educate businesses on how to develop
16 programs according to recognized and promising practices
17 and on how to measure the success of implemented pro-
18 grams.

19 (h) EFFECTIVE DATE.—This section shall take effect
20 on July 1, 2010.

21 (i) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated such sums as are nec-
23 essary to carry out this section.

1 **SEC. 113. EXTENSION OF COBRA CONTINUATION COV-**
2 **ERAGE.**

3 (a) **EXTENSION OF CURRENT PERIODS OF CONTINU-**
4 **ATION COVERAGE.—**

5 (1) **IN GENERAL.—**In the case of any individual
6 who is, under a COBRA continuation coverage pro-
7 vision, covered under COBRA continuation coverage
8 on or after the date of the enactment of this Act,
9 the required period of any such coverage which has
10 not subsequently terminated under the terms of such
11 provision for any reason other than the expiration of
12 a period of a specified number of months shall, not-
13 withstanding such provision and subject to sub-
14 section (b), extend to the earlier of the date on
15 which such individual becomes eligible for acceptable
16 coverage or the date on which such individual be-
17 comes eligible for health insurance coverage through
18 the Health Insurance Exchange (or a State-based
19 Health Insurance Exchange operating in a State or
20 group of States).

21 (2) **NOTICE.—**As soon as practicable after the
22 date of the enactment of this Act, the Secretary of
23 Labor, in consultation with the Secretary of the
24 Treasury and the Secretary of Health and Human
25 Services, shall, in consultation with administrators
26 of the group health plans (or other entities) that

1 provide or administer the COBRA continuation cov-
2 erage involved, provide rules setting forth the form
3 and manner in which prompt notice to individuals of
4 the continued availability of COBRA continuation
5 coverage to such individuals under paragraph (1).

6 (b) CONTINUED EFFECT OF OTHER TERMINATING
7 EVENTS.—Notwithstanding subsection (a), any required
8 period of COBRA continuation coverage which is extended
9 under such subsection shall terminate upon the occur-
10 rence, prior to the date of termination otherwise provided
11 in such subsection, of any terminating event specified in
12 the applicable continuation coverage provision other than
13 the expiration of a period of a specified number of months.

14 (c) ACCESS TO STATE HEALTH BENEFITS RISK
15 POOLS.—This section shall supersede any provision of the
16 law of a State or political subdivision thereof to the extent
17 that such provision has the effect of limiting or precluding
18 access by a qualified beneficiary whose COBRA continu-
19 ation coverage has been extended under this section to a
20 State health benefits risk pool recognized by the Commis-
21 sioner for purposes of this section solely by reason of the
22 extension of such coverage beyond the date on which such
23 coverage otherwise would have expired.

24 (d) DEFINITIONS.—For purposes of this section—

1 (1) COBRA CONTINUATION COVERAGE.—The
2 term “COBRA continuation coverage” means con-
3 tinuation coverage provided pursuant to part 6 of
4 subtitle B of title I of the Employee Retirement In-
5 come Security Act of 1974 (other than under section
6 609), title XXII of the Public Health Service Act,
7 section 4980B of the Internal Revenue Code of 1986
8 (other than subsection (f)(1) of such section insofar
9 as it relates to pediatric vaccines), or section 905a
10 of title 5, United States Code, or under a State pro-
11 gram that provides comparable continuation cov-
12 erage. Such term does not include coverage under a
13 health flexible spending arrangement under a cafe-
14 teria plan within the meaning of section 125 of the
15 Internal Revenue Code of 1986.

16 (2) COBRA CONTINUATION PROVISION.—The
17 term “COBRA continuation provision” means the
18 provisions of law described in paragraph (1).

19 **SEC. 114. STATE HEALTH ACCESS PROGRAM GRANTS.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services (in this section referred to as the “Sec-
22 retary”) shall provide grants to States (as defined for pur-
23 poses of title XIX of the Social Security Act) to establish
24 programs to expand access to affordable health care cov-
25 erage for the uninsured populations in that State in a

1 manner consistent with reforms to take effect under this
2 division in Y1.

3 (b) TYPES OF PROGRAMS.—The types of programs
4 for which grants are available under subsection (a) include
5 the following:

6 (1) STATE INSURANCE EXCHANGES.—State in-
7 surance exchanges that develop new, less expensive,
8 portable benefit packages for small employers and
9 part-time and seasonal workers.

10 (2) COMMUNITY COVERAGE PROGRAM.—Com-
11 munity coverage with shared responsibility between
12 employers, governmental or nonprofit entity, and the
13 individual.

14 (3) REINSURANCE PLAN PROGRAM.—Reinsur-
15 ance plans that subsidize a certain share of carrier
16 losses within a certain risk corridor health insurance
17 premium assistance.

18 (4) TRANSPARENT MARKETPLACE PROGRAM.—
19 Transparent marketplace that provides an organized
20 structure for the sale of insurance products such as
21 a Web exchange or portal.

22 (5) AUTOMATED ENROLLMENT PROGRAM.—
23 Statewide or automated enrollment systems for pub-
24 lic assistance programs.

1 (6) INNOVATIVE STRATEGIES.—Innovative
2 strategies to insure low-income childless adults.

3 (7) PURCHASING COLLABORATIVES.—Business/
4 consumer collaborative that provides direct contract
5 health care service purchasing options for group
6 plan sponsors.

7 (c) ELIGIBILITY AND ADMINISTRATION.—

8 (1) IMPLEMENTATION OF KEY STATUTORY OR
9 REGULATORY CHANGES.—In order to be awarded a
10 grant under this section for a program, a State shall
11 demonstrate that—

12 (A) it has achieved the key State and local
13 statutory or regulatory changes required to
14 begin implementing the new program within 1
15 year after the initiation of funding under the
16 grant; and

17 (B) it will be able to sustain the program
18 without Federal funding after the end of the
19 period of the grant.

20 (2) INELIGIBILITY.—A State that has already
21 developed a comprehensive health insurance access
22 program is not eligible for a grant under this sec-
23 tion.

24 (3) APPLICATION REQUIRED.—No State shall
25 receive a grant under this section unless the State

1 has approved by the Secretary such an application,
2 in such form and manner as the Secretary specifies.

3 (4) ADMINISTRATION BASED ON CURRENT PRO-
4 GRAM.—The program under this section is intended
5 to build on the State Health Access Program funded
6 under the Omnibus Appropriations Act, 2009 (Pub-
7 lic Law 111–8).

8 (d) FUNDING LIMITATIONS.—

9 (1) IN GENERAL.—A grant under this section
10 shall—

11 (A) only be available for expenditures be-
12 fore Y1; and

13 (B) only be used to supplement, and not
14 supplant, funds otherwise provided.

15 (2) MATCHING FUND REQUIREMENT.—

16 (A) IN GENERAL.—Subject to subpara-
17 graph (B), no grant may be awarded to a State
18 unless the State demonstrates the seriousness
19 of its effort by matching at least 20 percent of
20 the grant amount through non-Federal re-
21 sources, which may be a combination of State,
22 local, private dollars from insurers, providers,
23 and other private organizations.

24 (B) WAIVER.—The Secretary may waive
25 the requirement of subparagraph (A) if the

1 State demonstrates to the Secretary financial
2 hardship in complying with such requirement.

3 (e) STUDY.—The Secretary shall review, study, and
4 benchmark the progress and results of the programs fund-
5 ed under this section.

6 (f) REPORT.—Each State receiving a grant under
7 this section shall submit to the Secretary a report on best
8 practices and lessons learned through the grant to inform
9 the health reform coverage expansions under this division
10 beginning in Y1.

11 (g) FUNDING.—There are authorized to be appro-
12 priated such sums as may be necessary to carry out this
13 section.

14 **SEC. 115. ADMINISTRATIVE SIMPLIFICATION.**

15 (a) STANDARDIZING ELECTRONIC ADMINISTRATIVE
16 TRANSACTIONS.—

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

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

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

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

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

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

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

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

17 “(D) enable the real-time (or near real-
18 time) determination of an individual’s financial
19 responsibility at the point of service and, to the
20 extent possible, prior to service, including
21 whether the individual is eligible for a specific
22 service with a specific physician at a specific fa-
23 cility, on a specific date or range of dates, in-
24 clude utilization of a machine-readable health

1 plan beneficiary identification card or similar
2 mechanism;

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

5 “(F) provide for timely acknowledgment,
6 response, and status reporting applicable to any
7 electronic transaction deemed appropriate by
8 the Secretary;

9 “(G) describe all data elements (such as
10 reason and remark codes) in unambiguous
11 terms, not permit optional fields, require that
12 data elements be either required or conditioned
13 upon set values in other fields, and prohibit ad-
14 ditional conditions except where required by (or
15 to implement) State or Federal law or to pro-
16 tect against fraud and abuse; and

17 “(H) harmonize all common data elements
18 across administrative and clinical transaction
19 standards.

20 “(3) TIME FOR ADOPTION.—Not later than 2
21 years after the date of the enactment of this section,
22 the Secretary shall adopt standards under this sec-
23 tion by interim, final rule.

1 “(4) REQUIREMENTS FOR SPECIFIC STAND-
2 ARDS.—The standards under this section shall be
3 developed, adopted, and enforced so as to—

4 “(A) clarify, refine, complete, and expand,
5 as needed, the standards required under section
6 1173;

7 “(B) require paper versions of standard-
8 ized transactions to comply with the same
9 standards as to data content such that a fully
10 compliant, equivalent electronic transaction can
11 be populated from the data from a paper
12 version;

13 “(C) enable electronic funds transfers, in
14 order to allow automated reconciliation with the
15 related health care payment and remittance ad-
16 vice;

17 “(D) require timely and transparent claim
18 and denial management processes, including
19 uniform claim edits, uniform reason and remark
20 denial codes, tracking, adjudication, and appeal
21 processing;

22 “(E) require the use of a standard elec-
23 tronic transaction with which health care pro-
24 viders may quickly and efficiently enroll with a

1 health plan to conduct the other electronic
2 transactions provided for in this part; and

3 “(F) provide for other requirements relat-
4 ing to administrative simplification as identified
5 by the Secretary, in consultation with stake-
6 holders.

7 “(5) BUILDING ON EXISTING STANDARDS.—In
8 adopting the standards under this section, the Sec-
9 retary shall consider existing and planned standards.

10 “(6) IMPLEMENTATION AND ENFORCEMENT.—
11 Not later than 6 months after the date of the enact-
12 ment of this section, the Secretary shall submit to
13 the appropriate committees of Congress a plan for
14 the implementation and enforcement, by not later
15 than 5 years after such date of enactment, of the
16 standards under this section. Such plan shall in-
17 clude—

18 “(A) a process and timeframe with mile-
19 stones for developing the complete set of stand-
20 ards;

21 “(B) a proposal for accommodating nec-
22 essary changes between version changes and a
23 process for upgrading standards as often as an-
24 nually by interim, final rulemaking;

1 “(C) programs to provide incentives for,
2 and ease the burden of, implementation for cer-
3 tain health care providers, with special consid-
4 eration given to such providers serving rural or
5 underserved areas and ensure coordination with
6 standards, implementation specifications, and
7 certification criteria being adopted under the
8 HITECH Act;

9 “(D) programs to provide incentives for,
10 and ease the burden of, health care providers
11 who volunteer to participate in the process of
12 setting standards for electronic transactions;

13 “(E) an estimate of total funds needed to
14 ensure timely completion of the implementation
15 plan; and

16 “(F) an enforcement process that includes
17 timely investigation of complaints, random au-
18 dits to ensure compliance, civil monetary and
19 programmatic penalties for noncompliance con-
20 sistent with existing laws and regulations, and
21 a fair and reasonable appeals process building
22 off of enforcement provisions under this part,
23 and concurrent State enforcement jurisdiction.

24 The Secretary may promulgate an annual audit and
25 certification process to ensure that all health plans

1 and clearinghouses are both syntactically and func-
2 tionally compliant with all the standard transactions
3 mandated pursuant to the administrative simplifica-
4 tion provisions of this part and the Health Insurance
5 Portability and Accountability Act of 1996.

6 “(b) LIMITATIONS ON USE OF DATA.—Nothing in
7 this section shall be construed to permit the use of infor-
8 mation collected under this section in a manner that would
9 violate State or Federal law.

10 “(c) PROTECTION OF DATA.—The Secretary shall en-
11 sure (through the promulgation of regulations or other-
12 wise) that all data collected pursuant to subsection (a) are
13 used and disclosed in a manner that meets the HIPAA
14 privacy and security law (as defined in section 3009(a)(2)
15 of the Public Health Service Act), including any privacy
16 or security standard adopted under section 3004 of such
17 Act.

18 **“SEC. 1173B. INTERIM COMPANION GUIDES, INCLUDING OP-**
19 **ERATING RULES.**

20 “(a) IN GENERAL.—The Secretary shall adopt a sin-
21 gle, binding, comprehensive companion guide, that in-
22 cludes operating rules for each X12 Version 5010 trans-
23 action described in section 1173(a)(2), to be effective until
24 the new version of these transactions which comply with
25 section 1173A are adopted and implemented.

1 “(b) COMPANION GUIDE AND OPERATING RULES
2 DEVELOPMENT.—In adopting such interim companion
3 guide and rules, the Secretary shall comply with section
4 1172, except that a nonprofit entity that meets the fol-
5 lowing criteria shall also be consulted:

6 “(1) The entity focuses its mission on adminis-
7 trative simplification.

8 “(2) The entity uses a multistakeholder process
9 that creates consensus-based companion guides, in-
10 cluding operating rules using a voting process that
11 ensures balanced representation by the critical
12 stakeholders (including health plans and health care
13 providers) so that no one group dominates the entity
14 and shall include others such as standards develop-
15 ment organizations, and relevant Federal or State
16 agencies.

17 “(3) The entity has in place a public set of
18 guiding principles that ensure the companion guide
19 and operating rules and process are open and trans-
20 parent.

21 “(4) The entity coordinates its activities with
22 the HIT Policy Committee, and the HIT Standards
23 Committee (established under title XXX of the Pub-
24 lic Health Service Act) and complements the efforts

1 of the Office of the National Healthcare Coordinator
2 and its related health information exchange goals.

3 “(5) The entity incorporates the standards
4 issued under Health Insurance Portability and Ac-
5 countability Act of 1996 and this part, and in devel-
6 oping the companion guide and operating rules does
7 not change the definition, data condition or use of
8 a data element or segment in a standard, add any
9 elements or segments to the maximum defined data
10 set, use any codes or data elements that are either
11 marked ‘not used’ in the standard’s implementation
12 specifications or are not in the standard’s implemen-
13 tation specifications, or change the meaning or in-
14 tent of the standard’s implementation specifications.

15 “(6) The entity uses existing market research
16 and proven best practices.

17 “(7) The entity has a set of measures that
18 allow for the evaluation of their market impact and
19 public reporting of aggregate stakeholder impact.

20 “(8) The entity supports nondiscrimination and
21 conflict of interest policies that demonstrate a com-
22 mitment to open, fair, and nondiscriminatory prac-
23 tices.

1 “(9) The entity allows for public reviews and
2 comment on updates of the companion guide, includ-
3 ing the operating rules.

4 “(c) IMPLEMENTATION.—The Secretary shall adopt
5 a single, binding companion guide, including operating
6 rules under this section, for each transaction, to become
7 effective with the X12 Version 5010 transaction imple-
8 mentation, or as soon thereafter as feasible. The com-
9 panion guide, including operating rules for the trans-
10 actions for eligibility for health plan and health claims sta-
11 tus under this section shall be adopted not later than Oc-
12 tober 1, 2011, in a manner such that such set of rules
13 is effective beginning not later than January 1, 2013. The
14 companion guide, including operating rules for the remain-
15 der of the transactions described in section 1173(a)(2)
16 shall be adopted not later than October 1, 2012, in a man-
17 ner such that such set of rules is effective beginning not
18 later than January 1, 2014.”.

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

21 (A) in paragraph (1), by inserting “, and
22 associated operational guidelines and instruc-
23 tions, as determined appropriate by the Sec-
24 retary” after “medical procedure codes”; and

1 (B) by adding at the end the following new
2 paragraph:

3 “(10) OPERATING RULES.—The term ‘oper-
4 ating rules’ means business rules for using and proc-
5 essing transactions, such as service level require-
6 ments, which do not impact the implementation
7 specifications or other data content requirements.”.

8 (3) CONFORMING AMENDMENT.—Section
9 1179(a) of such Act (42 U.S.C. 1320d–8(a)) is
10 amended, in the matter before paragraph (1)—

11 (A) by inserting “on behalf of an indi-
12 vidual” after “1978”); and

13 (B) by inserting “on behalf of an indi-
14 vidual” after “for a financial institution” and

15 (b) STANDARDS FOR CLAIMS ATTACHMENTS AND
16 COORDINATION OF BENEFITS.—

17 (1) STANDARD FOR HEALTH CLAIMS ATTACH-
18 MENTS.—Not later than 1 year after the date of the
19 enactment of this Act, the Secretary of Health and
20 Human Services shall promulgate an interim, final
21 rule to establish a standard for health claims attach-
22 ment transaction described in section 1173(a)(2)(B)
23 of the Social Security Act (42 U.S.C. 1320d–
24 2(a)(2)(B)) and coordination of benefits.

1 (2) REVISION IN PROCESSING PAYMENT TRANS-
2 ACTIONS BY FINANCIAL INSTITUTIONS.—

3 (A) IN GENERAL.—Section 1179 of the So-
4 cial Security Act (42 U.S.C. 1320d–8) is
5 amended, in the matter before paragraph (1)—

6 (i) by striking “or is engaged” and in-
7 serting “and is engaged”; and

8 (ii) by inserting “(other than as a
9 business associate for a covered entity)”
10 after “for a financial institution”.

11 (B) COMPLIANCE DATE.—The amend-
12 ments made by subparagraph (A) shall apply to
13 transactions occurring on or after such date
14 (not later than January 1, 2014) as the Sec-
15 retary of Health and Human Services shall
16 specify.

17 (c) STANDARDS FOR FIRST REPORT OF INJURY.—
18 Not later than January 1, 2014, the Secretary of Health
19 and Human Services shall promulgate an interim final
20 rule to establish a standard for the first report of injury
21 transaction described in section 1173(a)(2)(G) of the So-
22 cial Security Act (42 U.S.C. 1320d–2(a)(2)(G)).

23 (d) UNIQUE HEALTH PLAN IDENTIFIER.—Not later
24 October 1, 2012, the Secretary of Health and Human
25 Services shall promulgate an interim final rule to establish

1 a unique health plan identifier described in section
2 1173(b) of the Social Security Act (42 U.S.C. 1320d–
3 2(b)) based on the input of the National Committee of
4 Vital and Health Statistics and consultation with health
5 plans, health care providers, and other interested parties.

6 (e) EXPANSION OF ELECTRONIC TRANSACTIONS IN
7 MEDICARE.—Section 1862(a) of the Social Security Act
8 (42 U.S.C. 1395y(a)) is amended—

9 (1) in paragraph (23), by striking “or” at the
10 end;

11 (2) in paragraph (24), by striking the period
12 and inserting “; or”; and

13 (3) by inserting after paragraph (24) the fol-
14 lowing new paragraph:

15 “(25) subject to subsection (h), not later than
16 January 1, 2015, for which the payment is other
17 than by electronic funds transfer (EFT) so long as
18 the Secretary has adopted and implemented a stand-
19 ard for electronic funds transfer under section
20 1173A.”.

21 (f) EXPANSION OF PENALTIES.—Section 1176 of
22 such Act (42 U.S.C. 1320d–5) is amended by adding at
23 the end the following new subsection:

24 “(c) EXPANSION OF PENALTY AUTHORITY.—The
25 Secretary may, in addition to the penalties provided under

1 subsections (a) and (b), provide for the imposition of pen-
2 alties for violations of this part that are comparable—

3 “(1) in the case of health plans, to the sanc-
4 tions the Secretary is authorized to impose under
5 part C or D of title XVIII in the case of a plan that
6 violates a provision of such part; or

7 “(2) in the case of a health care provider, to
8 the sanctions the Secretary is authorized to impose
9 under part A, B, or D of title XVIII in the case of
10 a health care provider that violations a provision of
11 such part with respect to that provider.”.

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

16 **SEC. 201. REQUIREMENTS REFORMING HEALTH INSUR-**
17 **ANCE MARKETPLACE.**

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

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

1 under this division unless the plan meets the applicable
2 requirements of the following subtitles for the type of plan
3 and plan year involved:

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

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

6 (3) Subtitle D (relating to consumer protec-
7 tion).

8 (c) TERMINOLOGY.—In this division:

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

16 (2) INDIVIDUAL AND GROUP HEALTH INSUR-
17 ANCE COVERAGE.—The terms “individual health in-
18 surance coverage” and “group health insurance cov-
19 erage” mean health insurance coverage offered in
20 the individual market or large or small group mar-
21 ket, respectively, as defined in section 2791 of the
22 Public Health Service Act.

1 **SEC. 202. PROTECTING THE CHOICE TO KEEP CURRENT**
2 **COVERAGE.**

3 (a) GRANDFATHERED HEALTH INSURANCE COV-
4 ERAGE DEFINED.—Subject to the succeeding provisions of
5 this section, for purposes of establishing acceptable cov-
6 erage under this division, the term “grandfathered health
7 insurance coverage” means individual health insurance
8 coverage that is offered and in force and effect before the
9 first day of Y1 if the following conditions are met:

10 (1) LIMITATION ON NEW ENROLLMENT.—

11 (A) IN GENERAL.—Except as provided in
12 this paragraph, the individual health insurance
13 issuer offering such coverage does not enroll
14 any individual in such coverage if the first ef-
15 fective date of coverage is on or after the first
16 day of Y1.

17 (B) DEPENDENT COVERAGE PER-
18 MITTED.—Subparagraph (A) shall not affect
19 the subsequent enrollment of a dependent of an
20 individual who is covered as of such first day.

21 (2) LIMITATION ON CHANGES IN TERMS OR
22 CONDITIONS.—Subject to paragraph (3) and except
23 as required by law, the issuer does not change any
24 of its terms or conditions, including benefits and
25 cost-sharing, from those in effect as of the day be-
26 fore the first day of Y1.

1 (3) RESTRICTIONS ON PREMIUM INCREASES.—

2 The issuer cannot vary the percentage increase in
3 the premium for a risk group of enrollees in specific
4 grandfathered health insurance coverage without
5 changing the premium for all enrollees in the same
6 risk group at the same rate, as specified by the
7 Commissioner.

8 (b) GRACE PERIOD FOR CURRENT EMPLOYMENT-
9 BASED HEALTH PLANS.—

10 (1) GRACE PERIOD.—

11 (A) IN GENERAL.—The Commissioner
12 shall establish a grace period whereby, for plan
13 years beginning after the end of the 5-year pe-
14 riod beginning with Y1, an employment-based
15 health plan in operation as of the day before
16 the first day of Y1 must meet the same require-
17 ments as apply to a qualified health benefits
18 plan under section 201, including the essential
19 benefit package requirement under section 221.

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

1 (i) Any coverage described in section
2 3001(a)(1)(B)(ii)(IV) of division B of the
3 American Recovery and Reinvestment Act
4 of 2009 (Public Law 111–5).

5 (ii) Excepted benefits (as defined in
6 section 733(c) of the Employee Retirement
7 Income Security Act of 1974), including
8 coverage under a specified disease or ill-
9 ness policy described in paragraph (3)(A)
10 of such section.

11 (iii) Such other limited benefits as the
12 Commissioner may specify.

13 In no case shall an employment-based health
14 plan in which the coverage consists only of one
15 or more of the coverage or benefits described in
16 clauses (i) through (iii) be treated as acceptable
17 coverage under this division.

18 (2) TRANSITIONAL TREATMENT AS ACCEPT-
19 ABLE COVERAGE.—During the grace period specified
20 in paragraph (1)(A), an employment-based health
21 plan (which may be a high deductible health plan, as
22 defined in section 223(c)(2) of the Internal Revenue
23 Code of 1986) that is described in such paragraph
24 shall be treated as acceptable coverage under this di-
25 vision.

1 (c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE
2 COVERAGE.—

3 (1) IN GENERAL.—Individual health insurance
4 coverage that is not grandfathered health insurance
5 coverage under subsection (a) may only be offered
6 on or after the first day of Y1 as an Exchange-participating health benefits plan.

7 (2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Nothing in—

8 (A) paragraph (1) shall prevent the offering
9 of excepted benefits described in section
10 2791(c) of the Public Health Service Act so
11 long as such benefits are offered outside the
12 Health Insurance Exchange and are priced separately from health insurance coverage; and

13 (B) this division shall be construed—

14 (i) to prevent the offering of a stand-alone plan that offers coverage of excepted benefits described in section 2791(c)(2)(A) of the Public Health Service Act (relating to limited scope dental or vision benefits) for individuals and families from a State-licensed dental and vision carrier; or

15 (ii) as applying requirements for a qualified health benefits plan to such a

1 stand-alone plan that is offered and priced
2 separately from a qualified health benefits
3 plan.

4 **Subtitle B—Standards Guaranteeing Access to Affordable Cov-**
5 **erage**

7 **SEC. 211. PROHIBITING PREEXISTING CONDITION EXCLU-**
8 **SIONS.**

9 A qualified health benefits plan may not impose any
10 preexisting condition exclusion (as defined in section
11 2701(b)(1)(A) of the Public Health Service Act) or other-
12 wise impose any limit or condition on the coverage under
13 the plan with respect to an individual or dependent based
14 on any of the following: health status, medical condition,
15 claims experience, receipt of health care, medical history,
16 genetic information, evidence of insurability, disability, or
17 source of injury (including conditions arising out of acts
18 of domestic violence) or any similar factors.

19 **SEC. 212. GUARANTEED ISSUE AND RENEWAL FOR IN-**
20 **SURED PLANS AND PROHIBITING RESCIS-**
21 **SIONS.**

22 The requirements of sections 2711 (other than sub-
23 sections (e) and (f)) and 2712 (other than paragraphs (3),
24 and (6) of subsection (b) and subsection (e)) of the Public
25 Health Service Act, relating to guaranteed availability and

1 renewability of health insurance coverage, shall apply to
2 individuals and employers in all individual and group
3 health insurance coverage, whether offered to individuals
4 or employers through the Health Insurance Exchange,
5 through any employment-based health plan, or otherwise,
6 in the same manner as such sections apply to employers
7 and health insurance coverage offered in the small group
8 market, except that such section 2712(b)(1) shall apply
9 only if, before nonrenewal or discontinuation of coverage,
10 the issuer has provided the enrollee with notice of non-
11 payment of premiums and there is a grace period during
12 which the enrollee has an opportunity to correct such non-
13 payment. Rescissions of such coverage shall be prohibited
14 except in cases of fraud as defined in section 2712(b)(2)
15 of such Act.

16 **SEC. 213. INSURANCE RATING RULES.**

17 (a) IN GENERAL.—The premium rate charged for a
18 qualified health benefits plan that is health insurance cov-
19 erage may not vary except as follows:

20 (1) LIMITED AGE VARIATION PERMITTED.—By
21 age (within such age categories as the Commissioner
22 shall specify) so long as the ratio of the highest such
23 premium to the lowest such premium does not ex-
24 ceed the ratio of 2 to 1.

1 (2) BY AREA.—By premium rating area (as
2 permitted by State insurance regulators or, in the
3 case of Exchange-participating health benefits plans,
4 as specified by the Commissioner in consultation
5 with such regulators).

6 (3) BY FAMILY ENROLLMENT.—By family en-
7 rollment (such as variations within categories and
8 compositions of families) so long as the ratio of the
9 premium for family enrollment (or enrollments) to
10 the premium for individual enrollment is uniform, as
11 specified under State law and consistent with rules
12 of the Commissioner.

13 (b) ACTUARIAL VALUE OF OPTIONAL SERVICE COV-
14 ERAGE.—

15 (1) IN GENERAL.—The Commissioner shall esti-
16 mate the basic per enrollee, per month cost, deter-
17 mined on an average actuarial basis, for including
18 coverage under a basic plan of the services described
19 in section 222(d)(4)(A).

20 (2) CONSIDERATIONS.—In making such esti-
21 mate the Commissioner—

22 (A) may take into account the impact on
23 overall costs of the inclusion of such coverage,
24 but may not take into account any cost reduc-
25 tion estimated to result from such services, in-

1 including prenatal care, delivery, or postnatal
2 care;

3 (B) shall estimate such costs as if such
4 coverage were included for the entire population
5 covered; and

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

8 (c) STUDY AND REPORTS.—

9 (1) STUDY.—The Commissioner, in coordina-
10 tion with the Secretary of Health and Human Serv-
11 ices and the Secretary of Labor, shall conduct a
12 study of the large-group-insured and self-insured
13 employer health care markets. Such study shall ex-
14 amine the following:

15 (A) The types of employers by key charac-
16 teristics, including size, that purchase insured
17 products versus those that self-insure.

18 (B) The similarities and differences be-
19 tween typical insured and self-insured health
20 plans.

21 (C) The financial solvency and capital re-
22 serve levels of employers that self-insure by em-
23 ployer size.

1 (D) The risk of self-insured employers not
2 being able to pay obligations or otherwise be-
3 coming financially insolvent.

4 (E) The extent to which rating rules are
5 likely to cause adverse selection in the large
6 group market or to encourage small and
7 midsize employers to self-insure.

8 (2) REPORTS.—Not later than 18 months after
9 the date of the enactment of this Act, the Commis-
10 sioner shall submit to Congress and the applicable
11 agencies a report on the study conducted under
12 paragraph (1). Such report shall include any rec-
13 ommendations the Commissioner deems appropriate
14 to ensure that the law does not provide incentives
15 for small and midsize employers to self-insure or cre-
16 ate adverse selection in the risk pools of large group
17 insurers and self-insured employers. Not later than
18 18 months after the first day of Y1, the Commis-
19 sioner shall submit to Congress and the applicable
20 agencies an updated report on such study, including
21 updates on such recommendations.

1 **SEC. 214. NONDISCRIMINATION IN BENEFITS; PARITY IN**
2 **MENTAL HEALTH AND SUBSTANCE ABUSE**
3 **DISORDER BENEFITS.**

4 (a) NONDISCRIMINATION IN BENEFITS.—A qualified
5 health benefits plan shall comply with standards estab-
6 lished by the Commissioner to prohibit discrimination in
7 health benefits or benefit structures for qualifying health
8 benefits plans, building from section 702 of the Employee
9 Retirement Income Security Act of 1974, section 2702 of
10 the Public Health Service Act, and section 9802 of the
11 Internal Revenue Code of 1986.

12 (b) PARITY IN MENTAL HEALTH AND SUBSTANCE
13 ABUSE DISORDER BENEFITS.—To the extent such provi-
14 sions are not superceded by or inconsistent with subtitle
15 C, the provisions of section 2705 (other than subsections
16 (a)(1), (a)(2), and (c)) of the Public Health Service Act
17 shall apply to a qualified health benefits plan, regardless
18 of whether it is offered in the individual or group market,
19 in the same manner as such provisions apply to health
20 insurance coverage offered in the large group market.

21 **SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.**

22 (a) IN GENERAL.—A qualified health benefits plan
23 that uses a provider network for items and services shall
24 meet such standards respecting provider networks as the
25 Commissioner may establish to assure the adequacy of
26 such networks in ensuring enrollee access to such items

1 and services and transparency in the cost-sharing differen-
2 tials among providers participating in the network and
3 policies for accessing out-of-network providers.

4 (b) INTERNET ACCESS TO INFORMATION.—A quali-
5 fied health benefits plan that uses a provider network shall
6 provide a current listing of all providers in its network
7 on its Website and such data shall be available on the
8 Health Insurance Exchange Website as a part of the basic
9 information on that plan. The Commissioner shall also es-
10 tablish an on-line system whereby an individual may select
11 by name any medical provider (as defined by the Commis-
12 sioner) and be informed of the plan or plans with which
13 that provider is contracting.

14 (c) PROVIDER NETWORK DEFINED.—In this division,
15 the term “provider network” means the providers with re-
16 spect to which covered benefits, treatments, and services
17 are available under a health benefits plan.

18 **SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DE-**
19 **PENDENT COVERAGE FOR UNINSURED**
20 **YOUNG ADULTS.**

21 (a) IN GENERAL.—A qualified health benefits plan
22 shall make available, at the option of the principal enrollee
23 under the plan, coverage for one or more qualified children
24 (as defined in subsection (b)) of the enrollee.

1 (b) QUALIFIED CHILD DEFINED.—In this section,
2 the term “qualified child” means, with respect to a prin-
3 cipal enrollee in a qualified health benefits plan, an indi-
4 vidual who (but for age) would be treated as a dependent
5 child of the enrollee under such plan and who—

6 (1) is under 27 years of age; and

7 (2) is not enrolled in a health benefits plan
8 other than under this section.

9 (c) PREMIUMS.—Nothing in this section shall be con-
10 strued as preventing a qualified health benefits plan from
11 increasing the premiums otherwise required for coverage
12 provided under this section consistent with standards es-
13 tablished by the Commissioner based upon family size
14 under section 213(a)(3).

15 **SEC. 217. CONSISTENCY OF COSTS AND COVERAGE UNDER**
16 **QUALIFIED HEALTH BENEFITS PLANS DUR-**
17 **ING PLAN YEAR.**

18 In the case of health insurance coverage offered
19 under a qualified health benefits plan, if the coverage de-
20 creases or the cost-sharing increases, the issuer of the cov-
21 erage shall notify enrollees of the change at least 90 days
22 before the change takes effect (or such shorter period of
23 time in cases where the change is necessary to ensure the
24 health and safety of enrollees).

1 **Subtitle C—Standards Guaranteing Access to Essential Benefits**
2 **teeing Access to Essential Bene-**
3 **fits**

4 **SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.**

5 (a) IN GENERAL.—A qualified health benefits plan
6 shall provide coverage that at least meets the benefit
7 standards adopted under section 224 for the essential ben-
8 efits package described in section 222 for the plan year
9 involved.

10 (b) CHOICE OF COVERAGE.—

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

17 (2) EXCHANGE-PARTICIPATING HEALTH BENE-
18 FITS PLANS.—In the case of an Exchange-partici-
19 pating health benefits plan, such plan is required
20 under section 203 to provide specified levels of bene-
21 fits and, in the case of a plan offering a premium-
22 plus level of benefits, provide additional benefits.

23 (3) CONTINUATION OF OFFERING OF SEPARATE
24 EXCEPTED BENEFITS COVERAGE.—Nothing in this
25 division shall be construed as affecting the offering

1 outside of the Health Insurance Exchange and
2 under State law of health benefits in the form of ex-
3 cepted benefits (described in section
4 202(b)(1)(B)(ii)) if such benefits are offered under
5 a separate policy, contract, or certificate of insur-
6 ance.

7 (c) CLINICAL APPROPRIATENESS.—Nothing in this
8 Act shall be construed to prohibit a group health plan or
9 health insurance issuer from using medical management
10 practices so long as such management practices are based
11 on valid medical evidence and are relevant to the patient
12 whose medical treatment is under review.

13 (d) PROVISION OF BENEFITS.—Nothing in this divi-
14 sion shall be construed as prohibiting a qualified health
15 benefits plan from subcontracting with stand-alone health
16 insurance issuers or insurers for the provision of dental,
17 vision, mental health, and other benefits and services.

18 **SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.**

19 (a) IN GENERAL.—In this division, the term “essen-
20 tial benefits package” means health benefits coverage,
21 consistent with standards adopted under section 224, to
22 ensure the provision of quality health care and financial
23 security, that—

24 (1) provides payment for the items and services
25 described in subsection (b) in accordance with gen-

1 erally accepted standards of medical or other appro-
2 priate clinical or professional practice;

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

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

9 (4) complies with section 215(a) (relating to
10 network adequacy); and

11 (5) is equivalent in its scope of benefits, as cer-
12 tified by Office of the Actuary of the Centers for
13 Medicare & Medicaid Services, to the average pre-
14 vailing employer-sponsored coverage in Y1.

15 In order to carry out paragraph (5), the Secretary of
16 Labor shall conduct a survey of employer-sponsored cov-
17 erage to determine the benefits typically covered by em-
18 ployers, including multiemployer plans, and provide a re-
19 port on such survey to the Health Benefits Advisory Com-
20 mittee and to the Secretary of Health and Human Serv-
21 ices.

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

25 (1) Hospitalization.

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

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

5 (4) Such services, equipment, and supplies inci-
6 dent to the services of a physician's or a health pro-
7 fessional's delivery of care in institutional settings,
8 physician offices, patients' homes or place of resi-
9 dence, or other settings, as appropriate.

10 (5) Prescription drugs.

11 (6) Rehabilitative and habilitative services.

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

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

19 (9) Maternity care.

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

23 (11) Durable medical equipment, prosthetics,
24 orthotics and related supplies.

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

3 (1) NO COST-SHARING FOR PREVENTIVE SERV-
4 ICES.—There shall be no cost-sharing under the es-
5 sential benefits package for—

6 (A) preventive items and services rec-
7 ommended with a grade of A or B by the Task
8 Force on Clinical Preventive Services and those
9 vaccines recommended for use by the Director
10 of the Centers for Disease Control and Preven-
11 tion; or

12 (B) well-baby and well-child care.

13 (2) ANNUAL LIMITATION.—

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

19 (B) APPLICABLE LEVEL.—The applicable
20 level specified in this subparagraph for Y1 is
21 not to exceed \$5,000 for an individual and not
22 to exceed \$10,000 for a family. Such levels
23 shall be increased (rounded to the nearest
24 \$100) for each subsequent year by the annual
25 percentage increase in the enrollment-weighted

1 average of premium increases for basic plans
2 applicable to such year, except that Secretary
3 shall adjust such increase to ensure that the ap-
4 plicable level specified in this subparagraph
5 meets the minimum actuarial value required
6 under paragraph (3).

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

12 (3) MINIMUM ACTUARIAL VALUE.—

13 (A) IN GENERAL.—The cost-sharing under
14 the essential benefits package shall be designed
15 to provide a level of coverage that is designed
16 to provide benefits that are actuarially equiva-
17 lent to approximately 70 percent of the full ac-
18 tuarial value of the benefits provided under the
19 reference benefits package described in sub-
20 paragraph (B).

21 (B) REFERENCE BENEFITS PACKAGE DE-
22 SCRIBED.—The reference benefits package de-
23 scribed in this subparagraph is the essential
24 benefits package if there were no cost-sharing
25 imposed.

1 (d) ASSESSMENT AND COUNSELING FOR DOMESTIC
2 VIOLENCE.—The Secretary shall support the need for an
3 assessment and brief counseling for domestic violence as
4 part of a behavioral health assessment or primary care
5 visit and determine the appropriate coverage for such as-
6 sessment and counseling.

7 (e) ABORTION COVERAGE PROHIBITED AS PART OF
8 MINIMUM BENEFITS PACKAGE.—

9 (1) PROHIBITION OF REQUIRED COVERAGE.—
10 The Health Benefits Advisory Committee may not
11 recommend under section 223(b), and the Secretary
12 may not adopt in standards under section 224(b),
13 the services described in paragraph (4)(A) or (4)(B)
14 as part of the essential benefits package and the
15 Commissioner may not require such services for
16 qualified health benefits plans to participate in the
17 Health Insurance Exchange.

18 (2) VOLUNTARY CHOICE OF COVERAGE BY
19 PLAN.—In the case of a qualified health benefits
20 plan, the plan is not required (or prohibited) under
21 this Act from providing coverage of services de-
22 scribed in paragraph (4)(A) or (4)(B) and the
23 QHBP offering entity shall determine whether such
24 coverage is provided.

1 (3) COVERAGE UNDER PUBLIC HEALTH INSUR-
2 ANCE OPTION.—The public health insurance option
3 shall provide coverage for services described in para-
4 graph (4)(B). Nothing in this Act shall be construed
5 as preventing the public health insurance option
6 from providing for or prohibiting coverage of serv-
7 ices described in paragraph (4)(A).

8 (4) ABORTION SERVICES.—

9 (A) ABORTIONS FOR WHICH PUBLIC FUND-
10 ING IS PROHIBITED.—The services described in
11 this subparagraph are abortions for which the
12 expenditure of Federal funds appropriated for
13 the Department of Health and Human Services
14 is not permitted, based on the law as in effect
15 as of the date that is 6 months before the be-
16 ginning of the plan year involved.

17 (B) ABORTIONS FOR WHICH PUBLIC FUND-
18 ING IS ALLOWED.—The services described in
19 this subparagraph are abortions for which the
20 expenditure of Federal funds appropriated for
21 the Department of Health and Human Services
22 is permitted, based on the law as in effect as
23 of the date that is 6 months before the begin-
24 ning of the plan year involved.

1 (f) REPORT REGARDING INCLUSION OF ORAL
2 HEALTH CARE IN ESSENTIAL BENEFITS PACKAGE.—Not
3 later than 1 year after the date of the enactment of this
4 Act, the Secretary of Health and Human Services shall
5 submit to Congress a report containing the results of a
6 study determining the need and cost of providing acces-
7 sible and affordable oral health care to adults as part of
8 the essential benefits package.

9 **SEC. 223. HEALTH BENEFITS ADVISORY COMMITTEE.**

10 (a) ESTABLISHMENT.—

11 (1) IN GENERAL.—There is established a pri-
12 vate-public advisory committee which shall be a
13 panel of medical and other experts to be known as
14 the Health Benefits Advisory Committee to rec-
15 ommend covered benefits and essential, enhanced,
16 and premium plans.

17 (2) CHAIR.—The Surgeon General shall be a
18 member and the chair of the Health Benefits Advi-
19 sory Committee.

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

23 (A) Nine members who are not Federal
24 employees or officers and who are appointed by
25 the President.

1 (B) Nine members who are not Federal
2 employees or officers and who are appointed by
3 the Comptroller General of the United States in
4 a manner similar to the manner in which the
5 Comptroller General appoints members to the
6 Medicare Payment Advisory Commission under
7 section 1805(e) of the Social Security Act.

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

11 Such initial appointments shall be made not later
12 than 60 days after the date of the enactment of this
13 Act.

14 (4) TERMS.—Each member of the Health Bene-
15 fits Advisory Committee shall serve a 3-year term on
16 the Committee, except that the terms of the initial
17 members shall be adjusted in order to provide for a
18 staggered term of appointment for all such mem-
19 bers.

20 (5) PARTICIPATION.—The membership of the
21 Health Benefits Advisory Committee shall at least
22 reflect providers, patient representatives, employers
23 (including small employers), labor, health insurance
24 issuers, experts in health care financing and deliv-
25 ery, experts in oral health care, experts in racial and

1 ethnic disparities, experts on health care needs and
2 disparities of individuals with disabilities, represent-
3 atives of relevant governmental agencies, and at
4 least one practicing physician or other health profes-
5 sional and an expert in child and adolescent health
6 and shall represent a balance among various sectors
7 of the health care system so that no single sector
8 unduly influences the recommendations of such
9 Committee.

10 (b) DUTIES.—

11 (1) RECOMMENDATIONS ON BENEFIT STAND-
12 ARDS.—The Health Benefits Advisory Committee
13 shall recommend to the Secretary of Health and
14 Human Services (in this subtitle referred to as the
15 “Secretary”) benefit standards (as defined in para-
16 graph (5)), and periodic updates to such standards.
17 In developing such recommendations, the Committee
18 shall take into account innovation in health care and
19 consider how such standards could reduce health dis-
20 parities.

21 (2) DEADLINE.—The Health Benefits Advisory
22 Committee shall recommend initial benefit standards
23 to the Secretary not later than 1 year after the date
24 of the enactment of this Act.

1 (3) STATE INPUT.—The Health Benefits Advi-
2 sory Committee shall examine the health coverage
3 laws and benefits of each State in developing rec-
4 ommendations under this subsection and may incor-
5 porate such coverage and benefits as the Committee
6 determines to be appropriate and consistent with
7 this Act. The Health Benefits Advisory Committee
8 shall also seek input from the States and consider
9 recommendations on how to ensure quality of health
10 coverage in all States.

11 (4) PUBLIC INPUT.—The Health Benefits Advi-
12 sory Committee shall allow for public input as a part
13 of developing recommendations under this sub-
14 section.

15 (5) BENEFIT STANDARDS DEFINED.—In this
16 subtitle, the term “benefit standards” means stand-
17 ards respecting—

18 (A) the essential benefits package de-
19 scribed in section 222, including categories of
20 covered treatments, items and services within
21 benefit classes, and cost-sharing consistent with
22 subsection (d) of such section; and

23 (B) the cost-sharing levels for enhanced
24 plans and premium plans (as provided under
25 section 303(c)) consistent with paragraph (5).

1 (6) LEVELS OF COST-SHARING FOR ENHANCED
2 AND PREMIUM PLANS.—

3 (A) ENHANCED PLAN.—The level of cost-
4 sharing for enhanced plans shall be designed so
5 that such plans have benefits that are actuari-
6 ally equivalent to approximately 85 percent of
7 the actuarial value of the benefits provided
8 under the reference benefits package described
9 in section 222(c)(3)(B).

10 (B) PREMIUM PLAN.—The level of cost-
11 sharing for premium plans shall be designed so
12 that such plans have benefits that are actuari-
13 ally equivalent to approximately 95 percent of
14 the actuarial value of the benefits provided
15 under the reference benefits package described
16 in section 222(c)(3)(B).

17 (c) OPERATIONS.—

18 (1) PER DIEM PAY.—Each member of the
19 Health Benefits Advisory Committee shall receive
20 travel expenses, including per diem in accordance
21 with applicable provisions under subchapter I of
22 chapter 57 of title 5, United States Code, and shall
23 otherwise serve without additional pay.

24 (2) MEMBERS NOT TREATED AS FEDERAL EM-
25 PLOYEES.—Members of the Health Benefits Advi-

1 sory Committee shall not be considered employees of
2 the Federal Government solely by reason of any
3 service on the Committee, except such members shall
4 be considered to be within the meaning of section
5 202(a) of title 18, United States Code, for the pur-
6 poses of disclosure and management of conflicts of
7 interest.

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

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

17 **SEC. 224. PROCESS FOR ADOPTION OF RECOMMENDA-**
18 **TIONS; ADOPTION OF BENEFIT STANDARDS.**

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

21 (1) REVIEW OF RECOMMENDED STANDARDS.—
22 Not later than 45 days after the date of receipt of
23 benefit standards recommended under section 223
24 (including such standards as modified under para-
25 graph (2)(B)), the Secretary shall review such

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

3 (2) DETERMINATION TO ADOPT STANDARDS.—

4 If the Secretary determines—

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

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

19 (3) CONTINGENCY.—If, because of the applica-
20 tion of paragraph (2)(B), the Secretary would other-
21 wise be unable to propose initial adoption of such
22 recommended standards by the deadline specified in
23 subsection (b)(1), the Secretary shall, by regulation
24 under section 553 of title 5, United States Code,

1 propose adoption of initial benefit standards by such
2 deadline.

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

7 (b) ADOPTION OF STANDARDS.—

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

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

17 (3) REQUIREMENT.—The Secretary may not
18 adopt any benefit standards for an essential benefits
19 package or for level of cost-sharing that are incon-
20 sistent with the requirements for such a package or
21 level under sections 222 (including subsection (d))
22 and 223(b)(5).

1 **Subtitle D—Additional Consumer**
2 **Protections**

3 **SEC. 231. REQUIRING FAIR MARKETING PRACTICES BY**
4 **HEALTH INSURERS.**

5 The Commissioner shall establish uniform marketing
6 standards that all QHBP offering entities shall meet with
7 respect to qualified health benefits plans that are health
8 insurance coverage.

9 **SEC. 232. REQUIRING FAIR GRIEVANCE AND APPEALS**
10 **MECHANISMS.**

11 (a) **IN GENERAL.**—A QHBP offering entity shall pro-
12 vide for timely grievance and appeals mechanisms with re-
13 spect to qualified health benefits plans that the Commis-
14 sioner shall establish consistent with this section. The
15 Commissioner shall establish time limits for each of such
16 mechanisms and implement them in a manner that is pro-
17 tective to the needs of patients.

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

1 and shall update such process in accordance with any
2 standards that the Commissioner may establish.

3 (c) EXTERNAL REVIEW PROCESS.—

4 (1) IN GENERAL.—The Commissioner shall es-
5 tablish an external review process (including proce-
6 dures for expedited reviews of urgent claims) that
7 provides for an impartial, independent, and de novo
8 review of denied claims under this division.

9 (2) REQUIRING FAIR GRIEVANCE AND APPEALS
10 MECHANISMS.—A determination made, with respect
11 to a qualified health benefits plan offered by a
12 QHBP offering entity, under the external review
13 process established under this subsection shall be
14 binding on the plan and the entity.

15 (d) TIME LIMITS.—The Commissioner shall establish
16 time limits for each of these processes and implement
17 them in a manner that is protective to the patient.

18 (e) CONSTRUCTION.—Nothing in this section shall be
19 construed as affecting the availability of judicial review
20 under State law for adverse decisions under subsection (b)
21 or (c), subject to section 251.

22 **SEC. 233. REQUIRING INFORMATION TRANSPARENCY AND**
23 **PLAN DISCLOSURE.**

24 (a) ACCURATE AND TIMELY DISCLOSURE.—

1 (1) FOR EXCHANGE-PARTICIPATING HEALTH
2 BENEFITS PLANS.—A QHBP offering entity offering
3 an Exchange-participating health benefits plan shall
4 comply with standards established by the Commis-
5 sioner for the accurate and timely disclosure to the
6 Commissioner and the public of plan documents,
7 plan terms and conditions, claims payment policies
8 and practices, periodic financial disclosure, data on
9 enrollment, data on disenrollment, data on the num-
10 ber of claims denials, data on rating practices, infor-
11 mation on cost-sharing and payments with respect to
12 any out-of-network coverage, and other information
13 as determined appropriate by the Commissioner.

14 (2) EMPLOYMENT-BASED HEALTH PLANS.—The
15 Secretary of Labor shall update and harmonize the
16 Secretary's rules concerning the accurate and timely
17 disclosure to participants by group health plans of
18 plan disclosure, plan terms and conditions, and peri-
19 odic financial disclosure with the standards estab-
20 lished by the Commissioner under paragraph (1).

21 (3) USE OF PLAIN LANGUAGE.—

22 (A) IN GENERAL.—The disclosures under
23 paragraphs (1) and (2) shall be provided in
24 plain language.

1 (B) DEFINITION.—In this paragraph, the
2 term “plain language” means language that the
3 intended audience, including individuals with
4 limited English proficiency, can readily under-
5 stand and use because that language is concise,
6 well-organized, and follows other best practices
7 of plain language writing.

8 (C) GUIDANCE.—The Commissioner and
9 the Secretary of Labor shall jointly develop and
10 issue guidance on best practices of plain lan-
11 guage writing.

12 (4) INFORMATION ON RIGHTS.—The informa-
13 tion disclosed under this subsection shall include in-
14 formation on enrollee and participant rights under
15 this division.

16 (5) COST-SHARING TRANSPARENCY.—A quali-
17 fied health benefits plan shall allow individuals to
18 learn the amount of cost-sharing (including
19 deductibles, copayments, and coinsurance) under the
20 individual’s plan or coverage that the individual
21 would be responsible for paying with respect to the
22 furnishing of a specific item or service by a partici-
23 pating provider in a timely manner upon request. At
24 a minimum, this information shall be made available

1 to such individual via an Internet Website and other
2 means for individuals without access to the Internet.

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

8 (c) PHARMACY BENEFIT MANAGERS TRANSPARENCY
9 REQUIREMENTS.—

10 (1) IN GENERAL.—If a QHBP offering entity
11 contracts with a pharmacy benefit manager or other
12 entity (in this subsection referred to as a “PBM”)
13 to manage prescription drug coverage or otherwise
14 control prescription drug costs under a qualified
15 health benefits plan, the PBM shall provide at least
16 annually to the Commissioner and to the QHBP of-
17 fering entity offering such plan the following infor-
18 mation, in a form and manner to be determined by
19 the Commissioner:

20 (A) Information on the number and total
21 cost of prescriptions under the contract that are
22 filled via mail order and at retail pharmacies.

23 (B) An estimate of aggregate average pay-
24 ments under the contract, per prescription
25 (weighted by prescription volume), made to mail

1 order and retail pharmacies, and the average
2 amount, per prescription, that the PBM was
3 paid by the plan for prescriptions filled at mail
4 order and retail pharmacists.

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

16 (D) Information on the overall percentage
17 of generic drugs dispensed under the contract
18 at retail and mail order pharmacies, and the
19 percentage of cases in which a generic drug is
20 dispensed when available.

21 (E) Information on the percentage and
22 number of cases under the contract in which in-
23 dividuals were switched because of PBM poli-
24 cies or at the direct or indirect control of the
25 PBM from a prescribed drug that had a lower

1 cost for the QHBP offering entity to a drug
2 that had a higher cost for the QHBP offering
3 entity, the rationale for these switches, and a
4 description of the PBM policies governing such
5 switches.

6 (2) CONFIDENTIALITY OF INFORMATION.—In-
7 formation disclosed by a PBM to the Commissioner
8 or a QHBP offering entity under this subsection is
9 confidential and shall not be disclosed by the Com-
10 missioner or the QHBP offering entity in a form
11 which discloses the identity of a specific PBM or
12 prices charged by such PBM or a specific retailer,
13 manufacturer, or wholesaler, except only by the
14 Commissioner—

15 (A) to permit State or Federal law enforce-
16 ment authorities to use the information pro-
17 vided for program compliance purposes and for
18 the purpose of combating waste, fraud, and
19 abuse;

20 (B) to permit the Comptroller General, the
21 Medicare Payment Advisory Commission, or the
22 Secretary of Health and Human Services to re-
23 view the information provided; and

1 (C) to permit the Director of the Congres-
2 sional Budget Office to review the information
3 provided.

4 (3) ANNUAL PUBLIC REPORT.—On an annual
5 basis, the Commissioner shall prepare a public re-
6 port providing industrywide aggregate or average in-
7 formation to be used in assessing the overall impact
8 of PBMs on prescription drug prices and spending.
9 Such report shall not disclose the identity of a spe-
10 cific PBM, or prices charged by such PBM, or a
11 specific retailer, manufacturer, or wholesaler, or any
12 other confidential or trade secret information.

13 (4) PENALTIES.—The provisions of subsection
14 (b)(3)(C) of section 1927 shall apply to a PBM that
15 fails to provide information required under sub-
16 section (a) or that knowingly provides false informa-
17 tion in the same manner as such provisions apply to
18 a manufacturer with an agreement under such sec-
19 tion that fails to provide information under sub-
20 section (b)(3)(A) of such section or knowingly pro-
21 vides false information under such section, respec-
22 tively.

1 **SEC. 234. APPLICATION TO QUALIFIED HEALTH BENEFITS**
2 **PLANS NOT OFFERED THROUGH THE**
3 **HEALTH INSURANCE EXCHANGE.**

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

8 **SEC. 235. TIMELY PAYMENT OF CLAIMS.**

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

16 **SEC. 236. STANDARDIZED RULES FOR COORDINATION AND**
17 **SUBROGATION OF BENEFITS.**

18 The Commissioner shall establish standards for the
19 coordination and subrogation of benefits and reimburse-
20 ment of payments in cases of qualified health benefits
21 plans involving individuals and multiple plan coverage.

22 **SEC. 237. APPLICATION OF ADMINISTRATIVE SIMPLIFICA-**
23 **TION.**

24 A QHBP offering entity is required to comply with
25 administrative simplification provisions under part C of

1 title XI of the Social Security Act with respect to qualified
2 health benefits plans it offers.

3 **SEC. 238. STATE PROHIBITIONS ON DISCRIMINATION**
4 **AGAINST HEALTH CARE PROVIDERS.**

5 This Act (and the amendments made by this Act)
6 shall not be construed as superseding laws, as they now
7 or hereinafter exist, of any State or jurisdiction designed
8 to prohibit a qualified health benefits plan from discrimi-
9 nating with respect to participation, reimbursement, cov-
10 ered services, indemnification, or related requirements
11 under such plan against a health care provider that is act-
12 ing within the scope of that provider's license or certifi-
13 cation under applicable State law.

14 **SEC. 239. PROTECTION OF PHYSICIAN PRESCRIBER INFOR-**
15 **MATION.**

16 (a) **STUDY.**—The Secretary of Health and Human
17 Services shall conduct a study on the use of physician pre-
18 scriber information in sales and marketing practices of
19 pharmaceutical manufacturers.

20 (b) **REPORT.**—Based on the study conducted under
21 subsection (a), the Secretary shall submit to Congress a
22 report on actions needed to be taken by the Congress or
23 the Secretary to protect providers from biased marketing
24 and sales practices.

1 **SEC. 240. DISSEMINATION OF ADVANCE CARE PLANNING**
2 **INFORMATION.**

3 (a) IN GENERAL.—The QHBP offering entity —

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

8 (2) shall present such individuals with—

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

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

15 (3) shall not promote suicide, assisted suicide,
16 euthanasia, or mercy killing.

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

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

23 (1) to require an individual to complete an ad-
24 vanced directive or a physician's order for life sus-
25 taining treatment or other end-of-life planning docu-
26 ment;

1 (2) to require an individual to consent to re-
2 strictions on the amount, duration, or scope of med-
3 ical benefits otherwise covered under a qualified
4 health benefits plan; or

5 (3) to promote suicide, assisted suicide, eutha-
6 nasia, or mercy killing.

7 (c) **ADVANCED DIRECTIVE DEFINED.**—In this sec-
8 tion, the term “advanced directive” includes a living will,
9 a comfort care order, or a durable power of attorney for
10 health care.

11 (d) **PROHIBITION ON THE PROMOTION OF ASSISTED**
12 **SUICIDE.**—

13 (1) **IN GENERAL.**—Subject to paragraph (3),
14 information provided to meet the requirements of
15 subsection (a)(2) shall not include advanced direc-
16 tives or other planning tools that list or describe as
17 an option suicide, assisted suicide, euthanasia, or
18 mercy killing, regardless of legality.

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

22 (A) withhold or withdraw of medical treat-
23 ment or medical care;

24 (B) withhold or withdraw of nutrition or
25 hydration; and

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

9 (3) NO PREEMPTION OF STATE LAW.—Nothing
10 in this section shall be construed to preempt or oth-
11 erwise have any effect on State laws regarding ad-
12 vance care planning, palliative care, or end-of-life de-
13 cision-making.

14 **Subtitle E—Governance**

15 **SEC. 241. HEALTH CHOICES ADMINISTRATION; HEALTH** 16 **CHOICES COMMISSIONER.**

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

21 (b) COMMISSIONER.—

22 (1) IN GENERAL.—The Administration shall be
23 headed by a Health Choices Commissioner (in this
24 division referred to as the “Commissioner”) who

1 shall be appointed by the President, by and with the
2 advice and consent of the Senate.

3 (2) COMPENSATION; ETC.—The provisions of
4 paragraphs (2), (5), and (7) of subsection (a) (relat-
5 ing to compensation, terms, general powers, rule-
6 making, and delegation) of section 702 of the Social
7 Security Act (42 U.S.C. 902) shall apply to the
8 Commissioner and the Administration in the same
9 manner as such provisions apply to the Commis-
10 sioner of Social Security and the Social Security Ad-
11 ministration.

12 (c) INSPECTOR GENERAL.—For provision estab-
13 lishing an Office of the Inspector General for the Health
14 Choices Administration, see section 1647.

15 **SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.**

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

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

1 (2) HEALTH INSURANCE EXCHANGE.—The es-
2 tablishment and operation of a Health Insurance
3 Exchange under subtitle A of title III.

4 (3) INDIVIDUAL AFFORDABILITY CREDITS.—
5 The administration of individual affordability credits
6 under subtitle C of title III, including determination
7 of eligibility for such credits.

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

10 (b) PROMOTING ACCOUNTABILITY.—

11 (1) IN GENERAL.—The Commissioner shall un-
12 dertake activities in accordance with this subtitle to
13 promote accountability of QHBP offering entities in
14 meeting Federal health insurance requirements, re-
15 gardless of whether such accountability is with re-
16 spect to qualified health benefits plans offered
17 through the Health Insurance Exchange or outside
18 of such Exchange.

19 (2) COMPLIANCE EXAMINATION AND AUDITS.—

20 (A) IN GENERAL.—The Commissioner
21 shall, in coordination with States, conduct au-
22 dits of qualified health benefits plan compliance
23 with Federal requirements. Such audits may
24 include random compliance audits and targeted

1 audits in response to complaints or other sus-
2 pected noncompliance.

3 (B) RECOUPMENT OF COSTS IN CONNEC-
4 TION WITH EXAMINATION AND AUDITS.—The
5 Commissioner is authorized to recoup from
6 qualified health benefits plans reimbursement
7 for the costs of such examinations and audit of
8 such QHBP offering entities.

9 (c) DATA COLLECTION.—The Commissioner shall
10 collect data for purposes of carrying out the Commis-
11 sioner's duties, including for purposes of promoting qual-
12 ity and value, protecting consumers, and addressing dis-
13 parities in health and health care and may share such data
14 with the Secretary of Health and Human Services.

15 (d) SANCTIONS AUTHORITY.—

16 (1) IN GENERAL.—In the case that the Com-
17 missioner determines that a QHBP offering entity
18 violates a requirement of this title, the Commis-
19 sioner may, in coordination with State insurance
20 regulators and the Secretary of Labor, provide, in
21 addition to any other remedies authorized by law,
22 for any of the remedies described in paragraph (2).

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

1 (A) civil money penalties of not more than
2 the amount that would be applicable under
3 similar circumstances for similar violations
4 under section 1857(g) of the Social Security
5 Act;

6 (B) suspension of enrollment of individuals
7 under such plan after the date the Commis-
8 sioner notifies the entity of a determination
9 under paragraph (1) and until the Commis-
10 sioner is satisfied that the basis for such deter-
11 mination has been corrected and is not likely to
12 recur;

13 (C) in the case of an Exchange-partici-
14 pating health benefits plan, suspension of pay-
15 ment to the entity under the Health Insurance
16 Exchange for individuals enrolled in such plan
17 after the date the Commissioner notifies the en-
18 tity of a determination under paragraph (1)
19 and until the Secretary is satisfied that the
20 basis for such determination has been corrected
21 and is not likely to recur; or

22 (D) working with State insurance regu-
23 lators to terminate plans for repeated failure by
24 the offering entity to meet the requirements of
25 this title.

1 (e) STANDARD DEFINITIONS OF INSURANCE AND
2 MEDICAL TERMS.—The Commissioner shall provide for
3 the development of standards for the definitions of terms
4 used in health insurance coverage, including insurance-re-
5 lated terms.

6 (f) EFFICIENCY IN ADMINISTRATION.—The Commis-
7 sioner shall issue regulations for the effective and efficient
8 administration of the Health Insurance Exchange and af-
9 fordability credits under subtitle C, including, with respect
10 to the determination of eligibility for affordability credits,
11 the use of personnel who are employed in accordance with
12 the requirements of title 5, United States Code, to carry
13 out the duties of the Commissioner or, in the case of sec-
14 tions 308 and 341(b)(2), the use of State personnel who
15 are employed in accordance with standards prescribed by
16 the Office of Personnel Management pursuant to section
17 208 of the Intergovernmental Personnel Act of 1970 (42
18 U.S.C. 4728).

19 **SEC. 243. CONSULTATION AND COORDINATION.**

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

23 (1) State attorneys general and State insurance
24 regulators, including concerning the standards for
25 health insurance coverage that is a qualified health

1 benefits plan under this title and enforcement of
2 such standards.

3 (2) The National Association of Insurance
4 Commissioners, including for purposes of using
5 model guidelines established by such association for
6 purposes of subtitles B and D.

7 (3) Appropriate State agencies, specifically con-
8 cerning the administration of individual affordability
9 credits under subtitle C of title III and the offering
10 of Exchange-participating health benefits plans, to
11 Medicaid eligible individuals under subtitle A of such
12 title.

13 (4) The Federal Trade Commission, specifically
14 concerning the development and issuance of guid-
15 ance, rules, or standards regarding fair marketing
16 practices under section 231 or otherwise, or any con-
17 sumer disclosure requirements under section 233 or
18 otherwise.

19 (5) Other appropriate Federal agencies.

20 (6) Indian tribes and tribal organizations.

21 (b) COORDINATION.—

22 (1) IN GENERAL.—In carrying out the func-
23 tions of the Commissioner, including with respect to
24 the enforcement of the provisions of this division,
25 the Commissioner shall work in coordination with

1 existing Federal and State entities to the maximum
2 extent feasible consistent with this division and in a
3 manner that prevents conflicts of interest in duties
4 and ensures effective enforcement.

5 (2) UNIFORM STANDARDS.—The Commissioner,
6 in coordination with such entities, shall seek to
7 achieve uniform standards that adequately protect
8 consumers in a manner that does not unreasonably
9 affect employers and insurers.

10 **SEC. 244. HEALTH INSURANCE OMBUDSMAN.**

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

16 (b) DUTIES.—The Qualified Health Benefits Plan
17 Ombudsman shall, in a linguistically appropriate man-
18 ner—

19 (1) receive complaints, grievances, and requests
20 for information submitted by individuals through
21 means such as the mail, by telephone, electronically,
22 and in person;

23 (2) provide assistance with respect to com-
24 plaints, grievances, and requests referred to in para-
25 graph (1), including—

1 (A) helping individuals determine the rel-
2 evant information needed to seek an appeal of
3 a decision or determination;

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

7 (C) assistance to such individuals with any
8 problems arising from disenrollment from such
9 a plan; and

10 (D) assistance to such individuals in pre-
11 senting information under subtitle C (relating
12 to affordability credits); and

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

1 **Subtitle F—Relation to Other**
2 **Requirements; Miscellaneous**

3 **SEC. 251. RELATION TO OTHER REQUIREMENTS.**

4 (a) COVERAGE NOT OFFERED THROUGH EX-
5 CHANGE.—

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

19 (2) CONSTRUCTION.—Nothing in paragraphs
20 (1) or (2) shall be construed as affecting the appli-
21 cation of section 514 of the Employee Retirement
22 Income Security Act of 1974.

23 (b) COVERAGE OFFERED THROUGH EXCHANGE.—

1 (1) IN GENERAL.—In the case of health insur-
2 ance coverage offered through the Health Insurance
3 Exchange—

4 (A) the requirements of this title do not
5 supercede any requirements (including require-
6 ments relating to genetic information non-
7 discrimination and mental health parity) appli-
8 cable under title XXVII of the Public Health
9 Service Act or under State law, except insofar
10 as such requirements prevent the application of
11 a requirement of this division, as determined by
12 the Commissioner; and

13 (B) individual rights and remedies under
14 State laws shall apply.

15 (2) CONSTRUCTION.—In the case of coverage
16 described in paragraph (1), nothing in such para-
17 graph shall be construed as preventing the applica-
18 tion of rights and remedies under State laws to
19 health insurance issuers generally with respect to
20 any requirement referred to in paragraph (1)(A).
21 The previous sentence shall not be construed as pro-
22 viding for the applicability of rights or remedies
23 under State laws with respect to requirements appli-
24 cable to employers or other plan sponsors in connec-
25 tion with arrangements which are treated as group

1 health plans under section 802(a)(1) of the Em-
2 ployee Retirement Income Security Act of 1974.

3 **SEC. 252. PROHIBITING DISCRIMINATION IN HEALTH CARE.**

4 (a) IN GENERAL.—Except as otherwise explicitly per-
5 mitted by this Act and by subsequent regulations con-
6 sistent with this Act, all health care and related services
7 (including insurance coverage and public health activities)
8 covered by this Act shall be provided without regard to
9 personal characteristics extraneous to the provision of
10 high quality health care or related services.

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

22 **SEC. 253. WHISTLEBLOWER PROTECTION.**

23 (a) RETALIATION PROHIBITED.—No employer may
24 discharge any employee or otherwise discriminate against
25 any employee with respect to his compensation, terms,

1 conditions, or other privileges of employment because the
2 employee (or any person acting pursuant to a request of
3 the employee)—

4 (1) provided, caused to be provided, or is about
5 to provide or cause to be provided to the employer,
6 the Federal Government, or the attorney general of
7 a State information relating to any violation of, or
8 any act or omission the employee reasonably believes
9 to be a violation of any provision of this Act or any
10 order, rule, or regulation promulgated under this
11 Act;

12 (2) testified or is about to testify in a pro-
13 ceeding concerning such violation;

14 (3) assisted or participated or is about to assist
15 or participate in such a proceeding; or

16 (4) objected to, or refused to participate in, any
17 activity, policy, practice, or assigned task that the
18 employee (or other such person) reasonably believed
19 to be in violation of any provision of this Act or any
20 order, rule, or regulation promulgated under this
21 Act.

22 (b) ENFORCEMENT ACTION.—An employee covered
23 by this section who alleges discrimination by an employer
24 in violation of subsection (a) may bring an action governed
25 by the rules, procedures, legal burdens of proof, and rem-

1 edies set forth in section 40(b) of the Consumer Product
2 Safety Act (15 U.S.C. 2087(b)).

3 (c) EMPLOYER DEFINED.—As used in this section,
4 the term “employer” means any person (including one or
5 more individuals, partnerships, associations, corporations,
6 trusts, professional membership organization including a
7 certification, disciplinary, or other professional body, unin-
8 corporated organizations, nongovernmental organizations,
9 or trustees) engaged in profit or nonprofit business or in-
10 dustry whose activities are governed by this Act, and any
11 agent, contractor, subcontractor, grantee, or consultant of
12 such person.

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

16 **SEC. 254. CONSTRUCTION REGARDING COLLECTIVE BAR-**
17 **GAINING.**

18 Nothing in this division shall be construed to alter
19 or supersede any statutory or other obligation to engage
20 in collective bargaining over the terms or conditions of em-
21 ployment related to health care. Any plan amendment
22 made pursuant to a collective bargaining agreement relat-
23 ing to the plan which amends the plan solely to conform
24 to any requirement added by this division shall not be

1 treated as a termination of such collective bargaining
2 agreement.

3 **SEC. 255. SEVERABILITY.**

4 If any provision of this Act, or any application of such
5 provision to any person or circumstance, is held to be un-
6 constitutional, the remainder of the provisions of this Act
7 and the application of the provision to any other person
8 or circumstance shall not be affected.

9 **SEC. 256. TREATMENT OF HAWAII PREPAID HEALTH CARE**
10 **ACT.**

11 (a) IN GENERAL.—Subject to this section—

12 (1) nothing in this division (or an amendment
13 made by this division) shall be construed to modify
14 or limit the application of the exemption for the Ha-
15 waii Prepaid Health Care Act (Haw. Rev. Stat. §§
16 393–1 et seq.) as provided for under section
17 514(b)(5) of the Employee Retirement Income Secu-
18 rity Act of 1974 (29 U.S.C. 1144(b)(5)), and such
19 exemption shall also apply with respect to the provi-
20 sions of this division; and

21 (2) for purposes of this division (and the
22 amendments made by this division), coverage pro-
23 vided pursuant to the Hawaii Prepaid Health Care
24 Act shall be treated as a qualified health benefits
25 plan providing acceptable coverage so long as the

1 Secretary of Labor determines that such coverage
2 for employees (taking into account the benefits and
3 the cost to employees for such benefits) is substan-
4 tially equivalent to or greater than the coverage pro-
5 vided for employees pursuant to the essential bene-
6 fits package.

7 (b) COORDINATION WITH STATE LAW OF HAWAII.—
8 The Commissioner shall, based on ongoing consultation
9 with the appropriate officials of the State of Hawaii, make
10 adjustments to rules and regulations of the Commissioner
11 under this division as may be necessary, as determined
12 by the Commissioner, to most effectively coordinate the
13 provisions of this division with the provisions of the Ha-
14 waii Prepaid Health Care Act, taking into account any
15 changes made from time to time to the Hawaii Prepaid
16 Health Care Act and related laws of such State.

17 **SEC. 257. ACTIONS BY STATE ATTORNEYS GENERAL.**

18 Any State attorney general may bring a civil action
19 in the name of such State as *parens patriae* on behalf of
20 natural persons residing in such State, in any district
21 court of the United States or State court having jurisdic-
22 tion of the defendant to secure monetary or equitable relief
23 for violation of any provisions of this title or regulations
24 issued thereunder. Nothing in this section shall be con-

1 strued as affecting the application of section 514 of the
2 Employee Retirement Income Security Act of 1974.

3 **SEC. 258. APPLICATION OF STATE AND FEDERAL LAWS RE-**
4 **GARDING ABORTION.**

5 (a) NO PREEMPTION OF STATE LAWS REGARDING
6 ABORTION.—Nothing in this Act shall be construed to
7 preempt or otherwise have any effect on State laws regard-
8 ing the prohibition of (or requirement of) coverage, fund-
9 ing, or procedural requirements on abortions, including
10 parental notification or consent for the performance of an
11 abortion on a minor.

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

14 (1) IN GENERAL.—Nothing in this Act shall be
15 construed to have any effect on Federal laws regard-
16 ing—

17 (A) conscience protection;

18 (B) willingness or refusal to provide abor-
19 tion; and

20 (C) discrimination on the basis of the will-
21 ingness or refusal to provide, pay for, cover, or
22 refer for abortion or to provide or participate in
23 training to provide abortion.

24 (c) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—
25 Nothing in this section shall alter the rights and obliga-

1 tions of employees and employers under title VII of the
2 Civil Rights Act of 1964.

3 **SEC. 259. NONDISCRIMINATION ON ABORTION AND RE-**
4 **SPECT FOR RIGHTS OF CONSCIENCE.**

5 (a) NONDISCRIMINATION.—A Federal agency or pro-
6 gram, and any State or local government that receives
7 Federal financial assistance under this Act (or an amend-
8 ment made by this Act), may not—

9 (1) subject any individual or institutional health
10 care entity to discrimination; or

11 (2) require any health plan created or regulated
12 under this Act (or an amendment made by this Act)
13 to subject any individual or institutional health care
14 entity to discrimination,

15 on the basis that the health care entity does not provide,
16 pay for, provide coverage of, or refer for abortions.

17 (b) DEFINITION.—In this section, the term “health
18 care entity” includes an individual physician or other
19 health care professional, a hospital, a provider-sponsored
20 organization, a health maintenance organization, a health
21 insurance plan, or any other kind of health care facility,
22 organization, or plan.

23 (c) ADMINISTRATION.—The Office for Civil Rights of
24 the Department of Health and Human Services is des-
25 ignated to receive complaints of discrimination based on

1 this section, and coordinate the investigation of such com-
2 plaints.

3 **SEC. 260. AUTHORITY OF FEDERAL TRADE COMMISSION.**

4 Section 6 of the Federal Trade Commission Act (15
5 U.S.C. 46) is amended by striking “and prepare reports”
6 and all that follows and inserting the following: “and pre-
7 pare reports, and to share information under clauses (f)
8 and (k), relating to the business of insurance. Notwith-
9 standing section 4, such authority shall include the au-
10 thority to conduct studies and prepare reports, and to
11 share information under clauses (f) and (k), relating to
12 the business of insurance, without regard to whether the
13 entity or entities that is the subject of such studies, re-
14 ports, or information is a for-profit or not-for-profit enti-
15 ty.”.

16 **SEC. 261. CONSTRUCTION REGARDING STANDARD OF**
17 **CARE.**

18 (a) IN GENERAL.—The development, recognition, or
19 implementation of any guideline or other standard under
20 a provision described in subsection (b) shall not be con-
21 strued to establish the standard of care or duty of care
22 owed by health care providers to their patients in any med-
23 ical malpractice action or claim (as defined in section
24 431(7) of the Health Care Quality Improvement Act of
25 1986 (42 U.S.C. 11151(7)).

1 (b) PROVISIONS DESCRIBED.—The provisions de-
2 scribed in this subsection are the following:

3 (1) Section 324 (relating to modernized pay-
4 ment initiatives and delivery system reform under
5 the public health option).

6 (2) The amendments made by section 1151 (re-
7 lating to reducing potentially preventable hospital re-
8 admissions).

9 (3) The amendments made by section 1751 (re-
10 lating to health care acquired conditions).

11 (4) Section 3131 of the Public Health Service
12 Act (relating to the Task Force on Clinical Preven-
13 tive Services), added by section 2301.

14 (5) Part D of title IX of the Public Health
15 Service Act (relating to implementation of best prac-
16 tices in the delivery of health care), added by section
17 2401.

18 **SEC. 262. RESTORING APPLICATION OF ANTITRUST LAWS**

19 **TO HEALTH SECTOR INSURERS.**

20 (a) AMENDMENT TO McCARRAN-FERGUSON ACT.—
21 Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013),
22 commonly known as the McCarran-Ferguson Act, is
23 amended by adding at the end the following:

24 “(c)(1) Except as provided in paragraph (2), nothing
25 contained in this Act shall modify, impair, or supersede

1 the operation of any of the antitrust laws with respect to
2 price fixing, market allocation, or monopolization (or at-
3 tempting to monopolize) by—

4 “(A) a person engaged in the business of health
5 insurance, in connection with providing health insur-
6 ance; or

7 “(B) a person engaged in the business of med-
8 ical malpractice insurance, in connection with pro-
9 viding medical malpractice insurance.

10 “(2) Paragraph (1) shall not apply to—

11 “(A) collecting, compiling, classifying, or dis-
12 seminating historical loss data;

13 “(B) determining a loss development factor ap-
14 plicable to historical loss data;

15 “(C) performing actuarial services if doing so
16 does not involve a restraint of trade; or

17 “(D) information gathering and rate setting ac-
18 tivities of a State insurance commission or other
19 State regulatory entity with authority to set insur-
20 ance rates.

21 “(3) For purposes of this subsection—

22 “(A) the term ‘antitrust laws’ has the meaning
23 given it in subsection (a) of the first section of the
24 Clayton Act, except that such term includes section
25 5 of the Federal Trade Commission Act to the ex-

1 tent that such section 5 applies to unfair methods of
2 competition;

3 “(B) the term ‘historical loss data’ means infor-
4 mation respecting claims paid, or reserves held for
5 claims reported, by any person engaged in the busi-
6 ness of insurance; and

7 “(C) the term ‘loss development factor’ means
8 an adjustment to be made to the aggregate of losses
9 incurred during a prior period of time that have
10 been paid, or for which claims have been received
11 and reserves are being held, in order to estimate the
12 aggregate of the losses incurred during such period
13 that will ultimately be paid.”.

14 (b) RELATED PROVISION.—For purposes of section
15 5 of the Federal Trade Commission Act (15 U.S.C. 45)
16 to the extent such section applies to unfair methods of
17 competition, section 3(e) of the McCarran-Ferguson Act
18 shall apply with respect to the business of health insur-
19 ance, and with respect to the business of medical mal-
20 practice insurance, without regard to whether such busi-
21 ness is carried on for profit, notwithstanding the definition
22 of “Corporation” contained in section 4 of the Federal
23 Trade Commission Act.

24 (c) RELATED PRESERVATION OF ANTITRUST
25 LAWS.—Except as provided in subsections (a) and (b),

1 nothing in this Act, or in the amendments made by this
2 Act, shall be construed to modify, impair, or supersede
3 the operation of any of the antitrust laws. For purposes
4 of the preceding sentence, the term “antitrust laws” has
5 the meaning given it in subsection (a) of the first section
6 of the Clayton Act, except that it includes section 5 of
7 the Federal Trade Commission Act to the extent that such
8 section 5 applies to unfair methods of competition.

9 **SEC. 263. STUDY AND REPORT ON METHODS TO INCREASE**
10 **EHR USE BY SMALL HEALTH CARE PRO-**
11 **VIDERS.**

12 (a) STUDY.—The Secretary of Health and Human
13 Services shall conduct a study of potential methods to in-
14 crease the use of qualified electronic health records (as
15 defined in section 3000(13) of the Public Health Service
16 Act) by small health care providers. Such study shall con-
17 sider at least the following methods:

18 (1) Providing for higher rates of reimbursement
19 or other incentives for such health care providers to
20 use electronic health records (taking into consider-
21 ation initiatives by private health insurance compa-
22 nies and incentives provided under Medicare under
23 title XVIII of the Social Security Act, Medicaid
24 under title XIX of such Act, and other programs).

1 (2) Promoting low-cost electronic health record
2 software packages that are available for use by such
3 health care providers, including software packages
4 that are available to health care providers through
5 the Veterans Administration and other sources.

6 (3) Training and education of such health care
7 providers on the use of electronic health records.

8 (4) Providing assistance to such health care
9 providers on the implementation of electronic health
10 records.

11 (b) REPORT.—Not later than December 31, 2013,
12 the Secretary of Health and Human Services shall submit
13 to Congress a report containing the results of the study
14 conducted under subsection (a), including recommenda-
15 tions for legislation or administrative action to increase
16 the use of electronic health records by small health care
17 providers that include the use of both public and private
18 funding sources.

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

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

6 **SEC. 301. ESTABLISHMENT OF HEALTH INSURANCE EX-**
7 **CHANGE; OUTLINE OF DUTIES; DEFINITIONS.**

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

15 (b) **OUTLINE OF DUTIES OF COMMISSIONER.**—In ac-
16 cordance with this subtitle and in coordination with appro-
17 priate Federal and State officials as provided under sec-
18 tion 243(b), the Commissioner shall—

19 (1) under section 304 establish standards for,
20 accept bids from, and negotiate and enter into con-
21 tracts with, QHBP offering entities for the offering
22 of health benefits plans through the Health Insur-
23 ance Exchange, with different levels of benefits re-
24 quired under section 303, and including with respect
25 to oversight and enforcement;

1 (2) under section 305 facilitate outreach and
2 enrollment in such plans of Exchange-eligible indi-
3 viduals and employers described in section 302; and

4 (3) conduct such activities related to the Health
5 Insurance Exchange as required, including establish-
6 ment of a risk pooling mechanism under section 306
7 and consumer protections under subtitle D of title
8 II.

9 **SEC. 302. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOY-**
10 **ERS.**

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

17 (b) DEFINITIONS.—In this division:

18 (1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The
19 term “Exchange-eligible individual” means an indi-
20 vidual who is eligible under this section to be en-
21 rolled through the Health Insurance Exchange in an
22 Exchange-participating health benefits plan and,
23 with respect to family coverage, includes dependents
24 of such individual.

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

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

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

16 (1) FIRST YEAR.—In Y1 (as defined in section
17 100(c))—

18 (A) individuals described in subsection
19 (d)(1), including individuals described in sub-
20 section (d)(3); and

21 (B) smallest employers described in sub-
22 section (e)(1).

23 (2) SECOND YEAR.—In Y2—

24 (A) individuals and employers described in
25 paragraph (1); and

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

3 (3) THIRD AND SUBSEQUENT YEARS.—In Y3—

4 (A) individuals and employers described in
5 paragraph (2);

6 (B) small employers described in sub-
7 section (e)(3); and

8 (C) larger employers as permitted by the
9 Commissioner under subsection (e)(4).

10 (d) INDIVIDUALS.—

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

15 (A) is not enrolled in coverage described in
16 subparagraph (C) or (D) of paragraph (2); and

17 (B) is not enrolled in coverage as a full-
18 time employee (or as a dependent of such an
19 employee) under a group health plan if the cov-
20 erage and an employer contribution under the
21 plan meet the requirements of section 412.

22 For purposes of subparagraph (B), in the case of an
23 individual who is self-employed, who has at least 1
24 employee, and who meets the requirements of section

1 412, such individual shall be deemed a full-time em-
2 ployee described in such subparagraph.

3 (2) ACCEPTABLE COVERAGE.—For purposes of
4 this division, the term “acceptable coverage” means
5 any of the following:

6 (A) QUALIFIED HEALTH BENEFITS PLAN
7 COVERAGE.—Coverage under a qualified health
8 benefits plan.

9 (B) GRANDFATHERED HEALTH INSURANCE
10 COVERAGE; COVERAGE UNDER CURRENT GROUP
11 HEALTH PLAN.—Coverage under a grand-
12 fathered health insurance coverage (as defined
13 in subsection (a) of section 202) or under a
14 current group health plan (described in sub-
15 section (b) of such section).

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

18 (D) MEDICAID.—Coverage for medical as-
19 sistance under title XIX of the Social Security
20 Act, excluding such coverage that is only avail-
21 able because of the application of subsection
22 (u), (z), or (aa) of section 1902 of such Act.

23 (E) MEMBERS OF THE ARMED FORCES
24 AND DEPENDENTS (INCLUDING TRICARE).—
25 Coverage under chapter 55 of title 10, United

1 States Code, including similar coverage fur-
2 nished under section 1781 of title 38 of such
3 Code.

4 (F) VA.—Coverage under the veteran’s
5 health care program under chapter 17 of title
6 38, United States Code.

7 (G) OTHER COVERAGE.—Such other health
8 benefits coverage, such as a State health bene-
9 fits risk pool, as the Commissioner, in coordina-
10 tion with the Secretary of the Treasury, recog-
11 nizes for purposes of this paragraph.

12 The Commissioner shall make determinations under
13 this paragraph in coordination with the Secretary of
14 the Treasury.

15 (3) CONTINUING ELIGIBILITY PERMITTED.—

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

1 with an Exchange-participating health benefits
2 plan.

3 (B) EXCEPTIONS.—

4 (i) IN GENERAL.—Subparagraph (A)
5 shall not apply to an individual once the
6 individual becomes eligible for coverage—

7 (I) under part A of the Medicare
8 program;

9 (II) under the Medicaid program
10 as a Medicaid-eligible individual, ex-
11 cept as permitted under clause (ii); or

12 (III) in such other circumstances
13 as the Commissioner may provide.

14 (ii) TRANSITION PERIOD.—In the case
15 described in clause (i)(II), the Commis-
16 sioner shall permit the individual to con-
17 tinue treatment under subparagraph (A)
18 until such limited time as the Commis-
19 sioner determines it is administratively fea-
20 sible, consistent with minimizing disruption
21 in the individual's access to health care.

22 (4) TRANSITION FOR CHIP ELIGIBLES.—An in-
23 dividual who is eligible for child health assistance
24 under title XXI of the Social Security Act for a pe-

1 riod during Y1 shall not be an Exchange-eligible in-
2 dividual during such period.

3 (e) EMPLOYERS.—

4 (1) SMALLEST EMPLOYER.—Subject to para-
5 graph (5), smallest employers described in this para-
6 graph are employers with 25 or fewer employees.

7 (2) SMALLER EMPLOYERS.—Subject to para-
8 graph (5), smaller employers described in this para-
9 graph are employers that are not smallest employers
10 described in paragraph (1) and have 50 or fewer em-
11 ployees.

12 (3) SMALL EMPLOYERS.—Subject to paragraph
13 (5), small employers described in this paragraph are
14 employers that are not described in paragraph (1) or
15 (2) and have 100 or fewer employees.

16 (4) LARGER EMPLOYERS.—

17 (A) IN GENERAL.—Beginning with Y3, the
18 Commissioner may permit employers not de-
19 scribed in paragraph (1), (2), or (3) to be Ex-
20 change-eligible employers.

21 (B) PHASE-IN.—In applying subparagraph
22 (A), the Commissioner may phase-in the appli-
23 cation of such subparagraph based on the num-
24 ber of full-time employees of an employer and

1 such other considerations as the Commissioner
2 deems appropriate.

3 (5) CONTINUING ELIGIBILITY.—Once an em-
4 ployer is permitted to be an Exchange-eligible em-
5 ployer under this subsection and enrolls employees
6 through the Health Insurance Exchange, the em-
7 ployer shall continue to be treated as an Exchange-
8 eligible employer for each subsequent plan year re-
9 gardless of the number of employees involved unless
10 and until the employer meets the requirement of sec-
11 tion 411(a) through paragraph (1) of such section
12 by offering a group health plan and not through of-
13 fering an Exchange-participating health benefits
14 plan.

15 (6) EMPLOYER PARTICIPATION AND CONTRIBU-
16 TIONS.—

17 (A) SATISFACTION OF EMPLOYER RESPON-
18 SIBILITY.—For any year in which an employer
19 is an Exchange-eligible employer, such employer
20 may meet the requirements of section 412 with
21 respect to employees of such employer by offer-
22 ing such employees the option of enrolling with
23 Exchange-participating health benefits plans
24 through the Health Insurance Exchange con-

1 sistent with the provisions of subtitle B of title
2 IV.

3 (B) EMPLOYEE CHOICE.—Any employee
4 offered Exchange-participating health benefits
5 plans by the employer of such employee under
6 subparagraph (A) may choose coverage under
7 any such plan. That choice includes, with re-
8 spect to family coverage, coverage of the de-
9 pendents of such employee.

10 (7) AFFILIATED GROUPS.—Any employer which
11 is part of a group of employers who are treated as
12 a single employer under subsection (b), (c), (m), or
13 (o) of section 414 of the Internal Revenue Code of
14 1986 shall be treated, for purposes of this subtitle,
15 as a single employer.

16 (8) TREATMENT OF MULTI-EMPLOYER
17 PLANS.—The plan sponsor of a group health plan
18 (as defined in section 773(a) of the Employee Re-
19 tirement Income Security Act of 1974) that is a
20 multi-employer plan (as defined in section 3(37) of
21 such Act) may obtain health insurance coverage with
22 respect to participants in the plan through the Ex-
23 change to the same extent that an employer not de-
24 scribed in paragraph (1) or (2) is permitted by the
25 Commissioner to obtain health insurance coverage

1 through the Exchange as an Exchange-eligible em-
2 ployer.

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

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

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

21 (h) EXCHANGE ACCESS STUDY.—

22 (1) IN GENERAL.—The Commissioner shall con-
23 duct a study of access to the Health Insurance Ex-
24 change for individuals and for employers, including
25 individuals and employers who are not eligible and

1 enrolled in Exchange-participating health benefits
2 plans. The goal of the study is to determine if there
3 are significant groups and types of individuals and
4 employers who are not Exchange-eligible individuals
5 or employers, but who would have improved benefits
6 and affordability if made eligible for coverage in the
7 Exchange.

8 (2) ITEMS INCLUDED IN STUDY.—Such study
9 also shall examine—

10 (A) the terms, conditions, and affordability
11 of group health coverage offered by employers
12 and QHBP offering entities outside of the Ex-
13 change compared to Exchange-participating
14 health benefits plans; and

15 (B) the affordability-test standard for ac-
16 cess of certain employed individuals to coverage
17 in the Health Insurance Exchange.

18 (3) REPORT.—Not later than January 1 of Y3,
19 in Y6, and thereafter, the Commissioner shall sub-
20 mit to Congress a report on the study conducted
21 under this subsection and shall include in such re-
22 port recommendations regarding changes in stand-
23 ards for Exchange eligibility for individuals and em-
24 ployers.

1 **SEC. 303. BENEFITS PACKAGE LEVELS.**

2 (a) IN GENERAL.—The Commissioner shall specify
3 the benefits to be made available under Exchange-partici-
4 pating health benefits plans during each plan year, con-
5 sistent with subtitle C of title II and this section.

6 (b) LIMITATION ON HEALTH BENEFITS PLANS OF-
7 FERED BY OFFERING ENTITIES.—The Commissioner may
8 not enter into a contract with a QHBP offering entity
9 under section 304(c) for the offering of an Exchange-par-
10 ticipating health benefits plan in a service area unless the
11 following requirements are met:

12 (1) REQUIRED OFFERING OF BASIC PLAN.—The
13 entity offers only one basic plan for such service
14 area.

15 (2) OPTIONAL OFFERING OF ENHANCED
16 PLAN.—If and only if the entity offers a basic plan
17 for such service area, the entity may offer one en-
18 hanced plan for such area.

19 (3) OPTIONAL OFFERING OF PREMIUM PLAN.—
20 If and only if the entity offers an enhanced plan for
21 such service area, the entity may offer one premium
22 plan for such area.

23 (4) OPTIONAL OFFERING OF PREMIUM-PLUS
24 PLANS.—If and only if the entity offers a premium
25 plan for such service area, the entity may offer one
26 or more premium-plus plans for such area.

1 All such plans may be offered under a single contract with
2 the Commissioner.

3 (c) SPECIFICATION OF BENEFIT LEVELS FOR
4 PLANS.—

5 (1) IN GENERAL.—The Commissioner shall es-
6 tablish the following standards consistent with this
7 subsection and title II:

8 (A) BASIC, ENHANCED, AND PREMIUM
9 PLANS.—Standards for 3 levels of Exchange-
10 participating health benefits plans: basic, en-
11 hanced, and premium (in this division referred
12 to as a “basic plan”, “enhanced plan”, and
13 “premium plan”, respectively).

14 (B) PREMIUM-PLUS PLAN BENEFITS.—
15 Standards for additional benefits that may be
16 offered, consistent with this subsection and sub-
17 title C of title II, under a premium plan (such
18 a plan with additional benefits referred to in
19 this division as a “premium-plus plan”) .

20 (2) BASIC PLAN.—

21 (A) IN GENERAL.—A basic plan shall offer
22 the essential benefits package required under
23 title II for a qualified health benefits plan with
24 an actuarial value of 70 percent of the full ac-

1 tuarial value of the benefits provided under the
2 reference benefits package.

3 (B) TIERED COST-SHARING FOR AFFORD-
4 ABLE CREDIT ELIGIBLE INDIVIDUALS.—In the
5 case of an affordable credit eligible individual
6 (as defined in section 342(a)(1)) enrolled in an
7 Exchange-participating health benefits plan, the
8 benefits under a basic plan are modified to pro-
9 vide for the reduced cost-sharing for the income
10 tier applicable to the individual under section
11 324(c).

12 (3) ENHANCED PLAN.—An enhanced plan shall
13 offer, in addition to the level of benefits under the
14 basic plan, a lower level of cost-sharing as provided
15 under title II consistent with section 223(b)(5)(A).

16 (4) PREMIUM PLAN.—A premium plan shall
17 offer, in addition to the level of benefits under the
18 basic plan, a lower level of cost-sharing as provided
19 under title II consistent with section 223(b)(5)(B).

20 (5) PREMIUM-PLUS PLAN.—A premium-plus
21 plan is a premium plan that also provides additional
22 benefits, such as adult oral health and vision care,
23 approved by the Commissioner. The portion of the
24 premium that is attributable to such additional ben-
25 efits shall be separately specified.

1 (6) RANGE OF PERMISSIBLE VARIATION IN
2 COST-SHARING.—The Commissioner shall establish a
3 permissible range of variation of cost-sharing for
4 each basic, enhanced, and premium plan, except with
5 respect to any benefit for which there is no cost-
6 sharing permitted under the essential benefits pack-
7 age. Such variation shall permit a variation of not
8 more than plus (or minus) 10 percent in cost-shar-
9 ing with respect to each benefit category specified
10 under section 222. Nothing in this subtitle shall be
11 construed as prohibiting tiering in cost-sharing, in-
12 cluding through preferred and participating pro-
13 viders and prescription drugs. In applying this para-
14 graph, a health benefits plan may increase the cost-
15 sharing by 10 percent within each category or tier,
16 as applicable, and may decrease or eliminate cost-
17 sharing in any category or tier as compared to the
18 essential benefits package.

19 (d) TREATMENT OF STATE BENEFIT MANDATES.—
20 Insofar as a State requires a health insurance issuer offer-
21 ing health insurance coverage to include benefits beyond
22 the essential benefits package, such requirement shall con-
23 tinue to apply to an Exchange-participating health bene-
24 fits plan, if the State has entered into an arrangement
25 satisfactory to the Commissioner to reimburse the Com-

1 missioner for the amount of any net increase in afford-
2 ability premium credits under subtitle C as a result of an
3 increase in premium in basic plans as a result of applica-
4 tion of such requirement.

5 (e) RULES REGARDING COVERAGE OF AND AFFORD-
6 ABILITY CREDITS FOR SPECIFIED SERVICES.—

7 (1) ASSURED AVAILABILITY OF VARIED COV-
8 ERAGE THROUGH THE HEALTH INSURANCE EX-
9 CHANGE.—The Commissioner shall assure that, of
10 the Exchange participating health benefits plan of-
11 fered in each premium rating area of the Health In-
12 surance Exchange—

13 (A) there is at least one such plan that
14 provides coverage of services described in sub-
15 paragraphs (A) and (B) of section 222(d)(4);
16 and

17 (B) there is at least one such plan that
18 does not provide coverage of services described
19 in section 222(d)(4)(A) which plan may also be
20 one that does not provide coverage of services
21 described in section 222(d)(4)(B).

22 (2) SEGREGATION OF FUNDS.—If a qualified
23 health benefits plan provides coverage of services de-
24 scribed in section 222(d)(4)(A), the plan shall pro-

1 vide assurances satisfactory to the Commissioner
2 that—

3 (A) any affordability credits provided
4 under subtitle C of title II are not used for pur-
5 poses of paying for such services; and

6 (B) only premium amounts attributable to
7 the actuarial value described in section 213(b)
8 are used for such purpose.

9 **SEC. 304. CONTRACTS FOR THE OFFERING OF EXCHANGE-**
10 **PARTICIPATING HEALTH BENEFITS PLANS.**

11 (a) **CONTRACTING DUTIES.**—In carrying out section
12 301(b)(1) and consistent with this subtitle:

13 (1) **OFFERING ENTITY AND PLAN STAND-**
14 **ARDS.**—The Commissioner shall—

15 (A) establish standards necessary to imple-
16 ment the requirements of this title and title II
17 for—

18 (i) QHBP offering entities for the of-
19 fering of an Exchange-participating health
20 benefits plan; and

21 (ii) Exchange-participating health
22 benefits plans; and

23 (B) certify QHBP offering entities and
24 qualified health benefits plans as meeting such

1 standards and requirements of this title and
2 title II for purposes of this subtitle.

3 (2) SOLICITING AND NEGOTIATING BIDS; CON-
4 TRACTS.—

5 (A) BID SOLICITATION.—The Commis-
6 sioner shall solicit bids from QHBP offering en-
7 tities for the offering of Exchange-participating
8 health benefits plans. Such bids shall include
9 justification for proposed premiums.

10 (B) BID REVIEW AND NEGOTIATION.—The
11 Commissioner shall, based upon a review of
12 such bids including the premiums and their af-
13 fordability, negotiate with such entities for the
14 offering of such plans.

15 (C) DENIAL OF EXCESSIVE PREMIUMS.—
16 The Commissioner shall deny excessive pre-
17 miums and premium increases.

18 (D) CONTRACTS.—The Commissioner shall
19 enter into contracts with such entities for the
20 offering of such plans through the Health In-
21 surance Exchange under terms (consistent with
22 this title) negotiated between the Commissioner
23 and such entities.

24 (3) FEDERAL ACQUISITION REGULATION.—In
25 carrying out this subtitle, the Commissioner may

1 waive such provisions of the Federal Acquisition
2 Regulation that the Commissioner determines to be
3 inconsistent with the furtherance of this subtitle,
4 other than provisions relating to confidentiality of
5 information. Competitive procedures shall be used in
6 awarding contracts under this subtitle to the extent
7 that such procedures are consistent with this sub-
8 title.

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

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

18 (2) DATA REPORTING.—The entity shall pro-
19 vide for the reporting of such information as the
20 Commissioner may specify, including information
21 necessary to administer the risk pooling mechanism
22 described in section 306(b) and information to ad-
23 dress disparities in health and health care.

24 (3) AFFORDABILITY.—The entity shall provide
25 for affordable premiums.

1 (4) IMPLEMENTING AFFORDABILITY CRED-
2 ITS.—The entity shall provide for implementation of
3 the affordability credits provided for enrollees under
4 subtitle C, including the reduction in cost-sharing
5 under section 344(c).

6 (5) ENROLLMENT.—The entity shall accept all
7 enrollments under this subtitle, subject to such ex-
8 ceptions (such as capacity limitations) in accordance
9 with the requirements under title II for a qualified
10 health benefits plan. The entity shall notify the
11 Commissioner if the entity projects or anticipates
12 reaching such a capacity limitation that would result
13 in a limitation in enrollment.

14 (6) RISK POOLING PARTICIPATION.—The entity
15 shall participate in such risk pooling mechanism as
16 the Commissioner establishes under section 306(b).

17 (7) ESSENTIAL COMMUNITY PROVIDERS.—With
18 respect to the basic plan offered by the entity, the
19 entity shall include within the plan network those es-
20 sential community providers, where available, that
21 serve predominantly low-income, medically-under-
22 served individuals, such as health care providers de-
23 fined in section 340B(a)(4) of the Public Health
24 Service Act and providers described in section
25 1927(e)(1)(D)(i)(IV) of the Social Security Act (as

1 amended by section 221 of Public Law 111–8). The
2 Commissioner shall specify the extent to which and
3 manner in which the previous sentence shall apply in
4 the case of a basic plan with respect to which the
5 Commissioner determines provides substantially all
6 benefits through a health maintenance organization,
7 as defined in section 2791(b)(3) of the Public
8 Health Service Act. This paragraph shall not be con-
9 strued to require a basic plan to contract with a pro-
10 vider if such provider refuses to accept the generally
11 applicable payment rates of such plan.

12 (8) CULTURALLY AND LINGUISTICALLY APPRO-
13 PRIATE SERVICES AND COMMUNICATIONS.—The en-
14 tity shall provide for culturally and linguistically ap-
15 propriate communication and health services.

16 (9) SPECIAL RULES WITH RESPECT TO INDIAN
17 ENROLLEES AND INDIAN HEALTH CARE PRO-
18 VIDERS.—

19 (A) CHOICE OF PROVIDERS.—The entity
20 shall—

21 (i) demonstrate to the satisfaction of
22 the Commissioner that it has contracted
23 with a sufficient number of Indian health
24 care providers to ensure timely access to
25 covered services furnished by such pro-

1 viders to individual Indians through the
2 entity's Exchange-participating health ben-
3 efits plan; and

4 (ii) agree to pay Indian health care
5 providers, whether such providers are par-
6 ticipating or nonparticipating providers
7 with respect to the entity, for covered serv-
8 ices provided to those enrollees who are eli-
9 gible to receive services from such pro-
10 viders at a rate that is not less than the
11 level and amount of payment which the en-
12 tity would make for the services of a par-
13 ticipating provider which is not an Indian
14 health care provider.

15 (B) SPECIAL RULE RELATING TO INDIAN
16 HEALTH CARE PROVIDERS.—Provision of serv-
17 ices by an Indian health care provider exclu-
18 sively to Indians and their dependents shall not
19 constitute discrimination under this Act.

20 (10) PROGRAM INTEGRITY STANDARDS.—The
21 entity shall establish and operate a program to pro-
22 tect and promote the integrity of Exchange-partici-
23 pating health benefits plans it offers, in accordance
24 with standards and functions established by the
25 Commissioner.

1 (11) ADDITIONAL REQUIREMENTS.—The entity
2 shall comply with other applicable requirements of
3 this title, as specified by the Commissioner, which
4 shall include standards regarding billing and collec-
5 tion practices for premiums and related grace peri-
6 ods and which may include standards to ensure that
7 the entity does not use coercive practices to force
8 providers not to contract with other entities offering
9 coverage through the Health Insurance Exchange.

10 (c) CONTRACTS.—

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

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

21 (3) ENFORCEMENT OF NETWORK ADEQUACY.—
22 In the case of a health benefits plan of a QHBP of-
23 fering entity that uses a provider network, the con-
24 tract under this section with the entity shall provide
25 that if—

1 (A) the Commissioner determines that
2 such provider network does not meet such
3 standards as the Commissioner shall establish
4 under section 215; and

5 (B) an individual enrolled in such plan re-
6 ceives an item or service from a provider that
7 is not within such network;
8 then any cost-sharing for such item or service shall
9 be equal to the amount of such cost-sharing that
10 would be imposed if such item or service was fur-
11 nished by a provider within such network.

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

20 (A) GRIEVANCE AND COMPLAINT MECHA-
21 NISMS.—The Commissioner shall establish, in
22 coordination with State insurance regulators, a
23 process under which Exchange-eligible individ-
24 uals and employers may file complaints con-
25 cerning violations of such standards.

1 (B) ENFORCEMENT.—In carrying out au-
2 thorities under this division relating to the
3 Health Insurance Exchange, the Commissioner
4 may impose one or more of the intermediate
5 sanctions described in section 242(d).

6 (C) TERMINATION.—

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

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

24 (II) the Commissioner provides
25 the entity with reasonable notice and

1 opportunity for hearing (including the
2 right to appeal an initial decision) be-
3 fore terminating the contract.

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

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

19 (5) SPECIAL RULE RELATED TO COST-SHARING
20 AND INDIAN HEALTH CARE PROVIDERS.—The con-
21 tract under this section with a QHBP offering entity
22 for a health benefits plan shall provide that if an in-
23 dividual who is an Indian is enrolled in such a plan
24 and such individual receives a covered item or serv-
25 ice from an Indian health care provider (regardless

1 of whether such provider is in the plan's provider
2 network), the cost-sharing for such item or service
3 shall be equal to the amount of cost-sharing that
4 would be imposed if such item or service—

5 (A) had been furnished by another pro-
6 vider in the plan's provider network; or

7 (B) in the case that the plan has no such
8 network, was furnished by a non-Indian pro-
9 vider.

10 (6) NATIONAL PLAN.—Nothing in this section
11 shall be construed as preventing the Commissioner
12 from entering into a contract under this subsection
13 with a QHBP offering entity for the offering of a
14 health benefits plan with the same benefits in every
15 State so long as such entity is licensed to offer such
16 plan in each State and the benefits meet the applica-
17 ble requirements in each such State.

18 (d) NO DISCRIMINATION ON THE BASIS OF PROVI-
19 SION OF ABORTION.—No Exchange participating health
20 benefits plan may discriminate against any individual
21 health care provider or health care facility because of its
22 willingness or unwillingness to provide, pay for, provide
23 coverage of, or refer for abortions.

1 **SEC. 305. OUTREACH AND ENROLLMENT OF EXCHANGE-EL-**
2 **IGIBLE INDIVIDUALS AND EMPLOYERS IN EX-**
3 **CHANGE-PARTICIPATING HEALTH BENEFITS**
4 **PLAN.**

5 (a) IN GENERAL.—

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

17 (2) ELIGIBILITY.—The Commissioner shall
18 make timely determinations of whether individuals
19 and employers are Exchange-eligible individuals and
20 employers (as defined in section 302).

21 (3) ENROLLMENT.—The Commissioner shall es-
22 tablish and carry out an enrollment process for Ex-
23 change-eligible individuals and employers, including
24 at community locations, in accordance with sub-
25 section (b).

26 (b) ENROLLMENT PROCESS.—

1 (1) IN GENERAL.—The Commissioner shall es-
2 tablish a process consistent with this title for enroll-
3 ments in Exchange-participating health benefits
4 plans. Such process shall provide for enrollment
5 through means such as the mail, by telephone, elec-
6 tronically, and in person.

7 (2) ENROLLMENT PERIODS.—

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

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

- 1 (i) loses acceptable coverage;
- 2 (ii) experiences a change in marital or
3 other dependent status;
- 4 (iii) moves outside the service area of
5 the Exchange-participating health benefits
6 plan in which the individual is enrolled; or
- 7 (iv) experiences a significant change
8 in income.

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

17 (3) AUTOMATIC ENROLLMENT FOR NON-MED-
18 ICAID ELIGIBLE INDIVIDUALS.—

19 (A) IN GENERAL.—The Commissioner
20 shall provide for a process under which individ-
21 uals who are Exchange-eligible individuals de-
22 scribed in subparagraph (B) are automatically
23 enrolled under an appropriate Exchange-partici-
24 pating health benefits plan. Such process may
25 involve a random assignment or some other

1 form of assignment that takes into account the
2 health care providers used by the individual in-
3 volved or such other relevant factors as the
4 Commissioner may specify.

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

9 (i) AFFORDABILITY CREDIT ELIGIBLE
10 INDIVIDUALS.—The individual—

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

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

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

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

1 Exchange-participating health benefits
2 plan.

3 (4) DIRECT PAYMENT OF PREMIUMS TO
4 PLANS.—Under the enrollment process, individuals
5 enrolled in an Exchange-participating health benefits
6 plan shall pay such plans directly, and not through
7 the Commissioner or the Health Insurance Ex-
8 change.

9 (c) COVERAGE INFORMATION AND ASSISTANCE.—

10 (1) COVERAGE INFORMATION.—The Commis-
11 sioner shall provide for the broad dissemination of
12 information on Exchange-participating health bene-
13 fits plans offered under this title. Such information
14 shall be provided in a comparative manner, and shall
15 include information on benefits, premiums, cost-
16 sharing, quality, provider networks, and consumer
17 satisfaction.

18 (2) CONSUMER ASSISTANCE WITH CHOICE.—To
19 provide assistance to Exchange-eligible individuals
20 and employers, the Commissioner shall—

21 (A) provide for the operation of a toll-free
22 telephone hotline to respond to requests for as-
23 sistance and maintain an Internet Web site
24 through which individuals may obtain informa-

1 tion on coverage under Exchange-participating
2 health benefits plans and file complaints;

3 (B) develop and disseminate information to
4 Exchange-eligible enrollees on their rights and
5 responsibilities;

6 (C) assist Exchange-eligible individuals in
7 selecting Exchange-participating health benefits
8 plans and obtaining benefits through such
9 plans; and

10 (D) ensure that the Internet Web site de-
11 scribed in subparagraph (A) and the informa-
12 tion described in subparagraph (B) is developed
13 using plain language (as defined in section
14 233(a)(2)).

15 (3) USE OF OTHER ENTITIES.—In carrying out
16 this subsection, the Commissioner may work with
17 other appropriate entities to facilitate the dissemina-
18 tion of information under this subsection and to pro-
19 vide assistance as described in paragraph (2).

20 (d) COVERAGE FOR CERTAIN NEWBORNS UNDER
21 MEDICAID.—

22 (1) IN GENERAL.—In the case of a child born
23 in the United States who at the time of birth is not
24 otherwise covered under acceptable coverage, for the
25 period of time beginning on the date of birth and

1 ending on the date the child otherwise is covered
2 under acceptable coverage (or, if earlier, the end of
3 the month in which the 60-day period, beginning on
4 the date of birth, ends), the child shall be deemed—

5 (A) to be a Medicaid eligible individual for
6 purposes of this division and Medicaid; and

7 (B) to be automatically enrolled in Med-
8 icaid as a traditional Medicaid eligible indi-
9 vidual (as defined in section 1943(c) of the So-
10 cial Security Act).

11 (2) EXTENDED TREATMENT AS MEDICAID ELI-
12 GIBLE INDIVIDUAL.—In the case of a child described
13 in paragraph (1) who at the end of the period re-
14 ferred to in such paragraph is not otherwise covered
15 under acceptable coverage, the child shall be deemed
16 (until such time as the child obtains such coverage
17 or the State otherwise makes a determination of the
18 child's eligibility for medical assistance under its
19 Medicaid plan pursuant to section 1943(b)(1) of the
20 Social Security Act) to be a Medicaid eligible indi-
21 vidual described in section 1902(l)(1)(B) of such
22 Act.

23 (e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE
24 INDIVIDUALS.—

1 (1) MEDICAID ENROLLMENT OBLIGATION.—An
2 individual may apply, in the manner described in
3 section 341(b)(1), for a determination of whether
4 the individual is a Medicaid-eligible individual. If the
5 individual is determined to be so eligible, the Com-
6 missioner, through the Medicaid memorandum of
7 understanding under paragraph (2), shall provide
8 for the enrollment of the individual under the State
9 Medicaid plan in accordance with such memorandum
10 of understanding. In the case of such an enrollment,
11 the State shall provide for the same periodic redeter-
12 mination of eligibility under Medicaid as would oth-
13 erwise apply if the individual had directly applied for
14 medical assistance to the State Medicaid agency.

15 (2) COORDINATED ENROLLMENT WITH STATE
16 THROUGH MEMORANDUM OF UNDERSTANDING.—
17 The Commissioner, in consultation with the Sec-
18 retary of Health and Human Services, shall enter
19 into a memorandum of understanding with each
20 State with respect to coordinating enrollment of in-
21 dividuals in Exchange-participating health benefits
22 plans and under the State's Medicaid program con-
23 sistent with this section and to otherwise coordinate
24 the implementation of the provisions of this division
25 with respect to the Medicaid program. Such memo-

1 random shall permit the exchange of information
2 consistent with the limitations described in section
3 1902(a)(7) of the Social Security Act. Nothing in
4 this section shall be construed as permitting such
5 memorandum to modify or vitiate any requirement
6 of a State Medicaid plan.

7 (f) EFFECTIVE CULTURALLY AND LINGUISTICALLY
8 APPROPRIATE COMMUNICATION.—In carrying out this
9 section, the Commissioner shall establish effective methods
10 for communicating in plain language and a culturally and
11 linguistically appropriate manner.

12 (g) ROLE FOR ENROLLMENT AGENTS AND BRO-
13 KERS.—Nothing in this division shall be construed to af-
14 fect the role of enrollment agents and brokers under State
15 law, including with regard to the enrollment of individuals
16 and employers in qualified health benefits plans including
17 the public health insurance option.

18 (h) ASSISTANCE FOR SMALL EMPLOYERS.—

19 (1) IN GENERAL.—The Commissioner, in con-
20 sultation with the Small Business Administration,
21 shall establish and carry out a program to provide
22 to small employers counseling and technical assist-
23 ance with respect to the provision of health insur-
24 ance to employees of such employers through the
25 Health Insurance Exchange.

1 (2) DUTIES.—The program established under
2 paragraph (1) shall include the following services:

3 (A) Educational activities to increase
4 awareness of the Health Insurance Exchange
5 and available small employer health plan op-
6 tions.

7 (B) Distribution of information to small
8 employers with respect to the enrollment and
9 selection process for health plans available
10 under the Health Insurance Exchange, includ-
11 ing standardized comparative information on
12 the health plans available under the Health In-
13 surance Exchange.

14 (C) Distribution of information to small
15 employers with respect to available affordability
16 credits or other financial assistance.

17 (D) Referrals to appropriate entities of
18 complaints and questions relating to the Health
19 Insurance Exchange.

20 (E) Enrollment and plan selection assist-
21 ance for employers with respect to the Health
22 Insurance Exchange.

23 (F) Responses to questions relating to the
24 Health Insurance Exchange and the program
25 established under paragraph (1).

1 (3) AUTHORITY TO PROVIDE SERVICES DI-
2 RECTLY OR BY CONTRACT.—The Commissioner may
3 provide services under paragraph (2) directly or by
4 contract with nonprofit entities that the Commis-
5 sioner determines capable of carrying out such serv-
6 ices.

7 (4) SMALL EMPLOYER DEFINED.—In this sub-
8 section, the term “small employer” means an em-
9 ployer with less than 100 employees.

10 (i) PARTICIPATION OF SMALL EMPLOYER BENEFIT
11 ARRANGEMENTS.—

12 (1) IN GENERAL.—The Commissioner may
13 enter into contracts with small employer benefit ar-
14 rangements to provide consumer information, out-
15 reach, and assistance in the enrollment of small em-
16 ployers (and their employees) who are members of
17 such an arrangement under Exchange participating
18 health benefits plans.

19 (2) SMALL EMPLOYER BENEFIT ARRANGEMENT
20 DEFINED.—In this subsection, the term “small em-
21 ployer benefit arrangement” means a not-for-profit
22 agricultural or other cooperative that—

23 (A) consists solely of its members and is
24 operated for the primary purpose of providing
25 affordable employee benefits to its members;

1 (B) only has as members small employers
2 in the same industry or line of business;

3 (C) has no member that has more than a
4 5 percent voting interest in the cooperative; and

5 (D) is governed by a board of directors
6 elected by its members.

7 **SEC. 306. OTHER FUNCTIONS.**

8 (a) COORDINATION OF AFFORDABILITY CREDITS.—

9 The Commissioner shall coordinate the distribution of af-
10 fordability premium and cost-sharing credits under sub-
11 title C to QHBP offering entities offering Exchange-par-
12 ticipating health benefits plans.

13 (b) COORDINATION OF RISK POOLING.—The Com-

14 missioner shall establish a mechanism whereby there is an

15 adjustment made of the premium amounts payable among

16 QHBP offering entities offering Exchange-participating

17 health benefits plans of premiums collected for such plans

18 that takes into account (in a manner specified by the Com-

19 missioner) the differences in the risk characteristics of in-

20 dividuals and employees enrolled under the different Ex-

21 change-participating health benefits plans offered by such

22 entities so as to minimize the impact of adverse selection

23 of enrollees among the plans offered by such entities. For

24 purposes of the previous sentence, the Commissioner may

25 utilize data regarding enrollee demographics, inpatient

1 and outpatient diagnoses (in a similar manner as such
2 data are used under parts C and D of title XVIII of the
3 Social Security Act), and such other information as the
4 Secretary determines may be necessary, such as the actual
5 medical costs of enrollees during the previous year.

6 **SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND.**

7 (a) ESTABLISHMENT OF HEALTH INSURANCE EX-
8 CHANGE TRUST FUND.—There is created within the
9 Treasury of the United States a trust fund to be known
10 as the “Health Insurance Exchange Trust Fund” (in this
11 section referred to as the “Trust Fund”), consisting of
12 such amounts as may be appropriated or credited to the
13 Trust Fund under this section or any other provision of
14 law.

15 (b) PAYMENTS FROM TRUST FUND.—The Commis-
16 sioner shall pay from time to time from the Trust Fund
17 such amounts as the Commissioner determines are nec-
18 essary to make payments to operate the Health Insurance
19 Exchange, including payments under subtitle C (relating
20 to affordability credits).

21 (c) TRANSFERS TO TRUST FUND.—

22 (1) DEDICATED PAYMENTS.—There are hereby
23 appropriated to the Trust Fund amounts equivalent
24 to the following:

1 (A) TAXES ON INDIVIDUALS NOT OBTAIN-
2 ING ACCEPTABLE COVERAGE.—The amounts re-
3 ceived in the Treasury under section 59B of the
4 Internal Revenue Code of 1986 (relating to re-
5 quirement of health insurance coverage for indi-
6 viduals).

7 (B) EMPLOYMENT TAXES ON EMPLOYERS
8 NOT PROVIDING ACCEPTABLE COVERAGE.—The
9 amounts received in the Treasury under sec-
10 tions 3111(c) and 3221(c) of the Internal Rev-
11 enue Code of 1986 (relating to employers elect-
12 ing to not provide health benefits).

13 (C) EXCISE TAX ON FAILURES TO MEET
14 CERTAIN HEALTH COVERAGE REQUIRE-
15 MENTS.—The amounts received in the Treasury
16 under section 4980H(b) (relating to excise tax
17 with respect to failure to meet health coverage
18 participation requirements).

19 (2) APPROPRIATIONS TO COVER GOVERNMENT
20 CONTRIBUTIONS.—There are hereby appropriated,
21 out of any moneys in the Treasury not otherwise ap-
22 propriated, to the Trust Fund, an amount equivalent
23 to the amount of payments made from the Trust
24 Fund under subsection (b) plus such amounts as are

1 necessary reduced by the amounts deposited under
2 paragraph (1).

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

7 **SEC. 308. OPTIONAL OPERATION OF STATE-BASED HEALTH**
8 **INSURANCE EXCHANGES.**

9 (a) IN GENERAL.—If—

10 (1) a State (or group of States, subject to the
11 approval of the Commissioner) applies to the Com-
12 missioner for approval of a State-based Health In-
13 surance Exchange to operate in the State (or group
14 of States); and

15 (2) the Commissioner approves such State-
16 based Health Insurance Exchange,

17 then, subject to subsections (c) and (d), the State-based
18 Health Insurance Exchange shall operate, instead of the
19 Health Insurance Exchange, with respect to such State
20 (or group of States). The Commissioner shall approve a
21 State-based Health Insurance Exchange if it meets the re-
22 quirements for approval under subsection (b).

23 (b) REQUIREMENTS FOR APPROVAL.—

24 (1) IN GENERAL.—The Commissioner may not
25 approve a State-based Health Insurance Exchange

1 under this section unless the following requirements
2 are met:

3 (A) The State-based Health Insurance Ex-
4 change must demonstrate the capacity to and
5 provide assurances satisfactory to the Commis-
6 sioner that the State-based Health Insurance
7 Exchange will carry out the functions specified
8 for the Health Insurance Exchange in the State
9 (or States) involved, including—

10 (i) negotiating and contracting with
11 QHBP offering entities for the offering of
12 Exchange-participating health benefits
13 plans, which satisfy the standards and re-
14 quirements of this title and title II;

15 (ii) enrolling Exchange-eligible indi-
16 viduals and employers in such State in
17 such plans;

18 (iii) the establishment of sufficient
19 local offices to meet the needs of Ex-
20 change-eligible individuals and employers;

21 (iv) administering affordability credits
22 under subtitle B using the same meth-
23 odologies (and at least the same income
24 verification methods) as would otherwise
25 apply under such subtitle and at a cost to

1 the Federal Government which does exceed
2 the cost to the Federal Government if this
3 section did not apply; and

4 (v) enforcement activities consistent
5 with Federal requirements.

6 (B) There is no more than one Health In-
7 surance Exchange operating with respect to any
8 one State.

9 (C) The State provides assurances satisfac-
10 tory to the Commissioner that approval of such
11 an Exchange will not result in any net increase
12 in expenditures to the Federal Government.

13 (D) The State provides for reporting of
14 such information as the Commissioner deter-
15 mines and assurances satisfactory to the Com-
16 missioner that it will vigorously enforce viola-
17 tions of applicable requirements.

18 (E) Such other requirements as the Com-
19 missioner may specify.

20 (2) PRESUMPTION FOR CERTAIN STATE-OPER-
21 ATED EXCHANGES.—

22 (A) IN GENERAL.—In the case of a State
23 operating an Exchange prior to January 1,
24 2010, that seeks to operate the State-based
25 Health Insurance Exchange under this section,

1 the Commissioner shall presume that such Ex-
2 change meets the standards under this section
3 unless the Commissioner determines, after com-
4 pletion of the process established under sub-
5 paragraph (B), that the Exchange does not
6 comply with such standards.

7 (B) PROCESS.—The Commissioner shall
8 establish a process to work with a State de-
9 scribed in subparagraph (A) to provide assist-
10 ance necessary to assure that the State’s Ex-
11 change comes into compliance with the stand-
12 ards for approval under this section.

13 (c) CEASING OPERATION.—

14 (1) IN GENERAL.—A State-based Health Insur-
15 ance Exchange may, at the option of each State in-
16 volved, and only after providing timely and reason-
17 able notice to the Commissioner, cease operation as
18 such an Exchange, in which case the Health Insur-
19 ance Exchange shall operate, instead of such State-
20 based Health Insurance Exchange, with respect to
21 such State (or States).

22 (2) TERMINATION; HEALTH INSURANCE EX-
23 CHANGE RESUMPTION OF FUNCTIONS.—The Com-
24 missioner may terminate the approval (for some or
25 all functions) of a State-based Health Insurance Ex-

1 change under this section if the Commissioner deter-
2 mines that such Exchange no longer meets the re-
3 quirements of subsection (b) or is no longer capable
4 of carrying out such functions in accordance with
5 the requirements of this subtitle. In lieu of termi-
6 nating such approval, the Commissioner may tempo-
7 rarily assume some or all functions of the State-
8 based Health Insurance Exchange until such time as
9 the Commissioner determines the State-based
10 Health Insurance Exchange meets such require-
11 ments of subsection (b) and is capable of carrying
12 out such functions in accordance with the require-
13 ments of this subtitle.

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

18 (d) RETENTION OF AUTHORITY.—

19 (1) AUTHORITY RETAINED.—Enforcement au-
20 thorities of the Commissioner shall be retained by
21 the Commissioner.

22 (2) DISCRETION TO RETAIN ADDITIONAL AU-
23 THORITY.—The Commissioner may specify functions
24 of the Health Insurance Exchange that—

1 (A) may not be performed by a State-
2 based Health Insurance Exchange under this
3 section; or

4 (B) may be performed by the Commis-
5 sioner and by such a State-based Health Insur-
6 ance Exchange.

7 (e) REFERENCES.—In the case of a State-based
8 Health Insurance Exchange, except as the Commissioner
9 may otherwise specify under subsection (d), any references
10 in this subtitle to the Health Insurance Exchange or to
11 the Commissioner in the area in which the State-based
12 Health Insurance Exchange operates shall be deemed a
13 reference to the State-based Health Insurance Exchange
14 and the head of such Exchange, respectively.

15 (f) FUNDING.—In the case of a State-based Health
16 Insurance Exchange, there shall be assistance provided for
17 the operation of such Exchange in the form of a matching
18 grant with a State share of expenditures required.

19 **SEC. 309. INTERSTATE HEALTH INSURANCE COMPACTS.**

20 (a) IN GENERAL.—Effective January 1, 2015, 2 or
21 more States may form Health Care Choice Compacts (in
22 this section referred to as “compacts”) to facilitate the
23 purchase of individual health insurance coverage across
24 State lines.

1 (b) MODEL GUIDELINES.—The Secretary of Health
2 and Human Services (in this section referred to as the
3 “Secretary”) shall request the National Association of In-
4 surance Commissioners (in this section referred to as
5 “NAIC”) to develop model guidelines for the creation of
6 compacts. In developing such guidelines, the NAIC shall
7 consult with consumers, health insurance issuers, the Sec-
8 retary, and other interested parties. Such guidelines
9 shall—

10 (1) provide for the sale of health insurance cov-
11 erage to residents of all compacting States subject to
12 the laws and regulations of a primary State des-
13 igned by the health insurance issuer;

14 (2) require health insurance issuers issuing
15 health insurance coverage in secondary States to
16 maintain licensure in every such State;

17 (3) preserve the authority of the State of an in-
18 dividual’s residence to address—

19 (A) market conduct;

20 (B) unfair trade practices;

21 (C) network adequacy;

22 (D) consumer protection standards;

23 (E) grievance and appeals;

24 (F) fair claims payment requirements; and

25 (G) prompt payment of claims;

1 (4) permit State insurance commissioners and
2 other State agencies in secondary States access to
3 the records of a health insurance issuer to the same
4 extent as if the policy were written in that State;
5 and

6 (5) provide for clear and conspicuous disclosure
7 to consumers that the policy may not be subject to
8 all the laws and regulations of the State in which
9 the purchaser resides.

10 (c) REQUIRED CONSIDERATION.—If model guidelines
11 developed under subsection (b) are submitted to the Sec-
12 retary by January 1, 2013, the Secretary shall issue them
13 as regulations. If the NAIC fails to submit such model
14 guidelines by such date, the Secretary shall, no later than
15 October 1, 2013, develop and promulgate the regulations
16 implementing model guidelines described in subsection (b).

17 (d) NO REQUIREMENT TO COMPACT.—Nothing in
18 this section shall be construed to require a State to join
19 a compact.

20 (e) STATE AUTHORITY.—A State may not enter into
21 a compact under this subsection unless the State enacts
22 a law after the date of enactment of this Act that specifi-
23 cally authorizes the State to enter into such compact.

24 (f) CONSUMER PROTECTIONS.—If a State enters into
25 a compact it must retain responsibility for the consumer

1 protections of its residents and its residents retain the
2 right to bring a claim in a State court in the State in
3 which the resident resides.

4 (g) ASSISTANCE TO COMPACTING STATES.—

5 (1) IN GENERAL.—Beginning January 1, 2015,
6 the Secretary shall make awards, from amounts ap-
7 propriated under paragraph (5), to States in the
8 amount specified in paragraph (2) for the uses de-
9 scribed in paragraph (3).

10 (2) AMOUNT SPECIFIED.—

11 (A) IN GENERAL.—For each fiscal year,
12 the Secretary shall determine the total amount
13 that the Secretary will make available for
14 grants under this subsection.

15 (B) STATE AMOUNT.—For each State that
16 is awarded a grant under paragraph (1), the
17 amount of such grants shall be based on a for-
18 mula established by the Secretary, not to exceed
19 \$1 million per State, under which States shall
20 receive an award in the amount that is based
21 on the following two components:

22 (i) A minimum amount for each
23 State.

24 (ii) An additional amount based on
25 population of the State.

1 (3) USE OF FUNDS.—A State shall use
2 amounts awarded under this subsection for activities
3 (including planning activities) related regulating
4 health insurance coverage sold in secondary States.

5 (4) RENEWABILITY OF GRANT.—The Secretary
6 may renew a grant award under paragraph (1) if the
7 State receiving the grant continues to be a member
8 of a compact.

9 (5) AUTHORIZATION OF APPROPRIATIONS.—
10 There are authorized to be appropriated such sums
11 as may be necessary to carry out this subsection in
12 each of fiscal years 2015 through 2020.

13 **SEC. 310. HEALTH INSURANCE COOPERATIVES.**

14 (a) ESTABLISHMENT.—Not later than 6 months after
15 the date of the enactment of this Act, the Commissioner,
16 in consultation with the Secretary of the Treasury, shall
17 establish a Consumer Operated and Oriented Plan pro-
18 gram (in this section referred to as the “CO-OP pro-
19 gram”) under which the Commissioner may make grants
20 and loans for the establishment and initial operation of
21 not-for-profit, member-run health insurance cooperatives
22 (in this section individually referred to as a “cooperative”)
23 that provide insurance through the Health Insurance Ex-
24 change or a State-based Health Insurance Exchange

1 under section 308. Nothing in this section shall be con-
2 strued as requiring a State to establish such a cooperative.

3 (b) START-UP AND SOLVENCY GRANTS AND
4 LOANS.—

5 (1) IN GENERAL.—Not later than 36 months
6 after the date of the enactment of this Act, the
7 Commissioner, acting through the CO-OP program,
8 may make—

9 (A) loans (of such period and with such
10 terms as the Secretary may specify) to coopera-
11 tives to assist such cooperatives with start-up
12 costs; and

13 (B) grants to cooperatives to assist such
14 cooperatives in meeting State solvency require-
15 ments in the States in which such cooperative
16 offers or issues insurance coverage.

17 (2) CONDITIONS.—A grant or loan may not be
18 awarded under this subsection with respect to a co-
19 operative unless the following conditions are met:

20 (A) The cooperative is structured as a not-
21 for-profit, member organization under the law
22 of each State in which such cooperative offers,
23 intends to offer, or issues insurance coverage,
24 with the membership of the cooperative being

1 made up entirely of beneficiaries of the insur-
2 ance coverage offered by such cooperative.

3 (B) The cooperative did not offer insur-
4 ance on or before July 16, 2009, and the coop-
5 erative is not an affiliate or successor to an in-
6 surance company offering insurance on or be-
7 fore such date.

8 (C) The governing documents of the coop-
9 erative incorporate ethical and conflict of inter-
10 est standards designed to protect against insur-
11 ance industry involvement and interference in
12 the governance of the cooperative.

13 (D) The cooperative is not sponsored by a
14 State government.

15 (E) Substantially all of the activities of the
16 cooperative consist of the issuance of qualified
17 health benefits plans through the Health Insur-
18 ance Exchange or a State-based health insur-
19 ance exchange.

20 (F) The cooperative is licensed to offer in-
21 surance in each State in which it offers insur-
22 ance.

23 (G) The governance of the cooperative
24 must be subject to a majority vote of its mem-
25 bers.

1 (H) As provided in guidance issued by the
2 Secretary of Health and Human Services, the
3 cooperative operates with a strong consumer
4 focus, including timeliness, responsiveness, and
5 accountability to members.

6 (I) Any profits made by the cooperative
7 are used to lower premiums, improve benefits,
8 or to otherwise improve the quality of health
9 care delivered to members.

10 (3) PRIORITY.—The Commissioner, in making
11 grants and loans under this subsection, shall give
12 priority to cooperatives that—

13 (A) operate on a statewide basis;

14 (B) use an integrated delivery system; or

15 (C) have a significant level of financial
16 support from nongovernmental sources.

17 (4) RULES OF CONSTRUCTION.—Nothing in
18 this section shall be construed to prevent a coopera-
19 tive established in one State from integrating with a
20 cooperative established in another State the adminis-
21 tration, issuance of coverage, or other activities re-
22 lated to acting as a QHBP offering entity. Nothing
23 in this section shall be construed as preventing State
24 governments from taking actions to permit such in-
25 tegration.

1 (5) AMORTIZATION OF GRANTS AND LOANS.—

2 The Secretary shall provide for the repayment of
3 grants or loans provided under this subsection to the
4 Treasury in an amortized manner over a 10-year pe-
5 riod.

6 (6) REPAYMENT FOR VIOLATIONS OF TERMS OF

7 PROGRAM.—If a cooperative violates the terms of the
8 CO-OP program and fails to correct the violation
9 within a reasonable period of time, as determined by
10 the Commissioner, the cooperative shall repay the
11 total amount of any loan or grant received by such
12 cooperative under this section, plus interest (at a
13 rate determined by the Secretary).

14 (7) AUTHORIZATION OF APPROPRIATIONS.—

15 There is authorized to be appropriated
16 \$5,000,000,000 for the period of fiscal years 2010
17 through 2014 to provide for grants and loans under
18 this subsection.

19 (c) DEFINITIONS.—For purposes of this section:

20 (1) STATE.—The term “State” means each of
21 the 50 States and the District of Columbia.

22 (2) MEMBER.—The term “member”, with re-
23 spect to a cooperative, means an individual who,
24 after the cooperative offers health insurance cov-
25 erage, is enrolled in such coverage.

1 **SEC. 311. RETENTION OF DOD AND VA AUTHORITY.**

2 Nothing in this subtitle shall be construed as affect-
3 ing any authority under title 38, United States Code, or
4 chapter 55 of title 10, United States Code.

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

7 **SEC. 321. ESTABLISHMENT AND ADMINISTRATION OF A**
8 **PUBLIC HEALTH INSURANCE OPTION AS AN**
9 **EXCHANGE-QUALIFIED HEALTH BENEFITS**
10 **PLAN.**

11 (a) **ESTABLISHMENT.**—For years beginning with Y1,
12 the Secretary of Health and Human Services (in this sub-
13 title referred to as the “Secretary”) shall provide for the
14 offering of an Exchange-participating health benefits plan
15 (in this division referred to as the “public health insurance
16 option”) that ensures choice, competition, and stability of
17 affordable, high quality coverage throughout the United
18 States in accordance with this subtitle. In designing the
19 option, the Secretary’s primary responsibility is to create
20 a low-cost plan without compromising quality or access to
21 care.

22 (b) **OFFERING AS AN EXCHANGE-PARTICIPATING**
23 **HEALTH BENEFITS PLAN.**—

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

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

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

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

12 (B) may offer premium-plus plans.

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

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

7 (e) DATA COLLECTION.—The Secretary shall collect
8 such data as may be required to establish premiums and
9 payment rates for the public health insurance option and
10 for other purposes under this subtitle, including to im-
11 prove quality and to reduce racial, ethnic, and other dis-
12 parities in health and health care. Nothing in this subtitle
13 may be construed as authorizing the Secretary (or any em-
14 ployee or contractor) to create or maintain lists of non-
15 medical personal property.

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

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

1 and individuals enrolled under such option under this title
2 in the same manner as such provisions apply to Medicare
3 and Medicare beneficiaries.

4 **SEC. 322. PREMIUMS AND FINANCING.**

5 (a) ESTABLISHMENT OF PREMIUMS.—

6 (1) IN GENERAL.—The Secretary shall establish
7 geographically adjusted premium rates for the public
8 health insurance option—

9 (A) in a manner that complies with the
10 premium rules established by the Commissioner
11 under section 213 for Exchange-participating
12 health benefits plans; and

13 (B) at a level sufficient to fully finance the
14 costs of—

15 (i) health benefits provided by the
16 public health insurance option; and

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

19 (2) CONTINGENCY MARGIN.—In establishing
20 premium rates under paragraph (1), the Secretary
21 shall include an appropriate amount for a contin-
22 gency margin (which shall be not less than 90 days
23 of estimated claims). Before setting such appropriate
24 amount for years starting with Y3, the Secretary

1 shall solicit a recommendation on such amount from
2 the American Academy of Actuaries.

3 (b) ACCOUNT.—

4 (1) ESTABLISHMENT.—There is established in
5 the Treasury of the United States an Account for
6 the receipts and disbursements attributable to the
7 operation of the public health insurance option, in-
8 cluding the start-up funding under paragraph (2).
9 Section 1854(g) of the Social Security Act shall
10 apply to receipts described in the previous sentence
11 in the same manner as such section applies to pay-
12 ments or premiums described in such section.

13 (2) START-UP FUNDING.—

14 (A) IN GENERAL.—In order to provide for
15 the establishment of the public health insurance
16 option, there is hereby appropriated to the Sec-
17 retary, out of any funds in the Treasury not
18 otherwise appropriated, \$2,000,000,000. In
19 order to provide for initial claims reserves be-
20 fore the collection of premiums, there are here-
21 by appropriated to the Secretary, out of any
22 funds in the Treasury not otherwise appro-
23 priated, such sums as necessary to cover 90
24 days worth of claims reserves based on pro-
25 jected enrollment.

1 (B) AMORTIZATION OF START-UP FUND-
2 ING.—The Secretary shall provide for the re-
3 payment of the startup funding provided under
4 subparagraph (A) to the Treasury in an amor-
5 tized manner over the 10-year period beginning
6 with Y1.

7 (C) LIMITATION ON FUNDING.—Nothing in
8 this section shall be construed as authorizing
9 any additional appropriations to the Account,
10 other than such amounts as are otherwise pro-
11 vided with respect to other Exchange-partici-
12 pating health benefits plans.

13 (3) NO BAILOUTS.—In no case shall the public
14 health insurance option receive any Federal funds
15 for purposes of insolvency in any manner similar to
16 the manner in which entities receive Federal funding
17 under the Troubled Assets Relief Program of the
18 Secretary of the Treasury.

19 **SEC. 323. PAYMENT RATES FOR ITEMS AND SERVICES.**

20 (a) NEGOTIATION OF PAYMENT RATES.—

21 (1) IN GENERAL.—The Secretary shall nego-
22 tiate payment for the public health insurance option
23 for health care providers and items and services, in-
24 cluding prescription drugs, consistent with this sec-
25 tion and section 324.

1 (2) MANNER OF NEGOTIATION.—The Secretary
2 shall negotiate such rates in a manner that results
3 in payment rates that are not lower, in the aggregate,
4 than rates under title XVIII of the Social Security
5 Act, and not higher, in the aggregate, than
6 the average rates paid by other QHBP offering entities
7 for services and health care providers.

8 (3) INNOVATIVE PAYMENT METHODS.—Nothing
9 in this subsection shall be construed as preventing
10 the use of innovative payment methods such as those
11 described in section 324 in connection with the negotiation
12 of payment rates under this subsection.

13 (b) ESTABLISHMENT OF A PROVIDER NETWORK.—

14 (1) IN GENERAL.—Health care providers (including
15 physicians and hospitals) participating in
16 Medicare are participating providers in the public
17 health insurance option unless they opt out in a
18 process established by the Secretary consistent with
19 this subsection.

20 (2) REQUIREMENTS FOR OPT-OUT PROCESS.—

21 Under the process established under paragraph

22 (1)—

23 (A) providers described in such paragraph
24 shall be provided at least a 1-year period prior

1 to the first day of Y1 to opt out of participating
2 in the public health insurance option;

3 (B) no provider shall be subject to a pen-
4 alty for not participating in the public health
5 insurance option;

6 (C) the Secretary shall include information
7 on how providers participating in Medicare who
8 chose to opt out of participating in the public
9 health insurance option may opt back in; and

10 (D) there shall be an annual enrollment
11 period in which providers may decide whether
12 to participate in the public health insurance op-
13 tion.

14 (3) RULEMAKING.—Not later than 18 months
15 before the first day of Y1, the Secretary shall pro-
16 mulgate rules (pursuant to notice and comment) for
17 the process described in paragraph (1).

18 (c) LIMITATIONS ON REVIEW.—There shall be no ad-
19 ministrative or judicial review of a payment rate or meth-
20 odology established under this section or under section
21 324.

22 **SEC. 324. MODERNIZED PAYMENT INITIATIVES AND DELIV-**
23 **ERY SYSTEM REFORM.**

24 (a) IN GENERAL.—For plan years beginning with Y1,
25 the Secretary may utilize innovative payment mechanisms

1 and policies to determine payments for items and services
2 under the public health insurance option. The payment
3 mechanisms and policies under this section may include
4 patient-centered medical home and other care manage-
5 ment payments, accountable care organizations, value-
6 based purchasing, bundling of services, differential pay-
7 ment rates, performance or utilization based payments,
8 partial capitation, and direct contracting with providers.

9 (b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—
10 The Secretary shall design and implement the payment
11 mechanisms and policies under this section in a manner
12 that—

13 (1) seeks to—

14 (A) improve health outcomes;

15 (B) reduce health disparities (including ra-
16 cial, ethnic, and other disparities);

17 (C) provide efficient and affordable care;

18 (D) address geographic variation in the
19 provision of health services; or

20 (E) prevent or manage chronic illness; and

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

23 (c) ENCOURAGING THE USE OF HIGH VALUE SERV-
24 ICES.—To the extent allowed by the benefit standards ap-
25 plied to all Exchange-participating health benefits plans,

1 the public health insurance option may modify cost-shar-
2 ing and payment rates to encourage the use of services
3 that promote health and value.

4 (d) PROMOTION OF DELIVERY SYSTEM REFORM.—

5 The Secretary shall monitor and evaluate the progress of
6 payment and delivery system reforms under this Act and
7 shall seek to implement such reforms subject to the fol-
8 lowing:

9 (1) To the extent that the Secretary finds a
10 payment and delivery system reform successful in
11 improving quality and reducing costs, the Secretary
12 shall implement such reform on as large a geo-
13 graphic scale as practical and economical.

14 (2) The Secretary may delay the implementa-
15 tion of such a reform in geographic areas in which
16 such implementation would place the public health
17 insurance option at a competitive disadvantage.

18 (3) The Secretary may prioritize implementa-
19 tion of such a reform in high cost geographic areas
20 or otherwise in order to reduce total program costs
21 or to promote high value care.

22 (e) NON-UNIFORMITY PERMITTED.—Nothing in this
23 subtitle shall prevent the Secretary from varying payments
24 based on different payment structure models (such as ac-
25 countable care organizations and medical homes) under

1 the public health insurance option for different geographic
2 areas.

3 **SEC. 325. PROVIDER PARTICIPATION.**

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

7 (b) LICENSURE OR CERTIFICATION.—

8 (1) IN GENERAL.—Except as provided in para-
9 graph (2), the Secretary shall not allow a health
10 care provider to participate in the public health in-
11 surance option unless such provider is appropriately
12 licensed, certified, or otherwise permitted to practice
13 under State law.

14 (2) SPECIAL RULE FOR IHS FACILITIES AND
15 PROVIDERS.—The requirements under paragraph (1)
16 shall not apply to—

17 (A) a facility that is operated by the In-
18 dian Health Service;

19 (B) a facility operated by an Indian Tribe
20 or tribal organization under the Indian Self-De-
21 termination Act (Public Law 93–638);

22 (C) a health care professional employed by
23 the Indian Health Service; or

24 (D) a health care professional—

- 1 (i) who is employed to provide health
2 care services in a facility operated by an
3 Indian Tribe or tribal organization under
4 the Indian Self-Determination Act; and
5 (ii) who is licensed or certified in any
6 State.

7 (c) PAYMENT TERMS FOR PROVIDERS.—

8 (1) PHYSICIANS.—The Secretary shall provide
9 for the annual participation of physicians under the
10 public health insurance option, for which payment
11 may be made for services furnished during the year,
12 in one of 2 classes:

13 (A) PREFERRED PHYSICIANS.—Those phy-
14 sicians who agree to accept the payment under
15 section 323 (without regard to cost-sharing) as
16 the payment in full.

17 (B) PARTICIPATING, NON-PREFERRED
18 PHYSICIANS.—Those physicians who agree not
19 to impose charges (in relation to the payment
20 described in section 323 for such physicians)
21 that exceed the sum of the in-network cost-
22 sharing plus 15 percent of the total payment
23 for each item and service. The Secretary shall
24 reduce the payment described in section 323 for
25 such physicians.

1 **SEC. 327. APPLICATION OF HIPAA INSURANCE REQUIRE-**
2 **MENTS.**

3 The requirements of sections 2701 through 2792 of
4 the Public Health Service Act shall apply to the public
5 health insurance option in the same manner as they apply
6 to health insurance coverage offered by a health insurance
7 issuer in the individual market.

8 **SEC. 328. APPLICATION OF HEALTH INFORMATION PRI-**
9 **VACY, SECURITY, AND ELECTRONIC TRANS-**
10 **ACTION REQUIREMENTS.**

11 Part C of title XI of the Social Security Act, relating
12 to standards for protections against the wrongful disclo-
13 sure of individually identifiable health information, health
14 information security, and the electronic exchange of health
15 care information, shall apply to the public health insur-
16 ance option in the same manner as such part applies to
17 other health plans (as defined in section 1171(5) of such
18 Act).

19 **SEC. 329. ENROLLMENT IN PUBLIC HEALTH INSURANCE**
20 **OPTION IS VOLUNTARY.**

21 Nothing in this division shall be construed as requir-
22 ing anyone to enroll in the public health insurance option.
23 Enrollment in such option is voluntary.

1 **SEC. 330. ENROLLMENT IN PUBLIC HEALTH INSURANCE**

2 **OPTION BY MEMBERS OF CONGRESS.**

3 Notwithstanding any other provision of this Act,
4 Members of Congress may enroll in the public health in-
5 surance option.

6 **SEC. 331. REIMBURSEMENT OF SECRETARY OF VETERANS**

7 **AFFAIRS.**

8 The Secretary of Health and Human Services shall
9 seek to enter into a memorandum of understanding with
10 the Secretary of Veterans Affairs regarding the recovery
11 of costs related to non-service-connected care or services
12 provided by the Secretary of Veterans Affairs to an indi-
13 vidual covered under the public health insurance option
14 in a manner consistent with recovery of costs related to
15 non-service-connected care from private health insurance
16 plans.

17 **Subtitle C—Individual**
18 **Affordability Credits**

19 **SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EX-**

20 **CHANGE.**

21 (a) IN GENERAL.—Subject to the succeeding provi-
22 sions of this subtitle, in the case of an affordable credit
23 eligible individual enrolled in an Exchange-participating
24 health benefits plan—

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

4 (A) an affordability premium credit under
5 section 343 to be applied against the premium
6 for the Exchange-participating health benefits
7 plan in which the individual is enrolled; and

8 (B) an affordability cost-sharing credit
9 under section 344 to be applied as a reduction
10 of the cost-sharing otherwise applicable to such
11 plan; and

12 (2) the Commissioner shall pay the QHBP of-
13 fering entity that offers such plan from the Health
14 Insurance Exchange Trust Fund the aggregate
15 amount of affordability credits for all affordable
16 credit eligible individuals enrolled in such plan.

17 (b) APPLICATION.—

18 (1) IN GENERAL.—An Exchange eligible indi-
19 vidual may apply to the Commissioner through the
20 Health Insurance Exchange or through another enti-
21 ty under an arrangement made with the Commis-
22 sioner, in a form and manner specified by the Com-
23 missioner. The Commissioner through the Health
24 Insurance Exchange or through another public enti-
25 ty under an arrangement made with the Commis-

1 sioner shall make a determination as to eligibility of
2 an individual for affordability credits under this sub-
3 title. The Commissioner shall establish a process
4 whereby, on the basis of information otherwise avail-
5 able, individuals may be deemed to be affordable
6 credit eligible individuals. In carrying this subtitle,
7 the Commissioner shall establish effective methods
8 that ensure that individuals with limited English
9 proficiency are able to apply for affordability credits.

10 (2) USE OF STATE MEDICAID AGENCIES.—If
11 the Commissioner determines that a State Medicaid
12 agency has the capacity to make a determination of
13 eligibility for affordability credits under this subtitle
14 and under the same standards as used by the Com-
15 missioner, under the Medicaid memorandum of un-
16 derstanding under section 305(e)(2)—

17 (A) the State Medicaid agency is author-
18 ized to conduct such determinations for any Ex-
19 change-eligible individual who requests such a
20 determination; and

21 (B) the Commissioner shall reimburse the
22 State Medicaid agency for the costs of con-
23 ducting such determinations.

24 (3) MEDICAID SCREEN AND ENROLL OBLIGA-
25 TION.—In the case of an application made under

1 paragraph (1), there shall be a determination of
2 whether the individual is a Medicaid-eligible indi-
3 vidual. If the individual is determined to be so eligi-
4 ble, the Commissioner, through the Medicaid memo-
5 randum of understanding under section 305(e)(2),
6 shall provide for the enrollment of the individual
7 under the State Medicaid plan in accordance with
8 such Medicaid memorandum of understanding. In
9 the case of such an enrollment, the State shall pro-
10 vide for the same periodic redetermination of eligi-
11 bility under Medicaid as would otherwise apply if the
12 individual had directly applied for medical assistance
13 to the State Medicaid agency.

14 (4) APPLICATION AND VERIFICATION OF RE-
15 QUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE
16 IN THE UNITED STATES.—

17 (A) REQUIREMENT.—No individual shall
18 be an affordable credit eligible individual (as
19 defined in section 342(a)(1)) unless the indi-
20 vidual is a citizen or national of the United
21 States or is lawfully present in a State in the
22 United States (other than as a nonimmigrant
23 described in a subparagraph (excluding sub-
24 paragraphs (K), (T), (U), and (V)) of section

1 101(a)(15) of the Immigration and Nationality
2 Act).

3 (B) DECLARATION OF CITIZENSHIP OR
4 LAWFUL IMMIGRATION STATUS.—No individual
5 shall be an affordable credit eligible individual
6 unless there has been a declaration made, in a
7 form and manner specified by the Health
8 Choices Commissioner similar to the manner re-
9 quired under section 1137(d)(1) of the Social
10 Security Act and under penalty of perjury, that
11 the individual—

12 (i) is a citizen or national of the
13 United States; or

14 (ii) is not such a citizen or national
15 but is lawfully present in a State in the
16 United States (other than as a non-
17 immigrant described in a subparagraph
18 (excluding subparagraphs (K), (T), (U),
19 and (V)) of section 101(a)(15) of the Im-
20 migration and Nationality Act).

21 Such declaration shall be verified in accordance
22 with subparagraph (C) or (D), as the case may
23 be.

24 (C) VERIFICATION PROCESS FOR CITI-
25 ZENS.—

1 (i) IN GENERAL.—In the case of an
2 individual making the declaration described
3 in subparagraph (B)(i), subject to clause
4 (ii), section 1902(ee) of the Social Security
5 Act shall apply to such declaration in the
6 same manner as such section applies to a
7 declaration described in paragraph (1) of
8 such section.

9 (ii) SPECIAL RULES.—In applying sec-
10 tion 1902(ee) of such Act under clause
11 (i)—

12 (I) any reference in such section
13 to a State is deemed a reference to
14 the Commissioner (or other public en-
15 tity making the eligibility determina-
16 tion);

17 (II) any reference to medical as-
18 sistance or enrollment under a State
19 plan is deemed a reference to provi-
20 sion of affordability credits under this
21 subtitle;

22 (III) a reference to a newly en-
23 rolled individual under paragraph
24 (2)(A) of such section is deemed a ref-
25 erence to an individual newly in re-

1 receipt of an affordability credit under
2 this subtitle;

3 (IV) approval by the Secretary
4 shall not be required in applying para-
5 graph (2)(B)(ii) of such section;

6 (V) paragraph (3) of such section
7 shall not apply; and

8 (VI) before the end of Y2, the
9 Health Choices Commissioner, in con-
10 sultation with the Commissioner of
11 Social Security, may extend the peri-
12 ods specified in paragraph (1)(B)(ii)
13 of such section.

14 (D) VERIFICATION PROCESS FOR NONCITI-
15 ZENS.—

16 (i) IN GENERAL.—In the case of an
17 individual making the declaration described
18 in subparagraph (B)(ii), subject to clause
19 (ii), the verification procedures of para-
20 graphs (2) through (5) of section 1137(d)
21 of the Social Security Act shall apply to
22 such declaration in the same manner as
23 such procedures apply to a declaration de-
24 scribed in paragraph (1) of such section.

1 (ii) SPECIAL RULES.—In applying
2 such paragraphs of section 1137(d) of such
3 Act under clause (i)—

4 (I) any reference in such para-
5 graphs to a State is deemed a ref-
6 erence to the Health Choices Commis-
7 sioner; and

8 (II) any reference to benefits
9 under a program is deemed a ref-
10 erence to affordability credits under
11 this subtitle.

12 (iii) APPLICATION TO STATE-BASED
13 EXCHANGES.—In the case of the applica-
14 tion of the verification process under this
15 subparagraph to a State-based Health In-
16 surance Exchange approved under section
17 308, section 1137(e) of such Act shall
18 apply to the Health Choices Commissioner
19 in relation to the State.

20 (E) ANNUAL REPORTS.—The Health
21 Choices Commissioner shall report to Congress
22 annually on the number of applicants for af-
23 fordability credits under this subtitle, their citi-
24 zenship or immigration status, and the disposi-
25 tion of their applications. Such report shall be

1 made publicly available and shall include infor-
2 mation on—

3 (i) the number of applicants whose
4 declaration of citizenship or immigration
5 status, name, or social security account
6 number was not consistent with records
7 maintained by the Commissioner of Social
8 Security or the Department of Homeland
9 Security and, of such applicants, the num-
10 ber who contested the inconsistency and
11 sought to document their citizenship or im-
12 migration status, name, or social security
13 account number or to correct the informa-
14 tion maintained in such records and, of
15 those, the results of such contestations;
16 and

17 (ii) the administrative costs of con-
18 ducting the status verification under this
19 paragraph.

20 (F) GAO REPORT.—Not later than the end
21 of Y2, the Comptroller General of the United
22 States shall submit to the Committee on Ways
23 and Means, the Committee on Energy and
24 Commerce, the Committee on Education and
25 Labor, and the Committee on the Judiciary of

1 the House of Representatives and the Com-
2 mittee on Finance, the Committee on Health,
3 Education, Labor, and Pensions, and the Com-
4 mittee on the Judiciary of the Senate a report
5 examining the effectiveness of the citizenship
6 and immigration verification systems applied
7 under this paragraph. Such report shall include
8 an analysis of the following:

9 (i) The causes of erroneous deter-
10 minations under such systems.

11 (ii) The effectiveness of the processes
12 used in remedying such erroneous deter-
13 minations.

14 (iii) The impact of such systems on
15 individuals, health care providers, and Fed-
16 eral and State agencies, including the ef-
17 fect of erroneous determinations under
18 such systems.

19 (iv) The effectiveness of such systems
20 in preventing ineligible individuals from re-
21 ceiving for affordability credits.

22 (v) The characteristics of applicants
23 described in subparagraph (E)(i).

24 (G) PROHIBITION OF DATABASE.—Nothing
25 in this paragraph or the amendments made by

1 paragraph (6) shall be construed as authorizing
2 the Health Choices Commissioner or the Com-
3 missioner of Social Security to establish a data-
4 base of information on citizenship or immigra-
5 tion status.

6 (H) INITIAL FUNDING.—

7 (i) IN GENERAL.—Out of any funds in
8 the Treasury not otherwise appropriated,
9 there is appropriated to the Commissioner
10 of Social Security \$30,000,000, to be avail-
11 able without fiscal year limit to carry out
12 this paragraph and section 205(v) of the
13 Social Security Act.

14 (ii) FUNDING LIMITATION.—In no
15 case shall funds from the Social Security
16 Administration's Limitation on Adminis-
17 trative Expenses be used to carry out ac-
18 tivities related to this paragraph or section
19 205(v) of the Social Security Act.

20 (5) AGREEMENT WITH SOCIAL SECURITY COM-
21 MISSIONER.—

22 (A) IN GENERAL.—The Health Choices
23 Commissioner shall enter into and maintain an
24 agreement described in section 205(v)(2) of the

1 Social Security Act with the Commissioner of
2 Social Security.

3 (B) FUNDING.—The agreement entered
4 into under subparagraph (A) shall, for each fis-
5 cal year (beginning with fiscal year 2013)—

6 (i) provide funds to the Commissioner
7 of Social Security for the full costs of the
8 responsibilities of the Commissioner of So-
9 cial Security under paragraph (4), includ-
10 ing—

11 (I) acquiring, installing, and
12 maintaining technological equipment
13 and systems necessary for the fulfill-
14 ment of the responsibilities of the
15 Commissioner of Social Security
16 under paragraph (4), but only that
17 portion of such costs that are attrib-
18 utable to such responsibilities; and

19 (II) responding to individuals
20 who contest with the Commissioner of
21 Social Security a reported inconsist-
22 ency with records maintained by the
23 Commissioner of Social Security or
24 the Department of Homeland Security
25 relating to citizenship or immigration

1 status, name, or social security ac-
2 count number under paragraph (4);

3 (ii) based on an estimating method-
4 ology agreed to by the Commissioner of
5 Social Security and the Health Choices
6 Commissioner, provide such funds, within
7 10 calendar days of the beginning of the
8 fiscal year for the first quarter and in ad-
9 vance for all subsequent quarters in that
10 fiscal year; and

11 (iii) provide for an annual accounting
12 and reconciliation of the actual costs in-
13 curred and the funds provided under the
14 agreement.

15 (C) REVIEW OF ACCOUNTING.—The an-
16 nual accounting and reconciliation conducted
17 pursuant to subparagraph (B)(iii) shall be re-
18 viewed by the Inspectors General of the Social
19 Security Administration and the Health Choices
20 Administration, including an analysis of consist-
21 ency with the requirements of paragraph (4).

22 (D) CONTINGENCY.—In any case in which
23 agreement with respect to the provisions re-
24 quired under subparagraph (B) for any fiscal
25 year has not been reached as of the first day

1 of such fiscal year, the latest agreement with
2 respect to such provisions shall be deemed in ef-
3 fect on an interim basis for such fiscal year
4 until such time as an agreement relating to
5 such provisions is subsequently reached. In any
6 case in which an interim agreement applies for
7 any fiscal year under this subparagraph, the
8 Commissioner of Social Security shall, not later
9 than the first day of such fiscal year, notify the
10 appropriate Committees of the Congress of the
11 failure to reach the agreement with respect to
12 such provisions for such fiscal year. Until such
13 time as the agreement with respect to such pro-
14 visions has been reached for such fiscal year,
15 the Commissioner of Social Security shall, not
16 later than the end of each 90-day period after
17 October 1 of such fiscal year, notify such Com-
18 mittees of the status of negotiations between
19 such Commissioner and the Health Choices
20 Commissioner in order to reach such an agree-
21 ment.

22 (E) APPLICATION TO PUBLIC ENTITIES
23 ADMINISTERING AFFORDABILITY CREDITS.—If
24 the Health Choices Commissioner provides for
25 the conduct of verifications under paragraph

1 (4) through a public entity, the Health Choices
2 Commissioner shall require the public entity to
3 enter into an agreement with the Commissioner
4 of Social Security which provides the same
5 terms as the agreement described in this para-
6 graph (and section 205(v) of the Social Security
7 Act) between the Health Choices Commissioner
8 and the Commissioner of Social Security, except
9 that the Health Choices Commissioner shall be
10 responsible for providing funds for the Commis-
11 sioner of Social Security in accordance with
12 subparagraphs (B) through (D).

13 (6) AMENDMENTS TO SOCIAL SECURITY ACT.—

14 (A) COORDINATION OF INFORMATION BE-
15 TWEEN SOCIAL SECURITY ADMINISTRATION AND
16 HEALTH CHOICES ADMINISTRATION.—

17 (i) IN GENERAL.—Section 205 of the
18 Social Security Act (42 U.S.C. 405) is
19 amended by adding at the end the fol-
20 lowing new subsection:

21 “Coordination of Information With Health Choices
22 Administration

23 “(v)(1) The Health Choices Commissioner may col-
24 lect and use the names and social security account num-
25 bers of individuals as required to provide for verification

1 of citizenship under subsection (b)(4)(C) of section 341
2 of the Affordable Health Care for America Act in connec-
3 tion with determinations of eligibility for affordability
4 credits under such section.

5 “(2)(A) The Commissioner of Social Security shall
6 enter into and maintain an agreement with the Health
7 Choices Commissioner for the purpose of establishing, in
8 compliance with the requirements of section 1902(ee) as
9 applied pursuant to section 341(b)(4)(C) of the Affordable
10 Health Care for America Act, a program for verifying in-
11 formation required to be collected by the Health Choices
12 Commissioner under such section 341(b)(4)(C).

13 “(B) The agreement entered into pursuant to sub-
14 paragraph (A) shall include such safeguards as are nec-
15 essary to ensure the maintenance of confidentiality of any
16 information disclosed for purposes of verifying information
17 described in subparagraph (A) and to provide procedures
18 for permitting the Health Choices Commissioner to use
19 the information for purposes of maintaining the records
20 of the Health Choices Administration.

21 “(C) The agreement entered into pursuant to sub-
22 paragraph (A) shall provide that information provided by
23 the Commissioner of Social Security to the Health Choices
24 Commissioner pursuant to the agreement shall be provided

1 at such time, at such place, and in such manner as the
2 Commissioner of Social Security determines appropriate.

3 “(D) Information provided by the Commissioner of
4 Social Security to the Health Choices Commissioner pur-
5 suant to an agreement entered into pursuant to subpara-
6 graph (A) shall be considered as strictly confidential and
7 shall be used only for the purposes described in this para-
8 graph and for carrying out such agreement. Any officer
9 or employee or former officer or employee of the Health
10 Choices Commissioner, or any officer or employee or
11 former officer or employee of a contractor of the Health
12 Choices Commissioner, who, without the written authority
13 of the Commissioner of Social Security, publishes or com-
14 municates any information in such individual’s possession
15 by reason of such employment or position as such an offi-
16 cer shall be guilty of a felony and, upon conviction thereof,
17 shall be fined or imprisoned, or both, as described in sec-
18 tion 208.

19 “(3) The agreement entered into under paragraph (2)
20 shall provide for funding to the Commissioner of Social
21 Security consistent with section 341(b)(5) of Affordable
22 Health Care for America Act.

23 “(4) This subsection shall apply in the case of a pub-
24 lic entity that conducts verifications under section
25 341(b)(4) of the Affordable Health Care for America Act

1 and the obligations of this subsection shall apply to such
2 an entity in the same manner as such obligations apply
3 to the Health Choices Commissioner when such Commis-
4 sioner is conducting such verifications.”.

5 (ii) CONFORMING AMENDMENT.—Sec-
6 tion 205(c)(2)(C) of such Act (42 U.S.C.
7 405(c)(2)(C)) is amended by adding at the
8 end the following new clause:

9 “(x) For purposes of the administration of the
10 verification procedures described in section 341(b)(4) of
11 the Affordable Health Care for America Act, the Health
12 Choices Commissioner may collect and use social security
13 account numbers as provided for in section 205(v)(1).”.

14 (B) IMPROVING THE INTEGRITY OF DATA
15 AND EFFECTIVENESS OF SAVE.—Section
16 1137(d) of the Social Security Act (42 U.S.C.
17 1320b–7(d)) is amended by adding at the end
18 the following new paragraphs:

19 “(6)(A) With respect to the use by any agency of the
20 system described in subsection (b) by programs specified
21 in subsection (b) or any other use of such system, the U.S.
22 Citizenship and Immigration Services and any other agen-
23 cy charged with the management of the system shall es-
24 tablish appropriate safeguards necessary to protect and

1 improve the integrity and accuracy of data relating to indi-
2 viduals by—

3 “(i) establishing a process through which such
4 individuals are provided access to, and the ability to
5 amend, correct, and update, their own personally
6 identifiable information contained within the system;

7 “(ii) providing a written response, without
8 undue delay, to any individual who has made such
9 a request to amend, correct, or update such individ-
10 ual’s own personally identifiable information con-
11 tained within the system; and

12 “(iii) developing a written notice for user agen-
13 cies to provide to individuals who are denied a ben-
14 efit due to a determination of ineligibility based on
15 a final verification determination under the system.

16 “(B) The notice described in subparagraph (A)(ii)
17 shall include—

18 “(i) information about the reason for such no-
19 tice;

20 “(ii) a description of the right of the recipient
21 of the notice under subparagraph (A)(i) to contest
22 such notice;

23 “(iii) a description of the right of the recipient
24 under subparagraph (A)(i) to access and attempt to
25 amend, correct, and update the recipient’s own per-

1 sonally identifiable information contained within
2 records of the system described in paragraph (3);
3 and

4 “(iv) instructions on how to contest such notice
5 and attempt to correct records of such system relat-
6 ing to the recipient, including contact information
7 for relevant agencies.”.

8 (C) STREAMLINING ADMINISTRATION OF
9 VERIFICATION PROCESS FOR UNITED STATES
10 CITIZENS.—Section 1902(ee)(2) of the Social
11 Security Act (42 U.S.C. 1396a(ee)(2)) is
12 amended by adding at the end the following:

13 “(D) In carrying out the verification procedures
14 under this subsection with respect to a State, if the Com-
15 missioner of Social Security determines that the records
16 maintained by such Commissioner are not consistent with
17 an individual’s allegation of United States citizenship,
18 pursuant to procedures which shall be established by the
19 State in coordination with the Commissioner of Social Se-
20 curity, the Secretary of Homeland Security, and the Sec-
21 retary of Health and Human Services—

22 “(i) the Commissioner of Social Security shall
23 inform the State of the inconsistency;

24 “(ii) upon being so informed of the inconsist-
25 ency, the State shall submit the information on the

1 individual to the Secretary of Homeland Security for
2 a determination of whether the records of the De-
3 partment of Homeland Security indicate that the in-
4 dividual is a citizen;

5 “(iii) upon making such determination, the De-
6 partment of Homeland Security shall inform the
7 State of such determination; and

8 “(iv) information provided by the Commissioner
9 of Social Security shall be considered as strictly con-
10 fidential and shall only be used by the State and the
11 Secretary of Homeland Security for the purposes of
12 such verification procedures.

13 “(E) Verification of status eligibility pursuant to the
14 procedures established under this subsection shall be
15 deemed a verification of status eligibility for purposes of
16 this title, title XXI, and affordability credits under section
17 341(b)(4) of the Affordable Health Care for America Act,
18 regardless of the program in which the individual is apply-
19 ing for benefits.”.

20 (c) USE OF AFFORDABILITY CREDITS.—

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

24 (2) FLEXIBILITY IN PLAN ENROLLMENT AU-
25 THORIZED.—Beginning with Y3, the Commissioner

1 shall establish a process to allow an affordability
2 premium credit under section 343, but not the af-
3 fordability cost-sharing credit under section 344, to
4 be used for enrollees in enhanced or premium plans.
5 In the case of an affordable credit eligible individual
6 who enrolls in an enhanced or premium plan, the in-
7 dividual shall be responsible for any difference be-
8 tween the premium for such plan and the afford-
9 ability credit amount otherwise applicable if the indi-
10 vidual had enrolled in a basic plan.

11 (3) PROHIBITION OF USE OF PUBLIC FUNDS
12 FOR ABORTION COVERAGE.—An affordability credit
13 may not be used for payment for services described
14 in section 222(d)(4)(A).

15 (d) ACCESS TO DATA.—In carrying out this subtitle,
16 the Commissioner shall request from the Secretary of the
17 Treasury consistent with section 6103 of the Internal Rev-
18 enue Code of 1986 such information as may be required
19 to carry out this subtitle.

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

23 **SEC. 342. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.**

24 (a) DEFINITION.—

1 (1) IN GENERAL.—For purposes of this divi-
2 sion, the term “affordable credit eligible individual”
3 means, subject to subsection (b) and section 346, an
4 individual who is lawfully present in a State in the
5 United States (other than as a nonimmigrant de-
6 scribed in a subparagraph (excluding subparagraphs
7 (K), (T), (U), and (V)) of section 101(a)(15) of the
8 Immigration and Nationality Act)—

9 (A) who is enrolled under an Exchange-
10 participating health benefits plan and is not en-
11 rolled under such plan as an employee (or de-
12 pendent of an employee) through an employer
13 qualified health benefits plan that meets the re-
14 quirements of section 412;

15 (B) with modified adjusted gross income
16 below 400 percent of the Federal poverty level
17 for a family of the size involved;

18 (C) who is not a Medicaid eligible indi-
19 vidual, other than an individual during a transi-
20 tion period under section 302(d)(3)(B)(ii); and

21 (D) subject to paragraph (3), who is not
22 enrolled in acceptable coverage (other than an
23 Exchange-participating health benefits plan).

24 (2) TREATMENT OF FAMILY.—Except as the
25 Commissioner may otherwise provide, members of

1 the same family who are affordable credit eligible in-
2 dividuals shall be treated as a single affordable cred-
3 it individual eligible for the applicable credit for such
4 a family under this subtitle.

5 (3) SPECIAL RULE FOR INDIANS.—Subpara-
6 graph (D) of paragraph (1) shall not apply to an in-
7 dividual who has coverage that is treated as accept-
8 able coverage for purposes of section 59B(d)(2) of
9 the Internal Revenue Code of 1986 but is not treat-
10 ed as acceptable coverage for purposes of this divi-
11 sion.

12 (b) LIMITATIONS ON EMPLOYEE AND DEPENDENT
13 DISQUALIFICATION.—

14 (1) IN GENERAL.—Subject to paragraph (2),
15 the term “affordable credit eligible individual” does
16 not include a full-time employee of an employer if
17 the employer offers the employee coverage (for the
18 employee and dependents) as a full-time employee
19 under a group health plan if the coverage and em-
20 ployer contribution under the plan meet the require-
21 ments of section 412.

22 (2) EXCEPTIONS.—

23 (A) FOR CERTAIN FAMILY CIR-
24 CUMSTANCES.—The Commissioner shall estab-
25 lish such exceptions and special rules in the

1 case described in paragraph (1) as may be ap-
2 propriate in the case of a divorced or separated
3 individual or such a dependent of an employee
4 who would otherwise be an affordable credit eli-
5 gible individual.

6 (B) FOR UNAFFORDABLE EMPLOYER COV-
7 ERAGE.—Beginning in Y2, in the case of full-
8 time employees for which the cost of the em-
9 ployee premium for coverage under a group
10 health plan would exceed 12 percent of current
11 modified adjusted gross income (determined by
12 the Commissioner on the basis of verifiable doc-
13 umentation), paragraph (1) shall not apply.

14 (c) INCOME DEFINED.—

15 (1) IN GENERAL.—In this title, the term “in-
16 come” means modified adjusted gross income (as de-
17 fined in section 59B of the Internal Revenue Code
18 of 1986).

19 (2) STUDY OF INCOME DISREGARDS.—The
20 Commissioner shall conduct a study that examines
21 the application of income disregards for purposes of
22 this subtitle. Not later than the first day of Y2, the
23 Commissioner shall submit to Congress a report on
24 such study and shall include such recommendations
25 as the Commissioner determines appropriate.

1 (d) CLARIFICATION OF TREATMENT OF AFFORD-
2 ABILITY CREDITS.—Affordability credits under this sub-
3 title shall not be treated, for purposes of title IV of the
4 Personal Responsibility and Work Opportunity Reconcili-
5 ation Act of 1996, to be a benefit provided under section
6 403 of such title.

7 **SEC. 343. AFFORDABILITY PREMIUM CREDIT.**

8 (a) IN GENERAL.—The affordability premium credit
9 under this section for an affordable credit eligible indi-
10 vidual enrolled in an Exchange-participating health bene-
11 fits plan is in an amount equal to the amount (if any)
12 by which the reference premium amount specified in sub-
13 section (c), exceeds the affordable premium amount speci-
14 fied in subsection (b) for the individual, except that in no
15 case shall the affordable premium credit exceed the pre-
16 mium for the plan.

17 (b) AFFORDABLE PREMIUM AMOUNT.—

18 (1) IN GENERAL.—The affordable premium
19 amount specified in this subsection for an individual
20 for the annual premium in a plan year shall be equal
21 to the product of—

22 (A) the premium percentage limit specified
23 in paragraph (2) for the individual based upon
24 the individual's modified adjusted gross income
25 for the plan year; and

1 (B) the individual's modified adjusted
2 gross income for such plan year.

3 (2) PREMIUM PERCENTAGE LIMITS BASED ON
4 TABLE.—The Commissioner shall establish premium
5 percentage limits so that for individuals whose modi-
6 fied adjusted gross income is within an income tier
7 specified in the table in subsection (d) such percent-
8 age limits shall increase, on a sliding scale in a lin-
9 ear manner, from the initial premium percentage to
10 the final premium percentage specified in such table
11 for such income tier.

12 (c) REFERENCE PREMIUM AMOUNT.—The reference
13 premium amount specified in this subsection for a plan
14 year for an individual in a premium rating area is equal
15 to the average premium for the 3 basic plans in the area
16 for the plan year with the lowest premium levels. In com-
17 puting such amount the Commissioner may exclude plans
18 with extremely limited enrollments.

19 (d) TABLE OF PREMIUM PERCENTAGE LIMITS, AC-
20 TUALIAL VALUE PERCENTAGES, AND OUT-OF-POCKET
21 LIMITS FOR Y1 BASED ON INCOME TIER.—

22 (1) IN GENERAL.—For purposes of this sub-
23 title, subject to paragraph (3) and section 346, the
24 table specified in this subsection is as follows:

| In the case of modified adjusted gross income (expressed as a percent of FPL) within the following income tier: | The initial premium percentage is— | The final premium percentage is— | The actuarial value percentage is— | The out-of-pocket limit for Y1 is— |
|---|------------------------------------|----------------------------------|------------------------------------|------------------------------------|
| 133% through 150% | 1.5% | 3.0% | 97% | \$500 |
| 150% through 200% | 3.0% | 5.5% | 93% | \$1,000 |
| 200% through 250% | 5.5% | 8.0% | 85% | \$2,000 |
| 250% through 300% | 8.0% | 10.0% | 78% | \$4,000 |
| 300% through 350% | 10.0% | 11.0% | 72% | \$4,500 |
| 350% through 400% | 11.0% | 12.0% | 70% | \$5,000 |

1 (2) SPECIAL RULES.—For purposes of applying
2 the table under paragraph (1):

3 (A) FOR LOWEST LEVEL OF INCOME.—In
4 the case of an individual with income that does
5 not exceed 133 percent of FPL, the individual
6 shall be considered to have income that is 133
7 percent of FPL.

8 (B) APPLICATION OF HIGHER ACTUARIAL
9 VALUE PERCENTAGE AT TIER TRANSITION
10 POINTS.—If two actuarial value percentages
11 may be determined with respect to an indi-
12 vidual, the actuarial value percentage shall be
13 the higher of such percentages.

14 (3) INDEXING.—For years after Y1, the Com-
15 missioner shall adjust the initial and final premium
16 percentages to maintain the ratio of governmental to

1 enrollee shares of premiums over time, for each in-
2 come tier identified in the table in paragraph (1).

3 **SEC. 344. AFFORDABILITY COST-SHARING CREDIT.**

4 (a) IN GENERAL.—The affordability cost-sharing
5 credit under this section for an affordable credit eligible
6 individual enrolled in an Exchange-participating health
7 benefits plan is in the form of the cost-sharing reduction
8 described in subsection (b) provided under this section for
9 the income tier in which the individual is classified based
10 on the individual's modified adjusted gross income.

11 (b) COST-SHARING REDUCTIONS.—The Commis-
12 sioner shall specify a reduction in cost-sharing amounts
13 and the annual limitation on cost-sharing specified in sec-
14 tion 222(c)(2)(B) under a basic plan for each income tier
15 specified in the table under section 343(d), with respect
16 to a year, in a manner so that, as estimated by the Com-
17 missioner—

18 (1) the actuarial value of the coverage with
19 such reduced cost-sharing amounts (and the reduced
20 annual cost-sharing limit) is equal to the actuarial
21 value percentage (specified in the table under section
22 343(d) for the income tier involved) of the full actu-
23 arial value if there were no cost-sharing imposed
24 under the plan; and

1 (2) the annual limitation on cost-sharing speci-
2 fied in section 222(c)(2)(B) is reduced to a level
3 that does not exceed the maximum out-of-pocket
4 limit specified in subsection (c).

5 (c) MAXIMUM OUT-OF-POCKET LIMIT.—

6 (1) IN GENERAL.—Subject to paragraph (2),
7 the maximum out-of-pocket limit specified in this
8 subsection for an individual within an income tier—

9 (A) for individual coverage—

10 (i) for Y1 is the out-of-pocket limit
11 for Y1 specified in subsection (c) in the
12 table under section 343(d) for the income
13 tier involved; or

14 (ii) for a subsequent year is such out-
15 of-pocket limit for the previous year under
16 this subparagraph increased (rounded to
17 the nearest \$10) for each subsequent year
18 by the percentage increase in the enroll-
19 ment-weighted average of premium in-
20 creases for basic plans applicable to such
21 year; or

22 (B) for family coverage is twice the max-
23 imum out-of-pocket limit under subparagraph
24 (A) for the year involved.

1 (2) ADJUSTMENT.—The Commissioner shall ad-
2 just the maximum out-of-pocket limits under para-
3 graph (1) to ensure that such limits meet the actu-
4 arial value percentage specified in the table under
5 section 343(d) for the income tier involved.

6 (d) DETERMINATION AND PAYMENT OF COST-SHAR-
7 ING AFFORDABILITY CREDIT.—In the case of an afford-
8 able credit eligible individual in a tier enrolled in an Ex-
9 change-participating health benefits plan offered by a
10 QHBP offering entity, the Commissioner shall provide for
11 payment to the offering entity of an amount equivalent
12 to the increased actuarial value of the benefits under the
13 plan provided under section 303(c)(2)(B) resulting from
14 the reduction in cost-sharing described in subsections (b)
15 and (c).

16 **SEC. 345. INCOME DETERMINATIONS.**

17 (a) IN GENERAL.—In applying this subtitle for an
18 affordability credit for an individual for a plan year, the
19 individual's income shall be the income (as defined in sec-
20 tion 342(c)) for the individual for the most recent taxable
21 year (as determined in accordance with rules of the Com-
22 missioner). The Federal poverty level applied shall be such
23 level in effect as of the date of the application.

24 (b) PROGRAM INTEGRITY; INCOME VERIFICATION
25 PROCEDURES.—

1 (1) PROGRAM INTEGRITY.—The Commissioner
2 shall take such steps as may be appropriate to en-
3 sure the accuracy of determinations and redeter-
4 minations under this subtitle.

5 (2) INCOME VERIFICATION.—

6 (A) IN GENERAL.—Upon an initial applica-
7 tion of an individual for an affordability credit
8 under this subtitle (or in applying section
9 342(b)) or upon an application for a change in
10 the affordability credit based upon a significant
11 change in modified adjusted gross income de-
12 scribed in subsection (c)(1)—

13 (i) the Commissioner shall request
14 from the Secretary of the Treasury the dis-
15 closure to the Commissioner of such infor-
16 mation as may be permitted to verify the
17 information contained in such application;
18 and

19 (ii) the Commissioner shall use the in-
20 formation so disclosed to verify such infor-
21 mation.

22 (B) ALTERNATIVE PROCEDURES.—The
23 Commissioner shall establish procedures for the
24 verification of income for purposes of this sub-

1 title if no income tax return is available for the
2 most recent completed tax year.

3 (c) SPECIAL RULES.—

4 (1) CHANGES IN INCOME AS A PERCENT OF
5 FPL.—In the case that an individual's income (ex-
6 pressed as a percentage of the Federal poverty level
7 for a family of the size involved) for a plan year is
8 expected (in a manner specified by the Commis-
9 sioner) to be significantly different from the income
10 (as so expressed) used under subsection (a), the
11 Commissioner shall establish rules requiring an indi-
12 vidual to report, consistent with the mechanism es-
13 tablished under paragraph (2), significant changes
14 in such income (including a significant change in
15 family composition) to the Commissioner and requir-
16 ing the substitution of such income for the income
17 otherwise applicable.

18 (2) REPORTING OF SIGNIFICANT CHANGES IN
19 INCOME.—The Commissioner shall establish rules
20 under which an individual determined to be an af-
21 fordable credit eligible individual would be required
22 to inform the Commissioner when there is a signifi-
23 cant change in the modified adjusted gross income
24 of the individual (expressed as a percentage of the
25 FPL for a family of the size involved) and of the in-

1 formation regarding such change. Such mechanism
2 shall provide for guidelines that specify the cir-
3 cumstances that qualify as a significant change, the
4 verifiable information required to document such a
5 change, and the process for submission of such in-
6 formation. If the Commissioner receives new infor-
7 mation from an individual regarding the modified
8 adjusted gross income of the individual, the Commis-
9 sioner shall provide for a redetermination of the in-
10 dividual's eligibility to be an affordable credit eligible
11 individual.

12 (3) TRANSITION FOR CHIP.—In the case of a
13 child described in section 302(d)(2), the Commis-
14 sioner shall establish rules under which the modified
15 adjusted gross income of the child is deemed to be
16 no greater than the family income of the child as
17 most recently determined before Y1 by the State
18 under title XXI of the Social Security Act.

19 (4) STUDY OF GEOGRAPHIC VARIATION IN AP-
20 PLICATION OF FPL.—

21 (A) IN GENERAL.—The Secretary of
22 Health and Human Services shall conduct a
23 study to examine the feasibility and implication
24 of adjusting the application of the Federal pov-
25 erty level under this subtitle for different geo-

1 graphic areas so as to reflect the variations in
2 cost-of-living among different areas within the
3 United States. If the Secretary determines that
4 an adjustment is feasible, the study should in-
5 clude a methodology to make such an adjust-
6 ment. Not later than the first day of Y1, the
7 Secretary shall submit to Congress a report on
8 such study and shall include such recommenda-
9 tions as the Secretary determines appropriate.

10 (B) INCLUSION OF TERRITORIES.—

11 (i) IN GENERAL.—The Secretary shall
12 ensure that the study under subparagraph
13 (A) covers the territories of the United
14 States and that special attention is paid to
15 the disparity that exists among poverty lev-
16 els and the cost of living in such territories
17 and to the impact of such disparity on ef-
18 forts to expand health coverage and ensure
19 health care.

20 (ii) TERRITORIES DEFINED.—In this
21 subparagraph, the term “territories of the
22 United States” includes the Common-
23 wealth of Puerto Rico, the United States
24 Virgin Islands, Guam, the Northern Mar-

1 iana Islands, and any other territory or
2 possession of the United States.

3 (d) **PENALTIES FOR MISREPRESENTATION.**—In the
4 case of an individual who intentionally misrepresents
5 modified adjusted gross income or the individual fails
6 (without regard to intent) to disclose to the Commissioner
7 a significant change in modified adjusted gross income
8 under subsection (c) in a manner that results in the indi-
9 vidual becoming an affordable credit eligible individual
10 when the individual is not or in the amount of the afford-
11 ability credit exceeding the correct amount—

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

14 (2) in the case of such an intentional misrepre-
15 sentation or other egregious circumstances specified
16 by the Commissioner, the Commissioner may impose
17 an additional penalty.

18 **SEC. 346. SPECIAL RULES FOR APPLICATION TO TERRI-**
19 **TORIES.**

20 (a) **ONE-TIME ELECTION FOR TREATMENT AND AP-**
21 **PLICATION OF FUNDING.**—

22 (1) **IN GENERAL.**—A territory may elect, in a
23 form and manner specified by the Commissioner in
24 consultation with the Secretary of Health and

1 Human Services and the Secretary of the Treasury
2 and not later than October 1, 2012, either—

3 (A) to be treated as a State for purposes
4 of applying this title and title II; or

5 (B) not to be so treated but instead, to
6 have the dollar limitation otherwise applicable
7 to the territory under subsections (f) and (g) of
8 section 1108 of the Social Security Act (42
9 U.S.C. 1308) for a fiscal year increased by a
10 dollar amount equivalent to the cap amount de-
11 termined under subsection (c)(2) for the terri-
12 tory as applied by the Secretary for the fiscal
13 year involved.

14 (2) CONDITIONS FOR ACCEPTANCE.—The Com-
15 missioner has the nonreviewable authority to accept
16 or reject an election described in paragraph (1)(A).
17 Any such acceptance is—

18 (A) contingent upon entering into an
19 agreement described in subsection (b) between
20 the Commissioner and the territory and sub-
21 section (c); and

22 (B) subject to the approval of the Sec-
23 retary of Health and Human Services and the
24 Secretary of the Treasury and subject to such
25 other terms and conditions as the Commis-

1 sioner, in consultation with such Secretaries,
2 may specify.

3 (3) DEFAULT RULE.—A territory failing to
4 make such an election (or having an election under
5 paragraph (1)(A) not accepted under paragraph (2))
6 shall be treated as having made the election de-
7 scribed in paragraph (1)(B).

8 (b) AGREEMENT FOR SUBSTITUTION OF PERCENT-
9 AGES FOR AFFORDABILITY CREDITS.—

10 (1) NEGOTIATION.—In the case of a territory
11 making an election under subsection (a)(1)(A) (in
12 this section referred to as an “electing territory”) ,
13 the Commissioner, in consultation with the Secre-
14 taries of Health and Human Services and the Treas-
15 ury, shall enter into negotiations with the govern-
16 ment of such territory so that, before Y1, there is
17 an agreement reached between the parties on the
18 percentages that shall be applied under paragraph
19 (2) for that territory. The Commissioner shall not
20 enter into such an agreement unless—

21 (A) payments made under this subtitle
22 with respect to residents of the territory are
23 consistent with the cap established under sub-
24 section (c) for such territory and with sub-
25 section (d); and

1 (B) the requirements of paragraphs (3)
2 and (4) are met.

3 (2) APPLICATION OF SUBSTITUTE PERCENT-
4 AGES AND DOLLAR AMOUNTS.—In the case of an
5 electing territory, there shall be substituted in sec-
6 tion 342(a)(1)(B) and in the table in section
7 341(d)(1) for 400 percent, 133 percent, and other
8 percentages and dollar amounts specified in such
9 table, such respective percentages and dollar
10 amounts as are established under the agreement
11 under paragraph (1) consistent with the following:

12 (A) NO INCOME GAP BETWEEN MEDICAID
13 AND AFFORDABILITY CREDITS.—The sub-
14 stituted percentages shall be specified in a man-
15 ner so as to prevent any gap in coverage for in-
16 dividuals between income level at which medical
17 assistance is available through Medicaid and
18 the income level at which affordability credits
19 are available.

20 (B) ADJUSTMENT FOR OUT-OF-POCKET
21 RESPONSIBILITY FOR PREMIUMS AND COST-
22 SHARING IN RELATION TO INCOME.—The sub-
23 stituted percentages of FPL for income tiers
24 under such table shall be specified in a manner
25 so that—

1 (i) affordable credit eligible individ-
2 uals residing in the territory bear the same
3 out-of-pocket responsibility for premiums
4 and cost-sharing in relation to average in-
5 come for residents in that territory, as

6 (ii) the out-of-pocket responsibility for
7 premiums and cost-sharing for affordable
8 credit eligible individuals residing in the 50
9 States or the District of Columbia in rela-
10 tion to average income for such residents.

11 (3) SPECIAL RULES WITH RESPECT TO APPLI-
12 CATION OF TAX AND PENALTY PROVISIONS.—The
13 electing territory shall enact one or more laws under
14 which provisions similar to the following provisions
15 apply with respect to such territory:

16 (A) Section 59B of the Internal Revenue
17 Code of 1986, except that any resident of the
18 territory who is not an affordable credit eligible
19 individual but who would be an affordable cred-
20 it eligible individual if such resident were a resi-
21 dent of one of the 50 States (and any quali-
22 fying child residing with such individual) may
23 be treated as covered by acceptable coverage.

24 (B) Section 4980H of the Internal Rev-
25 enue Code of 1986 and section 502(c)(11) of

1 the Employee Retirement Income Security Act
2 of 1974.

3 (C) Section 3121(c) of the Internal Rev-
4 enue Code of 1986.

5 (4) IMPLEMENTATION OF INSURANCE REFORM
6 AND CONSUMER PROTECTION REQUIREMENTS.—The
7 electing territory shall enact and implement such
8 laws and regulations as may be required to apply the
9 requirements of title II with respect to health insur-
10 ance coverage offered in the territory.

11 (c) CAP ON ADDITIONAL EXPENDITURES.—

12 (1) IN GENERAL.—In entering into an agree-
13 ment with an electing territory under subsection (b),
14 the Commissioner shall ensure that the aggregate
15 expenditures under this subtitle with respect to resi-
16 dents of such territory during the period beginning
17 with Y1 and ending with 2019 will not exceed the
18 cap amount specified in paragraph (2) for such ter-
19 ritory. The Commissioner shall adjust from time to
20 time the percentages applicable under such agree-
21 ment as needed in order to carry out the previous
22 sentence.

23 (2) CAP AMOUNT.—

24 (A) IN GENERAL.—The cap amount speci-
25 fied in this paragraph—

1 (i) for Puerto Rico is \$3,700,000,000
2 increased by the amount (if any) elected
3 under subparagraph (C); or

4 (ii) for another territory is the portion
5 of \$300,000,000 negotiated for such terri-
6 tory under subparagraph (B).

7 (B) NEGOTIATION FOR CERTAIN TERRI-
8 TORIES.—The Commissioner in consultation
9 with the Secretary of Health and Human Serv-
10 ices shall negotiate with the governments of the
11 territories (other than Puerto Rico) to allocate
12 the amount specified in subparagraph (A)(ii)
13 among such territories.

14 (C) OPTIONAL SUPPLEMENTATION FOR
15 PUERTO RICO.—

16 (i) IN GENERAL.—Puerto Rico may
17 elect, in a form and manner specified by
18 the Secretary of Health and Human Serv-
19 ices in consultation with the Commissioner
20 to increase the dollar amount specified in
21 subparagraph (A)(i) by up to
22 \$1,000,000,000.

23 (ii) OFFSET IN MEDICAID CAP.—If
24 Puerto Rico makes the election described
25 in clause (i), the Secretary shall decrease

1 the dollar limitation otherwise applicable to
2 Puerto Rico under subsections (f) and (g)
3 of section 1108 of the Social Security Act
4 (42 U.S.C. 1308) for a fiscal year by the
5 additional aggregate payments the Sec-
6 retary estimates will be payable under this
7 section for the fiscal year because of such
8 election.

9 (d) LIMITATION ON FUNDING.—In no case shall this
10 section (including the agreement under subsection (b))
11 permit—

12 (1) the obligation of funds for expenditures
13 under this subtitle for periods beginning on or after
14 January 1, 2020; or

15 (2) any increase in the dollar limitation de-
16 scribed in subsection (a)(1)(B) for any portion of
17 any fiscal year occurring on or after such date.

18 **SEC. 347. NO FEDERAL PAYMENT FOR UNDOCUMENTED**
19 **ALIENS.**

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

1 **TITLE IV—SHARED**
2 **RESPONSIBILITY**
3 **Subtitle A—Individual**
4 **Responsibility**

5 **SEC. 401. INDIVIDUAL RESPONSIBILITY.**

6 For an individual's responsibility to obtain acceptable
7 coverage, see section 59B of the Internal Revenue Code
8 of 1986 (as added by section 501 of this Act).

9 **Subtitle B—Employer**
10 **Responsibility**

11 **PART 1—HEALTH COVERAGE PARTICIPATION**
12 **REQUIREMENTS**

13 **SEC. 411. HEALTH COVERAGE PARTICIPATION REQUIRE-**
14 **MENTS.**

15 An employer meets the requirements of this section
16 if such employer does all of the following:

17 (1) **OFFER OF COVERAGE.**—The employer of-
18 fers each employee individual and family coverage
19 under a qualified health benefits plan (or under a
20 current employment-based health plan (within the
21 meaning of section 202(b))) in accordance with sec-
22 tion 412.

23 (2) **CONTRIBUTION TOWARDS COVERAGE.**—If
24 an employee accepts such offer of coverage, the em-

1 ployer makes timely contributions towards such cov-
2 erage in accordance with section 412.

3 (3) CONTRIBUTION IN LIEU OF COVERAGE.—
4 Beginning with Y2, if an employee declines such
5 offer but otherwise obtains coverage in an Exchange-
6 participating health benefits plan (other than by rea-
7 son of being covered by family coverage as a spouse
8 or dependent of the primary insured), the employer
9 shall make a timely contribution to the Health In-
10 surance Exchange with respect to each such em-
11 ployee in accordance with section 413.

12 **SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TO-**
13 **WARD EMPLOYEE AND DEPENDENT COV-**
14 **ERAGE.**

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

18 (1) OFFERING OF COVERAGE.—The employer
19 offers the coverage described in section 411(1). In
20 the case of an Exchange-eligible employer, the em-
21 ployer may offer such coverage either through an
22 Exchange-participating health benefits plan or other
23 than through such a plan.

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

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

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

11 (A) The name, date, and employer identi-
12 fication number of the employer.

13 (B) A certification as to whether the em-
14 ployer offers to its full-time employees (and
15 their dependents) the opportunity to enroll in a
16 qualified health benefits plan or a current em-
17 ployment-based health plan (within the meaning
18 of section 202(b)).

19 (C) If the employer certifies that the em-
20 ployer did offer to its full-time employees (and
21 their dependents) the opportunity to so enroll—

22 (i) the months during the calendar
23 year for which such coverage was available;
24 and

1 (ii) the monthly premium for the low-
2 est cost option in each of the enrollment
3 categories under each such plan offered to
4 employees.

5 (D) The name, address, and TIN of each
6 full-time employee during the calendar year and
7 the months (if any) during which such employee
8 (and any dependents) were covered under any
9 such plans.

10 (4) AUTOENROLLMENT OF EMPLOYEES.—The
11 employer provides for autoenrollment of the em-
12 ployee in accordance with subsection (c).

13 This subsection shall supersede any law of a State which
14 would prevent automatic payroll deduction of employee
15 contributions to an employment-based health plan.

16 (b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH
17 MINIMUM EMPLOYER CONTRIBUTION.—

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

1 (A) in case of individual coverage, not less
2 than 72.5 percent of the applicable premium
3 (as defined in section 4980B(f)(4) of such
4 Code, subject to paragraph (2)) of the lowest
5 cost plan offered by the employer that is a
6 qualified health benefits plan (or is such cur-
7 rent employment-based health plan); and

8 (B) in the case of family coverage which
9 includes coverage of such spouse and children,
10 not less 65 percent of such applicable premium
11 of such lowest cost plan.

12 (2) APPLICABLE PREMIUM FOR EXCHANGE COV-
13 ERAGE.—In this subtitle, the amount of the applica-
14 ble premium of the lowest cost plan with respect to
15 coverage of an employee under an Exchange-partici-
16 pating health benefits plan is the reference premium
17 amount under section 343(c) for individual coverage
18 (or, if elected, family coverage) for the premium rat-
19 ing area in which the individual or family resides.

20 (3) MINIMUM EMPLOYER CONTRIBUTION FOR
21 EMPLOYEES OTHER THAN FULL-TIME EMPLOY-
22 EES.—In the case of coverage for an employee who
23 is not a full-time employee, the amount of the min-
24 imum employer contribution under this subsection
25 shall be a proportion (as determined in accordance

1 with rules of the Health Choices Commissioner, the
2 Secretary of Labor, the Secretary of Health and
3 Human Services, and the Secretary of the Treasury,
4 as applicable) of the minimum employer contribution
5 under this subsection with respect to a full-time em-
6 ployee that reflects the proportion of—

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

9 (B) the minimum weekly hours specified
10 by the Commissioner for an employee to be a
11 full-time employee.

12 (4) SALARY REDUCTIONS NOT TREATED AS EM-
13 PLOYER CONTRIBUTIONS.—For purposes of this sec-
14 tion, any contribution on behalf of an employee with
15 respect to which there is a corresponding reduction
16 in the compensation of the employee shall not be
17 treated as an amount paid by the employer.

18 (c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPON-
19 SORED HEALTH BENEFITS.—

20 (1) IN GENERAL.—The requirement of this sub-
21 section with respect to an employer and an employee
22 is that the employer automatically enroll such em-
23 ployee into the employment-based health benefits
24 plan for individual coverage under the plan option
25 with the lowest applicable employee premium.

1 (2) OPT-OUT.—In no case may an employer
2 automatically enroll an employee in a plan under
3 paragraph (1) if such employee makes an affirmative
4 election to opt out of such plan or to elect coverage
5 under an employment-based health benefits plan of-
6 fered by such employer. An employer shall provide
7 an employee with a 30-day period to make such an
8 affirmative election before the employer may auto-
9 matically enroll the employee in such a plan.

10 (3) NOTICE REQUIREMENTS.—

11 (A) IN GENERAL.—Each employer de-
12 scribed in paragraph (1) who automatically en-
13 rolls an employee into a plan as described in
14 such paragraph shall provide the employees,
15 within a reasonable period before the beginning
16 of each plan year (or, in the case of new em-
17 ployees, within a reasonable period before the
18 end of the enrollment period for such a new em-
19 ployee), written notice of the employees' rights
20 and obligations relating to the automatic enroll-
21 ment requirement under such paragraph. Such
22 notice must be comprehensive and understood
23 by the average employee to whom the automatic
24 enrollment requirement applies.

1 (B) INCLUSION OF SPECIFIC INFORMA-
2 TION.—The written notice under subparagraph
3 (A) must explain an employee’s right to opt out
4 of being automatically enrolled in a plan and in
5 the case that more than one level of benefits or
6 employee premium level is offered by the em-
7 ployer involved, the notice must explain which
8 level of benefits and employee premium level the
9 employee will be automatically enrolled in the
10 absence of an affirmative election by the em-
11 ployee.

12 **SEC. 413. EMPLOYER CONTRIBUTIONS IN LIEU OF COV-**
13 **ERAGE.**

14 (a) IN GENERAL.—A contribution is made in accord-
15 ance with this section with respect to an employee if such
16 contribution is equal to an amount equal to 8 percent of
17 the average wages paid by the employer during the period
18 of enrollment (determined by taking into account all em-
19 ployees of the employer and in such manner as the Com-
20 missioner provides, including rules providing for the ap-
21 propriate aggregation of related employers) but not to ex-
22 ceed the minimum employer contribution described in sec-
23 tion 412(b)(1)(A). Any such contribution—

1 (1) shall be paid to the Health Choices Com-
 2 missioner for deposit into the Health Insurance Ex-
 3 change Trust Fund; and

4 (2) shall not be applied against the premium of
 5 the employee under the Exchange-participating
 6 health benefits plan in which the employee is en-
 7 rolled.

8 (b) SPECIAL RULES FOR SMALL EMPLOYERS.—

9 (1) IN GENERAL.—In the case of any employer
 10 who is a small employer for any calendar year, sub-
 11 section (a) shall be applied by substituting the appli-
 12 cable percentage determined in accordance with the
 13 following table for “8 percent”:

| If the annual payroll of such employer for the preceding calendar year: | The applicable percentage is: |
|--|--|
| Does not exceed \$500,000 | 0 percent |
| Exceeds \$500,000, but does not exceed \$585,000 | 2 percent |
| Exceeds \$585,000, but does not exceed \$670,000 | 4 percent |
| Exceeds \$670,000, but does not exceed \$750,000 | 6 percent |

14 (2) SMALL EMPLOYER.—For purposes of this
 15 subsection, the term “small employer” means any
 16 employer for any calendar year if the annual payroll
 17 of such employer for the preceding calendar year
 18 does not exceed \$750,000.

19 (3) ANNUAL PAYROLL.—For purposes of this
 20 paragraph, the term “annual payroll” means, with
 21 respect to any employer for any calendar year, the

1 aggregate wages paid by the employer during such
2 calendar year.

3 (4) AGGREGATION RULES.—Related employers
4 and predecessors shall be treated as a single em-
5 ployer for purposes of this subsection.

6 **SEC. 414. AUTHORITY RELATED TO IMPROPER STEERING.**

7 The Health Choices Commissioner (in coordination
8 with the Secretary of Labor, the Secretary of Health and
9 Human Services, and the Secretary of the Treasury) shall
10 have authority to set standards for determining whether
11 employers or insurers are undertaking any actions to af-
12 fect the risk pool within the Health Insurance Exchange
13 by inducing individuals to decline coverage under a quali-
14 fied health benefits plan (or current employment-based
15 health plan (within the meaning of section 202(b)) offered
16 by the employer and instead to enroll in an Exchange-par-
17 ticipating health benefits plan. An employer violating such
18 standards shall be treated as not meeting the require-
19 ments of this section.

20 **SEC. 415. IMPACT STUDY ON EMPLOYER RESPONSIBILITY**
21 **REQUIREMENTS.**

22 (a) IN GENERAL.—The Secretary of Labor shall con-
23 duct a study to examine the effect of the exemptions under
24 section 512(a) and coverage thresholds under this division
25 (in this section referred to collectively as “employer re-

1 sponsibility requirements)on employment-based health
2 plan sponsorship, generally and within specific industries,
3 and the effect of such requirements and thresholds on em-
4 ployers, employment-based health plans, and employees in
5 each industry.

6 (b) ANNUAL REPORT.—The Secretary of Labor an-
7 nually shall submit to Congress a report on findings on
8 how employer responsibility requirements have impacted
9 and are likely to impact employers, plans, and employees
10 during the previous year and projected trends.

11 (c) LEGISLATIVE RECOMMENDATIONS.—No later
12 than January 1, 2012 and on an annual basis thereafter,
13 the Secretary of Labor shall submit legislative rec-
14 ommendations to Congress to modify the employer respon-
15 sibility requirements if the Secretary determines that the
16 requirements are detrimentally affecting or will detrimen-
17 tally affect employer plan sponsorship or otherwise cre-
18 ating inequities among employers, health plans, and em-
19 ployees. The Secretary may also submit such recommenda-
20 tions as the Secretary determines necessary to improve
21 and strengthen employment-based health plan sponsor-
22 ship, employer responsibility, and related proposals that
23 would enhance the delivery of health care benefits between
24 employers and employees.

1 **SEC. 416. STUDY ON EMPLOYER HARDSHIP EXEMPTION.**

2 (a) IN GENERAL.—The Secretary of Labor together
3 with the Secretary of Treasury, the Secretary of Health
4 and Human Services, and the Commissioner, shall conduct
5 a study to examine the impact of the employer responsi-
6 bility requirements described in section 415(a) and make
7 a recommendation to Congress about whether an employer
8 hardship exemption would be appropriate.

9 (b) ITEMS INCLUDED IN STUDY.—Within such study
10 the Secretaries and Commissioner shall examine cases
11 where such employer responsibility requirements may pose
12 a particular hardship, and specifically look at employers
13 by industry, profit margin, length of time in business, and
14 size. In this examination, the economic conditions shall be
15 considered, including the rate of increase in business costs,
16 the availability of short-term credit lines, and abilities to
17 restructure debt. In addition, the study shall examine the
18 impact an employer hardship waiver could have on employ-
19 ees.

20 (c) REPORT.—Not later than January 1, 2012, the
21 Secretaries and Commissioner shall report to Congress on
22 their findings and make a recommendation regarding the
23 need or lack of need for a partial or complete employer
24 hardship waiver. The Secretaries and Commissioner may
25 also submit recommendations about the criteria Congress
26 should include when developing eligibility requirements for

1 the employer hardship waiver and what safeguards are
2 necessary to protect the employees of that employer.

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

4 **PARTICIPATION REQUIREMENTS**

5 **SEC. 421. SATISFACTION OF HEALTH COVERAGE PARTICI-**

6 **PATION REQUIREMENTS UNDER THE EM-**

7 **PLOYEE RETIREMENT INCOME SECURITY**

8 **ACT OF 1974.**

9 (a) IN GENERAL.—Subtitle B of title I of the Em-
10 ployee Retirement Income Security Act of 1974 is amend-
11 ed by adding at the end the following new part:

12 **“PART 8—NATIONAL HEALTH COVERAGE**

13 **PARTICIPATION REQUIREMENTS**

14 **“SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NA-**

15 **TIONAL HEALTH COVERAGE PARTICIPATION**

16 **REQUIREMENTS.**

17 “(a) IN GENERAL.—An employer may make an elec-
18 tion with the Secretary to be subject to the health coverage
19 participation requirements.

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

1 **“SEC. 802. TREATMENT OF COVERAGE RESULTING FROM**
2 **ELECTION.**

3 “(a) IN GENERAL.—If an employer makes an election
4 to the Secretary under section 801—

5 “(1) such election shall be treated as the estab-
6 lishment and maintenance of a group health plan (as
7 defined in section 733(a)) for purposes of this title,
8 subject to section 251 of the ; and

9 “(2) the health coverage participation require-
10 ments shall be deemed to be included as terms and
11 conditions of such plan.

12 “(b) PERIODIC INVESTIGATIONS TO DISCOVER NON-
13 COMPLIANCE.—The Secretary shall regularly audit a rep-
14 resentative sampling of employers and group health plans
15 and conduct investigations and other activities under sec-
16 tion 504 with respect to such sampling of plans so as to
17 discover noncompliance with the health coverage participa-
18 tion requirements in connection with such plans. The Sec-
19 retary shall communicate findings of noncompliance made
20 by the Secretary under this subsection to the Secretary
21 of the Treasury and the Health Choices Commissioner.
22 The Secretary shall take such timely enforcement action
23 as appropriate to achieve compliance.

24 “(c) RECORDKEEPING.—To facilitate the audits de-
25 scribed in subsection (b), the Secretary shall promulgate
26 recordkeeping requirements for employers to account for

1 both employees of the employer and individuals whom the
2 employer has not treated as employees of the employer but
3 with whom the employer, in the course of its trade or busi-
4 ness, has engaged for the performance of labor or services.
5 The scope and content of such recordkeeping requirements
6 shall be determined by the Secretary and shall be designed
7 to ensure that employees who are not properly treated as
8 such may be identified and properly treated.

9 **“SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIRE-**
10 **MENTS.**

11 “For purposes of this part, the term ‘health coverage
12 participation requirements’ means the requirements of
13 part 1 of subtitle B of title IV of division A of (as in effect
14 on the date of the enactment of such Act).

15 **“SEC. 804. RULES FOR APPLYING REQUIREMENTS.**

16 “(a) **AFFILIATED GROUPS.**—In the case of any em-
17 ployer which is part of a group of employers who are treat-
18 ed as a single employer under subsection (b), (c), (m), or
19 (o) of section 414 of the Internal Revenue Code of 1986,
20 the election under section 801 shall be made by such em-
21 ployer as the Secretary may provide. Any such election,
22 once made, shall apply to all members of such group.

23 “(b) **SEPARATE ELECTIONS.**—Under regulations pre-
24 scribed by the Secretary, separate elections may be made
25 under section 801 with respect to—

1 “(1) separate lines of business, and

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

4 **“SEC. 805. TERMINATION OF ELECTION IN CASES OF SUB-**
5 **STANTIAL NONCOMPLIANCE.**

6 “The Secretary may terminate the election of any em-
7 ployer under section 801 if the Secretary (in coordination
8 with the Health Choices Commissioner) determines that
9 such employer is in substantial noncompliance with the
10 health coverage participation requirements and shall refer
11 any such determination to the Secretary of the Treasury
12 as appropriate.

13 **“SEC. 806. REGULATIONS.**

14 “The Secretary may promulgate such regulations as
15 may be necessary or appropriate to carry out the provi-
16 sions of this part, in accordance with section 424(a) of
17 the . The Secretary may promulgate any interim final
18 rules as the Secretary determines are appropriate to carry
19 out this part.”.

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

23 (1) in subsection (a)(6), by striking “para-
24 graph” and all that follows through “subsection (c)”

1 and inserting “paragraph (2), (4), (5), (6), (7), (8),
2 (9), (10), or (11) of subsection (c)”; and

3 (2) in subsection (c), by redesignating the sec-
4 ond paragraph (10) as paragraph (12) and by in-
5 serting after the first paragraph (10) the following
6 new paragraph:

7 “(11) HEALTH COVERAGE PARTICIPATION RE-
8 QUIREMENTS.—

9 “(A) CIVIL PENALTIES.—In the case of
10 any employer who fails (during any period with
11 respect to which an election under section
12 801(a) is in effect) to satisfy the health cov-
13 erage participation requirements with respect to
14 any employee, the Secretary may assess a civil
15 penalty against the employer of \$100 for each
16 day in the period beginning on the date such
17 failure first occurs and ending on the date such
18 failure is corrected.

19 “(B) HEALTH COVERAGE PARTICIPATION
20 REQUIREMENTS.—For purposes of this para-
21 graph, the term ‘health coverage participation
22 requirements’ has the meaning provided in sec-
23 tion 803.

24 “(C) LIMITATIONS ON AMOUNT OF PEN-
25 ALTY.—

1 “(i) PENALTY NOT TO APPLY WHERE
2 FAILURE NOT DISCOVERED EXERCISING
3 REASONABLE DILIGENCE.—No penalty
4 shall be assessed under subparagraph (A)
5 with respect to any failure during any pe-
6 riod for which it is established to the satis-
7 faction of the Secretary that the employer
8 did not know, or exercising reasonable dili-
9 gence would not have known, that such
10 failure existed.

11 “(ii) PENALTY NOT TO APPLY TO
12 FAILURES CORRECTED WITHIN 30 DAYS.—
13 No penalty shall be assessed under sub-
14 paragraph (A) with respect to any failure
15 if—

16 “(I) such failure was due to rea-
17 sonable cause and not to willful ne-
18 glect, and

19 “(II) such failure is corrected
20 during the 30-day period beginning on
21 the 1st date that the employer knew,
22 or exercising reasonable diligence
23 would have known, that such failure
24 existed.

1 “(iii) OVERALL LIMITATION FOR UN-
2 INTENTIONAL FAILURES.—In the case of
3 failures which are due to reasonable cause
4 and not to willful neglect, the penalty as-
5 sessed under subparagraph (A) for failures
6 during any 1-year period shall not exceed
7 the amount equal to the lesser of—

8 “(I) 10 percent of the aggregate
9 amount paid or incurred by the em-
10 ployer (or predecessor employer) dur-
11 ing the preceding 1-year period for
12 group health plans, or

13 “(II) \$500,000.

14 “(D) ADVANCE NOTIFICATION OF FAILURE
15 PRIOR TO ASSESSMENT.—Before a reasonable
16 time prior to the assessment of any penalty
17 under this paragraph with respect to any failure
18 by an employer, the Secretary shall inform the
19 employer in writing of such failure and shall
20 provide the employer information regarding ef-
21 forts and procedures which may be undertaken
22 by the employer to correct such failure.

23 “(E) COORDINATION WITH EXCISE TAX.—
24 Under regulations prescribed in accordance
25 with section 424 of the , the Secretary and the

1 Secretary of the Treasury shall coordinate the
2 assessment of penalties under this section in
3 connection with failures to satisfy health cov-
4 erage participation requirements with the impo-
5 sition of excise taxes on such failures under sec-
6 tion 4980H(b) of the Internal Revenue Code of
7 1986 so as to avoid duplication of penalties
8 with respect to such failures.

9 “(F) DEPOSIT OF PENALTY COLLECTED.—
10 Any amount of penalty collected under this
11 paragraph shall be deposited as miscellaneous
12 receipts in the Treasury of the United States.”.

13 (c) CLERICAL AMENDMENTS.—The table of contents
14 in section 1 of such Act is amended by inserting after the
15 item relating to section 734 the following new items:

“PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

“Sec. 801. Election of employer to be subject to national health coverage par-
ticipation requirements.

“Sec. 802. Treatment of coverage resulting from election.

“Sec. 803. Health coverage participation requirements.

“Sec. 804. Rules for applying requirements.

“Sec. 805. Termination of election in cases of substantial noncompliance.

“Sec. 806. Regulations.”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to periods beginning after Decem-
18 ber 31, 2012.

1 **SEC. 422. SATISFACTION OF HEALTH COVERAGE PARTICI-**
2 **PATION REQUIREMENTS UNDER THE INTER-**
3 **NAL REVENUE CODE OF 1986.**

4 (a) FAILURE TO ELECT, OR SUBSTANTIALLY COM-
5 PLY WITH, HEALTH COVERAGE PARTICIPATION RE-
6 QUIREMENTS.—For employment tax on employers who fail
7 to elect, or substantially comply with, the health coverage
8 participation requirements described in part 1, see section
9 3111(c) of the Internal Revenue Code of 1986 (as added
10 by section 512 of this Act).

11 (b) OTHER FAILURES.—For excise tax on other fail-
12 ures of electing employers to comply with such require-
13 ments, see section 4980H of the Internal Revenue Code
14 of 1986 (as added by section 511 of this Act).

15 **SEC. 423. SATISFACTION OF HEALTH COVERAGE PARTICI-**
16 **PATION REQUIREMENTS UNDER THE PUBLIC**
17 **HEALTH SERVICE ACT.**

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

21 **“SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION**
22 **REQUIREMENTS.**

23 **“(a) ELECTION OF EMPLOYER TO BE SUBJECT TO**
24 **NATIONAL HEALTH COVERAGE PARTICIPATION REQUIRE-**
25 **MENTS.—**

1 “(1) IN GENERAL.—An employer may make an
2 election with the Secretary to be subject to the
3 health coverage participation requirements.

4 “(2) TIME AND MANNER.—An election under
5 paragraph (1) may be made at such time and in
6 such form and manner as the Secretary may pre-
7 scribe.

8 “(b) TREATMENT OF COVERAGE RESULTING FROM
9 ELECTION.—

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

12 “(A) such election shall be treated as the
13 establishment and maintenance of a group
14 health plan for purposes of this title, subject to
15 section 251 of the Affordable Health Care for
16 America Act; and

17 “(B) the health coverage participation re-
18 quirements shall be deemed to be included as
19 terms and conditions of such plan.

20 “(2) PERIODIC INVESTIGATIONS TO DETERMINE
21 COMPLIANCE WITH HEALTH COVERAGE PARTICIPA-
22 TION REQUIREMENTS.—The Secretary shall regu-
23 larly audit a representative sampling of employers
24 and conduct investigations and other activities with
25 respect to such sampling of employers so as to dis-

1 cover noncompliance with the health coverage par-
2 ticipation requirements in connection with such em-
3 ployers (during any period with respect to which an
4 election under subsection (a) is in effect). The Sec-
5 retary shall communicate findings of noncompliance
6 made by the Secretary under this subsection to the
7 Secretary of the Treasury and the Health Choices
8 Commissioner. The Secretary shall take such timely
9 enforcement action as appropriate to achieve compli-
10 ance.

11 “(3) RECORDKEEPING.—To facilitate the audits
12 described in subsection (b), the Secretary shall pro-
13 mulgate recordkeeping requirements for employers
14 to account for both employees of the employer and
15 individuals whom the employer has not treated as
16 employees of the employer but with whom the em-
17 ployer, in the course of its trade or business, has en-
18 gaged for the performance of labor or services. The
19 scope and content of such recordkeeping require-
20 ments shall be determined by the Secretary and
21 shall be designed to ensure that employees who are
22 not properly treated as such may be identified and
23 properly treated.

24 “(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
25 MENTS.—For purposes of this section, the term ‘health

1 coverage participation requirements’ means the require-
2 ments of part 1 of subtitle B of title IV of division A of
3 the (as in effect on the date of the enactment of this sec-
4 tion).

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

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

17 “(f) ENFORCEMENT OF HEALTH COVERAGE PAR-
18 TICIPATION REQUIREMENTS.—

19 “(1) CIVIL PENALTIES.—In the case of any em-
20 ployer who fails (during any period with respect to
21 which the election under subsection (a) is in effect)
22 to satisfy the health coverage participation require-
23 ments with respect to any employee, the Secretary
24 may assess a civil penalty against the employer of
25 \$100 for each day in the period beginning on the

1 date such failure first occurs and ending on the date
2 such failure is corrected.

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

4 “(A) PENALTY NOT TO APPLY WHERE
5 FAILURE NOT DISCOVERED EXERCISING REA-
6 SONABLE DILIGENCE.—No penalty shall be as-
7 sessed under paragraph (1) with respect to any
8 failure during any period for which it is estab-
9 lished to the satisfaction of the Secretary that
10 the employer did not know, or exercising rea-
11 sonable diligence would not have known, that
12 such failure existed.

13 “(B) PENALTY NOT TO APPLY TO FAIL-
14 URES CORRECTED WITHIN 30 DAYS.—No pen-
15 alty shall be assessed under paragraph (1) with
16 respect to any failure if—

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

19 “(ii) such failure is corrected during
20 the 30-day period beginning on the 1st
21 date that the employer knew, or exercising
22 reasonable diligence would have known,
23 that such failure existed.

24 “(C) OVERALL LIMITATION FOR UNINTEN-
25 TIONAL FAILURES.—In the case of failures

1 which are due to reasonable cause and not to
2 willful neglect, the penalty assessed under para-
3 graph (1) for failures during any 1-year period
4 shall not exceed the amount equal to the lesser
5 of—

6 “(i) 10 percent of the aggregate
7 amount paid or incurred by the employer
8 (or predecessor employer) during the pre-
9 ceding taxable year for group health plans,
10 or

11 “(ii) \$500,000.

12 “(3) ADVANCE NOTIFICATION OF FAILURE
13 PRIOR TO ASSESSMENT.—Before a reasonable time
14 prior to the assessment of any penalty under para-
15 graph (1) with respect to any failure by an em-
16 ployer, the Secretary shall inform the employer in
17 writing of such failure and shall provide the em-
18 ployer information regarding efforts and procedures
19 which may be undertaken by the employer to correct
20 such failure.

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

1 “(5) COORDINATION WITH EXCISE TAX.—

2 Under regulations prescribed in accordance with sec-
3 tion 424 of the , the Secretary and the Secretary of
4 the Treasury shall coordinate the assessment of pen-
5 alties under paragraph (1) in connection with fail-
6 ures to satisfy health coverage participation require-
7 ments with the imposition of excise taxes on such
8 failures under section 4980H(b) of the Internal Rev-
9 enue Code of 1986 so as to avoid duplication of pen-
10 alties with respect to such failures.

11 “(6) DEPOSIT OF PENALTY COLLECTED.—Any
12 amount of penalty collected under this subsection
13 shall be deposited as miscellaneous receipts in the
14 Treasury of the United States.

15 “(g) REGULATIONS.—The Secretary may promulgate
16 such regulations as may be necessary or appropriate to
17 carry out the provisions of this section, in accordance with
18 section 424(a) of the . The Secretary may promulgate any
19 interim final rules as the Secretary determines are appro-
20 priate to carry out this section.”.

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

1 **SEC. 424. ADDITIONAL RULES RELATING TO HEALTH COV-**
2 **ERAGE PARTICIPATION REQUIREMENTS.**

3 (a) ASSURING COORDINATION.—The officers con-
4 sisting of the Secretary of Labor, the Secretary of the
5 Treasury, the Secretary of Health and Human Services,
6 and the Health Choices Commissioner shall ensure,
7 through the execution of an interagency memorandum of
8 understanding among such officers, that—

9 (1) regulations, rulings, and interpretations
10 issued by such officers relating to the same matter
11 over which two or more of such officers have respon-
12 sibility under subpart B of part 8 of subtitle B of
13 title I of the Employee Retirement Income Security
14 Act of 1974, section 4980H of the Internal Revenue
15 Code of 1986, and section 2793 of the Public Health
16 Service Act are administered so as to have the same
17 effect at all times; and

18 (2) coordination of policies relating to enforcing
19 the same requirements through such officers in
20 order to have a coordinated enforcement strategy
21 that avoids duplication of enforcement efforts and
22 assigns priorities in enforcement.

23 (b) MULTIEMPLOYER PLANS.—In the case of a group
24 health plan that is a multiemployer plan (as defined in
25 section 3(37) of the Employee Retirement Income Secu-
26 rity Act of 1974), the regulations prescribed in accordance

1 with subsection (a) by the officers referred to in subsection
2 (a) shall provide for the application of the health coverage
3 participation requirements to the plan sponsor and con-
4 tributing employers of such plan. For purposes of this di-
5 vision, contributions made pursuant to a collective bar-
6 gaining agreement or other agreement to such a group
7 health plan shall be treated as amounts paid by the em-
8 ployer.

9 **TITLE V—AMENDMENTS TO IN-**
10 **TERNAL REVENUE CODE OF**
11 **1986**

12 **Subtitle A—Provisions Relating to**
13 **Health Care Reform**

14 **PART 1—SHARED RESPONSIBILITY**

15 **Subpart A—Individual Responsibility**

16 **SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE**
17 **HEALTH CARE COVERAGE.**

18 (a) IN GENERAL.—Subchapter A of chapter 1 of the
19 Internal Revenue Code of 1986 is amended by adding at
20 the end the following new part:

21 **“PART VIII—HEALTH CARE RELATED TAXES**

“SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE
COVERAGE.

22 **“Subpart A—Tax on Individuals Without Acceptable**
23 **Health Care Coverage**

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

1 **“SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE**
2 **HEALTH CARE COVERAGE.**

3 “(a) TAX IMPOSED.—In the case of any individual
4 who does not meet the requirements of subsection (d) at
5 any time during the taxable year, there is hereby imposed
6 a tax equal to 2.5 percent of the excess of—

7 “(1) the taxpayer’s modified adjusted gross in-
8 come for the taxable year, over

9 “(2) the amount of gross income specified in
10 section 6012(a)(1) with respect to the taxpayer.

11 “(b) LIMITATIONS.—

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

13 “(A) IN GENERAL.—The tax imposed
14 under subsection (a) with respect to any tax-
15 payer for any taxable year shall not exceed the
16 applicable national average premium for such
17 taxable year.

18 “(B) APPLICABLE NATIONAL AVERAGE
19 PREMIUM.—

20 “(i) IN GENERAL.—For purposes of
21 subparagraph (A), the ‘applicable national
22 average premium’ means, with respect to
23 any taxable year, the average premium (as
24 determined by the Secretary, in coordina-
25 tion with the Health Choices Commis-
26 sioner) for self-only coverage under a basic

1 plan which is offered in a Health Insur-
2 ance Exchange for the calendar year in
3 which such taxable year begins.

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

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

19 “(A) the aggregate periods during such
20 taxable year for which such individual failed to
21 meet the requirements of subsection (d), bears
22 to

23 “(B) the entire taxable year.

24 “(c) EXCEPTIONS.—

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

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

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

17 “(4) INDIVIDUALS RESIDING IN POSSESSIONS
18 OF THE UNITED STATES.—Any individual who is a
19 bona fide resident of any possession of the United
20 States (as determined under section 937(a)) for any
21 taxable year (and any qualifying child residing with
22 such individual) shall be treated for purposes of this
23 section as covered by acceptable coverage during
24 such taxable year.

25 “(5) RELIGIOUS CONSCIENCE EXEMPTION.—

1 “(A) IN GENERAL.—Subsection (a) shall
2 not apply to any individual (and any qualifying
3 child residing with such individual) for any pe-
4 riod if such individual has in effect an exemp-
5 tion which certifies that such individual is a
6 member of a recognized religious sect or divi-
7 sion thereof described in section 1402(g)(1) and
8 an adherent of established tenets or teachings
9 of such sect or division as described in such sec-
10 tion.

11 “(B) EXEMPTION.—An application for the
12 exemption described in subparagraph (A) shall
13 be filed with the Secretary at such time and in
14 such form and manner as the Secretary may
15 prescribe. The Secretary may treat an applica-
16 tion for exemption under section 1402(g)(1) as
17 an application for exemption under this section,
18 or may otherwise coordinate applications under
19 such sections, as the Secretary determines ap-
20 propriate. Any such exemption granted by the
21 Secretary shall be effective for such period as
22 the Secretary determines appropriate.

23 “(d) ACCEPTABLE COVERAGE REQUIREMENT.—

24 “(1) IN GENERAL.—The requirements of this
25 subsection are met with respect to any individual for

1 any period if such individual (and each qualifying
2 child of such individual) is covered by acceptable
3 coverage at all times during such period.

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

7 “(A) QUALIFIED HEALTH BENEFITS PLAN
8 COVERAGE.—Coverage under a qualified health
9 benefits plan (as defined in section 100(c) of
10 the).

11 “(B) GRANDFATHERED HEALTH INSUR-
12 ANCE COVERAGE; COVERAGE UNDER GRAND-
13 FATHERED EMPLOYMENT-BASED HEALTH
14 PLAN.—Coverage under a grandfathered health
15 insurance coverage (as defined in subsection (a)
16 of section 202 of the) or under a current em-
17 ployment-based health plan (within the meaning
18 of subsection (b) of such section).

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

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

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

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

5 “(F) VA.—Coverage under the veteran’s
6 health care program under chapter 17 of title
7 38, United States Code.

8 “(G) MEMBERS OF INDIAN TRIBES.—
9 Health care services made available through the
10 Indian Health Service, a tribal organization (as
11 defined in section 4 of the Indian Health Care
12 Improvement Act), or an urban Indian organi-
13 zation (as defined in such section) to members
14 of an Indian tribe (as defined in such section).

15 “(H) OTHER COVERAGE.—Such other
16 health benefits coverage as the Secretary, in co-
17 ordination with the Health Choices Commis-
18 sioner, recognizes for purposes of this sub-
19 section.

20 “(e) OTHER DEFINITIONS AND SPECIAL RULES.—

21 “(1) QUALIFYING CHILD.—For purposes of this
22 section, the term ‘qualifying child’ has the meaning
23 given such term by section 152(c). With respect to
24 any period during which health coverage for a child
25 must be provided by an individual pursuant to a

1 child support order, such child shall be treated as a
2 qualifying child of such individual (and not as a
3 qualifying child of any other individual).

4 “(2) BASIC PLAN.—For purposes of this sec-
5 tion, the term ‘basic plan’ has the meaning given
6 such term under section 100(c) of the .

7 “(3) HEALTH INSURANCE EXCHANGE.—For
8 purposes of this section, the term ‘Health Insurance
9 Exchange’ has the meaning given such term under
10 section 100(c) of the , including any State-based
11 health insurance exchange approved for operation
12 under section 308 of such Act.

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

16 “(5) MODIFIED ADJUSTED GROSS INCOME.—
17 For purposes of this section, the term ‘modified ad-
18 justed gross income’ means adjusted gross income
19 increased by—

20 “(A) any amount excluded from gross in-
21 come under section 911, and

22 “(B) any amount of interest received or
23 accrued by the taxpayer during the taxable year
24 which is exempt from tax.

1 “(6) NOT TREATED AS TAX IMPOSED BY THIS
2 CHAPTER FOR CERTAIN PURPOSES.—The tax im-
3 posed under this section shall not be treated as tax
4 imposed by this chapter for purposes of determining
5 the amount of any credit under this chapter or for
6 purposes of section 55.

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

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

16 “(2) a waiver of the application of subsection
17 (a) in cases of hardship, including a process for ap-
18 plying for such a waiver.”.

19 (b) INFORMATION REPORTING.—

20 (1) IN GENERAL.—Subpart B of part III of
21 subchapter A of chapter 61 of such Code is amended
22 by inserting after section 6050W the following new
23 section:

1 **“SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE**
2 **COVERAGE.**

3 “(a) REQUIREMENT OF REPORTING.—Every person
4 who provides acceptable coverage (as defined in section
5 59B(d)) to any individual during any calendar year shall,
6 at such time as the Secretary may prescribe, make the
7 return described in subsection (b) with respect to such in-
8 dividual.

9 “(b) FORM AND MANNER OF RETURNS.—A return
10 is described in this subsection if such return—

11 “(1) is in such form as the Secretary may pre-
12 scribe, and

13 “(2) contains—

14 “(A) the name, address, and TIN of the
15 primary insured and the name of each other in-
16 dividual obtaining coverage under the policy,

17 “(B) the period for which each such indi-
18 vidual was provided with the coverage referred
19 to in subsection (a), and

20 “(C) such other information as the Sec-
21 retary may require.

22 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
23 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
24 QUIRED.—Every person required to make a return under
25 subsection (a) shall furnish to each primary insured whose

1 name is required to be set forth in such return a written
2 statement showing—

3 “(1) the name and address of the person re-
4 quired to make such return and the phone number
5 of the information contact for such person, and

6 “(2) the information required to be shown on
7 the return with respect to such individual.

8 The written statement required under the preceding sen-
9 tence shall be furnished on or before January 31 of the
10 year following the calendar year for which the return
11 under subsection (a) is required to be made.

12 “(d) COVERAGE PROVIDED BY GOVERNMENTAL
13 UNITS.—In the case of coverage provided by any govern-
14 mental unit or any agency or instrumentality thereof, the
15 officer or employee who enters into the agreement to pro-
16 vide such coverage (or the person appropriately designated
17 for purposes of this section) shall make the returns and
18 statements required by this section.”.

19 (2) PENALTY FOR FAILURE TO FILE.—

20 (A) RETURN.—Subparagraph (B) of sec-
21 tion 6724(d)(1) of such Code is amended by
22 striking “or” at the end of clause (xxii), by
23 striking “and” at the end of clause (xxiii) and
24 inserting “or”, and by adding at the end the
25 following new clause:

1 “(xxiv) section 6050X (relating to re-
2 turns relating to health insurance cov-
3 erage), and”.

4 (B) STATEMENT.—Paragraph (2) of sec-
5 tion 6724(d) of such Code is amended by strik-
6 ing “or” at the end of subparagraph (EE), by
7 striking the period at the end of subparagraph
8 (F) and inserting “, or”, and by inserting
9 after subparagraph (FF) the following new sub-
10 paragraph:

11 “(GG) section 6050X (relating to returns
12 relating to health insurance coverage).”.

13 (c) RETURN REQUIREMENT.—Subsection (a) of sec-
14 tion 6012 of such Code is amended by inserting after
15 paragraph (9) the following new paragraph:

16 “(10) Every individual to whom section 59B(a)
17 applies and who fails to meet the requirements of
18 section 59B(d) with respect to such individual or
19 any qualifying child (as defined in section 152(c)) of
20 such individual.”.

21 (d) CLERICAL AMENDMENTS.—

22 (1) The table of parts for subchapter A of chap-
23 ter 1 of the Internal Revenue Code of 1986 is
24 amended by adding at the end the following new
25 item:

“PART VIII. HEALTH CARE RELATED TAXES.”.

1 (2) The table of sections for subpart B of part
2 III of subchapter A of chapter 61 is amended by
3 adding at the end the following new item:

“Sec. 6050X. Returns relating to health insurance coverage.”.

4 (e) SECTION 15 NOT TO APPLY.—The amendment
5 made by subsection (a) shall not be treated as a change
6 in a rate of tax for purposes of section 15 of the Internal
7 Revenue Code of 1986.

8 (f) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendments made by
10 this section shall apply to taxable years beginning
11 after December 31, 2012.

12 (2) RETURNS.—The amendments made by sub-
13 section (b) shall apply to calendar years beginning
14 after December 31, 2012.

15 **Subpart B—Employer Responsibility**

16 **SEC. 511. ELECTION TO SATISFY HEALTH COVERAGE PAR-**
17 **TICIPATION REQUIREMENTS.**

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 new section:

21 **“SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COV-**
22 **ERAGE PARTICIPATION REQUIREMENTS.**

23 “(a) ELECTION OF EMPLOYER RESPONSIBILITY TO
24 PROVIDE HEALTH COVERAGE.—

1 “(1) IN GENERAL.—Subsection (b) shall apply
2 to any employer with respect to whom an election
3 under paragraph (2) is in effect.

4 “(2) TIME AND MANNER.—An employer may
5 make an election under this paragraph at such time
6 and in such form and manner as the Secretary may
7 prescribe.

8 “(3) AFFILIATED GROUPS.—In the case of any
9 employer which is part of a group of employers who
10 are treated as a single employer under subsection
11 (b), (c), (m), or (o) of section 414, the election
12 under paragraph (2) shall be made by such person
13 as the Secretary may provide. Any such election,
14 once made, shall apply to all members of such
15 group.

16 “(4) SEPARATE ELECTIONS.—Under regula-
17 tions prescribed by the Secretary, separate elections
18 may be made under paragraph (2) with respect to—

19 “(A) separate lines of business, and

20 “(B) full-time employees and employees
21 who are not full-time employees.

22 “(5) TERMINATION OF ELECTION IN CASES OF
23 SUBSTANTIAL NONCOMPLIANCE.—The Secretary
24 may terminate the election of any employer under
25 paragraph (2) if the Secretary (in coordination with

1 the Health Choices Commissioner) determines that
2 such employer is in substantial noncompliance with
3 the health coverage participation requirements.

4 “(b) EXCISE TAX WITH RESPECT TO FAILURE TO
5 MEET HEALTH COVERAGE PARTICIPATION REQUIRE-
6 MENTS.—

7 “(1) IN GENERAL.—In the case of any employer
8 who fails (during any period with respect to which
9 the election under subsection (a) is in effect) to sat-
10 isfy the health coverage participation requirements
11 with respect to any employee to whom such election
12 applies, there is hereby imposed on each such failure
13 with respect to each such employee a tax of \$100 for
14 each day in the period beginning on the date such
15 failure first occurs and ending on the date such fail-
16 ure is corrected.

17 “(2) LIMITATIONS ON AMOUNT OF TAX.—

18 “(A) TAX NOT TO APPLY WHERE FAILURE
19 NOT DISCOVERED EXERCISING REASONABLE
20 DILIGENCE.—No tax shall be imposed by para-
21 graph (1) on any failure during any period for
22 which it is established to the satisfaction of the
23 Secretary that the employer neither knew, nor
24 exercising reasonable diligence would have
25 known, that such failure existed.

1 “(B) TAX NOT TO APPLY TO FAILURES
2 CORRECTED WITHIN 30 DAYS.—No tax shall be
3 imposed by paragraph (1) on any failure if—

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

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

11 “(C) OVERALL LIMITATION FOR UNINTEN-
12 TIONAL FAILURES.—In the case of failures
13 which are due to reasonable cause and not to
14 willful neglect, the tax imposed by subsection
15 (a) for failures during the taxable year of the
16 employer shall not exceed the amount equal to
17 the lesser of—

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

23 “(ii) \$500,000.

24 “(D) COORDINATION WITH OTHER EN-
25 FORCEMENT PROVISIONS.—The tax imposed

1 under paragraph (1) with respect to any failure
2 shall be reduced (but not below zero) by the
3 amount of any civil penalty collected under sec-
4 tion 502(e)(11) of the Employee Retirement In-
5 come Security Act of 1974 or section 2793(g)
6 of the Public Health Service Act with respect to
7 such failure.

8 “(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
9 MENTS.—For purposes of this section, the term ‘health
10 coverage participation requirements’ means the require-
11 ments of part I of subtitle B of title IV of the (as in effect
12 on the date of the enactment of this section).”.

13 (b) CLERICAL AMENDMENT.—The table of sections
14 for chapter 43 of such Code is amended by adding at the
15 end the following new item:

“Sec. 4980H. Election with respect to health coverage participation require-
ments.”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to periods beginning after Decem-
18 ber 31, 2012.

19 **SEC. 512. HEALTH CARE CONTRIBUTIONS OF NON-**
20 **ELECTING EMPLOYERS.**

21 (a) IN GENERAL.—Section 3111 of the Internal Rev-
22 enue Code of 1986 is amended by redesignating subsection
23 (c) as subsection (d) and by inserting after subsection (b)
24 the following new subsection:

1 “(c) EMPLOYERS ELECTING NOT TO PROVIDE
2 HEALTH BENEFITS.—

3 “(1) IN GENERAL.—In addition to other taxes,
4 there is hereby imposed on every nonelecting em-
5 ployer an excise tax, with respect to having individ-
6 uals in his employ, equal to 8 percent of the wages
7 (as defined in section 3121(a)) paid by him with re-
8 spect to employment (as defined in section 3121(b)).

9 “(2) SPECIAL RULES FOR SMALL EMPLOY-
10 ERS.—

11 “(A) IN GENERAL.—In the case of any em-
12 ployer who is small employer for any calendar
13 year, paragraph (1) shall be applied by sub-
14 stituting the applicable percentage determined
15 in accordance with the following table for ‘8
16 percent’:

| “If the annual payroll of such employer for the preceding calendar year: | The applicable percentage is: |
|---|--|
| Does not exceed \$500,000 | 0 percent |
| Exceeds \$500,000, but does not exceed \$585,000 | 2 percent |
| Exceeds \$585,000, but does not exceed \$670,000 | 4 percent |
| Exceeds \$670,000, but does not exceed \$750,000 | 6 percent |

17 “(B) SMALL EMPLOYER.—For purposes of
18 this paragraph, the term ‘small employer’
19 means any employer for any calendar year if
20 the annual payroll of such employer for the pre-
21 ceding calendar year does not exceed \$750,000.

1 “(C) ANNUAL PAYROLL.—For purposes of
2 this paragraph, the term ‘annual payroll’
3 means, with respect to any employer for any
4 calendar year, the aggregate wages (as defined
5 in section 3121(a)) paid by him with respect to
6 employment (as defined in section 3121(b))
7 during such calendar year.

8 “(3) NONELECTING EMPLOYER.—For purposes
9 of paragraph (1), the term ‘nonelecting employer’
10 means any employer for any period with respect to
11 which such employer does not have an election under
12 section 4980H(a) in effect.

13 “(4) SPECIAL RULE FOR SEPARATE ELEC-
14 TIONS.—In the case of an employer who makes a
15 separate election described in section 4980H(a)(4)
16 for any period, paragraph (1) shall be applied for
17 such period by taking into account only the wages
18 paid to employees who are not subject to such elec-
19 tion.

20 “(5) AGGREGATION; PREDECESSORS.—For pur-
21 poses of this subsection—

22 “(A) all persons treated as a single em-
23 ployer under subsection (b), (c), (m), or (o) of
24 section 414 shall be treated as 1 employer, and

1 “(B) any reference to any person shall be
2 treated as including a reference to any prede-
3 cessor of such person.”.

4 (b) DEFINITIONS.—Section 3121 of such Code is
5 amended by adding at the end the following new sub-
6 section:

7 “(aa) SPECIAL RULES FOR TAX ON EMPLOYERS
8 ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For
9 purposes of section 3111(c)—

10 “(1) Paragraphs (1), (5), and (19) of sub-
11 section (b) shall not apply.

12 “(2) Paragraph (7) of subsection (b) shall apply
13 by treating all services as not covered by the retire-
14 ment systems referred to in subparagraphs (C) and
15 (F) thereof.

16 “(3) Subsection (e) shall not apply and the
17 term ‘State’ shall include the District of Columbia.”.

18 (c) CONFORMING AMENDMENT.—Subsection (d) of
19 section 3111 of such Code, as redesignated by this section,
20 is amended by striking “this section” and inserting “sub-
21 sections (a) and (b)”.

22 (d) APPLICATION TO RAILROADS.—

23 (1) IN GENERAL.—Section 3221 of such Code
24 is amended by redesignating subsection (c) as sub-

1 section (d) and by inserting after subsection (b) the
2 following new subsection:

3 “(c) EMPLOYERS ELECTING NOT TO PROVIDE
4 HEALTH BENEFITS.—

5 “(1) IN GENERAL.—In addition to other taxes,
6 there is hereby imposed on every nonelecting em-
7 ployer an excise tax, with respect to having individ-
8 uals in his employ, equal to 8 percent of the com-
9 pensation paid during any calendar year by such em-
10 ployer for services rendered to such employer.

11 “(2) EXCEPTION FOR SMALL EMPLOYERS.—
12 Rules similar to the rules of section 3111(c)(2) shall
13 apply for purposes of this subsection.

14 “(3) NONELECTING EMPLOYER.—For purposes
15 of paragraph (1), the term ‘nonelecting employer’
16 means any employer for any period with respect to
17 which such employer does not have an election under
18 section 4980H(a) in effect.

19 “(4) SPECIAL RULE FOR SEPARATE ELEC-
20 TIONS.—In the case of an employer who makes a
21 separate election described in section 4980H(a)(4)
22 for any period, subsection (a) shall be applied for
23 such period by taking into account only the com-
24 pensation paid to employees who are not subject to
25 such election.”.

1 (2) DEFINITIONS.—Subsection (e) of section
2 3231 of such Code is amended by adding at the end
3 the following new paragraph:

4 “(13) SPECIAL RULES FOR TAX ON EMPLOYERS
5 ELECTING NOT TO PROVIDE HEALTH BENEFITS.—
6 For purposes of section 3221(c)—

7 “(A) Paragraph (1) shall be applied with-
8 out regard to the third sentence thereof.

9 “(B) Paragraph (2) shall not apply.”.

10 (3) CONFORMING AMENDMENT.—Subsection (d)
11 of section 3221 of such Code, as redesignated by
12 this section, is amended by striking “subsections (a)
13 and (b), see section 3231(e)(2)” and inserting “this
14 section, see paragraphs (2) and (13)(B) of section
15 3231(e)”.

16 (e) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to periods beginning after Decem-
18 ber 31, 2012.

19 **PART 2—CREDIT FOR SMALL BUSINESS**

20 **EMPLOYEE HEALTH COVERAGE EXPENSES**

21 **SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE**
22 **HEALTH COVERAGE EXPENSES.**

23 (a) IN GENERAL.—Subpart D of part IV of sub-
24 chapter A of chapter 1 of the Internal Revenue Code of

1 1986 (relating to business-related credits) is amended by
2 adding at the end the following new section:

3 **“SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COV-**
4 **ERAGE CREDIT.**

5 “(a) IN GENERAL.—For purposes of section 38, in
6 the case of a qualified small employer, the small business
7 employee health coverage credit determined under this sec-
8 tion for the taxable year is an amount equal to the applica-
9 ble percentage of the qualified employee health coverage
10 expenses of such employer for such taxable year.

11 “(b) APPLICABLE PERCENTAGE.—

12 “(1) IN GENERAL.—For purposes of this sec-
13 tion, the applicable percentage is 50 percent.

14 “(2) PHASEOUT BASED ON AVERAGE COM-
15 PENSATION OF EMPLOYEES.—In the case of an em-
16 ployer whose average annual employee compensation
17 for the taxable year exceeds \$20,000, the percentage
18 specified in paragraph (1) shall be reduced by a
19 number of percentage points which bears the same
20 ratio to 50 as such excess bears to \$20,000.

21 “(c) LIMITATIONS.—

22 “(1) PHASEOUT BASED ON EMPLOYER SIZE.—
23 In the case of an employer who employs more than
24 10 qualified employees during the taxable year, the
25 credit determined under subsection (a) shall be re-

1 duced by an amount which bears the same ratio to
2 the amount of such credit (determined without re-
3 gard to this paragraph and after the application of
4 the other provisions of this section) as—

5 “(A) the excess of—

6 “(i) the number of qualified employees
7 employed by the employer during the tax-
8 able year, over

9 “(ii) 10, bears to

10 “(B) 15.

11 “(2) CREDIT NOT ALLOWED WITH RESPECT TO
12 CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No
13 credit shall be determined under subsection (a) with
14 respect to qualified employee health coverage ex-
15 penses paid or incurred with respect to any employee
16 for any taxable year if the aggregate compensation
17 paid by the employer to such employee during such
18 taxable year exceeds \$80,000.

19 “(3) CREDIT ALLOWED FOR ONLY 2 TAXABLE
20 YEARS.—No credit shall be determined under sub-
21 section (a) with respect to any employer for any tax-
22 able year unless the employer elects to have this sec-
23 tion apply for such taxable year. An employer may
24 elect the application of this section with respect to
25 not more than 2 taxable years.

1 “(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EX-
2 PENSES.—For purposes of this section—

3 “(1) IN GENERAL.—The term ‘qualified em-
4 ployee health coverage expenses’ means, with respect
5 to any employer for any taxable year, the aggregate
6 amount paid or incurred by such employer during
7 such taxable year for coverage of any qualified em-
8 ployee of the employer (including any family cov-
9 erage which covers such employee) under qualified
10 health coverage.

11 “(2) QUALIFIED HEALTH COVERAGE.—The
12 term ‘qualified health coverage’ means acceptable
13 coverage (as defined in section 59B(d)) which—

14 “(A) is provided pursuant to an election
15 under section 4980H(a), and

16 “(B) satisfies the requirements referred to
17 in section 4980H(c).

18 “(e) OTHER DEFINITIONS.—For purposes of this
19 section—

20 “(1) QUALIFIED SMALL EMPLOYER.—For pur-
21 poses of this section, the term ‘qualified small em-
22 ployer’ means any employer for any taxable year
23 if—

1 “(A) the number of qualified employees
2 employed by such employer during the taxable
3 year does not exceed 25, and

4 “(B) the average annual employee com-
5 pensation of such employer for such taxable
6 year does not exceed the sum of the dollar
7 amounts in effect under subsection (b)(2).

8 “(2) QUALIFIED EMPLOYEE.—The term ‘quali-
9 fied employee’ means any employee of an employer
10 for any taxable year of the employer if such em-
11 ployee received at least \$5,000 of compensation from
12 such employer for services performed in the trade or
13 business of such employer during such taxable year.

14 “(3) AVERAGE ANNUAL EMPLOYEE COMPENSA-
15 TION.—The term ‘average annual employee com-
16 pensation’ means, with respect to any employer for
17 any taxable year, the average amount of compensa-
18 tion paid by such employer to qualified employees of
19 such employer during such taxable year.

20 “(4) COMPENSATION.—The term ‘compensa-
21 tion’ has the meaning given such term in section
22 408(p)(6)(A).

23 “(5) FAMILY COVERAGE.—The term ‘family
24 coverage’ means any coverage other than self-only
25 coverage.

1 “(f) SPECIAL RULES.—For purposes of this sec-
2 tion—

3 “(1) SPECIAL RULE FOR PARTNERSHIPS AND
4 SELF-EMPLOYED.—In the case of a partnership (or
5 a trade or business carried on by an individual)
6 which has one or more qualified employees (deter-
7 mined without regard to this paragraph) with re-
8 spect to whom the election under section 4980H(a)
9 applies, each partner (or, in the case of a trade or
10 business carried on by an individual, such indi-
11 vidual) shall be treated as an employee.

12 “(2) AGGREGATION RULE.—All persons treated
13 as a single employer under subsection (b), (c), (m),
14 or (o) of section 414 shall be treated as 1 employer.

15 “(3) PREDECESSORS.—Any reference in this
16 section to an employer shall include a reference to
17 any predecessor of such employer.

18 “(4) DENIAL OF DOUBLE BENEFIT.—Any de-
19 duction otherwise allowable with respect to amounts
20 paid or incurred for health insurance coverage to
21 which subsection (a) applies shall be reduced by the
22 amount of the credit determined under this section.

23 “(5) INFLATION ADJUSTMENT.—In the case of
24 any taxable year beginning after 2013, each of the

1 dollar amounts in subsections (b)(2), (c)(2), and
2 (e)(2) shall be increased by an amount equal to—

3 “(A) such dollar amount, multiplied by
4 “(B) the cost of living adjustment deter-
5 mined under section 1(f)(3) for the calendar
6 year in which the taxable year begins deter-
7 mined by substituting ‘calendar year 2012’ for
8 ‘calendar year 1992’ in subparagraph (B)
9 thereof.

10 If any increase determined under this paragraph is
11 not a multiple of \$50, such increase shall be rounded
12 to the next lowest multiple of \$50.”.

13 (b) CREDIT TO BE PART OF GENERAL BUSINESS
14 CREDIT.—Subsection (b) of section 38 of such Code (re-
15 lating to general business credit) is amended by striking
16 “plus” at the end of paragraph (34), by striking the period
17 at the end of paragraph (35) and inserting “, plus” , and
18 by adding at the end the following new paragraph:

19 “(36) in the case of a qualified small employer
20 (as defined in section 45R(e)), the small business
21 employee health coverage credit determined under
22 section 45R(a).”.

23 (c) CLERICAL AMENDMENT.—The table of sections
24 for subpart D of part IV of subchapter A of chapter 1

1 of such Code is amended by inserting after the item relat-
2 ing to section 45Q the following new item:

“Sec. 45R. Small business employee health coverage credit.”.

3 (d) **EFFECTIVE DATE.**—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 2012.

6 **PART 3—LIMITATIONS ON HEALTH CARE**
7 **RELATED EXPENDITURES**

8 **SEC. 531. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY**
9 **IF FOR PRESCRIBED DRUG OR INSULIN.**

10 (a) **HSAs.**—Subparagraph (A) of section 223(d)(2)
11 of the Internal Revenue Code of 1986 is amended by add-
12 ing at the end the following: “Such term shall include an
13 amount paid for medicine or a drug only if such medicine
14 or drug is a prescribed drug or is insulin.”.

15 (b) **ARCHER MSAs.**—Subparagraph (A) of section
16 220(d)(2) of such Code is amended by adding at the end
17 the following: “Such term shall include an amount paid
18 for medicine or a drug only if such medicine or drug is
19 a prescribed drug or is insulin.”.

20 (c) **HEALTH FLEXIBLE SPENDING ARRANGEMENTS**
21 **AND HEALTH REIMBURSEMENT ARRANGEMENTS.**—Sec-
22 tion 106 of such Code is amended by adding at the end
23 the following new subsection:

24 “(f) **REIMBURSEMENTS FOR MEDICINE RESTRICTED**
25 **TO PRESCRIBED DRUGS AND INSULIN.**—For purposes of

1 this section and section 105, reimbursement for expenses
2 incurred for a medicine or a drug shall be treated as a
3 reimbursement for medical expenses only if such medicine
4 or drug is a prescribed drug or is insulin.”.

5 (d) **EFFECTIVE DATES.**—The amendment made by
6 this section shall apply to expenses incurred after Decem-
7 ber 31, 2010.

8 **SEC. 532. LIMITATION ON HEALTH FLEXIBLE SPENDING AR-**
9 **RANGEMENTS UNDER CAFETERIA PLANS.**

10 (a) **IN GENERAL.**—Section 125 of the Internal Rev-
11 enue Code of 1986 is amended—

12 (1) by redesignating subsections (i) and (j) as
13 subsections (j) and (k), respectively, and

14 (2) by inserting after subsection (h) the fol-
15 lowing new subsection:

16 “(i) **LIMITATION ON HEALTH FLEXIBLE SPENDING**
17 **ARRANGEMENTS.**—

18 “(1) **IN GENERAL.**—For purposes of this sec-
19 tion, if a benefit is provided under a cafeteria plan
20 through employer contributions to a health flexible
21 spending arrangement, such benefit shall not be
22 treated as a qualified benefit unless the cafeteria
23 plan provides that an employee may not elect for
24 any taxable year to have salary reduction contribu-
25 tions in excess of \$2,500 made to such arrangement.

1 “(2) INFLATION ADJUSTMENT.—In the case of
2 any taxable year beginning after 2013, the dollar
3 amount in paragraph (1) shall be increased by an
4 amount equal to—

5 “(A) such dollar amount, multiplied by

6 “(B) the cost of living adjustment deter-
7 mined under section 1(f)(3) for the calendar
8 year in which the taxable year begins deter-
9 mined by substituting ‘calendar year 2012’ for
10 ‘calendar year 1992’ in subparagraph (B)
11 thereof.

12 If any increase determined under this paragraph is
13 not a multiple of \$50, such increase shall be rounded
14 to the next lowest multiple of \$50.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 2012.

18 **SEC. 533. INCREASE IN PENALTY FOR NONQUALIFIED DIS-**
19 **TRIBUTIONS FROM HEALTH SAVINGS AC-**
20 **COUNTS.**

21 (a) IN GENERAL.—Subparagraph (A) of section
22 223(f)(4) of the Internal Revenue Code of 1986 is amend-
23 ed by striking “10 percent” and inserting “20 percent”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to taxable years beginning after
3 December 31, 2010.

4 **SEC. 534. DENIAL OF DEDUCTION FOR FEDERAL SUBSIDIES**
5 **FOR PRESCRIPTION DRUG PLANS WHICH**
6 **HAVE BEEN EXCLUDED FROM GROSS IN-**
7 **COME.**

8 (a) IN GENERAL.—Section 139A of the Internal Rev-
9 enue Code of 1986 is amended by striking the second sen-
10 tence.

11 (b) EFFECTIVE DATE.—The amendment made by
12 this section shall apply to taxable years beginning after
13 December 31, 2010.

14 **PART 4—OTHER PROVISIONS TO CARRY OUT**
15 **HEALTH INSURANCE REFORM**

16 **SEC. 541. DISCLOSURES TO CARRY OUT HEALTH INSUR-**
17 **ANCE EXCHANGE SUBSIDIES.**

18 (a) IN GENERAL.—Subsection (l) of section 6103 of
19 the Internal Revenue Code of 1986 is amended by adding
20 at the end the following new paragraph:

21 “(21) DISCLOSURE OF RETURN INFORMATION
22 TO CARRY OUT HEALTH INSURANCE EXCHANGE SUB-
23 SIDIES.—

24 “(A) IN GENERAL.—The Secretary, upon
25 written request from the Health Choices Com-

1 missioner or the head of a State-based health
2 insurance exchange approved for operation
3 under section 308 of the , shall disclose to offi-
4 cers and employees of the Health Choices Ad-
5 ministration or such State-based health insur-
6 ance exchange, as the case may be, return in-
7 formation of any taxpayer whose income is rel-
8 evant in determining any affordability credit de-
9 scribed in subtitle C of title III of the . Such
10 return information shall be limited to—

11 “(i) taxpayer identity information
12 with respect to such taxpayer,

13 “(ii) the filing status of such tax-
14 payer,

15 “(iii) the modified adjusted gross in-
16 come of such taxpayer (as defined in sec-
17 tion 59B(e)(5)),

18 “(iv) the number of dependents of the
19 taxpayer,

20 “(v) such other information as is pre-
21 scribed by the Secretary by regulation as
22 might indicate whether the taxpayer is eli-
23 gible for such affordability credits (and the
24 amount thereof), and

1 “(vi) the taxable year with respect to
2 which the preceding information relates or,
3 if applicable, the fact that such informa-
4 tion is not available.

5 “(B) RESTRICTION ON USE OF DISCLOSED
6 INFORMATION.—Return information disclosed
7 under subparagraph (A) may be used by offi-
8 cers and employees of the Health Choices Ad-
9 ministration or such State-based health insur-
10 ance exchange, as the case may be, only for the
11 purposes of, and to the extent necessary in, es-
12 tablishing and verifying the appropriate amount
13 of any affordability credit described in subtitle
14 C of title III of the and providing for the repay-
15 ment of any such credit which was in excess of
16 such appropriate amount.”.

17 (b) PROCEDURES AND RECORDKEEPING RELATED
18 TO DISCLOSURES.—Paragraph (4) of section 6103(p) of
19 such Code is amended—

20 (1) by inserting “, or any entity described in
21 subsection (l)(21),” after “or (20)” in the matter
22 preceding subparagraph (A),

23 (2) by inserting “or any entity described in sub-
24 section (l)(21),” after “or (o)(1)(A),” in subpara-
25 graph (F)(ii), and

1 (1) by striking “For purposes of this section,
2 the term” and inserting “For purposes of this sec-
3 tion—

4 “(1) IN GENERAL.—The term”, and

5 (2) by striking “Such term shall not include”
6 and inserting the following:

7 “(2) LONG-TERM CARE INSURANCE NOT QUALI-
8 FIED.—The term ‘qualified benefit’ shall not in-
9 clude”.

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 2012.

13 **SEC. 543. EXCLUSION FROM GROSS INCOME OF PAYMENTS**
14 **MADE UNDER REINSURANCE PROGRAM FOR**
15 **RETIRES.**

16 (a) IN GENERAL.—Section 139A of the Internal Rev-
17 enue Code of 1986 is amended—

18 (1) by striking “Gross income” and inserting
19 the following:

20 “(a) FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG
21 PLANS.—Gross income”, and

22 (2) by adding at the end the following new sub-
23 section:

24 “(b) FEDERAL REINSURANCE PROGRAM FOR RETIR-
25 EES.—A rule similar to the rule of subsection (a) shall

1 apply with respect to payments made under section 111
2 of the Affordable Health Care for America Act.”.

3 (b) CONFORMING AMENDMENT.—The heading of sec-
4 tion 139A of such Code (and the item relating to such
5 section in the table of sections for part III of subchapter
6 B of chapter 1 of such Code) is amended by inserting
7 “**AND RETIREE HEALTH PLANS**” after “**PRESCRIP-**
8 **TION DRUG PLANS**”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years ending after the
11 date of the enactment of this Act.

12 **SEC. 544. CLASS PROGRAM TREATED IN SAME MANNER AS**
13 **LONG-TERM CARE INSURANCE.**

14 (a) IN GENERAL.—Subsection (f) of section 7702B
15 of the Internal Revenue Code of 1986 is amended—

16 (1) by striking “State long-term care plan” in
17 paragraph (1)(A) and inserting “government long-
18 term care plan”,

19 (2) by redesignating paragraph (2) as para-
20 graph (3), and

21 (3) by inserting after paragraph (2) the fol-
22 lowing new paragraph:

23 “(2) GOVERNMENT LONG-TERM CARE PLAN.—
24 For purposes of this subsection, the term ‘govern-
25 ment long-term care plan’ means—

1 “(A) the CLASS program established
2 under title XXXII of the Public Health Service
3 Act, and

4 “(B) any State long-term care plan.”.

5 (b) CONFORMING AMENDMENTS.—

6 (1) Paragraph (3) of section 7702B(f) of such
7 Code, as redesignated by subsection (a), is amended
8 by striking “paragraph (1)” and inserting “this sub-
9 section”.

10 (2) Subsection (f) of section 7702(B) of such
11 Code is amended by striking “STATE-MAINTAINED”
12 in the heading thereof and inserting “GOVERN-
13 MENT”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to taxable years ending after De-
16 cember 31, 2010.

17 **SEC. 545. EXCLUSION FROM GROSS INCOME FOR MEDICAL**
18 **CARE PROVIDED FOR INDIANS.**

19 (a) IN GENERAL.—Part III of subchapter B of chap-
20 ter 1 of the Internal Revenue Code of 1986 (relating to
21 items specifically excluded from gross income) is amended
22 by inserting after section 139C the following new section:

23 **“SEC. 139D. MEDICAL CARE PROVIDED FOR INDIANS.**

24 “(a) IN GENERAL.—Gross income does not include—

1 “(1) health services or benefits provided or pur-
2 chased by the Indian Health Service, either directly
3 or indirectly, through a grant to or a contract or
4 compact with an Indian tribe or tribal organization
5 or through programs of third parties funded by the
6 Indian Health Service,

7 “(2) medical care provided by an Indian tribe
8 or tribal organization to a member of an Indian
9 tribe (including for this purpose, to the member’s
10 spouse or dependents) through any one of the fol-
11 lowing: provided or purchased medical care services;
12 accident or health insurance (or an arrangement
13 having the effect of accident or health insurance); or
14 amounts paid, directly or indirectly, to reimburse the
15 member for expenses incurred for medical care,

16 “(3) the value of accident or health plan cov-
17 erage provided by an Indian tribe or tribal organiza-
18 tion for medical care to a member of an Indian tribe
19 (including for this purpose, coverage that extends to
20 such member’s spouse or dependents) under an acci-
21 dent or health plan (or through an arrangement hav-
22 ing the effect of accident or health insurance), and

23 “(4) any other medical care provided by an In-
24 dian tribe that supplements, replaces, or substitutes

1 for the programs and services provided by the Fed-
2 eral Government to Indian tribes or Indians.

3 “(b) DEFINITIONS.—For purposes of this section—

4 “(1) IN GENERAL.—The terms ‘accident or
5 health insurance’ and ‘accident or health plan’ have
6 the same meaning as when used in sections 104 and
7 106.

8 “(2) MEDICAL CARE.—The term ‘medical care’
9 has the meaning given such term in section 213.

10 “(3) DEPENDENT.—The term ‘dependent’ has
11 the meaning given such term in section 152, deter-
12 mined without regard to subsections (b)(1), (b)(2),
13 and (d)(1)(B).

14 “(4) INDIAN TRIBE.—The term ‘Indian tribe’
15 means any Indian tribe, band, nation, pueblo, or
16 other organized group or community, including any
17 Alaska Native village, or regional or village corpora-
18 tion, as defined in, or established pursuant to, the
19 Alaska Native Claims Settlement Act (43 U.S.C.
20 1601 et seq.), which is recognized as eligible for the
21 special programs and services provided by the
22 United States to Indians because of their status as
23 Indians.

24 “(5) TRIBAL ORGANIZATION.—The term ‘tribal
25 organization’ has the meaning given such term in

1 section 4(l) of the Indian Self-Determination and
2 Education Assistance Act (25 U.S.C. 450b(l)).”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 for such part III is amended by inserting after the item
5 relating to section 139C the following new item:

“Sec. 139D. Medical care provided for Indians.”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to health benefits and coverage
8 provided after the date of enactment of this Act.

9 (d) NO INFERENCE.—Nothing in the amendments
10 made by this section shall be construed to create an infer-
11 ence with respect to the exclusion from gross income of—

12 (1) benefits provided by Indian tribes that are
13 not within the scope of this section, and

14 (2) health benefits or coverage provided by In-
15 dian tribes prior to the effective date of this section.

16 **Subtitle B—Other Revenue** 17 **Provisions**

18 **PART 1—GENERAL PROVISIONS**

19 **SEC. 551. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

20 (a) IN GENERAL.—Part VIII of subchapter A of
21 chapter 1 of the Internal Revenue Code of 1986, as added
22 by this title, is amended by adding at the end the following
23 new subpart:

24 **“Subpart B—Surcharge on High Income Individuals**

“Sec. 59C. Surcharge on high income individuals.

1 **“SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

2 “(a) GENERAL RULE.—In the case of a taxpayer
3 other than a corporation, there is hereby imposed (in addi-
4 tion to any other tax imposed by this subtitle) a tax equal
5 to 5.4 percent of so much of the modified adjusted gross
6 income of the taxpayer as exceeds \$1,000,000.

7 “(b) TAXPAYERS NOT MAKING A JOINT RETURN.—
8 In the case of any taxpayer other than a taxpayer making
9 a joint return under section 6013 or a surviving spouse
10 (as defined in section 2(a)), subsection (a) shall be applied
11 by substituting ‘\$500,000’ for ‘\$1,000,000’.

12 “(c) MODIFIED ADJUSTED GROSS INCOME.—For
13 purposes of this section, the term ‘modified adjusted gross
14 income’ means adjusted gross income reduced by any de-
15 duction (not taken into account in determining adjusted
16 gross income) allowed for investment interest (as defined
17 in section 163(d)). In the case of an estate or trust, ad-
18 justed gross income shall be determined as provided in sec-
19 tion 67(e).

20 “(d) SPECIAL RULES.—

21 “(1) NONRESIDENT ALIEN.—In the case of a
22 nonresident alien individual, only amounts taken
23 into account in connection with the tax imposed
24 under section 871(b) shall be taken into account
25 under this section.

1 “(2) CITIZENS AND RESIDENTS LIVING
2 ABROAD.—The dollar amount in effect under sub-
3 section (a) (after the application of subsection (b))
4 shall be decreased by the excess of—

5 “(A) the amounts excluded from the tax-
6 payer’s gross income under section 911, over

7 “(B) the amounts of any deductions or ex-
8 clusions disallowed under section 911(d)(6)
9 with respect to the amounts described in sub-
10 paragraph (A).

11 “(3) CHARITABLE TRUSTS.—Subsection (a)
12 shall not apply to a trust all the unexpired interests
13 in which are devoted to one or more of the purposes
14 described in section 170(c)(2)(B).

15 “(4) NOT TREATED AS TAX IMPOSED BY THIS
16 CHAPTER FOR CERTAIN PURPOSES.—The tax im-
17 posed under this section shall not be treated as tax
18 imposed by this chapter for purposes of determining
19 the amount of any credit under this chapter or for
20 purposes of section 55.”.

21 (b) CLERICAL AMENDMENT.—The table of subparts
22 for part VIII of subchapter A of chapter 1 of such Code,
23 as added by this title, is amended by inserting after the
24 item relating to subpart A the following new item:

“SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.”.

1 (c) SECTION 15 NOT TO APPLY.—The amendment
2 made by subsection (a) shall not be treated as a change
3 in a rate of tax for purposes of section 15 of the Internal
4 Revenue Code of 1986.

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to taxable years beginning after
7 December 31, 2010.

8 **SEC. 552. EXCISE TAX ON MEDICAL DEVICES.**

9 (a) IN GENERAL.—Chapter 31 of the Internal Rev-
10 enue Code of 1986 is amended by adding at the end the
11 following new subchapter:

12 **“Subchapter D—Medical Devices**

“Sec. 4061. Medical devices.

13 **“SEC. 4061. MEDICAL DEVICES.**

14 “(a) IN GENERAL.—There is hereby imposed on the
15 first taxable sale of any medical device a tax equal to 2.5
16 percent of the price for which so sold.

17 “(b) FIRST TAXABLE SALE.—For purposes of this
18 section—

19 “(1) IN GENERAL.—The term ‘first taxable
20 sale’ means the first sale, for a purpose other than
21 for resale, after production, manufacture, or impor-
22 tation.

1 “(2) EXCEPTION FOR SALES AT RETAIL ESTAB-
2 LISHMENTS.—Such term shall not include the sale
3 of any medical device if—

4 “(A) such sale is made at a retail estab-
5 lishment on terms which are available to the
6 general public, and

7 “(B) such medical device is of a type (and
8 purchased in a quantity) which is purchased by
9 the general public.

10 “(3) EXCEPTION FOR EXPORTS, ETC.—Rules
11 similar to the rules of sections 4221 (other than
12 paragraphs (3), (4), (5), and (6) of subsection (a)
13 thereof) and 4222 shall apply for purposes of this
14 section. To the extent provided by the Secretary,
15 section 4222 may be extended to, and made applica-
16 ble with respect to, the exemption provided by para-
17 graph (2).

18 “(4) SALES TO PATIENTS NOT TREATED AS RE-
19 SALES.—If a medical device is sold for use in con-
20 nection with providing any health care service to an
21 individual, such sale shall not be treated as being for
22 the purpose of resale (even if such device is sold to
23 such individual).

24 “(c) OTHER DEFINITIONS AND SPECIAL RULES.—
25 For purposes of this section—

1 “(1) MEDICAL DEVICE.—The term ‘medical de-
2 vice’ means any device (as defined in section 201(h)
3 of the Federal Food, Drug, and Cosmetic Act) in-
4 tended for humans.

5 “(2) LEASE TREATED AS SALE.—Rules similar
6 to the rules of section 4217 shall apply.

7 “(3) USE TREATED AS SALE.—

8 “(A) IN GENERAL.—If any person uses a
9 medical device before the first taxable sale of
10 such device, then such person shall be liable for
11 tax under such subsection in the same manner
12 as if such use were the first taxable sale of such
13 device.

14 “(B) EXCEPTIONS.—The preceding sen-
15 tence shall not apply to—

16 “(i) use of a medical device as mate-
17 rial in the manufacture or production of,
18 or as a component part of, another medical
19 device to be manufactured or produced by
20 such person, or

21 “(ii) use of a medical device after a
22 sale described in subsection (b)(2).

23 “(4) DETERMINATION OF PRICE.—

1 “(A) IN GENERAL.—Rules similar to the
2 rules of subsections (a), (c), and (d) of section
3 4216 shall apply for purposes of this section.

4 “(B) CONSTRUCTIVE SALE PRICE.—If—

5 “(i) a medical device is sold (otherwise
6 than through an arm’s length transaction)
7 at less than the fair market price, or

8 “(ii) a person is liable for tax for a
9 use described in paragraph (3),

10 the tax under this section shall be computed on
11 the price for which such or similar devices are
12 sold in the ordinary course of trade as deter-
13 mined by the Secretary.

14 “(5) RESALES PURSUANT TO CERTAIN CON-
15 TRACT ARRANGEMENTS.—

16 “(A) IN GENERAL.—In the case of a speci-
17 fied contract sale of a medical device, the seller
18 referred to in subparagraph (B)(i) shall be enti-
19 tled to recover from the producer, manufac-
20 turer, or importer referred to in subparagraph
21 (B)(ii) the amount of the tax paid by such sell-
22 er under this section with respect to such sale.

23 “(B) SPECIFIED CONTRACT SALE.—For
24 purposes of this paragraph, the term ‘specified
25 contract sale’ means, with respect to any med-

1 ical device, the first taxable sale of such device
2 if—

3 “(i) the seller is not the producer,
4 manufacturer, or importer of such device,

5 “(ii) the price at which such device is
6 so sold is determined in accordance with a
7 contract between the producer, manufac-
8 turer, or importer of such device and the
9 person to whom such device is so sold.

10 “(C) SPECIAL RULES RELATED TO CRED-
11 ITS AND REFUNDS.—In the case of any credit
12 or refund under section 6416 of the tax im-
13 posed under this section on a specified contract
14 sale of a medical device—

15 “(i) such credit or refund shall be al-
16 lowed or made only if the seller has filed
17 with the Secretary the written consent of
18 the producer, manufacturer, or importer
19 referred to in subparagraph (B)(ii) to the
20 allowance of such credit or the making of
21 such refund, and

22 “(ii) the amount of tax taken into ac-
23 count under subparagraph (A) shall be re-
24 duced by the amount of such credit or re-
25 fund.”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) Paragraph (2) of section 6416(b) of such
3 Code is amended—

4 (A) by inserting “or 4061” after “under
5 section 4051”, and

6 (B) by adding at the end the following: “In
7 the case of the tax imposed by section 4061,
8 subparagraphs (B), (C), (D), and (E) shall not
9 apply.”.

10 (2) The table of subchapters for chapter 31 of
11 such Code is amended by adding at the end the fol-
12 lowing new item:

“SUBCHAPTER D. MEDICAL DEVICES.”.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to sales (and leases and uses treat-
15 ed as sales) after December 31, 2012.

16 **SEC. 553. EXPANSION OF INFORMATION REPORTING RE-**
17 **QUIREMENTS.**

18 (a) IN GENERAL.—Section 6041 of the Internal Rev-
19 enue Code of 1986 is amended by adding at the end the
20 following new subsections:

21 “(h) APPLICATION TO CORPORATIONS.—Notwith-
22 standing any regulation prescribed by the Secretary before
23 the date of the enactment of this subsection, for purposes
24 of this section the term ‘person’ includes any corporation

1 that is not an organization exempt from tax under section
2 501(a).

3 “(i) REGULATIONS.—The Secretary may prescribe
4 such regulations and other guidance as may be appro-
5 priate or necessary to carry out the purposes of this sec-
6 tion, including rules to prevent duplicative reporting of
7 transactions.”.

8 (b) PAYMENTS FOR PROPERTY AND OTHER GROSS
9 PROCEEDS.—Subsection (a) of section 6041 of the Inter-
10 nal Revenue Code of 1986 is amended—

11 (1) by inserting “amounts in consideration for
12 property,” after “wages,”,

13 (2) by inserting “gross proceeds,” after “emolu-
14 ments, or other”, and

15 (3) by inserting “gross proceeds,” after “setting
16 forth the amount of such”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to payments made after December
19 31, 2011.

20 **SEC. 554. DELAY IN APPLICATION OF WORLDWIDE ALLOCA-**
21 **TION OF INTEREST.**

22 (a) IN GENERAL.—Paragraphs (5)(D) and (6) of sec-
23 tion 864(f) of the Internal Revenue Code of 1986 are each
24 amended by striking “December 31, 2010” and inserting
25 “December 31, 2019”.

1 (b) TRANSITION.—Subsection (f) of section 864 of
2 such Code is amended by striking paragraph (7).

3 **PART 2—PREVENTION OF TAX AVOIDANCE**

4 **SEC. 561. LIMITATION ON TREATY BENEFITS FOR CERTAIN**

5 **DEDUCTIBLE PAYMENTS.**

6 (a) IN GENERAL.—Section 894 of the Internal Rev-
7 enue Code of 1986 (relating to income affected by treaty)
8 is amended by adding at the end the following new sub-
9 section:

10 “(d) LIMITATION ON TREATY BENEFITS FOR CER-
11 TAIN DEDUCTIBLE PAYMENTS.—

12 “(1) IN GENERAL.—In the case of any deduct-
13 ible related-party payment, any withholding tax im-
14 posed under chapter 3 (and any tax imposed under
15 subpart A or B of this part) with respect to such
16 payment may not be reduced under any treaty of the
17 United States unless any such withholding tax would
18 be reduced under a treaty of the United States if
19 such payment were made directly to the foreign par-
20 ent corporation.

21 “(2) DEDUCTIBLE RELATED-PARTY PAY-
22 MENT.—For purposes of this subsection, the term
23 ‘deductible related-party payment’ means any pay-
24 ment made, directly or indirectly, by any person to
25 any other person if the payment is allowable as a de-

1 duction under this chapter and both persons are
2 members of the same foreign controlled group of en-
3 tities.

4 “(3) FOREIGN CONTROLLED GROUP OF ENTI-
5 TIES.—For purposes of this subsection—

6 “(A) IN GENERAL.—The term ‘foreign
7 controlled group of entities’ means a controlled
8 group of entities the common parent of which
9 is a foreign corporation.

10 “(B) CONTROLLED GROUP OF ENTITIES.—
11 The term ‘controlled group of entities’ means a
12 controlled group of corporations as defined in
13 section 1563(a)(1), except that—

14 “(i) ‘more than 50 percent’ shall be
15 substituted for ‘at least 80 percent’ each
16 place it appears therein, and

17 “(ii) the determination shall be made
18 without regard to subsections (a)(4) and
19 (b)(2) of section 1563.

20 A partnership or any other entity (other than a
21 corporation) shall be treated as a member of a
22 controlled group of entities if such entity is con-
23 trolled (within the meaning of section
24 954(d)(3)) by members of such group (includ-

1 ing any entity treated as a member of such
2 group by reason of this sentence).

3 “(4) FOREIGN PARENT CORPORATION.—For
4 purposes of this subsection, the term ‘foreign parent
5 corporation’ means, with respect to any deductible
6 related-party payment, the common parent of the
7 foreign controlled group of entities referred to in
8 paragraph (3)(A).

9 “(5) REGULATIONS.—The Secretary may pre-
10 scribe such regulations or other guidance as are nec-
11 essary or appropriate to carry out the purposes of
12 this subsection, including regulations or other guid-
13 ance which provide for—

14 “(A) the treatment of two or more persons
15 as members of a foreign controlled group of en-
16 tities if such persons would be the common par-
17 ent of such group if treated as one corporation,
18 and

19 “(B) the treatment of any member of a
20 foreign controlled group of entities as the com-
21 mon parent of such group if such treatment is
22 appropriate taking into account the economic
23 relationships among such entities.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to payments made after the date
3 of the enactment of this Act.

4 **SEC. 562. CODIFICATION OF ECONOMIC SUBSTANCE DOC-**
5 **TRINE; PENALTIES.**

6 (a) IN GENERAL.—Section 7701 of the Internal Rev-
7 enue Code of 1986 is amended by redesignating subsection
8 (o) as subsection (p) and by inserting after subsection (n)
9 the following new subsection:

10 “(o) CLARIFICATION OF ECONOMIC SUBSTANCE
11 DOCTRINE.—

12 “(1) APPLICATION OF DOCTRINE.—In the case
13 of any transaction to which the economic substance
14 doctrine is relevant, such transaction shall be treated
15 as having economic substance only if—

16 “(A) the transaction changes in a mean-
17 ingful way (apart from Federal income tax ef-
18 fects) the taxpayer’s economic position, and

19 “(B) the taxpayer has a substantial pur-
20 pose (apart from Federal income tax effects)
21 for entering into such transaction.

22 “(2) SPECIAL RULE WHERE TAXPAYER RELIES
23 ON PROFIT POTENTIAL.—

24 “(A) IN GENERAL.—The potential for
25 profit of a transaction shall be taken into ac-

1 count in determining whether the requirements
2 of subparagraphs (A) and (B) of paragraph (1)
3 are met with respect to the transaction only if
4 the present value of the reasonably expected
5 pre-tax profit from the transaction is substan-
6 tial in relation to the present value of the ex-
7 pected net tax benefits that would be allowed if
8 the transaction were respected.

9 “(B) TREATMENT OF FEES AND FOREIGN
10 TAXES.—Fees and other transaction expenses
11 and foreign taxes shall be taken into account as
12 expenses in determining pre-tax profit under
13 subparagraph (A).

14 “(3) STATE AND LOCAL TAX BENEFITS.—For
15 purposes of paragraph (1), any State or local income
16 tax effect which is related to a Federal income tax
17 effect shall be treated in the same manner as a Fed-
18 eral income tax effect.

19 “(4) FINANCIAL ACCOUNTING BENEFITS.—For
20 purposes of paragraph (1)(B), achieving a financial
21 accounting benefit shall not be taken into account as
22 a purpose for entering into a transaction if the ori-
23 gin of such financial accounting benefit is a reduc-
24 tion of Federal income tax.

1 “(5) DEFINITIONS AND SPECIAL RULES.—For
2 purposes of this subsection—

3 “(A) ECONOMIC SUBSTANCE DOCTRINE.—
4 The term ‘economic substance doctrine’ means
5 the common law doctrine under which tax bene-
6 fits under subtitle A with respect to a trans-
7 action are not allowable if the transaction does
8 not have economic substance or lacks a business
9 purpose.

10 “(B) EXCEPTION FOR PERSONAL TRANS-
11 ACTIONS OF INDIVIDUALS.—In the case of an
12 individual, paragraph (1) shall apply only to
13 transactions entered into in connection with a
14 trade or business or an activity engaged in for
15 the production of income.

16 “(C) OTHER COMMON LAW DOCTRINES
17 NOT AFFECTED.—Except as specifically pro-
18 vided in this subsection, the provisions of this
19 subsection shall not be construed as altering or
20 supplanting any other rule of law, and the re-
21 quirements of this subsection shall be construed
22 as being in addition to any such other rule of
23 law.

24 “(D) DETERMINATION OF APPLICATION OF
25 DOCTRINE NOT AFFECTED.—The determination

1 of whether the economic substance doctrine is
2 relevant to a transaction (or series of trans-
3 actions) shall be made in the same manner as
4 if this subsection had never been enacted.

5 “(6) REGULATIONS.—The Secretary shall pre-
6 scribe such regulations as may be necessary or ap-
7 propriate to carry out the purposes of this sub-
8 section.”.

9 (b) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE
10 TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

11 (1) IN GENERAL.—Subsection (b) of section
12 6662 of such Code is amended by inserting after
13 paragraph (5) the following new paragraph:

14 “(6) Any disallowance of claimed tax benefits
15 by reason of a transaction lacking economic sub-
16 stance (within the meaning of section 7701(o)) or
17 failing to meet the requirements of any similar rule
18 of law.”.

19 (2) INCREASED PENALTY FOR NONDISCLOSED
20 TRANSACTIONS.—Section 6662 of such Code is
21 amended by adding at the end the following new
22 subsection:

23 “(i) INCREASE IN PENALTY IN CASE OF NONDIS-
24 CLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

1 “(1) IN GENERAL.—In the case of any portion
2 of an underpayment which is attributable to one or
3 more nondisclosed noneconomic substance trans-
4 actions, subsection (a) shall be applied with respect
5 to such portion by substituting ‘40 percent’ for ‘20
6 percent’.

7 “(2) NONDISCLOSED NONECONOMIC SUB-
8 STANCE TRANSACTIONS.—For purposes of this sub-
9 section, the term ‘nondisclosed noneconomic sub-
10 stance transaction’ means any portion of a trans-
11 action described in subsection (b)(6) with respect to
12 which the relevant facts affecting the tax treatment
13 are not adequately disclosed in the return nor in a
14 statement attached to the return.

15 “(3) SPECIAL RULE FOR AMENDED RE-
16 TURNS.—Except as provided in regulations, in no
17 event shall any amendment or supplement to a re-
18 turn of tax be taken into account for purposes of
19 this subsection if the amendment or supplement is
20 filed after the earlier of the date the taxpayer is first
21 contacted by the Secretary regarding the examina-
22 tion of the return or such other date as is specified
23 by the Secretary.”.

1 (3) CONFORMING AMENDMENT.—Subparagraph
2 (B) of section 6662A(e)(2) of such Code is amend-
3 ed—

4 (A) by striking “section 6662(h)” and in-
5 serting “subsections (h) or (i) of section 6662”,
6 and

7 (B) by striking “GROSS VALUATION
8 MISSTATEMENT PENALTY” in the heading and
9 inserting “CERTAIN INCREASED UNDER-
10 PAYMENT PENALTIES”.

11 (c) REASONABLE CAUSE EXCEPTION NOT APPLICA-
12 BLE TO NONECONOMIC SUBSTANCE TRANSACTIONS AND
13 TAX SHELTERS.—

14 (1) REASONABLE CAUSE EXCEPTION FOR UN-
15 DERPAYMENTS.—Subsection (c) of section 6664 of
16 such Code is amended—

17 (A) by redesignating paragraphs (2) and
18 (3) as paragraphs (3) and (4), respectively,

19 (B) by striking “paragraph (2)” in para-
20 graph (4)(A), as so redesignated, and inserting
21 “paragraph (3)”, and

22 (C) by inserting after paragraph (1) the
23 following new paragraph:

24 “(2) EXCEPTION.—Paragraph (1) shall not
25 apply to any portion of an underpayment which is

1 attributable to one or more tax shelters (as defined
2 in section 6662(d)(2)(C)) or transactions described
3 in section 6662(b)(6).”.

4 (2) REASONABLE CAUSE EXCEPTION FOR RE-
5 PORTABLE TRANSACTION UNDERSTATEMENTS.—
6 Subsection (d) of section 6664 of such Code is
7 amended—

8 (A) by redesignating paragraphs (2) and
9 (3) as paragraphs (3) and (4), respectively,

10 (B) by striking “paragraph (2)(C)” in
11 paragraph (4), as so redesignated, and inserting
12 “paragraph (3)(C)”, and

13 (C) by inserting after paragraph (1) the
14 following new paragraph:

15 “(2) EXCEPTION.—Paragraph (1) shall not
16 apply to any portion of a reportable transaction un-
17 derstatement which is attributable to one or more
18 tax shelters (as defined in section 6662(d)(2)(C)) or
19 transactions described in section 6662(b)(6).”.

20 (d) APPLICATION OF PENALTY FOR ERRONEOUS
21 CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUB-
22 STANCE TRANSACTIONS.—Section 6676 of such Code is
23 amended by redesignating subsection (c) as subsection (d)
24 and inserting after subsection (b) the following new sub-
25 section:

1 “(c) NONECONOMIC SUBSTANCE TRANSACTIONS
2 TREATED AS LACKING REASONABLE BASIS.—For pur-
3 poses of this section, any excessive amount which is attrib-
4 utable to any transaction described in section 6662(b)(6)
5 shall not be treated as having a reasonable basis.”.

6 (e) EFFECTIVE DATE.—

7 (1) IN GENERAL.—Except as otherwise pro-
8 vided in this subsection, the amendments made by
9 this section shall apply to transactions entered into
10 after the date of the enactment of this Act.

11 (2) UNDERPAYMENTS.—The amendments made
12 by subsections (b) and (c)(1) shall apply to under-
13 payments attributable to transactions entered into
14 after the date of the enactment of this Act.

15 (3) UNDERSTATEMENTS.—The amendments
16 made by subsection (c)(2) shall apply to understate-
17 ments attributable to transactions entered into after
18 the date of the enactment of this Act.

19 (4) REFUNDS AND CREDITS.—The amendment
20 made by subsection (d) shall apply to refunds and
21 credits attributable to transactions entered into after
22 the date of the enactment of this Act.

1 **SEC. 563. CERTAIN LARGE OR PUBLICLY TRADED PERSONS**
2 **MADE SUBJECT TO A MORE LIKELY THAN**
3 **NOT STANDARD FOR AVOIDING PENALTIES**
4 **ON UNDERPAYMENTS.**

5 (a) IN GENERAL.—Subsection (c) of section 6664 of
6 the Internal Revenue Code of 1986, as amended by section
7 562, is amended—

8 (1) by redesignating paragraphs (3) and (4) as
9 paragraphs (4) and (5), respectively,

10 (2) by striking “paragraph (3)” in paragraph
11 (4)(A), as so redesignated, and inserting “paragraph
12 (4)”, and

13 (3) by inserting after paragraph (2) the fol-
14 lowing new paragraph:

15 “(3) SPECIAL RULE FOR CERTAIN LARGE OR
16 PUBLICLY TRADED PERSONS.—

17 “(A) IN GENERAL.—In the case of any
18 specified person, paragraph (1) shall apply to
19 the portion of an underpayment which is attrib-
20 utable to any item only if such person has a
21 reasonable belief that the tax treatment of such
22 item by such person is more likely than not the
23 proper tax treatment of such item.

24 “(B) SPECIFIED PERSON.—For purposes
25 of this paragraph, the term ‘specified person’
26 means—

1 “(i) any person required to file peri-
2 odic or other reports under section 13 of
3 the Securities Exchange Act of 1934, and

4 “(ii) any corporation with gross re-
5 ceipts in excess of \$100,000,000 for the
6 taxable year involved.

7 All persons treated as a single employer under
8 section 52(a) shall be treated as one person for
9 purposes of clause (ii).”.

10 (b) NONAPPLICATION OF SUBSTANTIAL AUTHORITY
11 AND REASONABLE BASIS STANDARDS FOR REDUCING
12 UNDERSTATEMENTS.—Paragraph (2) of section 6662(d)
13 of such Code is amended by adding at the end the fol-
14 lowing new subparagraph:

15 “(D) REDUCTION NOT TO APPLY TO CER-
16 TAIN LARGE OR PUBLICLY TRADED PERSONS.—
17 Subparagraph (B) shall not apply to any speci-
18 fied person (as defined in section
19 6664(c)(3)(B)).”.

20 (c) EFFECTIVE DATE.—

21 (1) IN GENERAL.—Except as provided in para-
22 graph (2), the amendments made by this section
23 shall apply to underpayments attributable to trans-
24 actions entered into after the date of the enactment
25 of this Act.

1 (2) NONAPPLICATION OF UNDERSTATEMENT
2 REDUCTION.—The amendment made by subsection
3 (b) shall apply to understatements attributable to
4 transactions entered into after the date of the enact-
5 ment of this Act.

6 **PART 3—PARITY IN HEALTH BENEFITS**

7 **SEC. 571. CERTAIN HEALTH RELATED BENEFITS APPLICA-**
8 **BLE TO SPOUSES AND DEPENDENTS EX-**
9 **TENDED TO ELIGIBLE BENEFICIARIES.**

10 (a) APPLICATION OF ACCIDENT AND HEALTH PLANS
11 TO ELIGIBLE BENEFICIARIES.—

12 (1) EXCLUSION OF CONTRIBUTIONS.—Section
13 106 of the Internal Revenue Code of 1986 (relating
14 to contributions by employer to accident and health
15 plans), as amended by section 531, is amended by
16 adding at the end the following new subsection:

17 “(g) COVERAGE PROVIDED FOR ELIGIBLE BENE-
18 FIARIES OF EMPLOYEES.—

19 “(1) IN GENERAL.—Subsection (a) shall apply
20 with respect to any eligible beneficiary of the em-
21 ployee.

22 “(2) ELIGIBLE BENEFICIARY.—For purposes of
23 this subsection, the term ‘eligible beneficiary’ means
24 any individual who is eligible to receive benefits or
25 coverage under an accident or health plan.”.

1 (2) EXCLUSION OF AMOUNTS EXPENDED FOR
2 MEDICAL CARE.—The first sentence of section
3 105(b) of such Code (relating to amounts expended
4 for medical care) is amended—

5 (A) by striking “and his dependents” and
6 inserting “his dependents”, and

7 (B) by inserting before the period the fol-
8 lowing: “and any eligible beneficiary (within the
9 meaning of section 106(g)) with respect to the
10 taxpayer”.

11 (3) PAYROLL TAXES.—

12 (A) Section 3121(a)(2) of such Code is
13 amended—

14 (i) by striking “or any of his depend-
15 ents” in the matter preceding subpara-
16 graph (A) and inserting “, any of his de-
17 pendents, or any eligible beneficiary (with-
18 in the meaning of section 106(g)) with re-
19 spect to the employee”,

20 (ii) by striking “or any of his depend-
21 ents,” in subparagraph (A) and inserting
22 “, any of his dependents, or any eligible
23 beneficiary (within the meaning of section
24 106(g)) with respect to the employee”,
25 and

1 (iii) by striking “and their depend-
2 ents” both places it appears and inserting
3 “and such employees’ dependents and eligi-
4 ble beneficiaries (within the meaning of
5 section 106(g))”.

6 (B) Section 3231(e)(1) of such Code is
7 amended—

8 (i) by striking “or any of his depend-
9 ents” and inserting “, any of his depend-
10 ents, or any eligible beneficiary (within the
11 meaning of section 106(g)) with respect to
12 the employee,” and

13 (ii) by striking “and their depend-
14 ents” both places it appears and inserting
15 “and such employees’ dependents and eligi-
16 ble beneficiaries (within the meaning of
17 section 106(g))”.

18 (C) Section 3306(b)(2) of such Code is
19 amended—

20 (i) by striking “or any of his depend-
21 ents” in the matter preceding subpara-
22 graph (A) and inserting “, any of his de-
23 pendents, or any eligible beneficiary (with-
24 in the meaning of section 106(g)) with re-
25 spect to the employee,”

1 (ii) by striking “or any of his depend-
2 ents” in subparagraph (A) and inserting “,
3 any of his dependents, or any eligible bene-
4 ficiary (within the meaning of section
5 106(g)) with respect to the employee”, and
6 (iii) by striking “and their depend-
7 ents” both places it appears and inserting
8 “and such employees’ dependents and eligi-
9 ble beneficiaries (within the meaning of
10 section 106(g))”.

11 (D) Section 3401(a) of such Code is
12 amended by striking “or” at the end of para-
13 graph (22), by striking the period at the end of
14 paragraph (23) and inserting “; or”, and by in-
15 serting after paragraph (23) the following new
16 paragraph:

17 “(24) for any payment made to or for the ben-
18 efit of an employee or any eligible beneficiary (within
19 the meaning of section 106(g)) if at the time of such
20 payment it is reasonable to believe that the employee
21 will be able to exclude such payment from income
22 under section 106 or under section 105 by reference
23 in section 105(b) to section 106(g).”.

1 (b) EXPANSION OF DEPENDENCY FOR PURPOSES OF
2 DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-
3 EMPLOYED INDIVIDUALS.—

4 (1) IN GENERAL.—Paragraph (1) of section
5 162(l) of the Internal Revenue Code of 1986 (relat-
6 ing to special rules for health insurance costs of self-
7 employed individuals) is amended to read as follows:

8 “(1) ALLOWANCE OF DEDUCTION.—In the case
9 of a taxpayer who is an employee within the mean-
10 ing of section 401(c)(1), there shall be allowed as a
11 deduction under this section an amount equal to the
12 amount paid during the taxable year for insurance
13 which constitutes medical care for—

14 “(A) the taxpayer,

15 “(B) the taxpayer’s spouse,

16 “(C) the taxpayer’s dependents,

17 “(D) any individual who—

18 “(i) satisfies the age requirements of
19 section 152(c)(3)(A),

20 “(ii) bears a relationship to the tax-
21 payer described in section 152(d)(2)(H),
22 and

23 “(iii) meets the requirements of sec-
24 tion 152(d)(1)(C), and

25 “(E) one individual who—

1 “(i) does not satisfy the age require-
2 ments of section 152(c)(3)(A),

3 “(ii) bears a relationship to the tax-
4 payer described in section 152(d)(2)(H),

5 “(iii) meets the requirements of sec-
6 tion 152(d)(1)(D), and

7 “(iv) is not the spouse of the taxpayer
8 and does not bear any relationship to the
9 taxpayer described in subparagraphs (A)
10 through (G) of section 152(d)(2).”.

11 (2) CONFORMING AMENDMENT.—Subparagraph
12 (B) of section 162(l)(2) of such Code is amended by
13 inserting “, any dependent, or individual described
14 in subparagraph (D) or (E) of paragraph (1) with
15 respect to” after “spouse”.

16 (c) EXTENSION TO ELIGIBLE BENEFICIARIES OF
17 SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS
18 OF A VOLUNTARY EMPLOYEES’ BENEFICIARY ASSOCIA-
19 TION AND THEIR DEPENDENTS.—Section 501(c)(9) of
20 the Internal Revenue Code of 1986 (relating to list of ex-
21 empt organizations) is amended by adding at the end the
22 following new sentence: “For purposes of providing for the
23 payment of sick and accident benefits to members of such
24 an association and their dependents, the term ‘dependents’
25 shall include any individual who is an eligible beneficiary

1 (within the meaning of section 106(g)), as determined
2 under the terms of a medical benefit, health insurance,
3 or other program under which members and their depend-
4 ents are entitled to sick and accident benefits.”.

5 (d) FLEXIBLE SPENDING ARRANGEMENTS AND
6 HEALTH REIMBURSEMENT ARRANGEMENTS.—The Sec-
7 retary of Treasury shall issue guidance of general applica-
8 bility providing that medical expenses that otherwise qual-
9 ify—

10 (1) for reimbursement from a flexible spending
11 arrangement under regulations in effect on the date
12 of the enactment of this Act may be reimbursed
13 from an employee’s flexible spending arrangement,
14 notwithstanding the fact that such expenses are at-
15 tributable to any individual who is not the employ-
16 ee’s spouse or dependent (within the meaning of sec-
17 tion 105(b) of the Internal Revenue Code of 1986)
18 but is an eligible beneficiary (within the meaning of
19 section 106(g) of such Code) under the flexible
20 spending arrangement with respect to the employee,
21 and

22 (2) for reimbursement from a health reimburse-
23 ment arrangement under regulations in effect on the
24 date of the enactment of this Act may be reimbursed
25 from an employee’s health reimbursement arrange-

1 ment, notwithstanding the fact that such expenses
2 are attributable to an individual who is not a spouse
3 or dependent (within the meaning of section 105(b)
4 of such Code) but is an eligible beneficiary (within
5 the meaning of section 106(g) of such Code) under
6 the health reimbursement arrangement with respect
7 to the employee.

8 (e) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 2009.

11 **DIVISION B—MEDICARE AND** 12 **MEDICAID IMPROVEMENTS**

13 **SEC. 1001. TABLE OF CONTENTS OF DIVISION.**

14 The table of contents of this division is as follows:

Sec. 1001. Table of contents of division.

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

- Sec. 1101. Skilled nursing facility payment update.
- Sec. 1102. Inpatient rehabilitation facility payment update.
- Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 2—OTHER MEDICARE PART A PROVISIONS

- Sec. 1111. Payments to skilled nursing facilities.
- Sec. 1112. Medicare DSH report and payment adjustments in response to coverage expansion.
- Sec. 1113. Extension of hospice regulation moratorium.
- Sec. 1114. 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.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

- Sec. 1121. Resource-based feedback program for physicians in Medicare.
- Sec. 1122. Misvalued codes under the physician fee schedule.
- Sec. 1123. Payments for efficient areas.
- Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).
- Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES

- Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 3—OTHER PROVISIONS

- Sec. 1141. Rental and purchase of power-driven wheelchairs.
- Sec. 1141A. Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends.
- Sec. 1142. Extension of payment rule for brachytherapy.
- Sec. 1143. Home infusion therapy report to Congress.
- Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data.
- Sec. 1145. Treatment of certain cancer hospitals.
- Sec. 1146. Payment for imaging services.
- Sec. 1147. Durable medical equipment program improvements.
- Sec. 1148. MedPAC study and report on bone mass measurement.
- Sec. 1149. Timely access to post-mastectomy items.
- Sec. 1149A. Payment for biosimilar biological products.
- Sec. 1149B. Study and report on DME competitive bidding process.

Subtitle C—Provisions Related to Medicare Parts A and B

- Sec. 1151. Reducing potentially preventable hospital readmissions.
- Sec. 1152. Post acute care services payment reform plan and bundling pilot program.
- Sec. 1153. Home health payment update for 2010.
- Sec. 1154. Payment adjustments for home health care.
- Sec. 1155. Incorporating productivity improvements into market basket update for home health services.
- Sec. 1155A. MedPAC study on variation in home health margins.
- Sec. 1155B. Permitting home health agencies to assign the most appropriate skilled service to make the initial assessment visit under a Medicare home health plan of care for rehabilitation cases.
- Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.
- Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.
- Sec. 1158. Revision of medicare payment systems to address geographic inequities.
- Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care.
- Sec. 1160. Implementation, and Congressional review, of proposal to revise Medicare payments to promote high value health care.

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

- Sec. 1161. Phase-in of payment based on fee-for-service costs; quality bonus payments.
- Sec. 1162. Authority for Secretarial coding intensity adjustment authority.
- Sec. 1163. Simplification of annual beneficiary election periods.
- Sec. 1164. Extension of reasonable cost contracts.
- Sec. 1165. Limitation of waiver authority for employer group plans.
- Sec. 1166. Improving risk adjustment for payments.
- Sec. 1167. Elimination of MA Regional Plan Stabilization Fund.
- Sec. 1168. Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

- Sec. 1171. Limitation on cost-sharing for individual health services.
- Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension.
- Sec. 1173. Information for beneficiaries on MA plan administrative costs.
- Sec. 1174. Strengthening audit authority.
- Sec. 1175. Authority to deny plan bids.
- Sec. 1175A. State authority to enforce standardized marketing requirements.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS

- Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals.
- Sec. 1177. Extension of authority of special needs plans to restrict enrollment; service area moratorium for certain SNPs.
- Sec. 1178. Extension of Medicare senior housing plans.

Subtitle E—Improvements to Medicare Part D

- Sec. 1181. Elimination of coverage gap.
- Sec. 1182. Discounts for certain part D drugs in original coverage gap.
- Sec. 1183. Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities.
- Sec. 1184. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
- Sec. 1185. No mid-year formulary changes permitted.
- Sec. 1186. Negotiation of lower covered part D drug prices on behalf of Medicare beneficiaries.
- Sec. 1187. Accurate dispensing in long-term care facilities.
- Sec. 1188. Free generic fill.
- Sec. 1189. State certification prior to waiver of licensure requirements under Medicare prescription drug program.

Subtitle F—Medicare Rural Access Protections

- Sec. 1191. Telehealth expansion and enhancements.
- Sec. 1192. Extension of outpatient hold harmless provision.
- Sec. 1193. Extension of section 508 hospital reclassifications.
- Sec. 1194. Extension of geographic floor for work.
- Sec. 1195. Extension of payment for technical component of certain physician pathology services.
- Sec. 1196. Extension of ambulance add-ons.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

- Sec. 1201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
- Sec. 1202. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
- Sec. 1203. Eliminating barriers to enrollment.
- Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low income subsidy enrollment.
- Sec. 1205. Intelligent assignment in enrollment.
- Sec. 1206. Special enrollment period and automatic enrollment process for certain subsidy eligible individuals.
- Sec. 1207. Application of MA premiums prior to rebate and quality bonus payments in calculation of low income subsidy benchmark.

Subtitle B—Reducing Health Disparities

- Sec. 1221. Ensuring effective communication in Medicare.
- Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
- Sec. 1223. IOM report on impact of language access services.
- Sec. 1224. Definitions.

Subtitle C—Miscellaneous Improvements

- Sec. 1231. Extension of therapy caps exceptions process.
- Sec. 1232. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions.
- Sec. 1233. Voluntary advance care planning consultation.
- Sec. 1234. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.
- Sec. 1235. Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related premium.
- Sec. 1236. Demonstration program on use of patient decisions aids.

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

- Sec. 1301. Accountable Care Organization pilot program.
- Sec. 1302. Medical home pilot program.
- Sec. 1303. Payment incentive for selected primary care services.
- Sec. 1304. Increased reimbursement rate for certified nurse-midwives.
- Sec. 1305. Coverage and waiver of cost-sharing for preventive services.
- Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
- Sec. 1307. Excluding clinical social worker services from coverage under the medicare skilled nursing facility prospective payment system and consolidated payment.
- Sec. 1308. Coverage of marriage and family therapist services and mental health counselor services.
- Sec. 1309. Extension of physician fee schedule mental health add-on.
- Sec. 1310. Expanding access to vaccines.

- Sec. 1311. Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers.
- Sec. 1312. Independence at home demonstration program.
- Sec. 1313. Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

- Sec. 1401. Comparative effectiveness research.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES, NURSING FACILITIES, AND OTHER LONG-TERM CARE FACILITIES

- Sec. 1411. Required disclosure of ownership and additional disclosable parties information.
- Sec. 1412. Accountability requirements.
- Sec. 1413. Nursing home compare Medicare website.
- Sec. 1414. Reporting of expenditures.
- Sec. 1415. Standardized complaint form.
- Sec. 1416. Ensuring staffing accountability.
- Sec. 1417. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers.

PART 2—TARGETING ENFORCEMENT

- Sec. 1421. Civil money penalties.
- Sec. 1422. National independent monitor pilot program.
- Sec. 1423. Notification of facility closure.

PART 3—IMPROVING STAFF TRAINING

- Sec. 1431. Dementia and abuse prevention training.
- Sec. 1432. Study and report on training required for certified nurse aides and supervisory staff.
- Sec. 1433. Qualification of director of food services of a skilled nursing facility or nursing facility.

Subtitle C—Quality Measurements

- Sec. 1441. Establishment of national priorities for quality improvement.
- Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement.
- Sec. 1443. Multi-stakeholder pre-rulemaking input into selection of quality measures.
- Sec. 1444. Application of quality measures.
- Sec. 1445. Consensus-based entity funding.

Subtitle D—Physician Payments Sunshine Provision

- Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities.

Subtitle E—Public Reporting on Health Care-Associated Infections

- Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on health care-associated infections.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

- Sec. 1501. Distribution of unused residency positions.
Sec. 1502. Increasing training in nonprovider settings.
Sec. 1503. Rules for counting resident time for didactic and scholarly activities and other activities.
Sec. 1504. Preservation of resident cap positions from closed hospitals.
Sec. 1505. Improving accountability for approved medical residency training.

TITLE VI—PROGRAM INTEGRITY

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

- Sec. 1601. Increased funding and flexibility to fight fraud and abuse.

Subtitle B—Enhanced Penalties for Fraud and Abuse

- Sec. 1611. Enhanced penalties for false statements on provider or supplier enrollment applications.
Sec. 1612. Enhanced penalties for submission of false statements material to a false claim.
Sec. 1613. Enhanced penalties for delaying inspections.
Sec. 1614. Enhanced hospice program safeguards.
Sec. 1615. Enhanced penalties for individuals excluded from program participation.
Sec. 1616. Enhanced penalties for provision of false information by Medicare Advantage and part D plans.
Sec. 1617. Enhanced penalties for Medicare Advantage and part D marketing violations.
Sec. 1618. Enhanced penalties for obstruction of program audits.
Sec. 1619. Exclusion of certain individuals and entities from participation in Medicare and State health care programs.
Sec. 1620. OIG authority to exclude from Federal health care programs officers and owners of entities convicted of fraud.
Sec. 1621. Self-referral disclosure protocol.

Subtitle C—Enhanced Program and Provider Protections

- Sec. 1631. Enhanced CMS program protection authority.
Sec. 1632. Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations.
Sec. 1633. Required inclusion of payment modifier for certain evaluation and management services.
Sec. 1634. Evaluations and reports required under Medicare Integrity Program.
Sec. 1635. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.

- Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months.
- Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals.
- Sec. 1638. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
- Sec. 1639. Face-to-face encounter with patient required before eligibility certifications for home health services or durable medical equipment.
- Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations.
- Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
- Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program.
- Sec. 1643. Access to certain information on renal dialysis facilities.
- Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.
- Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.
- Sec. 1646. Requiring provider and supplier payments under Medicare to be made through direct deposit or electronic funds transfer (EFT) at insured depository institutions.
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- Sec. 1787. Demonstration project for stabilization of emergency medical conditions by institutions for mental diseases.
- Sec. 1788. Application of Medicaid Improvement Fund.
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TITLE VIII—REVENUE-RELATED PROVISIONS

- Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration's outreach to eligible individuals.
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- Sec. 1901. Repeal of trigger provision.
- Sec. 1902. Repeal of comparative cost adjustment (CCA) program.
- Sec. 1903. Extension of gainsharing demonstration.
- Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.
- Sec. 1905. Improved coordination and protection for dual eligibles.
- Sec. 1906. Assessment of medicare cost-intensive diseases and conditions.
- Sec. 1907. Establishment of Center for Medicare and Medicaid Innovation within CMS.
- Sec. 1908. Application of emergency services laws.
- Sec. 1909. Disregard under the Supplemental Security Income program of compensation for participation in clinical trials for rare diseases or conditions.

1 **TITLE I—IMPROVING HEALTH**
2 **CARE VALUE**
3 **Subtitle A—Provisions Related to**
4 **Medicare Part A**

5 **PART 1—MARKET BASKET UPDATES**

6 **SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.**

7 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the
8 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is
9 amended—

10 (1) in subclause (III), by striking “and” at the
11 end;

12 (2) by redesignating subclause (IV) as sub-
13 clause (VI); and

14 (3) by inserting after subclause (III) the fol-
15 lowing new subclauses:

16 “(IV) for each of fiscal years
17 2004 through 2009, the rate com-
18 puted for the previous fiscal year in-
19 creased by the skilled nursing facility
20 market basket percentage change for
21 the fiscal year involved;

22 “(V) for fiscal year 2010, the
23 rate computed for the previous fiscal
24 year; and”.

1 (b) DELAYED EFFECTIVE DATE.—Section
2 1888(e)(4)(E)(ii)(V) of the Social Security Act, as in-
3 serted by subsection (a)(3), shall not apply to payment
4 for days before January 1, 2010.

5 **SEC. 1102. INPATIENT REHABILITATION FACILITY PAY-**
6 **MENT UPDATE.**

7 (a) IN GENERAL.—Section 1886(j)(3)(C) of the So-
8 cial Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended
9 by striking “and 2009” and inserting “through 2010”.

10 (b) DELAYED EFFECTIVE DATE.—The amendment
11 made by subsection (a) shall not apply to payment units
12 occurring before January 1, 2010.

13 **SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVE-**
14 **MENTS INTO MARKET BASKET UPDATES**
15 **THAT DO NOT ALREADY INCORPORATE SUCH**
16 **IMPROVEMENTS.**

17 (a) INPATIENT ACUTE HOSPITALS.—Section
18 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
19 1395ww(b)(3)(B)) is amended—

20 (1) in clause (iii)—

21 (A) by striking “(iii) For purposes of this
22 subparagraph,” and inserting “(iii)(I) For pur-
23 poses of this subparagraph, subject to the pro-
24 ductivity adjustment described in subclause
25 (II),”; and

1 (B) by adding at the end the following new
2 subclause:

3 “(II) The productivity adjustment described in this
4 subclause, with respect to an increase or change for a fis-
5 cal year or year or cost reporting period, or other annual
6 period, is a productivity offset in the form of a reduction
7 in such increase or change equal to the percentage change
8 in the 10-year moving average of annual economy-wide
9 private nonfarm business multi-factor productivity (as re-
10 cently published in final form before the promulgation or
11 publication of such increase for the year or period in-
12 volved). Except as otherwise provided, any reference to the
13 increase described in this clause shall be a reference to
14 the percentage increase described in subclause (I) minus
15 the percentage change under this subclause.”;

16 (2) in the first sentence of clause (viii)(I), by
17 inserting “(but not below zero)” after “shall be re-
18 duced”; and

19 (3) in the first sentence of clause (ix)(I)—

20 (A) by inserting “(determined without re-
21 gard to clause (iii)(II))” after “clause (i)” the
22 second time it appears; and

23 (B) by inserting “(but not below zero)”
24 after “reduced”.

1 (b) SKILLED NURSING FACILITIES.—Section
2 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5)(B))
3 is amended by inserting “subject to the productivity ad-
4 justment described in section 1886(b)(3)(B)(iii)(II)” after
5 “as calculated by the Secretary”.

6 (c) LONG TERM CARE HOSPITALS.—Section
7 1886(m) of the Social Security Act (42 U.S.C.
8 1395ww(m)) is amended by adding at the end the fol-
9 lowing new paragraph:

10 “(3) PRODUCTIVITY ADJUSTMENT.—In imple-
11 menting the system described in paragraph (1) for
12 discharges occurring on or after January 1, 2010,
13 during the rate year ending in 2010 or any subse-
14 quent rate year for a hospital, to the extent that an
15 annual percentage increase factor applies to a stand-
16 ard Federal rate for such discharges for the hos-
17 pital, such factor shall be subject to the productivity
18 adjustment described in subsection
19 (b)(3)(B)(iii)(II).”.

20 (d) INPATIENT REHABILITATION FACILITIES.—The
21 second sentence of section 1886(j)(3)(C) of the Social Se-
22 curity Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by in-
23 serting “(subject to the productivity adjustment described
24 in subsection (b)(3)(B)(iii)(II))” after “appropriate per-
25 centage increase”.

1 (e) PSYCHIATRIC HOSPITALS.—Section 1886 of the
2 Social Security Act (42 U.S.C. 1395ww) is amended by
3 adding at the end the following new subsection:

4 “(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC
5 HOSPITALS.—

6 “(1) REFERENCE TO ESTABLISHMENT AND IM-
7 PLEMENTATION OF SYSTEM.—For provisions related
8 to the establishment and implementation of a pro-
9 spective payment system for payments under this
10 title for inpatient hospital services furnished by psy-
11 chiatric hospitals (as described in clause (i) of sub-
12 section (d)(1)(B) and psychiatric units (as described
13 in the matter following clause (v) of such sub-
14 section), see section 124 of the Medicare, Medicaid,
15 and SCHIP Balanced Budget Refinement Act of
16 1999.

17 “(2) PRODUCTIVITY ADJUSTMENT.—In imple-
18 menting the system described in paragraph (1) for
19 days occurring during the rate year ending in 2011
20 or any subsequent rate year for a psychiatric hos-
21 pital or unit described in such paragraph, to the ex-
22 tent that an annual percentage increase factor ap-
23 plies to a base rate for such days for the hospital
24 or unit, respectively, such factor shall be subject to

1 the productivity adjustment described in subsection
2 (b)(3)(B)(iii)(II).”.

3 (f) HOSPICE CARE.—Subclause (VII) of section
4 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.
5 1395f(i)(1)(C)(ii)) is amended by inserting after “the
6 market basket percentage increase” the following: “(which
7 is subject to the productivity adjustment described in sec-
8 tion 1886(b)(3)(B)(iii)(II))”.

9 (g) EFFECTIVE DATES.—

10 (1) IPPS.—The amendments made by sub-
11 section (a) shall apply to annual increases effected
12 for fiscal years beginning with fiscal year 2010, but
13 only with respect to discharges occurring on or after
14 January 1, 2010.

15 (2) SNF AND IRF.—The amendments made by
16 subsections (b) and (d) shall apply to annual in-
17 creases effected for fiscal years beginning with fiscal
18 year 2011.

19 (3) HOSPICE CARE.—The amendment made by
20 subsection (f) shall apply to annual increases ef-
21 fected for fiscal years beginning with fiscal year
22 2010, but only with respect to days of care occurring
23 on or after January 1, 2010.

1 **PART 2—OTHER MEDICARE PART A PROVISIONS**

2 **SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.**

3 (a) CHANGE IN RECALIBRATION FACTOR.—

4 (1) ANALYSIS.—The Secretary of Health and
5 Human Services shall conduct, using calendar year
6 2006 claims data, an initial analysis comparing total
7 payments under title XVIII of the Social Security
8 Act for skilled nursing facility services under the
9 RUG–53 and under the RUG–44 classification sys-
10 tems.

11 (2) ADJUSTMENT IN RECALIBRATION FAC-
12 TOR.—Based on the initial analysis under paragraph
13 (1), the Secretary shall adjust the case mix indexes
14 under section 1888(e)(4)(G)(i) of the Social Security
15 Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year
16 2010 by the appropriate recalibration factor as pro-
17 posed in the proposed rule for Medicare skilled nurs-
18 ing facilities issued by such Secretary on May 12,
19 2009 (74 Federal Register 22214 et seq.).

20 (b) CHANGE IN PAYMENT FOR NONTHERAPY ANCIL-
21 LARY (NTA) SERVICES AND THERAPY SERVICES.—

22 (1) CHANGES UNDER CURRENT SNF CLASSI-
23 FICATION SYSTEM.—

24 (A) IN GENERAL.—Subject to subpara-
25 graph (B), the Secretary of Health and Human
26 Services shall, under the system for payment of

1 skilled nursing facility services under section
2 1888(e) of the Social Security Act (42 U.S.C.
3 1395yy(e)), increase payment by 10 percent for
4 non-therapy ancillary services (as specified by
5 the Secretary in the notice issued on November
6 27, 1998 (63 Federal Register 65561 et seq.))
7 and shall decrease payment for the therapy case
8 mix component of such rates by 5.5 percent.

9 (B) EFFECTIVE DATE.—The changes in
10 payment described in subparagraph (A) shall
11 apply for days on or after January 1, 2010,
12 and until the Secretary implements an alter-
13 native case mix classification system for pay-
14 ment of skilled nursing facility services under
15 section 1888(e) of the Social Security Act (42
16 U.S.C. 1395yy(e)).

17 (C) IMPLEMENTATION.—Notwithstanding
18 any other provision of law, the Secretary may
19 implement by program instruction or otherwise
20 the provisions of this paragraph.

21 (2) CHANGES UNDER A FUTURE SNF CASE MIX
22 CLASSIFICATION SYSTEM.—

23 (A) ANALYSIS.—

24 (i) IN GENERAL.—The Secretary of
25 Health and Human Services shall analyze

1 payments for non-therapy ancillary services
2 under a future skilled nursing facility clas-
3 sification system to ensure the accuracy of
4 payment for non-therapy ancillary services.
5 Such analysis shall consider use of appro-
6 priate predictors which may include age,
7 physical and mental status, ability to per-
8 form activities of daily living, prior nursing
9 home stay, diagnoses, broad RUG cat-
10 egory, and a proxy for length of stay.

11 (ii) APPLICATION.—Such analysis
12 shall be conducted in a manner such that
13 the future skilled nursing facility classifica-
14 tion system is implemented to apply to
15 services furnished during a fiscal year be-
16 ginning with fiscal year 2011.

17 (B) CONSULTATION.—In conducting the
18 analysis under subparagraph (A), the Secretary
19 shall consult with interested parties, including
20 the Medicare Payment Advisory Commission
21 and other interested stakeholders, to identify
22 appropriate predictors of nontherapy ancillary
23 costs.

24 (C) RULEMAKING.—The Secretary shall
25 include the result of the analysis under sub-

1 paragraph (A) in the fiscal year 2011 rule-
2 making cycle for purposes of implementation
3 beginning for such fiscal year.

4 (D) IMPLEMENTATION.—Subject to sub-
5 paragraph (E) and consistent with subpara-
6 graph (A)(ii), the Secretary shall implement
7 changes to payments for non-therapy ancillary
8 services (which shall include a separate rate
9 component for non-therapy ancillary services
10 and may include use of a model that predicts
11 payment amounts applicable for non-therapy
12 ancillary services) under such future skilled
13 nursing facility services classification system as
14 the Secretary determines appropriate based on
15 the analysis conducted pursuant to subpara-
16 graph (A).

17 (E) BUDGET NEUTRALITY.—The Secretary
18 shall implement changes described in subpara-
19 graph (D) in a manner such that the estimated
20 expenditures under such future skilled nursing
21 facility services classification system for a fiscal
22 year beginning with fiscal year 2011 with such
23 changes would be equal to the estimated ex-
24 penditures that would otherwise occur under
25 title XVIII of the Social Security Act under

1 such future skilled nursing facility services clas-
2 sification system for such year without such
3 changes.

4 (c) OUTLIER POLICY FOR NTA AND THERAPY.—Sec-
5 tion 1888(e) of the Social Security Act (42 U.S.C.
6 1395yy(e)) is amended by adding at the end the following
7 new paragraph:

8 “(13) OUTLIERS FOR NTA AND THERAPY.—

9 “(A) IN GENERAL.—With respect to
10 outliers because of unusual variations in the
11 type or amount of medically necessary care, be-
12 ginning with October 1, 2010, the Secretary—

13 “(i) shall provide for an addition or
14 adjustment to the payment amount other-
15 wise made under this section with respect
16 to non-therapy ancillary services in the
17 case of such outliers; and

18 “(ii) may provide for such an addition
19 or adjustment to the payment amount oth-
20 erwise made under this section with re-
21 spect to therapy services in the case of
22 such outliers.

23 “(B) OUTLIERS BASED ON AGGREGATE
24 COSTS.—Outlier adjustments or additional pay-
25 ments described in subparagraph (A) shall be

1 based on aggregate costs during a stay in a
2 skilled nursing facility and not on the number
3 of days in such stay.

4 “(C) BUDGET NEUTRALITY.—The Sec-
5 retary shall reduce estimated payments that
6 would otherwise be made under the prospective
7 payment system under this subsection with re-
8 spect to a fiscal year by 2 percent. The total
9 amount of the additional payments or payment
10 adjustments for outliers made under this para-
11 graph with respect to a fiscal year may not ex-
12 ceed 2 percent of the total payments projected
13 or estimated to be made based on the prospec-
14 tive payment system under this subsection for
15 the fiscal year.”.

16 (d) CONFORMING AMENDMENTS.—Section
17 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is
18 amended—

19 (1) in subparagraph (A)—

20 (A) by striking “and” before “adjust-
21 ments”; and

22 (B) by inserting “, and adjustment under
23 section 1111(b) of the Affordable Health Care
24 for America Act” before the semicolon at the
25 end;

- 1 (2) in subparagraph (B), by striking “and”;
- 2 (3) in subparagraph (C), by striking the period
- 3 and inserting “; and”; and
- 4 (4) by adding at the end the following new sub-
- 5 paragraph:
- 6 “(D) the establishment of outliers under
- 7 paragraph (13).”.

8 **SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUST-**

9 **MENTS IN RESPONSE TO COVERAGE EXPAN-**

10 **SION.**

11 (a) DSH REPORT.—

12 (1) IN GENERAL.—Not later than January 1,

13 2016, the Secretary of Health and Human Services

14 shall submit to Congress a report on Medicare DSH

15 taking into account the impact of the health care re-

16 forms carried out under division A in reducing the

17 number of uninsured individuals. The report shall

18 include recommendations relating to the following:

19 (A) The appropriate amount, targeting,

20 and distribution of Medicare DSH to com-

21 pensate for higher Medicare costs associated

22 with serving low-income beneficiaries (taking

23 into account variations in the empirical jus-

24 tification for Medicare DSH attributable to hos-

25 pital characteristics, including bed size), con-

1 sistent with the original intent of Medicare
2 DSH.

3 (B) The appropriate amount, targeting,
4 and distribution of Medicare DSH to hospitals
5 given their continued uncompensated care costs,
6 to the extent such costs remain.

7 (2) COORDINATION WITH MEDICAID DSH RE-
8 PORT.—The Secretary shall coordinate the report
9 under this subsection with the report on Medicaid
10 DSH under section 1704(a).

11 (b) PAYMENT ADJUSTMENTS IN RESPONSE TO COV-
12 ERAGE EXPANSION.—

13 (1) IN GENERAL.—If there is a significant de-
14 crease in the national rate of uninsurance as a result
15 of this Act (as determined under paragraph (2)(A)),
16 then the Secretary of Health and Human Services
17 shall, beginning in fiscal year 2017, implement the
18 following adjustments to Medicare DSH:

19 (A) In lieu of the amount of Medicare
20 DSH payment that would otherwise be made
21 under section 1886(d)(5)(F) of the Social Secu-
22 rity Act, the amount of Medicare DSH payment
23 shall be an amount based on the recommenda-
24 tions of the report under subsection (a)(1)(A)
25 and shall take into account variations in the

1 empirical justification for Medicare DSH attrib-
2 utable to hospital characteristics, including bed
3 size.

4 (B) Subject to paragraph (3), make an ad-
5 ditional payment to a hospital by an amount
6 that is estimated based on the amount of un-
7 compensated care provided by the hospital
8 based on criteria for uncompensated care as de-
9 termined by the Secretary, which shall exclude
10 bad debt.

11 (2) SIGNIFICANT DECREASE IN NATIONAL RATE
12 OF UNINSURANCE AS A RESULT OF THIS ACT.—For
13 purposes of this subsection—

14 (A) IN GENERAL.—There is a “significant
15 decrease in the national rate of uninsurance as
16 a result of this Act” if there is a decrease in
17 the national rate of uninsurance (as defined in
18 subparagraph (B)) from 2012 to 2014 that ex-
19 ceeds 8 percentage points.

20 (B) NATIONAL RATE OF UNINSURANCE
21 DEFINED.—The term “national rate of
22 uninsurance” means, for a year, such rate for
23 the under-65 population for the year as deter-
24 mined and published by the Bureau of the Cen-

1 sus in its Current Population Survey in or
2 about September of the succeeding year.

3 (3) UNCOMPENSATED CARE INCREASE.—

4 (A) COMPUTATION OF DSH SAVINGS.—For
5 each fiscal year (beginning with fiscal year
6 2017), the Secretary shall estimate the aggregate
7 reduction in the amount of Medicare DSH
8 payment that would be expected to result from
9 the adjustment under paragraph (1)(A).

10 (B) STRUCTURE OF PAYMENT IN-
11 CREASE.—The Secretary shall compute the additional
12 payment to a hospital as described in
13 paragraph (1)(B) for a fiscal year in accordance
14 with a formula established by the Secretary
15 that provides that—

16 (i) the estimated aggregate amount of
17 such increase for the fiscal year does not
18 exceed 50 percent of the aggregate reduction
19 in Medicare DSH estimated by the
20 Secretary for such fiscal year; and

21 (ii) hospitals with higher levels of un-
22 compensated care receive a greater in-
23 crease.

24 (c) MEDICARE DSH.—In this section, the term
25 “Medicare DSH” means adjustments in payments under

1 section 1886(d)(5)(F) of the Social Security Act (42
2 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services
3 furnished by disproportionate share hospitals.

4 **SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATO-**
5 **RIUM.**

6 Section 4301(a) of division B of the American Recov-
7 ery and Reinvestment Act of 2009 (Public Law 111–5)
8 is amended—

9 (1) by striking “October 1, 2009” and inserting
10 “October 1, 2010”; and

11 (2) by striking “for fiscal year 2009” and in-
12 serting “for fiscal years 2009 and 2010”.

13 **SEC. 1114. PERMITTING PHYSICIAN ASSISTANTS TO ORDER**
14 **POST-HOSPITAL EXTENDED CARE SERVICES**
15 **AND TO PROVIDE FOR RECOGNITION OF AT-**
16 **TENDING PHYSICIAN ASSISTANTS AS AT-**
17 **TENDING PHYSICIANS TO SERVE HOSPICE**
18 **PATIENTS.**

19 (a) ORDERING POST-HOSPITAL EXTENDED CARE
20 SERVICES.—Section 1814(a) of the Social Security Act
21 (42 U.S.C. 1395f(a)) is amended—

22 (1) in paragraph (2) in the matter preceding
23 subparagraph (A), is amended by striking “nurse
24 practitioner or clinical nurse specialist” and insert-

1 ing “nurse practitioner, a clinical nurse specialist, or
2 a physician assistant”.

3 (2) in the second sentence, by striking “or clinical
4 nurse specialist” and inserting “clinical nurse
5 specialist, or physician assistant”.

6 (b) RECOGNITION OF ATTENDING PHYSICIAN AS-
7 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE
8 PATIENTS.—

9 (1) IN GENERAL.—Section 1861(dd)(3)(B) of
10 such Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

11 (A) by striking “or nurse” and inserting “,
12 the nurse”; and

13 (B) by inserting “or the physician assist-
14 ant (as defined in such subsection),” after
15 “subsection (aa)(5)),”.

16 (2) CONFORMING AMENDMENT.—Section
17 1814(a)(7)(A)(i)(I) of such Act (42 U.S.C.
18 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a
19 physician assistant” after “a nurse practitioner”.

20 (3) CONSTRUCTION.—Nothing in the amend-
21 ments made by this subsection shall be construed as
22 changing the requirements of section 1842(b)(6)(C)
23 of the Social Security Act (42 U.S.C.
24 1395u(b)(6)(C)) with respect to payment for serv-

1 “(i) IN GENERAL.—The Secretary
2 shall develop and specify the nature of the
3 reports that will be disseminated under
4 this subsection, based on results and find-
5 ings from the Program under this sub-
6 section as in existence before the date of
7 the enactment of this paragraph. Such re-
8 ports may be based on a per capita basis,
9 an episode basis that combines separate
10 but clinically related physicians’ services
11 and other items and services furnished or
12 ordered by a physician into an episode of
13 care, as appropriate, or both.

14 “(ii) TIMELINE FOR DEVELOP-
15 MENT.—The nature of the reports de-
16 scribed in clause (i) shall be developed by
17 not later than January 1, 2012.

18 “(iii) PUBLIC AVAILABILITY.—The
19 Secretary shall make the details of the na-
20 ture of the reports developed under clause
21 (i) available to the public.

22 “(C) ANALYSIS OF DATA.—The Secretary
23 shall, for purposes of preparing reports under
24 this subsection, establish methodologies as ap-
25 propriate such as to—

1 “(i) attribute items and services, in
2 whole or in part, to physicians;

3 “(ii) identify appropriate physicians
4 for purposes of comparison under subpara-
5 graph (B)(i); and

6 “(iii) aggregate items and services at-
7 tributed to a physician under clause (i)
8 into a composite measure per individual.

9 “(D) FEEDBACK PROGRAM.—The Sec-
10 retary shall engage in efforts to disseminate re-
11 ports under this subsection. In disseminating
12 such reports, the Secretary shall consider the
13 following:

14 “(i) Direct meetings between con-
15 tracted physicians, facilitated by the Sec-
16 retary, to discuss the contents of reports
17 under this subsection, including any rea-
18 sons for divergence from local or national
19 averages.

20 “(ii) Contract with local, non-profit
21 entities engaged in quality improvement ef-
22 forts at the community level. Such entities
23 shall use the reports under this subsection,
24 or such equivalent tool as specified by the
25 Secretary. Any exchange of data under this

1 paragraph shall be protected by appro-
2 priate privacy safeguards.

3 “(iii) Mailings or other methods of
4 communication that facilitate large-scale
5 dissemination.

6 “(iv) Other methods specified by the
7 Secretary.

8 “(E) EVALUATION AND EXPANSION.—

9 “(i) EVALUATION.—The Secretary
10 shall evaluate the methods specified in sub-
11 paragraph (D) with regard to their efficacy
12 in changing practice patterns to improve
13 quality and decrease costs.

14 “(ii) EXPANSION.—Taking into ac-
15 count the cost of each method specified in
16 subparagraph (D), the Secretary shall de-
17 velop a plan to disseminate reports under
18 this subsection in a significant manner in
19 the regions and cities of the country with
20 the highest utilization of services under
21 this title. To the extent practicable, reports
22 under this subsection shall be disseminated
23 to increasing numbers of physicians each
24 year, such that during 2014 and subse-
25 quent years, reports are disseminated at

1 least to physicians with utilization rates
2 among the highest 5 percent of the nation,
3 subject the authority to focus under para-
4 graph (4).

5 “(F) ADMINISTRATION.—

6 “(i) Chapter 35 of title 44, United
7 States Code shall not apply to this para-
8 graph.

9 “(ii) Notwithstanding any other provi-
10 sion of law, the Secretary may implement
11 the provisions of this paragraph by pro-
12 gram instruction or otherwise.”.

13 **SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE**
14 **SCHEDULE.**

15 (a) IN GENERAL.—Section 1848(c)(2) of the Social
16 Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by
17 adding at the end the following new subparagraphs:

18 “(K) POTENTIALLY MISVALUED CODES.—

19 “(i) IN GENERAL.—The Secretary
20 shall—

21 “(I) periodically identify services
22 as being potentially misvalued using
23 criteria specified in clause (ii); and

24 “(II) review and make appro-
25 priate adjustments to the relative val-

1 ues established under this paragraph
2 for services identified as being poten-
3 tially misvalued under subclause (I).

4 “(ii) IDENTIFICATION OF POTEN-
5 TIALY MISVALUED CODES.—For purposes
6 of identifying potentially misvalued services
7 pursuant to clause (i)(I), the Secretary
8 shall examine (as the Secretary determines
9 to be appropriate) codes (and families of
10 codes as appropriate) for which there has
11 been the fastest growth; codes (and fami-
12 lies of codes as appropriate) that have ex-
13 perienced substantial changes in practice
14 expenses; codes for new technologies or
15 services within an appropriate period (such
16 as three years) after the relative values are
17 initially established for such codes; mul-
18 tiple codes that are frequently billed in
19 conjunction with furnishing a single serv-
20 ice; codes with low relative values, particu-
21 larly those that are often billed multiple
22 times for a single treatment; codes which
23 have not been subject to review since the
24 implementation of the RBRVS (the so-
25 called ‘Harvard-valued codes’); and such

1 other codes determined to be appropriate
2 by the Secretary.

3 “(iii) REVIEW AND ADJUSTMENTS.—

4 “(I) The Secretary may use ex-
5 isting processes to receive rec-
6 ommendations on the review and ap-
7 propriate adjustment of potentially
8 misvalued services described clause
9 (i)(II).

10 “(II) The Secretary may conduct
11 surveys, other data collection activi-
12 ties, studies, or other analyses as the
13 Secretary determines to be appro-
14 priate to facilitate the review and ap-
15 propriate adjustment described in
16 clause (i)(II).

17 “(III) The Secretary may use
18 analytic contractors to identify and
19 analyze services identified under
20 clause (i)(I), conduct surveys or col-
21 lect data, and make recommendations
22 on the review and appropriate adjust-
23 ment of services described in clause
24 (i)(II).

1 “(IV) The Secretary may coordi-
2 nate the review and appropriate ad-
3 justment described in clause (i)(II)
4 with the periodic review described in
5 subparagraph (B).

6 “(V) As part of the review and
7 adjustment described in clause (i)(II),
8 including with respect to codes with
9 low relative values described in clause
10 (ii), the Secretary may make appro-
11 priate coding revisions (including
12 using existing processes for consider-
13 ation of coding changes) which may
14 include consolidation of individual
15 services into bundled codes for pay-
16 ment under the fee schedule under
17 subsection (b).

18 “(VI) The provisions of subpara-
19 graph (B)(ii)(II) shall apply to adjust-
20 ments to relative value units made
21 pursuant to this subparagraph in the
22 same manner as such provisions apply
23 to adjustments under subparagraph
24 (B)(ii)(II).

1 “(L) VALIDATING RELATIVE VALUE
2 UNITS.—

3 “(i) IN GENERAL.—The Secretary
4 shall establish a process to validate relative
5 value units under the fee schedule under
6 subsection (b).

7 “(ii) COMPONENTS AND ELEMENTS
8 OF WORK.—The process described in
9 clause (i) may include validation of work
10 elements (such as time, mental effort and
11 professional judgment, technical skill and
12 physical effort, and stress due to risk) in-
13 volved with furnishing a service and may
14 include validation of the pre, post, and
15 intra-service components of work.

16 “(iii) SCOPE OF CODES.—The valida-
17 tion of work relative value units shall in-
18 clude a sampling of codes for services that
19 is the same as the codes listed under sub-
20 paragraph (K)(ii)

21 “(iv) METHODS.—The Secretary may
22 conduct the validation under this subpara-
23 graph using methods described in sub-
24 clauses (I) through (V) of subparagraph

1 (K)(iii) as the Secretary determines to be
2 appropriate.

3 “(v) ADJUSTMENTS.—The Secretary
4 shall make appropriate adjustments to the
5 work relative value units under the fee
6 schedule under subsection (b). The provi-
7 sions of subparagraph (B)(ii)(II) shall
8 apply to adjustments to relative value units
9 made pursuant to this subparagraph in the
10 same manner as such provisions apply to
11 adjustments under subparagraph
12 (B)(ii)(II).”.

13 (b) IMPLEMENTATION.—

14 (1) FUNDING.—For purposes of carrying out
15 the provisions of subparagraphs (K) and (L) of
16 1848(e)(2) of the Social Security Act, as added by
17 subsection (a), in addition to funds otherwise avail-
18 able, out of any funds in the Treasury not otherwise
19 appropriated, there are appropriated to the Sec-
20 retary of Health and Human Services for the Center
21 for Medicare & Medicaid Services Program Manage-
22 ment Account \$20,000,000 for fiscal year 2010 and
23 each subsequent fiscal year. Amounts appropriated
24 under this paragraph for a fiscal year shall be avail-
25 able until expended.

1 (2) ADMINISTRATION.—

2 (A) Chapter 35 of title 44, United States
3 Code and the provisions of the Federal Advisory
4 Committee Act (5 U.S.C. App.) shall not apply
5 to this section or the amendment made by this
6 section.

7 (B) Notwithstanding any other provision of
8 law, the Secretary may implement subpara-
9 graphs (K) and (L) of 1848(c)(2) of the Social
10 Security Act, as added by subsection (a), by
11 program instruction or otherwise.

12 (C) Section 4505(d) of the Balanced
13 Budget Act of 1997 is repealed.

14 (D) Except for provisions related to con-
15 fidentiality of information, the provisions of the
16 Federal Acquisition Regulation shall not apply
17 to this section or the amendment made by this
18 section.

19 (3) FOCUSING CMS RESOURCES ON POTEN-
20 Tially OVERVALUED CODES.—Section 1868(a) of
21 the Social Security Act (42 1395ee(a)) is repealed.

22 **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.**

23 Section 1833 of the Social Security Act (42 U.S.C.
24 1395l) is amended by adding at the end the following new
25 subsection:

1 “(x) INCENTIVE PAYMENTS FOR EFFICIENT
2 AREAS.—

3 “(1) IN GENERAL.—In the case of services fur-
4 nished under the physician fee schedule under sec-
5 tion 1848 on or after January 1, 2011, and before
6 January 1, 2013, by a supplier that is paid under
7 such fee schedule in an efficient area (as identified
8 under paragraph (2)), in addition to the amount of
9 payment that would otherwise be made for such
10 services under this part, there also shall be paid (on
11 a monthly or quarterly basis) an amount equal to 5
12 percent of the payment amount for the services
13 under this part.

14 “(2) IDENTIFICATION OF EFFICIENT AREAS.—

15 “(A) IN GENERAL.—Based upon available
16 data, the Secretary shall identify those counties
17 or equivalent areas in the United States in the
18 lowest fifth percentile of utilization based on
19 per capita spending under this part and part A
20 for services provided in the most recent year for
21 which data are available as of the date of the
22 enactment of this subsection, as standardized to
23 eliminate the effect of geographic adjustments
24 in payment rates.

1 “(B) IDENTIFICATION OF COUNTIES
2 WHERE SERVICE IS FURNISHED.—For pur-
3 poses of paying the additional amount specified
4 in paragraph (1), if the Secretary uses the 5-
5 digit postal ZIP Code where the service is fur-
6 nished, the dominant county of the postal ZIP
7 Code (as determined by the United States Post-
8 al Service, or otherwise) shall be used to deter-
9 mine whether the postal ZIP Code is in a coun-
10 ty described in subparagraph (A).

11 “(C) LIMITATION ON REVIEW.—There
12 shall be no administrative or judicial review
13 under section 1869, 1878, or otherwise, respect-
14 ing—

15 “(i) the identification of a county or
16 other area under subparagraph (A); or

17 “(ii) the assignment of a postal ZIP
18 Code to a county or other area under sub-
19 paragraph (B).

20 “(D) PUBLICATION OF LIST OF COUNTIES;
21 POSTING ON WEBSITE.—With respect to a year
22 for which a county or area is identified under
23 this paragraph, the Secretary shall identify
24 such counties or areas as part of the proposed
25 and final rule to implement the physician fee

1 schedule under section 1848 for the applicable
2 year. The Secretary shall post the list of coun-
3 ties identified under this paragraph on the
4 Internet website of the Centers for Medicare &
5 Medicaid Services.”.

6 **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY**
7 **REPORTING INITIATIVE (PQR).**

8 (a) **FEEDBACK.**—Section 1848(m)(5) of the Social
9 Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by
10 adding at the end the following new subparagraph:

11 “(H) **FEEDBACK.**—The Secretary shall
12 provide timely feedback to eligible professionals
13 on the performance of the eligible professional
14 with respect to satisfactorily submitting data on
15 quality measures under this subsection.”.

16 (b) **APPEALS.**—Such section is further amended—

17 (1) in subparagraph (E), by striking “There
18 shall be” and inserting “Except as provided in sub-
19 paragraph (I), there shall be”; and

20 (2) by adding at the end the following new sub-
21 paragraph:

22 “(I) **INFORMAL APPEALS PROCESS.**—By
23 not later than January 1, 2011, the Secretary
24 shall establish and have in place an informal
25 process for eligible professionals to seek a re-

1 view of the determination that an eligible pro-
2 fessional did not satisfactorily submit data on
3 quality measures under this subsection.”.

4 (c) INTEGRATION OF PHYSICIAN QUALITY REPORT-
5 ING AND EHR REPORTING.—Section 1848(m) of such
6 Act is amended by adding at the end the following new
7 paragraph:

8 “(7) INTEGRATION OF PHYSICIAN QUALITY RE-
9 PORTING AND EHR REPORTING.—Not later than
10 January 1, 2012, the Secretary shall develop a plan
11 to integrate clinical reporting on quality measures
12 under this subsection with reporting requirements
13 under subsection (o) relating to the meaningful use
14 of electronic health records. Such integration shall
15 consist of the following:

16 “(A) The development of measures, the re-
17 porting of which would both demonstrate—

18 “(i) meaningful use of an electronic
19 health record for purposes of subsection
20 (o); and

21 “(ii) clinical quality of care furnished
22 to an individual.

23 “(B) The collection of health data to iden-
24 tify deficiencies in the quality and coordination

1 of care for individuals eligible for benefits under
2 this part.

3 “(C) Such other activities as specified by
4 the Secretary.”.

5 (d) EXTENSION OF INCENTIVE PAYMENTS.—Section
6 1848(m)(1) of such Act (42 U.S.C. 1395w-4(m)(1)) is
7 amended—

8 (1) in subparagraph (A), by striking “2010”
9 and inserting “2012”; and

10 (2) in subparagraph (B)(ii), by striking “2009
11 and 2010” and inserting “for each of the years 2009
12 through 2012”.

13 **SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**
14 **ITIES.**

15 (a) IN GENERAL.—Section 1848(e) of the Social Se-
16 curity Act (42 U.S.C.1395w-4(e)) is amended by adding
17 at the end the following new paragraph:

18 “(6) TRANSITION TO USE OF MSAS AS FEE
19 SCHEDULE AREAS IN CALIFORNIA.—

20 “(A) IN GENERAL.—

21 “(i) REVISION.—Subject to clause (ii)
22 and notwithstanding the previous provi-
23 sions of this subsection, for services fur-
24 nished on or after January 1, 2011, the
25 Secretary shall revise the fee schedule

1 areas used for payment under this section
2 applicable to the State of California using
3 the Metropolitan Statistical Area (MSA)
4 iterative Geographic Adjustment Factor
5 methodology as follows:

6 “(I) The Secretary shall con-
7 figure the physician fee schedule areas
8 using the Metropolitan Statistical
9 Areas (each in this paragraph referred
10 to as an ‘MSA’), as defined by the Di-
11 rector of the Office of Management
12 and Budget and published in the Fed-
13 eral Register, using the most recent
14 available decennial population data as
15 of the date of the enactment of the
16 Affordable Health Care for America
17 Act, as the basis for the fee schedule
18 areas.

19 “(II) For purposes of this clause,
20 the Secretary shall treat all areas not
21 included in an MSA as a single rest of
22 the State MSA.

23 “(III) The Secretary shall list all
24 MSAs within the State by Geographic
25 Adjustment Factor described in para-

1 graph (2) (in this paragraph referred
2 to as a ‘GAF’) in descending order.

3 “(IV) In the first iteration, the
4 Secretary shall compare the GAF of
5 the highest cost MSA in the State to
6 the weighted-average GAF of all the
7 remaining MSAs in the State (includ-
8 ing the rest of State MSA described
9 in subclause (II)). If the ratio of the
10 GAF of the highest cost MSA to the
11 weighted-average of the GAF of re-
12 maining lower cost MSAs is 1.05 or
13 greater, the highest cost MSA shall be
14 a separate fee schedule area.

15 “(V) In the next iteration, the
16 Secretary shall compare the GAF of
17 the MSA with the second-highest
18 GAF to the weighted-average GAF of
19 the all the remaining MSAs (excluding
20 MSAs that become separate fee sched-
21 ule areas). If the ratio of the second-
22 highest MSA’s GAF to the weighted-
23 average of the remaining lower cost
24 MSAs is 1.05 or greater, the second-
25 highest MSA shall be a separate fee

1 schedule area. “(VI) The iterative
2 process shall continue until the ratio
3 of the GAF of the MSA with highest
4 remaining GAF to the weighted-aver-
5 age of the remaining MSAs with lower
6 GAFS is less than 1.05, and the re-
7 maining group of MSAs with lower
8 GAFS shall be treated as a single fee
9 schedule area.

10 “(VI) For purposes of the
11 iterative process described in this
12 clause, if two MSAs have identical
13 GAFs, they shall be combined.

14 “(ii) TRANSITION.—For services fur-
15 nished on or after January 1, 2011, and
16 before January 1, 2016, in the State of
17 California, after calculating the work, prac-
18 tice expense, and malpractice geographic
19 indices that would otherwise be determined
20 under clauses (i), (ii), and (iii) of para-
21 graph (1)(A) for a fee schedule area deter-
22 mined under clause (i), if the index for a
23 county within a fee schedule area is less
24 than the index in effect for such county on
25 December 31, 2010, the Secretary shall in-

1 stead apply the index in effect for such
2 county on such date.

3 “(B) SUBSEQUENT REVISIONS.—After the
4 transition described in subparagraph (A)(ii),
5 not less than every 3 years the Secretary shall
6 review and update the fee schedule areas using
7 the methodology described in subparagraph
8 (A)(i) and any updated MSAs as defined by the
9 Director of the Office of Management and
10 Budget and published in the Federal Register.
11 The Secretary shall review and make any
12 changes pursuant to such reviews concurrent
13 with the application of the periodic review of
14 the adjustment factors required under para-
15 graph (1)(C) for California.

16 “(C) REFERENCES TO FEE SCHEDULE
17 AREAS.—Effective for services furnished on or
18 after January 1, 2011, for the State of Cali-
19 fornia, any reference in this section to a fee
20 schedule area shall be deemed a reference to an
21 MSA in the State (including the single rest of
22 state MSA described in subparagraph
23 (A)(i)(II)).”.

24 (b) CONFORMING AMENDMENT TO DEFINITION OF
25 FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social

1 Security Act (42 U.S.C. 1395w(j)(2)) is amended by strik-
2 ing “The term” and inserting “Except as provided in sub-
3 section (e)(6)(C), the term”.

4 **PART 2—MARKET BASKET UPDATES**

5 **SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVE-**
6 **MENTS INTO MARKET BASKET UPDATES**
7 **THAT DO NOT ALREADY INCORPORATE SUCH**
8 **IMPROVEMENTS.**

9 (a) OUTPATIENT HOSPITALS.—

10 (1) IN GENERAL.—Section 1833(t)(3)(C)(iv) of
11 the Social Security Act (42 U.S.C.
12 1395l(t)(3)(C)(iv)) is amended—

13 (A) in the first sentence—

14 (i) by inserting “(which is subject to
15 the productivity adjustment described in
16 subclause (II) of such section)” after
17 “1886(b)(3)(B)(iii)”; and

18 (ii) by inserting “(but not below 0)”
19 after “reduced”; and

20 (B) in the second sentence, by inserting
21 “and which is subject, beginning with 2010, to
22 the productivity adjustment described in section
23 1886(b)(3)(B)(iii)(II)”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to increase factors for
3 services furnished in years beginning with 2010.

4 (b) AMBULANCE SERVICES.—Section 1834(l)(3)(B)
5 of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by
6 inserting before the period at the end the following: “and,
7 in the case of years beginning with 2010, subject to the
8 productivity adjustment described in section
9 1886(b)(3)(B)(iii)(II)”.

10 (c) AMBULATORY SURGICAL CENTER SERVICES.—
11 Section 1833(i)(2)(D) of such Act (42 U.S.C.
12 1395l(i)(2)(D)) is amended—

13 (1) by redesignating clause (v) as clause (vi);
14 and

15 (2) by inserting after clause (iv) the following
16 new clause:

17 “(v) In implementing the system described in clause
18 (i), for services furnished during 2010 or any subsequent
19 year, to the extent that an annual percentage change fac-
20 tor applies, such factor shall be subject to the productivity
21 adjustment described in section 1886(b)(3)(B)(iii)(II).”.

22 (d) LABORATORY SERVICES.—Section 1833(h)(2)(A)
23 of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

1 (1) in clause (i), by striking “for each of the
2 years 2009 through 2013” and inserting “for
3 2009”; and

4 (2) clause (ii)—

5 (A) by striking “and” at the end of sub-
6 clause (III);

7 (B) by striking the period at the end of
8 subclause (IV) and inserting “; and”; and

9 (C) by adding at the end the following new
10 subclause:

11 “(V) the annual adjustment in the fee schedules
12 determined under clause (i) for years beginning with
13 2010 shall be subject to the productivity adjustment
14 described in section 1886(b)(3)(B)(iii)(II).”.

15 (e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Sec-
16 tion 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14))
17 is amended—

18 (1) in subparagraph (K), by inserting before
19 the semicolon at the end the following: “, subject to
20 the productivity adjustment described in section
21 1886(b)(3)(B)(iii)(II)”;

22 (2) in subparagraph (L)(i), by inserting after
23 “June 2013,” the following: “subject to the produc-
24 tivity adjustment described in section
25 1886(b)(3)(B)(iii)(II),”;

1 (3) in subparagraph (L)(ii), by inserting after
2 “June 2013” the following: “, subject to the produc-
3 tivity adjustment described in section
4 1886(b)(3)(B)(iii)(II)”; and

5 (4) in subparagraph (M), by inserting before
6 the period at the end the following: “, subject to the
7 productivity adjustment described in section
8 1886(b)(3)(B)(iii)(II)”.

9 **PART 3—OTHER PROVISIONS**

10 **SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN** 11 **WHEELCHAIRS.**

12 (a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the
13 Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is
14 amended—

15 (1) in the heading, by inserting “CERTAIN COM-
16 PLEX REHABILITATIVE” after “OPTION FOR”; and

17 (2) by striking “power-driven wheelchair” and
18 inserting “complex rehabilitative power-driven wheel-
19 chair recognized by the Secretary as classified within
20 group 3 or higher”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 subsection (a) shall take effect on January 1, 2011, and
23 shall apply to power-driven wheelchairs furnished on or
24 after such date. Such amendments shall not apply to con-
25 tracts entered into under section 1847 of the Social Secu-

1 rity Act (42 U.S.C. 1395w-3) pursuant to a bid submitted
2 under such section before October 1, 2010, under sub-
3 section (a)(1)(B)(i)(I) of such section.

4 **SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DE-**
5 **CLINE OWNERSHIP, OF A CERTAIN ITEM OF**
6 **COMPLEX DURABLE MEDICAL EQUIPMENT**
7 **AFTER THE 13-MONTH CAPPED RENTAL PE-**
8 **RIOD ENDS.**

9 (a) IN GENERAL.—Section 1834(a)(7)(A) of the So-
10 cial Security Act (42 U.S.C. 1395m(a)(7)(A)) is amend-
11 ed—

12 (1) in clause (ii)—

13 (A) by striking “RENTAL.—On” and in-
14 serting “RENTAL.—

15 “(I) IN GENERAL.—Except as
16 provided in subclause (II), on”; and

17 (B) by adding at the end the following new
18 subclause:

19 “(II) OPTION TO ACCEPT OR RE-
20 JECT TRANSFER OF TITLE TO GROUP
21 3 SUPPORT SURFACE.—

22 “(aa) IN GENERAL.—During
23 the 10th continuous month dur-
24 ing which payment is made for
25 the rental of a Group 3 Support

1 Surface under clause (i), the sup-
2 plier of such item shall offer the
3 individual the option to accept or
4 reject transfer of title to a Group
5 3 Support Surface after the 13th
6 continuous month during which
7 payment is made for the rental of
8 the Group 3 Support Surface
9 under clause (i). Such title shall
10 be transferred to the individual
11 only if the individual notifies the
12 supplier not later than 1 month
13 after the supplier makes such
14 offer that the individual agrees to
15 accept transfer of the title to the
16 Group 3 Support Surface. Unless
17 the individual accepts transfer of
18 title to the Group 3 Support Sur-
19 face in the manner set forth in
20 this subclause, the individual
21 shall be deemed to have rejected
22 transfer of title. If the individual
23 agrees to accept the transfer of
24 the title to the Group 3 Support
25 Surface, the supplier shall trans-

1 fer such title to the individual on
2 the first day that begins after the
3 13th continuous month during
4 which payment is made for the
5 rental of the Group 3 Support
6 Surface under clause (i).

7 “(bb) SPECIAL RULE.—If,
8 on the effective date of this sub-
9 clause, an individual’s rental pe-
10 riod for a Group 3 Support Sur-
11 face has exceeded 10 continuous
12 months, but the first day that be-
13 gins after the 13th continuous
14 month during which payment is
15 made for the rental under clause
16 (i) has not been reached, the sup-
17 plier shall, within 1 month fol-
18 lowing such effective date, offer
19 the individual the option to ac-
20 cept or reject transfer of title to
21 a Group 3 Support Surface. Such
22 title shall be transferred to the
23 individual only if the individual
24 notifies the supplier not later
25 than 1 month after the supplier

1 makes such offer that the indi-
2 vidual agrees to accept transfer
3 of title to the Group 3 Support
4 Surface. Unless the individual ac-
5 cepts transfer of title to the
6 Group 3 Support Surface in the
7 manner set forth in this sub-
8 clause, the individual shall be
9 deemed to have rejected transfer
10 of title. If the individual agrees
11 to accept the transfer of the title
12 to the Group 3 Support Surface,
13 the supplier shall transfer such
14 title to the individual on the first
15 day that begins after the 13th
16 continuous month during which
17 payment is made for the rental of
18 the Group 3 Support Surface
19 under clause (i) unless that day
20 has passed, in which case the
21 supplier shall transfer such title
22 to the individual not later than 1
23 month after notification that the
24 individual accepts transfer of
25 title.

1 “(cc) TREATMENT OF SUB-
2 SEQUENT RESUPPLY WITHIN PE-
3 RIOD OF REASONABLE USEFUL
4 LIFETIME OF GROUP 3 SUPPORT
5 SURFACE IN CASE OF NEED.—If
6 an individual rejects transfer of
7 title to a Group 3 Support Sur-
8 face under this subclause and the
9 individual requires such Support
10 Surface at any subsequent time
11 during the period of the reason-
12 able useful lifetime of such equip-
13 ment (as defined by the Sec-
14 retary) beginning with the first
15 month for which payment is
16 made for the rental of such
17 equipment under clause (i), the
18 supplier shall supply the equip-
19 ment without charge to the indi-
20 vidual or the program under this
21 title during the remainder of
22 such period, other than payment
23 for maintenance and servicing
24 during such period which would
25 otherwise have been paid if the

1 individual had accepted title to
2 such equipment. The previous
3 sentence shall not affect the pay-
4 ment of amounts under this part
5 for such equipment after the end
6 of such period of the reasonable
7 useful lifetime of the equipment.

8 “(dd) PAYMENTS.—Mainte-
9 nance and servicing payments
10 shall be made in accordance with
11 clause (iv), in the case of a sup-
12 plier that transfers title to the
13 Group 3 Support Surface under
14 this subclause, after such trans-
15 fer and, in the case of an indi-
16 vidual who rejects transfer of
17 title under this subclause, after
18 the end of the period of medical
19 need during which payment is
20 made under clause (i).”; and

21 (2) in clause (iv), by inserting “or, in the case
22 of an individual who rejects transfer of title to a
23 Group 3 Support Surface under clause (ii), after the
24 end of the period of medical need during which pay-

1 ment is made under clause (i),” after “under clause
2 (ii)”.

3 (b) **EFFECTIVE DATE.**—The amendments made by
4 this section shall apply with respect to durable medical
5 equipment not later than January 1, 2011.

6 **SEC. 1142. EXTENSION OF PAYMENT RULE FOR**
7 **BRACHYTHERAPY.**

8 Section 1833(t)(16)(C) of the Social Security Act (42
9 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the
10 Medicare Improvements for Patients and Providers Act of
11 2008 (Public Law 110–275), is amended by striking, the
12 first place it appears, “January 1, 2010” and inserting
13 “January 1, 2012”.

14 **SEC. 1143. HOME INFUSION THERAPY REPORT TO CON-**
15 **GRESS.**

16 Not later than July 1, 2011, the Medicare Payment
17 Advisory Commission shall submit to Congress a report
18 on the following:

19 (1) The scope of coverage for home infusion
20 therapy in the fee-for-service Medicare program
21 under title XVIII of the Social Security Act, Medi-
22 care Advantage under part C of such title, the vet-
23 eran’s health care program under chapter 17 of title
24 38, United States Code, and among private payers,
25 including an analysis of the scope of services pro-

1 vided by home infusion therapy providers to their
2 patients in such programs.

3 (2) The benefits and costs of providing such
4 coverage under the Medicare program, including a
5 calculation of the potential savings achieved through
6 avoided or shortened hospital and nursing home
7 stays as a result of Medicare coverage of home infu-
8 sion therapy.

9 (3) An assessment of sources of data on the
10 costs of home infusion therapy that might be used
11 to construct payment mechanisms in the Medicare
12 program.

13 (4) Recommendations, if any, on the structure
14 of a payment system under the Medicare program
15 for home infusion therapy, including an analysis of
16 the payment methodologies used under Medicare Ad-
17 vantage plans and private health plans for the provi-
18 sion of home infusion therapy and their applicability
19 to the Medicare program.

20 **SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS**
21 **(ASCS) TO SUBMIT COST DATA AND OTHER**
22 **DATA.**

23 (a) COST REPORTING.—

1 (1) IN GENERAL.—Section 1833(i) of the Social
2 Security Act (42 U.S.C. 1395l(i)) is amended by
3 adding at the end the following new paragraph:

4 “(8) The Secretary shall require, as a condition of
5 the agreement described in section 1832(a)(2)(F)(i), the
6 submission of such cost report as the Secretary may speci-
7 fy, taking into account the requirements for such reports
8 under section 1815 in the case of a hospital.”.

9 (2) DEVELOPMENT OF COST REPORT.—Not
10 later than 3 years after the date of the enactment
11 of this Act, the Secretary of Health and Human
12 Services shall develop a cost report form for use
13 under section 1833(i)(8) of the Social Security Act,
14 as added by paragraph (1).

15 (3) AUDIT REQUIREMENT.—The Secretary shall
16 provide for periodic auditing of cost reports sub-
17 mitted under section 1833(i)(8) of the Social Secu-
18 rity Act, as added by paragraph (1).

19 (4) EFFECTIVE DATE.—The amendment made
20 by paragraph (1) shall apply to agreements applica-
21 ble to cost reporting periods beginning 18 months
22 after the date the Secretary develops the cost report
23 form under paragraph (2).

24 (b) ADDITIONAL DATA ON QUALITY.—

1 (1) IN GENERAL.—Section 1833(i)(7) of such
2 Act (42 U.S.C. 1395l(i)(7)) is amended—

3 (A) in subparagraph (B), by inserting
4 “subject to subparagraph (C),” after “may oth-
5 erwise provide,”; and

6 (B) by adding at the end the following new
7 subparagraph:

8 “(C) Under subparagraph (B) the Secretary shall re-
9 quire the reporting of such additional data relating to
10 quality of services furnished in an ambulatory surgical fa-
11 cility, including data on health care associated infections,
12 as the Secretary may specify.”.

13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) shall to reporting for years begin-
15 ning with 2012.

16 **SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.**

17 Section 1833(t) of the Social Security Act (42 U.S.C.
18 1395l(t)) is amended by adding at the end the following
19 new paragraph:

20 “(18) AUTHORIZATION OF ADJUSTMENT FOR
21 CANCER HOSPITALS.—

22 “(A) STUDY.—The Secretary shall conduct
23 a study to determine if, under the system under
24 this subsection, costs incurred by hospitals de-
25 scribed in section 1886(d)(1)(B)(v) with respect

1 to ambulatory payment classification groups ex-
2 ceed those costs incurred by other hospitals fur-
3 nishing services under this subsection (as deter-
4 mined appropriate by the Secretary).

5 “(B) AUTHORIZATION OF ADJUSTMENT.—
6 Insofar as the Secretary determines under sub-
7 paragraph (A) that costs incurred by hospitals
8 described in section 1886(d)(1)(B)(v) exceed
9 those costs incurred by other hospitals fur-
10 nishing services under this subsection, the Sec-
11 retary shall provide for an appropriate adjust-
12 ment under paragraph (2)(E) to reflect those
13 higher costs effective for services furnished on
14 or after January 1, 2011.”.

15 **SEC. 1146. PAYMENT FOR IMAGING SERVICES.**

16 (a) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
17 FLECT A PRESUMED LEVEL OF UTILIZATION.—Section
18 1848 of the Social Security Act (42 U.S.C. 1395w-4) is
19 amended—

20 (1) in subsection (b)(4)—

21 (A) in subparagraph (B), by striking “sub-
22 paragraph (A)” and inserting “this paragraph”;
23 and

24 (B) by adding at the end the following new
25 subparagraph:

1 “(C) ADJUSTMENT IN PRACTICE EXPENSE
2 TO REFLECT A PRESUMED LEVEL OF UTILIZA-
3 TION.—Consistent with the methodology for
4 computing the number of practice expense rel-
5 ative value units under subsection (c)(2)(C)(ii)
6 with respect to advanced diagnostic imaging
7 services (as defined in section 1834(e)(1)(B))
8 furnished on or after January 1, 2011, the Sec-
9 retary shall adjust such number of units so it
10 reflects a presumed rate of utilization of imag-
11 ing equipment of 75 percent.”; and

12 (2) in subsection (c)(2)(B)(v)), by adding at the
13 end the following new subclause:

14 “(III) CHANGE IN PRESUMED
15 UTILIZATION LEVEL OF CERTAIN AD-
16 VANCED DIAGNOSTIC IMAGING SERV-
17 ICES.—Effective for fee schedules es-
18 tablished beginning with 2011, re-
19 duced expenditures attributable to the
20 presumed utilization of 75 percent
21 under subsection (b)(4)(C) instead of
22 a presumed utilization of imaging
23 equipment of 50 percent.”.

24 (b) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-
25 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE

1 BODY PARTS.—Section 1848 of such Act (42 U.S.C.
2 1395w-4) is further amended—

3 (1) in subsection (b)(4), by adding at the end
4 the following new subparagraph:

5 “(D) ADJUSTMENT IN TECHNICAL COMPO-
6 NENT DISCOUNT ON SINGLE-SESSION IMAGING
7 INVOLVING CONSECUTIVE BODY PARTS.—For
8 services furnished on or after January 1, 2011,
9 the Secretary shall increase the reduction in ex-
10 penditures attributable to the multiple proce-
11 dure payment reduction applicable to the tech-
12 nical component for imaging under the final
13 rule published by the Secretary in the Federal
14 Register on November 21, 2005 (part 405 of
15 title 42, Code of Federal Regulations) from 25
16 percent to 50 percent.”; and

17 (2) in subsection (c)(2)(B)(v), by adding at the
18 end the following new subclause:

19 “(III) ADDITIONAL REDUCED
20 PAYMENT FOR MULTIPLE IMAGING
21 PROCEDURES.—Effective for fee
22 schedules established beginning with
23 2011, reduced expenditures attrib-
24 utable to the increase in the multiple
25 procedure payment reduction from 25

1 percent to 50 percent as described in
2 subsection (b)(4)(D).”.

3 **SEC. 1147. DURABLE MEDICAL EQUIPMENT PROGRAM IM-**
4 **PROVEMENTS.**

5 (a) **WAIVER OF SURETY BOND REQUIREMENT.**—Sec-
6 tion 1834(a)(16) of the Social Security Act (42 U.S.C.
7 1395m(a)(16)) is amended by adding at the end the fol-
8 lowing sentence: “The requirement for a surety bond de-
9 scribed in subparagraph (B) shall not apply in the case
10 of a pharmacy or supplier that exclusively furnishes eye-
11 glasses or contact lenses described in section 1861(s)(8)
12 if the pharmacy or supply has been enrolled under section
13 1866(j) as a supplier of durable medical equipment, pros-
14 thetics, orthotics, and supplies and has been issued (which
15 may include renewal of) a supplier number (as described
16 in the first sentence of this paragraph) for at least 5 years,
17 and if a final adverse action (as defined in section
18 424.57(a) of title 42, Code of Federal Regulations) has
19 never been imposed for such pharmacy or supplier.”.

20 (b) **ENSURING SUPPLY OF OXYGEN EQUIPMENT .**—

21 (1) **IN GENERAL.**—Section 1834(a)(5)(F) of the
22 Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is
23 amended—

1 (A) in clause (ii), by striking “After the”
2 and inserting “Except as provided in clause
3 (iii), after the”; and

4 (B) by adding at the end the following new
5 clause:

6 “(iii) CONTINUATION OF SUPPLY.—In
7 the case of a supplier furnishing such
8 equipment to an individual under this sub-
9 section as of the 27th month of the 36
10 months described in clause (i), the supplier
11 furnishing such equipment as of such
12 month shall continue to furnish such
13 equipment to such individual (either di-
14 rectly or through arrangements with other
15 suppliers of such equipment) during any
16 subsequent period of medical need for the
17 remainder of the reasonable useful lifetime
18 of the equipment, as determined by the
19 Secretary, regardless of the location of the
20 individual, unless another supplier has ac-
21 cepted responsibility for continuing to fur-
22 nish such equipment during the remainder
23 of such period.”.

24 (2) EFFECTIVE DATE.—The amendments made
25 by paragraph (1) shall take effect as of the date of

1 the enactment of this Act and shall apply to the fur-
2 nishing of equipment to individuals for whom the
3 27th month of a continuous period of use of oxygen
4 equipment described in section 1834(a)(5)(F) of the
5 Social Security Act occurs on or after July 1, 2010.

6 (c) TREATMENT OF CURRENT ACCREDITATION AP-
7 PPLICATIONS.—Section 1834(a)(20)(F) of such Act (42
8 U.S.C. 1395m(a)(20)(F)) is amended—

9 (1) in clause (i)—

10 (A) by striking “clause (ii)” and inserting
11 “clauses (ii) and (iii)”; and

12 (B) by striking “and” at the end;

13 (2) by striking the period at the end of clause
14 (ii)(II) and by inserting a semicolon;

15 (3) by inserting after clause (ii) the following
16 new clauses:

17 “(iii) the requirement for accredita-
18 tion described in clause (i) shall not apply
19 for purposes of supplying diabetic testing
20 supplies, canes, and crutches in the case of
21 a pharmacy that is enrolled under section
22 1866(j) as a supplier of durable medical
23 equipment, prosthetics, orthotics, and sup-
24 plies; and

1 “(iv) a supplier that has submitted an
2 application for accreditation before August
3 1, 2009, shall retain the supplier’s provider
4 or supplier number until an independent
5 accreditation organization determines if
6 such supplier complies with requirements
7 under this paragraph.”; and

8 (4) by adding at the end the following new sen-
9 tence: “Nothing in clauses (iii) and (iv) shall be con-
10 strued as affecting the application of an accredita-
11 tion requirement for suppliers to qualify for bidding
12 in a competitive acquisition area under section
13 1847.”.

14 (d) RESTORING 36-MONTH OXYGEN RENTAL PERIOD
15 IN CASE OF SUPPLIER BANKRUPTCY FOR CERTAIN INDI-
16 VIDUALS.—Section 1834(a)(5)(F) of such Act (42 U.S.C.
17 1395m(a)(5)(F)), as amended by subsection (b), is further
18 amended by adding at the end the following new clause:

19 “(iv) EXCEPTION FOR BANK-
20 RUPTCY.—If a supplier who furnishes oxy-
21 gen and oxygen equipment to an individual
22 is declared bankrupt and its assets are liq-
23 uidated and at the time of such declaration
24 and liquidation more than 24 months of
25 rental payments have been made, such in-

1 dividual may begin a new 36-month rental
2 period under this subparagraph with an-
3 other supplier of oxygen.”.

4 **SEC. 1148. MEDPAC STUDY AND REPORT ON BONE MASS**
5 **MEASUREMENT.**

6 (a) IN GENERAL.—The Medicare Payment Advisory
7 Commission shall conduct a study regarding bone mass
8 measurement, including computed tomography, dual-en-
9 ergy x-ray absorptriometry, and vertebral fracture assess-
10 ment. The study shall focus on the following:

11 (1) An assessment of the adequacy of Medicare
12 payment rates for such services, taking into account
13 costs of acquiring the necessary equipment, profes-
14 sional work time, and practice expense costs.

15 (2) The impact of Medicare payment changes
16 since 2006 on beneficiary access to bone mass meas-
17 urement benefits in general and in rural and minor-
18 ity communities specifically.

19 (3) A review of the clinically appropriate and
20 recommended use among Medicare beneficiaries and
21 how usage rates among such beneficiaries compares
22 to such recommendations.

23 (4) In conjunction with the findings under (3),
24 recommendations, if necessary, regarding methods

1 for reaching appropriate use of bone mass measure-
2 ment studies among Medicare beneficiaries.

3 (b) REPORT.—The Commission shall submit a report
4 to the Congress, not later than 9 months after the date
5 of the enactment of this Act, containing a description of
6 the results of the study conducted under subsection (a)
7 and the conclusions and recommendations, if any, regard-
8 ing each of the issues described in paragraphs (1), (2) (3)
9 and (4) of such subsection.

10 **SEC. 1149. TIMELY ACCESS TO POST-MASTECTOMY ITEMS.**

11 (a) IN GENERAL.—Section 1834(h)(1) of the Social
12 Security Act (42 U.S.C. 1395m) is amended—

13 (1) by redesignating subparagraph (H) as sub-
14 paragraph (I); and

15 (2) by inserting after subparagraph (G) the fol-
16 lowing new subparagraph:

17 “(H) SPECIAL PAYMENT RULE FOR POST-
18 MASTECTOMY EXTERNAL BREAST PROSTHESIS
19 GARMENTS.—Payment for post-mastectomy ex-
20 ternal breast prosthesis garments shall be made
21 regardless of whether such items are supplied to
22 the beneficiary prior to or after the mastectomy
23 procedure or other breast cancer surgical proce-
24 dure. The Secretary shall develop policies to en-
25 sure appropriate beneficiary access and utiliza-

1 tion safeguards for such items supplied to a
2 beneficiary prior to the mastectomy or other
3 breast cancer surgical procedure.”

4 (b) EFFECTIVE DATE.—This amendment shall apply
5 not later than January 1, 2011.

6 **SEC. 1149A. PAYMENT FOR BIOSIMILAR BIOLOGICAL PROD-**
7 **UCTS.**

8 (a) IN GENERAL.—Section 1847A of the Social Secu-
9 rity Act (42 U.S.C. 1395w–3a) is amended—

10 (1) in subsection (b)(1)—

11 (A) in subparagraph (A), by striking “or”
12 at the end;

13 (B) in subparagraph (B), by striking the
14 period at the end and inserting “; or”; and

15 (C) by adding at the end the following new
16 subparagraph:

17 “(C) in the case of one or more inter-
18 changeable biological products (as defined in
19 subsection (c)(6)(I)) and their reference biologi-
20 cal product (as defined in subsection (c)(6)(J)),
21 which shall be included in the same billing and
22 payment code, the sum of—

23 “(i) the average sales price as deter-
24 mined using the methodology described in
25 paragraph (6) applied to such interchange-

1 able and reference products for all Na-
2 tional Drug Codes assigned to such prod-
3 ucts in the same manner as such para-
4 graph (6) is applied to multiple source
5 drugs; and

6 “(ii) 6 percent of the amount deter-
7 mined under clause (i);

8 “(D) in the case of a biosimilar biological
9 product (as defined in subsection (c)(6)(H)),
10 the sum of—

11 “(i) the average sales price as deter-
12 mined using the methodology described in
13 paragraph (4) applied to such biosimilar
14 biological product for all National Drug
15 Codes assigned to such product in the
16 same manner as such paragraph (4) is ap-
17 plied to a single source drug; and

18 “(ii) 6 percent of the amount deter-
19 mined under paragraph (4) or the amount
20 determined under subparagraph (C)(ii), as
21 the case may be, for the reference biologi-
22 cal product (as defined in subsection
23 (c)(6)(J)); or

24 “(E) in the case of a reference biological
25 product for both an interchangeable biological

1 product and a biosimilar product, the amount
2 determined in subparagraph (C).”; and

3 (2) in subsection (c)(6)—

4 (A) by amending subparagraph (D)(i) to
5 read as follows:

6 “(i) a biological, including a reference
7 biological product for a biosimilar product,
8 but excluding—

9 “(I) a biosimilar biological prod-
10 uct;

11 “(II) an interchangeable biologi-
12 cal product;

13 “(III) a reference biological prod-
14 uct for an interchangeable biological
15 product; and

16 “(IV) a reference biological prod-
17 uct for both an interchangeable bio-
18 logical product and a biosimilar prod-
19 uct; or”; and

20 (B) by adding at the end the following new
21 subparagraphs:

22 “(H) BIOSIMILAR BIOLOGICAL PRODUCT.—
23 The term ‘biosimilar biological product’ means
24 a biological product licensed as a biosimilar bio-

1 ical equipment and supplies through a competitive bidding
2 process among manufacturers of such equipment and sup-
3 plies. Such study shall address the following:

4 (1) Identification of types of durable medical
5 equipment and supplies that would be appropriate
6 for bidding under such a program.

7 (2) Recommendations on how to structure such
8 an acquisition program in order to promote fiscal re-
9 sponsibility while also ensuring beneficiary access to
10 high quality equipment and supplies.

11 (3) Recommendations on how such a program
12 could be phased-in and on what geographic level
13 would bidding be most appropriate.

14 (4) In addition to price, recommendations on
15 criteria that could be factored into the bidding proc-
16 ess.

17 (5) Recommendations on how suppliers could be
18 compensated for furnishing and servicing equipment
19 and supplies acquired under such a program.

20 (6) Comparison of such a program to the cur-
21 rent competitive bidding program under Medicare
22 for durable medical equipment, as well as any other
23 similar Federal acquisition programs, such as the
24 General Services Administration's vehicle purchasing
25 program.

1 (7) Any other consideration relevant to the ac-
2 quisition, supply, and service of durable medical
3 equipment and supplies that is deemed appropriate
4 by the Comptroller General.

5 (b) REPORT.—Not later than 12 months after the
6 date of the enactment of this Act, the Comptroller General
7 of the United States shall submit to Congress a report
8 on the findings of the study under subsection (a).

9 **Subtitle C—Provisions Related to**
10 **Medicare Parts A and B**

11 **SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOS-**
12 **PITAL READMISSIONS.**

13 (a) HOSPITALS.—

14 (1) IN GENERAL.—Section 1886 of the Social
15 Security Act (42 U.S.C. 1395ww), as amended by
16 section 1103(a), is amended by adding at the end
17 the following new subsection:

18 “(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR
19 EXCESS READMISSIONS.—

20 “(1) IN GENERAL.—With respect to payment
21 for discharges from an applicable hospital (as de-
22 fined in paragraph (5)(C)) occurring during a fiscal
23 year beginning on or after October 1, 2011, in order
24 to account for excess readmissions in the hospital,
25 the Secretary shall reduce the payments that would

1 otherwise be made to such hospital under subsection
2 (d) (or section 1814(b)(3), as the case may be) for
3 such a discharge by an amount equal to the product
4 of—

5 “(A) the base operating DRG payment
6 amount (as defined in paragraph (2)) for the
7 discharge; and

8 “(B) the adjustment factor (described in
9 paragraph (3)(A)) for the hospital for the fiscal
10 year.

11 “(2) BASE OPERATING DRG PAYMENT
12 AMOUNT.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraph (B), for purposes of this sub-
15 section, the term ‘base operating DRG payment
16 amount’ means, with respect to a hospital for a
17 fiscal year, the payment amount that would
18 otherwise be made under subsection (d) for a
19 discharge if this subsection did not apply, re-
20 duced by any portion of such amount that is at-
21 tributable to payments under subparagraphs
22 (B) and (F) of paragraph (5).

23 “(B) ADJUSTMENTS.—For purposes of
24 subparagraph (A), in the case of a hospital that
25 is paid under section 1814(b)(3), the term ‘base

1 operating DRG payment amount' means the
2 payment amount under such section.

3 “(3) ADJUSTMENT FACTOR.—

4 “(A) IN GENERAL.—For purposes of para-
5 graph (1), the adjustment factor under this
6 paragraph for an applicable hospital for a fiscal
7 year is equal to the greater of—

8 “(i) the ratio described in subpara-
9 graph (B) for the hospital for the applica-
10 ble period (as defined in paragraph (5)(D))
11 for such fiscal year; or

12 “(ii) the floor adjustment factor speci-
13 fied in subparagraph (C).

14 “(B) RATIO.—The ratio described in this
15 subparagraph for a hospital for an applicable
16 period is equal to 1 minus the ratio of—

17 “(i) the aggregate payments for ex-
18 cess readmissions (as defined in paragraph
19 (4)(A)) with respect to an applicable hos-
20 pital for the applicable period; and

21 “(ii) the aggregate payments for all
22 discharges (as defined in paragraph
23 (4)(B)) with respect to such applicable
24 hospital for such applicable period.

1 “(C) FLOOR ADJUSTMENT FACTOR.—For
2 purposes of subparagraph (A), the floor adjust-
3 ment factor specified in this subparagraph
4 for—

5 “(i) fiscal year 2012 is 0.99;

6 “(ii) fiscal year 2013 is 0.98;

7 “(iii) fiscal year 2014 is 0.97; or

8 “(iv) a subsequent fiscal year is 0.95.

9 “(4) AGGREGATE PAYMENTS, EXCESS READMIS-
10 SION RATIO DEFINED.—For purposes of this sub-
11 section:

12 “(A) AGGREGATE PAYMENTS FOR EXCESS
13 READMISSIONS.—The term ‘aggregate payments
14 for excess readmissions’ means, for a hospital
15 for a fiscal year, the sum, for applicable condi-
16 tions (as defined in paragraph (5)(A)), of the
17 product, for each applicable condition, of—

18 “(i) the base operating DRG payment
19 amount for such hospital for such fiscal
20 year for such condition;

21 “(ii) the number of admissions for
22 such condition for such hospital for such
23 fiscal year; and

24 “(iii) the excess readmissions ratio (as
25 defined in subparagraph (C)) for such hos-

1 pital for the applicable period for such fis-
2 cal year minus 1.

3 “(B) AGGREGATE PAYMENTS FOR ALL DIS-
4 CHARGES.—The term ‘aggregate payments for
5 all discharges’ means, for a hospital for a fiscal
6 year, the sum of the base operating DRG pay-
7 ment amounts for all discharges for all condi-
8 tions from such hospital for such fiscal year.

9 “(C) EXCESS READMISSION RATIO.—

10 “(i) IN GENERAL.—Subject to clauses
11 (ii) and (iii), the term ‘excess readmissions
12 ratio’ means, with respect to an applicable
13 condition for a hospital for an applicable
14 period, the ratio (but not less than 1.0)
15 of—

16 “(I) the risk adjusted readmis-
17 sions based on actual readmissions, as
18 determined consistent with a readmis-
19 sion measure methodology that has
20 been endorsed under paragraph
21 (5)(A)(ii)(I), for an applicable hospital
22 for such condition with respect to the
23 applicable period; to

24 “(II) the risk adjusted expected
25 readmissions (as determined con-

1 sistent with such a methodology) for
2 such hospital for such condition with
3 respect to such applicable period.

4 “(ii) EXCLUSION OF CERTAIN RE-
5 ADMISSIONS.—For purposes of clause (i),
6 with respect to a hospital, excess readmis-
7 sions shall not include readmissions for an
8 applicable condition for which there are
9 fewer than a minimum number (as deter-
10 mined by the Secretary) of discharges for
11 such applicable condition for the applicable
12 period and such hospital.

13 “(iii) ADJUSTMENT.—In order to pro-
14 mote a reduction over time in the overall
15 rate of readmissions for applicable condi-
16 tions, the Secretary may provide, beginning
17 with discharges for fiscal year 2014, for
18 the determination of the excess readmis-
19 sions ratio under subparagraph (C) to be
20 based on a ranking of hospitals by read-
21 mission ratios (from lower to higher read-
22 mission ratios) normalized to a benchmark
23 that is lower than the 50th percentile.

24 “(5) DEFINITIONS.—For purposes of this sub-
25 section:

1 “(A) APPLICABLE CONDITION.—The term
2 ‘applicable condition’ means, subject to sub-
3 paragraph (B), a condition or procedure se-
4 lected by the Secretary among conditions and
5 procedures for which—

6 “(i) readmissions (as defined in sub-
7 paragraph (E)) that represent conditions
8 or procedures that are high volume or high
9 expenditures under this title (or other cri-
10 teria specified by the Secretary); and

11 “(ii) measures of such readmissions—

12 “(I) have been endorsed by the
13 entity with a contract under section
14 1890(a); and

15 “(II) such endorsed measures
16 have appropriate exclusions for re-
17 admissions that are unrelated to the
18 prior discharge (such as a planned re-
19 admission or transfer to another ap-
20 plicable hospital).

21 “(B) EXPANSION OF APPLICABLE CONDI-
22 TIONS.—Beginning with fiscal year 2013, the
23 Secretary shall expand the applicable conditions
24 beyond the 3 conditions for which measures
25 have been endorsed as described in subpara-

1 graph (A)(ii)(I) as of the date of the enactment
2 of this subsection to the additional 4 conditions
3 that have been so identified by the Medicare
4 Payment Advisory Commission in its report to
5 Congress in June 2007 and to other conditions
6 and procedures which may include an all-condi-
7 tion measure of readmissions, as determined
8 appropriate by the Secretary. In expanding
9 such applicable conditions, the Secretary shall
10 seek the endorsement described in subpara-
11 graph (A)(ii)(I) but may apply such measures
12 without such an endorsement.

13 “(C) APPLICABLE HOSPITAL.—The term
14 ‘applicable hospital’ means a subsection (d) hos-
15 pital or a hospital that is paid under section
16 1814(b)(3).

17 “(D) APPLICABLE PERIOD.—The term ‘ap-
18 plicable period’ means, with respect to a fiscal
19 year, such period as the Secretary shall specify
20 for purposes of determining excess readmis-
21 sions.

22 “(E) READMISSION.—The term ‘readmis-
23 sion’ means, in the case of an individual who is
24 discharged from an applicable hospital, the ad-
25 mission of the individual to the same or another

1 applicable hospital within a time period speci-
2 fied by the Secretary from the date of such dis-
3 charge. Insofar as the discharge relates to an
4 applicable condition for which there is an en-
5 dorsed measure described in subparagraph
6 (A)(ii)(I), such time period (such as 30 days)
7 shall be consistent with the time period speci-
8 fied for such measure.

9 “(6) LIMITATIONS ON REVIEW.—There shall be
10 no administrative or judicial review under section
11 1869, section 1878, or otherwise of—

12 “(A) the determination of base operating
13 DRG payment amounts;

14 “(B) the methodology for determining the
15 adjustment factor under paragraph (3), includ-
16 ing excess readmissions ratio under paragraph
17 (4)(C), aggregate payments for excess readmis-
18 sions under paragraph (4)(A), and aggregate
19 payments for all discharges under paragraph
20 (4)(B), and applicable periods and applicable
21 conditions under paragraph (5);

22 “(C) the measures of readmissions as de-
23 scribed in paragraph (5)(A)(ii); and

24 “(D) the determination of a targeted hos-
25 pital under paragraph (8)(B)(i), the increase in

1 payment under paragraph (8)(B)(ii), the aggregate
2 cap under paragraph (8)(C)(i), the hospital-specific
3 limit under paragraph (8)(C)(ii),
4 and the form of payment made by the Secretary
5 under paragraph (8)(D).

6 “(7) MONITORING INAPPROPRIATE CHANGES IN
7 ADMISSIONS PRACTICES.—The Secretary shall monitor
8 the activities of applicable hospitals to determine
9 if such hospitals have taken steps to avoid patients
10 at risk in order to reduce the likelihood of increasing
11 readmissions for applicable conditions or taken other
12 inappropriate steps involving readmissions or transfers.
13 If the Secretary determines that such a hospital
14 has taken such a step, after notice to the hospital
15 and opportunity for the hospital to undertake
16 action to alleviate such steps, the Secretary may impose
17 an appropriate sanction.

18 “(8) ASSISTANCE TO CERTAIN HOSPITALS.—

19 “(A) IN GENERAL.—For purposes of providing
20 funds to applicable hospitals to take
21 steps described in subparagraph (E) to address
22 factors that may impact readmissions of individuals
23 who are discharged from such a hospital,
24 for fiscal years beginning on or after October
25 1, 2011, the Secretary shall make a pay-

1 ment adjustment for a hospital described in
2 subparagraph (B), with respect to each such
3 fiscal year, by a percent estimated by the Sec-
4 retary to be consistent with subparagraph (C).
5 The Secretary shall provide priority to hospitals
6 that serve Medicare beneficiaries at highest risk
7 for readmission or for a poor transition from
8 such a hospital to a post-hospital site of care.

9 “(B) TARGETED HOSPITALS.—Subpara-
10 graph (A) shall apply to an applicable hospital
11 that—

12 “(i) had (or, in the case of an
13 1814(b)(3) hospital, otherwise would have
14 had) a disproportionate patient percentage
15 (as defined in section 1886(d)(5)(F)) of at
16 least 30 percent, using the latest available
17 data as estimated by the Secretary; and

18 “(ii) provides assurances satisfactory
19 to the Secretary that the increase in pay-
20 ment under this paragraph shall be used
21 for purposes described in subparagraph
22 (E).

23 “(C) CAPS.—

24 “(i) AGGREGATE CAP.—The aggregate
25 amount of the payment adjustment under

1 this paragraph for a fiscal year shall not
2 exceed 5 percent of the estimated dif-
3 ference in the spending that would occur
4 for such fiscal year with and without appli-
5 cation of the adjustment factor described
6 in paragraph (3) and applied pursuant to
7 paragraph (1).

8 “(ii) HOSPITAL-SPECIFIC LIMIT.—The
9 aggregate amount of the payment adjust-
10 ment for a hospital under this paragraph
11 shall not exceed the estimated difference in
12 spending that would occur for such fiscal
13 year for such hospital with and without ap-
14 plication of the adjustment factor de-
15 scribed in paragraph (3) and applied pur-
16 suant to paragraph (1).

17 “(D) FORM OF PAYMENT.—The Secretary
18 may make the additional payments under this
19 paragraph on a lump sum basis, a periodic
20 basis, a claim by claim basis, or otherwise.

21 “(E) USE OF ADDITIONAL PAYMENT.—

22 “(i) IN GENERAL.—Funding under
23 this paragraph shall be used by targeted
24 hospitals for activities designed to address
25 the patient noncompliance issues that re-

1 sult in higher than normal readmission
2 rates, including transitional care services
3 described in clause (ii) and any or all of
4 the other activities described in clause (iii).

5 “(ii) TRANSITIONAL CARE SERV-
6 ICES.—The transitional care services de-
7 scribed in this clause are transitional care
8 services furnished by a qualified transi-
9 tional care provider, such as a nurse or
10 other health professional, who meets rel-
11 evant experience and training requirements
12 as specified by the Secretary that support
13 a beneficiary under this section beginning
14 on the date of an individual’s admission to
15 a hospital for inpatient hospital services
16 and ending at the latest on the last day of
17 the 90-day period beginning on the date of
18 the individual’s discharge from the applica-
19 ble hospital. The Secretary shall determine
20 and update services to be included in tran-
21 sitional care services under this clause as
22 appropriate, based on evidence of their ef-
23 fectiveness in reducing hospital readmis-
24 sions and improving health outcomes. Such
25 services shall include the following:

1 “(I) Conduct of an assessment
2 prior to discharge, which assessment
3 may include an assessment of the in-
4 dividual’s physical and mental condi-
5 tion, cognitive and functional capac-
6 ities, medication regimen and adher-
7 ence, social and environmental needs,
8 and primary caregiver needs and re-
9 sources.

10 “(II) Development of a evidence-
11 based plan of transitional care for the
12 individual developed after consultation
13 with the individual and the individ-
14 ual’s primary caregiver and other
15 health team members, as appropriate.
16 Such plan shall include a list of cur-
17 rent therapies prescribed, treatment
18 goals and may include other items or
19 elements as determined by the Sec-
20 retary, such as identifying list of po-
21 tential health risks and future services
22 for both the individual and any pri-
23 mary caregiver.

1 “(iii) OTHER ACTIVITIES.—The other
2 activities described in this clause are the
3 following:

4 “(I) Providing other care coordi-
5 nation services not described under
6 clause (ii).

7 “(II) Hiring translators and in-
8 terpreters.

9 “(III) Increasing services offered
10 by discharge planners.

11 “(IV) Ensuring that individuals
12 receive a summary of care and medi-
13 cation orders upon discharge.

14 “(V) Developing a quality im-
15 provement plan to assess and remedy
16 preventable readmission rates.

17 “(VI) Assigning appropriate fol-
18 low-up care for discharged individuals.

19 “(VII) Doing other activities as
20 determined appropriate by the Sec-
21 retary.

22 “(F) GAO REPORT ON USE OF FUNDS.—
23 Not later than 3 years after the date on which
24 funds are first made available under this para-
25 graph, the Comptroller General of the United

1 States shall submit to Congress a report on the
2 use of such funds. Such report shall consider
3 information on the effective uses of such funds,
4 how the uses of such funds affected hospital re-
5 admission rates (including at 6 months post-
6 discharge), health outcomes and quality, reduc-
7 tions in expenditures under this title and the
8 experiences of beneficiaries, primary caregivers,
9 and providers, as well as any appropriate rec-
10 ommendations.”.

11 (b) APPLICATION TO CRITICAL ACCESS HOS-
12 PITALS.—Section 1814(l) of the Social Security Act (42
13 U.S.C. 1395f(l)) is amended—

14 (1) in paragraph (5)—

15 (A) by striking “and” at the end of sub-
16 paragraph (C);

17 (B) by striking the period at the end of
18 subparagraph (D) and inserting “; and”;

19 (C) by inserting at the end the following
20 new subparagraph:

21 “(E) the methodology for determining the ad-
22 justment factor under paragraph (5), including the
23 determination of aggregate payments for actual and
24 expected readmissions, applicable periods, applicable
25 conditions and measures of readmissions.”; and

1 (D) by redesignating such paragraph as
2 paragraph (6); and

3 (2) by inserting after paragraph (4) the fol-
4 lowing new paragraph:

5 “(5) The adjustment factor described in section
6 1886(p)(3) shall apply to payments with respect to a crit-
7 ical access hospital with respect to a cost reporting period
8 beginning in fiscal year 2012 and each subsequent fiscal
9 year (after application of paragraph (4) of this subsection)
10 in a manner similar to the manner in which such section
11 applies with respect to a fiscal year to an applicable hos-
12 pital as described in section 1886(p)(2).”.

13 (c) POST ACUTE CARE PROVIDERS.—

14 (1) INTERIM POLICY.—

15 (A) IN GENERAL.—With respect to a read-
16 mission to an applicable hospital or a critical
17 access hospital (as described in section 1814(l)
18 of the Social Security Act) from a post acute
19 care provider (as defined in paragraph (3)) and
20 such a readmission is not governed by section
21 412.531 of title 42, Code of Federal Regula-
22 tions, if the claim submitted by such a post-
23 acute care provider under title XVIII of the So-
24 cial Security Act indicates that the individual
25 was readmitted to a hospital from such a post-

1 acute care provider or admitted from home and
2 under the care of a home health agency within
3 30 days of an initial discharge from an applica-
4 ble hospital or critical access hospital, the pay-
5 ment under such title on such claim shall be the
6 applicable percent specified in subparagraph
7 (B) of the payment that would otherwise be
8 made under the respective payment system
9 under such title for such post-acute care pro-
10 vider if this subsection did not apply. In apply-
11 ing the previous sentence, the Secretary shall
12 exclude a period of 1 day from the date the in-
13 dividual is first admitted to or under the care
14 of the post-acute care provider.

15 (B) APPLICABLE PERCENT DEFINED.—For
16 purposes of subparagraph (A), the applicable
17 percent is—

18 (i) for fiscal or rate year 2012 is
19 0.996;

20 (ii) for fiscal or rate year 2013 is
21 0.993; and

22 (iii) for fiscal or rate year 2014 is
23 0.99.

24 (C) EFFECTIVE DATE.—Subparagraph (1)
25 shall apply to discharges or services furnished

1 (as the case may be with respect to the applica-
2 ble post acute care provider) on or after the
3 first day of the fiscal year or rate year, begin-
4 ning on or after October 1, 2011, with respect
5 to the applicable post acute care provider.

6 (2) DEVELOPMENT AND APPLICATION OF PER-
7 FORMANCE MEASURES.—

8 (A) IN GENERAL.—The Secretary of
9 Health and Human Services shall develop ap-
10 propriate measures of readmission rates for
11 post acute care providers. The Secretary shall
12 seek endorsement of such measures by the enti-
13 ty with a contract under section 1890(a) of the
14 Social Security Act but may adopt and apply
15 such measures under this paragraph without
16 such an endorsement. The Secretary shall ex-
17 pand such measures in a manner similar to the
18 manner in which applicable conditions are ex-
19 panded under paragraph (5)(B) of section
20 1886(p) of the Social Security Act, as added by
21 subsection (a).

22 (B) IMPLEMENTATION.—The Secretary
23 shall apply, on or after October 1, 2014, with
24 respect to post acute care providers, policies
25 similar to the policies applied with respect to

1 applicable hospitals and critical access hospitals
2 under the amendments made by subsection (a).
3 The provisions of paragraph (1) shall apply
4 with respect to any period on or after October
5 1, 2014, and before such application date de-
6 scribed in the previous sentence in the same
7 manner as such provisions apply with respect to
8 fiscal or rate year 2014.

9 (C) MONITORING AND PENALTIES.—The
10 provisions of paragraph (7) of such section
11 1886(p) shall apply to providers under this
12 paragraph in the same manner as they apply to
13 hospitals under such section.

14 (3) DEFINITIONS.—For purposes of this sub-
15 section:

16 (A) POST ACUTE CARE PROVIDER.—The
17 term “post acute care provider” means—

18 (i) a skilled nursing facility (as de-
19 fined in section 1819(a) of the Social Secu-
20 rity Act);

21 (ii) an inpatient rehabilitation facility
22 (described in section 1886(h)(1)(A) of such
23 Act);

24 (iii) a home health agency (as defined
25 in section 1861(o) of such Act); and

1 (iv) a long term care hospital (as de-
2 fined in section 1861(ccc) of such Act).

3 (B) OTHER TERMS.—The terms “applica-
4 ble condition”, “applicable hospital”, and “re-
5 admission” have the meanings given such terms
6 in section 1886(p)(5) of the Social Security
7 Act, as added by subsection (a)(1).

8 (d) PHYSICIANS.—

9 (1) STUDY.—The Secretary of Health and
10 Human Services shall conduct a study to determine
11 how the readmissions policy described in the pre-
12 vious subsections could be applied to physicians.

13 (2) CONSIDERATIONS.—In conducting the
14 study, the Secretary shall consider approaches such
15 as—

16 (A) creating a new code (or codes) and
17 payment amount (or amounts) under the fee
18 schedule in section 1848 of the Social Security
19 Act (in a budget neutral manner) for services
20 furnished by an appropriate physician who sees
21 an individual within the first week after dis-
22 charge from a hospital or critical access hos-
23 pital;

24 (B) developing measures of rates of read-
25 mission for individuals treated by physicians;

1 (C) applying a payment reduction for phy-
2 sicians who treat the patient during the initial
3 admission that results in a readmission; and

4 (D) methods for attributing payments or
5 payment reductions to the appropriate physi-
6 cian or physicians.

7 (3) REPORT.—The Secretary shall issue a pub-
8 lic report on such study not later than the date that
9 is one year after the date of the enactment of this
10 Act.

11 (e) FUNDING.—For purposes of carrying out the pro-
12 visions of this section, in addition to funds otherwise avail-
13 able, out of any funds in the Treasury not otherwise ap-
14 propriated, there are appropriated to the Secretary of
15 Health and Human Services for the Center for Medicare
16 & Medicaid Services Program Management Account
17 \$25,000,000 for each fiscal year beginning with 2010.
18 Amounts appropriated under this subsection for a fiscal
19 year shall be available until expended.

20 **SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM**
21 **PLAN AND BUNDLING PILOT PROGRAM.**

22 (a) PLAN.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services (in this section referred to as the
25 “Secretary”) shall develop a detailed plan to reform

1 payment for post acute care (PAC) services under
2 the Medicare program under title XVIII of the So-
3 cial Security Act (in this section referred to as the
4 “Medicare program”). The goals of such payment
5 reform are to—

6 (A) improve the coordination, quality, and
7 efficiency of such services; and

8 (B) improve outcomes for individuals such
9 as reducing the need for readmission to hos-
10 pitals from providers of such services.

11 (2) BUNDLING POST ACUTE SERVICES.—The
12 plan described in paragraph (1) shall include de-
13 tailed specifications for a bundled payment for post
14 acute services (in this section referred to as the
15 “post acute care bundle”), and may include other
16 approaches determined appropriate by the Secretary.

17 (3) POST ACUTE SERVICES.—For purposes of
18 this section, the term “post acute services” means
19 services for which payment may be made under the
20 Medicare program that are furnished by skilled
21 nursing facilities, inpatient rehabilitation facilities,
22 long term care hospitals, hospital based outpatient
23 rehabilitation facilities and home health agencies to
24 an individual after discharge of such individual from

1 a hospital, and such other services determined ap-
2 propriate by the Secretary.

3 (b) DETAILS.—The plan described in subsection
4 (a)(1) shall include consideration of the following issues:

5 (1) The nature of payments under a post acute
6 care bundle, including the type of provider or entity
7 to whom payment should be made, the scope of ac-
8 tivities and services included in the bundle, whether
9 payment for physicians' services should be included
10 in the bundle, and the period covered by the bundle.

11 (2) Whether the payment should be consoli-
12 dated with the payment under the inpatient prospec-
13 tive system under section 1886 of the Social Secu-
14 rity Act (in this section referred to as MS-DRGs)
15 or a separate payment should be established for such
16 bundle, and if a separate payment is established,
17 whether it should be made only upon use of post
18 acute care services or for every discharge.

19 (3) Whether the bundle should be applied
20 across all categories of providers of inpatient serv-
21 ices (including critical access hospitals) and post
22 acute care services or whether it should be limited
23 to certain categories of providers, services, or dis-
24 charges, such as high volume or high cost MS-
25 DRGs.

1 (4) The extent to which payment rates could be
2 established to achieve offsets for efficiencies that
3 could be expected to be achieved with a bundle pay-
4 ment, whether such rates should be established on a
5 national basis or for different geographic areas,
6 should vary according to discharge, case mix,
7 outliers, and geographic differences in wages or
8 other appropriate adjustments, and how to update
9 such rates.

10 (5) The nature of protections needed for indi-
11 viduals under a system of bundled payments to en-
12 sure that individuals receive quality care, are fur-
13 nished the level and amount of services needed as
14 determined by an appropriate assessment instru-
15 ment, are offered choice of provider, and the extent
16 to which transitional care services would improve
17 quality of care for individuals and the functioning of
18 a bundled post-acute system.

19 (6) The nature of relationships that may be re-
20 quired between hospitals and providers of post acute
21 care services to facilitate bundled payments, includ-
22 ing the application of gainsharing, anti-referral,
23 anti-kickback, and anti-trust laws.

24 (7) Quality measures that would be appropriate
25 for reporting by hospitals and post acute providers

1 (such as measures that assess changes in functional
2 status and quality measures appropriate for each
3 type of post acute services provider including how
4 the reporting of such quality measures could be co-
5 ordinated with other reporting of such quality meas-
6 ures by such providers otherwise required).

7 (8) How cost-sharing for a post acute care bun-
8 dle should be treated relative to current rules for
9 cost-sharing for inpatient hospital, home health,
10 skilled nursing facility, and other services.

11 (9) How other programmatic issues should be
12 treated in a post acute care bundle, including rules
13 specific to various types of post-acute providers such
14 as the post-acute transfer policy, three-day hospital
15 stay to qualify for services furnished by skilled nurs-
16 ing facilities, and the coordination of payments and
17 care under the Medicare program and the Medicaid
18 program.

19 (10) Such other issues as the Secretary deems
20 appropriate.

21 (c) CONSULTATIONS AND ANALYSIS.—

22 (1) CONSULTATION WITH STAKEHOLDERS.—In
23 developing the plan under subsection (a)(1), the Sec-
24 retary shall consult with relevant stakeholders and
25 shall consider experience with such research studies

1 and demonstrations that the Secretary determines
2 appropriate.

3 (2) ANALYSIS AND DATA COLLECTION.—In de-
4 veloping such plan, the Secretary shall—

5 (A) analyze the issues described in sub-
6 section (b) and other issues that the Secretary
7 determines appropriate;

8 (B) analyze the impacts (including geo-
9 graphic impacts) of post acute service reform
10 approaches, including bundling of such services
11 on individuals, hospitals, post acute care pro-
12 viders, and physicians;

13 (C) use existing data (such as data sub-
14 mitted on claims) and collect such data as the
15 Secretary determines are appropriate to develop
16 such plan required in this section; and

17 (D) if patient functional status measures
18 are appropriate for the analysis, to the extent
19 practical, build upon the CARE tool being de-
20 veloped pursuant to section 5008 of the Deficit
21 Reduction Act of 2005.

22 (d) ADMINISTRATION.—

23 (1) FUNDING.—For purposes of carrying out
24 the provisions of this section, in addition to funds
25 otherwise available, out of any funds in the Treasury

1 not otherwise appropriated, there are appropriated
2 to the Secretary for the Center for Medicare & Med-
3 icaid Services Program Management Account
4 \$15,000,000 for each of the fiscal years 2010
5 through 2012. Amounts appropriated under this
6 paragraph for a fiscal year shall be available until
7 expended.

8 (2) EXPEDITED DATA COLLECTION.—Chapter
9 35 of title 44, United States Code shall not apply to
10 this section.

11 (e) PUBLIC REPORTS.—

12 (1) INTERIM REPORTS.—The Secretary shall
13 issue interim public reports on a periodic basis on
14 the plan described in subsection (a)(1), the issues
15 described in subsection (b), and impact analyses as
16 the Secretary determines appropriate.

17 (2) FINAL REPORT.—Not later than the date
18 that is 3 years after the date of the enactment of
19 this Act, the Secretary shall issue a final public re-
20 port on such plan, including analysis of issues de-
21 scribed in subsection (b) and impact analyses.

22 (f) CONVERSION OF ACUTE CARE EPISODE DEM-
23 ONSTRATION TO PILOT PROGRAM AND EXPANSION TO IN-
24 CLUDE POST ACUTE SERVICES.—

1 (1) IN GENERAL.—Part E of title XVIII of the
2 Social Security Act is amended by inserting after
3 section 1866C the following new section:

4 “CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION
5 TO PILOT PROGRAM AND EXPANSION TO INCLUDE
6 POST ACUTE SERVICES

7 “SEC. 1866D. (a) CONVERSION AND EXPANSION.—

8 “(1) IN GENERAL.—By not later than January
9 1, 2011, the Secretary shall, for the purpose of pro-
10 moting the use of bundled payments to promote effi-
11 cient, coordinated, and high quality delivery of
12 care—

13 “(A) convert the acute care episode dem-
14 onstration program conducted under section
15 1866C to a pilot program; and

16 “(B) subject to subsection (c), expand such
17 program as so converted to include post acute
18 services and such other services the Secretary
19 determines to be appropriate, which may in-
20 clude transitional services.

21 “(2) BUNDLED PAYMENT STRUCTURES.—

22 “(A) IN GENERAL.—In carrying out para-
23 graph (1), the Secretary may apply bundled
24 payments with respect to—

25 “(i) hospitals and physicians;

1 “(ii) hospitals and post-acute care
2 providers;

3 “(iii) hospitals, physicians, and post-
4 acute care providers; or

5 “(iv) combinations of post-acute pro-
6 viders.

7 “(B) FURTHER APPLICATION.—

8 “(i) IN GENERAL.—In carrying out
9 paragraph (1), the Secretary shall apply
10 bundled payments in a manner so as to in-
11 clude collaborative care networks and con-
12 tinuing care hospitals.

13 “(ii) COLLABORATIVE CARE NETWORK
14 DEFINED.—For purposes of this subpara-
15 graph, the term ‘collaborative care net-
16 work’ means a consortium of health care
17 providers that provides a comprehensive
18 range of coordinated and integrated health
19 care services to low-income patient popu-
20 lations (including the uninsured) which
21 may include coordinated and comprehen-
22 sive care by safety net providers to reduce
23 any unnecessary use of items and services
24 furnished in emergency departments, man-
25 age chronic conditions, improve quality and

1 efficiency of care, increase preventive serv-
2 ices, and promote adherence to post-acute
3 and follow-up care plans.

4 “(iii) CONTINUING CARE HOSPITAL
5 DEFINED.—For purposes of this subpara-
6 graph, the term ‘continuing care hospital’
7 means an entity that has demonstrated the
8 ability to meet patient care and patient
9 safety standards and that provides under
10 common management the medical and re-
11 habilitation services provided in inpatient
12 rehabilitation hospitals and units (as de-
13 fined in section 1886(d)(1)(B)(ii)), long-
14 term care hospitals (as defined in section
15 1886(d)(1)(B)(iv)(I)), and skilled nursing
16 facilities (as defined in section 1819(a))
17 that are located in a hospital described in
18 section 1886(d).

19 “(b) SCOPE.—The Secretary shall set specific goals
20 for the number of acute and post-acute bundling test sites
21 under the pilot program to ensure that over time the pilot
22 program is of sufficient size and scope to—

23 “(1) test the approaches under the pilot pro-
24 gram in a variety of settings, including urban, rural,
25 and underserved areas;

1 “(2) include geographic areas and additional
2 conditions that account for significant program
3 spending, as defined by the Secretary; and

4 “(3) subject to subsection (d), disseminate the
5 pilot program rapidly on a national basis.

6 To the extent that the Secretary finds inpatient and post
7 acute care bundling to be successful in improving quality
8 and reducing costs, the Secretary shall implement such
9 mechanisms and reforms under the pilot program on as
10 large a geographic scale as practical and economical, con-
11 sistent with subsection (e). Nothing in this subsection
12 shall be construed as limiting the number of hospital and
13 physician groups or the number of hospital and post-acute
14 provider groups that may participate in the pilot program.

15 “(c) LIMITATION.—The Secretary shall only expand
16 the pilot program under subsection (a) if the Secretary
17 finds that—

18 “(1) the demonstration program under section
19 1866C and pilot program under this section main-
20 tain or increase the quality of care received by indi-
21 viduals enrolled under this title; and

22 “(2) such demonstration program and pilot pro-
23 gram reduce program expenditures and, based on
24 the certification under subsection (d), that the ex-
25 pansion of such pilot program would result in esti-

1 mated spending that would be less than what spend-
2 ing would otherwise be in the absence of this section.

3 “(d) CERTIFICATION.—For purposes of subsection
4 (c), the Chief Actuary of the Centers for Medicare & Med-
5 icaid Services shall certify whether expansion of the pilot
6 program under this section would result in estimated
7 spending that would be less than what spending would
8 otherwise be in the absence of this section.

9 “(e) VOLUNTARY PARTICIPATION.—Nothing in this
10 paragraph shall be construed as requiring the participa-
11 tion of an entity in the pilot program under this section.

12 “(f) EVALUATION ON COST AND QUALITY OF
13 CARE.—The Secretary shall conduct an evaluation of the
14 pilot program under subsection (a) to study the effect of
15 such program on costs and quality of care. The findings
16 of such evaluation shall be included in the final report re-
17 quired under section 1152(e)(2) of the Affordable Health
18 Care for America Act.

19 “(g) STUDY OF ADDITIONAL BUNDLING AND EPI-
20 SODE-BASED PAYMENT FOR PHYSICIANS’ SERVICES.—

21 “(1) IN GENERAL.—The Secretary shall provide
22 for a study of and development of a plan for testing
23 additional ways to increase bundling of payments for
24 physicians in connection with an episode of care,
25 such as in connection with outpatient hospital serv-

1 ices or services rendered in physicians' offices, other
2 than those provided under the pilot program.

3 “(2) APPLICATION.—The Secretary may imple-
4 ment such a plan through a demonstration pro-
5 gram.”.

6 (2) CONFORMING AMENDMENT.—Section
7 1866C(b) of the Social Security Act (42 U.S.C.
8 1395cc–3(b)) is amended by striking “The Sec-
9 retary” and inserting “Subject to section 1866D, the
10 Secretary”.

11 **SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.**

12 Section 1895(b)(3)(B)(ii) of the Social Security Act
13 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

14 (1) in subclause (IV), by striking “and”;

15 (2) by redesignating subclause (V) as subclause
16 (VII); and

17 (3) by inserting after subclause (IV) the fol-
18 lowing new subclauses:

19 “(V) 2007, 2008, and 2009, sub-
20 ject to clause (v), the home health
21 market basket percentage increase;

22 “(VI) 2010, subject to clause (v),
23 0 percent; and”.

1 **SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH**
2 **CARE.**

3 (a) ACCELERATION OF ADJUSTMENT FOR CASE MIX
4 CHANGES.—Section 1895(b)(3)(B) of the Social Security
5 Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

6 (1) in clause (iv), by striking “Insofar as” and
7 inserting “Subject to clause (vi), insofar as”; and

8 (2) by adding at the end the following new
9 clause:

10 “(vi) SPECIAL RULE FOR CASE MIX
11 CHANGES FOR 2011.—

12 “(I) IN GENERAL.—With respect
13 to the case mix adjustments estab-
14 lished in section 484.220(a) of title
15 42, Code of Federal Regulations, the
16 Secretary shall apply, in 2010, the ad-
17 justment established in paragraph (3)
18 of such section for 2011, in addition
19 to applying the adjustment established
20 in paragraph (2) for 2010.

21 “(II) CONSTRUCTION.—Nothing
22 in this clause shall be construed as
23 limiting the amount of adjustment for
24 case mix for 2010 or 2011 if more re-
25 cent data indicate an appropriate ad-
26 justment that is greater than the

1 amount established in the section de-
2 scribed in subclause (I).”.

3 (b) REBASING HOME HEALTH PROSPECTIVE PAY-
4 MENT AMOUNT.—Section 1895(b)(3)(A) of the Social Se-
5 curity Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

6 (1) in clause (i)—

7 (A) in subclause (III), by inserting “and
8 before 2011” after “after the period described
9 in subclause (II)”; and

10 (B) by inserting after subclause (III) the
11 following new subclauses:

12 “(IV) Subject to clause (iii)(I),
13 for 2011, such amount (or amounts)
14 shall be adjusted by a uniform per-
15 centage determined to be appropriate
16 by the Secretary based on analysis of
17 factors such as changes in the average
18 number and types of visits in an epi-
19 sode, the change in intensity of visits
20 in an episode, growth in cost per epi-
21 sode, and other factors that the Sec-
22 retary considers to be relevant.

23 “(V) Subject to clause (iii)(II),
24 for a year after 2011, such a amount
25 (or amounts) shall be equal to the

1 amount (or amounts) determined
2 under this clause for the previous
3 year, updated under subparagraph
4 (B).”; and

5 (2) by adding at the end the following new
6 clause:

7 “(iii) SPECIAL RULE IN CASE OF IN-
8 ABILITY TO EFFECT TIMELY REBASING.—

9 “(I) APPLICATION OF PROXY
10 AMOUNT FOR 2011.—If the Secretary
11 is not able to compute the amount (or
12 amounts) under clause (i)(IV) so as to
13 permit, on a timely basis, the applica-
14 tion of such clause for 2011, the Sec-
15 retary shall substitute for such
16 amount (or amounts) 95 percent of
17 the amount (or amounts) that would
18 otherwise be specified under clause
19 (i)(III) if it applied for 2011.

20 “(II) ADJUSTMENT FOR SUBSE-
21 QUENT YEARS BASED ON DATA.—If
22 the Secretary applies subclause (I),
23 the Secretary before July 1, 2011,
24 shall compare the amount (or
25 amounts) applied under such sub-

1 clause with the amount (or amounts)
2 that should have been applied under
3 clause (i)(IV). The Secretary shall de-
4 crease or increase the prospective pay-
5 ment amount (or amounts) under
6 clause (i)(V) for 2012 (or, at the Sec-
7 retary's discretion, over a period of
8 several years beginning with 2012) by
9 the amount (if any) by which the
10 amount (or amounts) applied under
11 subclause (I) is greater or less, re-
12 spectively, than the amount (or
13 amounts) that should have been ap-
14 plied under clause (i)(IV).”.

15 **SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVE-**
16 **MENTS INTO MARKET BASKET UPDATE FOR**
17 **HOME HEALTH SERVICES.**

18 (a) IN GENERAL.—Section 1895(b)(3)(B) of the So-
19 cial Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amend-
20 ed—

21 (1) in clause (iii), by inserting “(including being
22 subject to the productivity adjustment described in
23 section 1886(b)(3)(B)(iii)(II))” after “in the same
24 manner”; and

1 (2) in clause (v)(I), by inserting “(but not
2 below 0)” after “reduced”.

3 (b) **EFFECTIVE DATE.**—The amendments made by
4 subsection (a) shall apply to home health market basket
5 percentage increases for years beginning with 2011.

6 **SEC. 1155A. MEDPAC STUDY ON VARIATION IN HOME**
7 **HEALTH MARGINS.**

8 (a) **IN GENERAL.**—The Medicare Payment Advisory
9 Commission shall conduct a study regarding variation in
10 performance of home health agencies in an effort to ex-
11 plain variation in Medicare margins for such agencies.
12 Such study shall include an examination of at least the
13 following issues:

14 (1) The demographic characteristics of individ-
15 uals served and the geographic distribution associ-
16 ated with transportation costs.

17 (2) The characteristics of such agencies, such
18 as whether such agencies operate 24 hours each day,
19 provide charity care, or are part of an integrated
20 health system.

21 (3) The socio-economic status of individuals
22 served, such as the proportion of such individuals
23 who are dually eligible for Medicare and Medicaid
24 benefits.

1 (4) The presence of severe and or chronic dis-
2 ease or disability in individuals served, as evidenced
3 by multiple discontinuous home health episodes with
4 a high number of visits per episode.

5 (5) The differences in services provided, such as
6 therapy and non-therapy services.

7 (b) REPORT.—Not later than June 1, 2011, the Com-
8 mission shall submit a report to the Congress on the re-
9 sults of the study conducted under subsection (a) and shall
10 include in the report the Commission’s conclusions and
11 recommendations, if appropriate, regarding each of the
12 issues described in paragraphs (1), (2) and (3) of such
13 subsection.

14 **SEC. 1155B. PERMITTING HOME HEALTH AGENCIES TO AS-**
15 **SIGN THE MOST APPROPRIATE SKILLED**
16 **SERVICE TO MAKE THE INITIAL ASSESSMENT**
17 **VISIT UNDER A MEDICARE HOME HEALTH**
18 **PLAN OF CARE FOR REHABILITATION CASES.**

19 (a) IN GENERAL.—Notwithstanding section
20 484.55(a)(2) of title 42 of the Code of Federal Regula-
21 tions or any other provision of law, a home health agency
22 may determine the most appropriate skilled therapist to
23 make the initial assessment visit for an individual who is
24 referred (and may be eligible) for home health services
25 under title XVIII of the Social Security Act but who does

1 not require skilled nursing care as long as the skilled serv-
2 ice (for which that therapist is qualified to provide the
3 service) is included as part of the plan of care for home
4 health services for such individual.

5 (b) **RULE OF CONSTRUCTION.**—Nothing in sub-
6 section (a) shall be construed to provide for initial eligi-
7 bility for coverage of home health services under title
8 XVIII of the Social Security Act on the basis of a need
9 for occupational therapy.

10 **SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE**
11 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
12 **FERRALS MADE TO HOSPITALS.**

13 (a) **IN GENERAL.**—Section 1877 of the Social Secu-
14 rity Act (42 U.S.C. 1395nn) is amended—

15 (1) in subsection (d)(2)—

16 (A) in subparagraph (A), by striking
17 “and” at the end;

18 (B) in subparagraph (B), by striking the
19 period at the end and inserting “; and”; and

20 (C) by adding at the end the following new
21 subparagraph:

22 “(C) in the case where the entity is a hos-
23 pital, the hospital meets the requirements of
24 paragraph (3)(D).”;

25 (2) in subsection (d)(3)—

1 (A) in subparagraph (B), by striking
2 “and” at the end;

3 (B) in subparagraph (C), by striking the
4 period at the end and inserting “; and”; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(D) the hospital meets the requirements
8 described in subsection (i)(1).”;

9 (3) by amending subsection (f) to read as fol-
10 lows:

11 “(f) REPORTING AND DISCLOSURE REQUIRE-
12 MENTS.—

13 “(1) IN GENERAL.—Each entity providing cov-
14 ered items or services for which payment may be
15 made under this title shall provide the Secretary
16 with the information concerning the entity’s owner-
17 ship, investment, and compensation arrangements,
18 including—

19 “(A) the covered items and services pro-
20 vided by the entity, and

21 “(B) the names and unique physician iden-
22 tification numbers of all physicians with an
23 ownership or investment interest (as described
24 in subsection (a)(2)(A)), or with a compensa-
25 tion arrangement (as described in subsection

1 (a)(2)(B)), in the entity, or whose immediate
2 relatives have such an ownership or investment
3 interest or who have such a compensation rela-
4 tionship with the entity.

5 Such information shall be provided in such form,
6 manner, and at such times as the Secretary shall
7 specify. The requirement of this subsection shall not
8 apply to designated health services provided outside
9 the United States or to entities which the Secretary
10 determines provide services for which payment may
11 be made under this title very infrequently.

12 “(2) REQUIREMENTS FOR HOSPITALS WITH
13 PHYSICIAN OWNERSHIP OR INVESTMENT.—In the
14 case of a hospital that meets the requirements de-
15 scribed in subsection (i)(1), the hospital shall—

16 “(A) submit to the Secretary an initial re-
17 port, and periodic updates at a frequency deter-
18 mined by the Secretary, containing a detailed
19 description of the identity of each physician
20 owner and physician investor and any other
21 owners or investors of the hospital;

22 “(B) require that any referring physician
23 owner or investor discloses to the individual
24 being referred, by a time that permits the indi-
25 vidual to make a meaningful decision regarding

1 the receipt of services, as determined by the
2 Secretary, the ownership or investment interest,
3 as applicable, of such referring physician in the
4 hospital; and

5 “(C) disclose the fact that the hospital is
6 partially or wholly owned by one or more physi-
7 cians or has one or more physician investors—

8 “(i) on any public website for the hos-
9 pital; and

10 “(ii) in any public advertising for the
11 hospital.

12 The information to be reported or disclosed under
13 this paragraph shall be provided in such form, man-
14 ner, and at such times as the Secretary shall specify.

15 The requirements of this paragraph shall not apply
16 to designated health services furnished outside the
17 United States or to entities which the Secretary de-
18 termines provide services for which payment may be
19 made under this title very infrequently.

20 “(3) PUBLICATION OF INFORMATION.—The
21 Secretary shall publish, and periodically update, the
22 information submitted by hospitals under paragraph
23 (2)(A) on the public Internet website of the Centers
24 for Medicare & Medicaid Services.”;

1 (4) by amending subsection (g)(5) to read as
2 follows:

3 “(5) FAILURE TO REPORT OR DISCLOSE INFOR-
4 MATION.—

5 “(A) REPORTING.—Any person who is re-
6 quired, but fails, to meet a reporting require-
7 ment of paragraphs (1) and (2)(A) of sub-
8 section (f) is subject to a civil money penalty of
9 not more than \$10,000 for each day for which
10 reporting is required to have been made.

11 “(B) DISCLOSURE.—Any physician who is
12 required, but fails, to meet a disclosure require-
13 ment of subsection (f)(2)(B) or a hospital that
14 is required, but fails, to meet a disclosure re-
15 quirement of subsection (f)(2)(C) is subject to
16 a civil money penalty of not more than \$10,000
17 for each case in which disclosure is required to
18 have been made.

19 “(C) APPLICATION.—The provisions of
20 section 1128A (other than the first sentence of
21 subsection (a) and other than subsection (b))
22 shall apply to a civil money penalty under sub-
23 paragraphs (A) and (B) in the same manner as
24 such provisions apply to a penalty or proceeding
25 under section 1128A(a).”; and

1 (5) by adding at the end the following new sub-
2 section:

3 “(i) REQUIREMENTS TO QUALIFY FOR RURAL PRO-
4 PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO
5 SELF-REFERRAL PROHIBITION.—

6 “(1) REQUIREMENTS DESCRIBED.—For pur-
7 poses of subsection (d)(3)(D), the requirements de-
8 scribed in this paragraph are as follows:

9 “(A) PROVIDER AGREEMENT.—The hos-
10 pital had—

11 “(i) physician ownership or invest-
12 ment on January 1, 2009; and

13 “(ii) a provider agreement under sec-
14 tion 1866 in effect on such date.

15 “(B) PROHIBITION ON PHYSICIAN OWNER-
16 SHIP OR INVESTMENT.—The percentage of the
17 total value of the ownership or investment in-
18 terests held in the hospital, or in an entity
19 whose assets include the hospital, by physician
20 owners or investors in the aggregate does not
21 exceed such percentage as of the date of enact-
22 ment of this subsection.

23 “(C) PROHIBITION ON EXPANSION OF FA-
24 CILITY CAPACITY.—Except as provided in para-
25 graph (2), the number of operating rooms, pro-

1 cedure rooms, or beds of the hospital at any
2 time on or after the date of the enactment of
3 this subsection are no greater than the number
4 of operating rooms, procedure rooms, or beds,
5 respectively, as of such date.

6 “(D) ENSURING BONA FIDE OWNERSHIP
7 AND INVESTMENT.—

8 “(i) Any ownership or investment in-
9 terests that the hospital offers to a physi-
10 cian are not offered on more favorable
11 terms than the terms offered to a person
12 who is not in a position to refer patients
13 or otherwise generate business for the hos-
14 pital.

15 “(ii) The hospital (or any investors in
16 the hospital) does not directly or indirectly
17 provide loans or financing for any physi-
18 cian owner or investor in the hospital.

19 “(iii) The hospital (or any investors in
20 the hospital) does not directly or indirectly
21 guarantee a loan, make a payment toward
22 a loan, or otherwise subsidize a loan, for
23 any physician owner or investor or group
24 of physician owners or investors that is re-

1 lated to acquiring any ownership or invest-
2 ment interest in the hospital.

3 “(iv) Ownership or investment returns
4 are distributed to each owner or investor in
5 the hospital in an amount that is directly
6 proportional to the ownership or invest-
7 ment interest of such owner or investor in
8 the hospital.

9 “(v) The investment interest of the
10 owner or investor is directly proportional
11 to the owner’s or investor’s capital con-
12 tributions made at the time the ownership
13 or investment interest is obtained.

14 “(vi) Physician owners and investors
15 do not receive, directly or indirectly, any
16 guaranteed receipt of or right to purchase
17 other business interests related to the hos-
18 pital, including the purchase or lease of
19 any property under the control of other
20 owners or investors in the hospital or lo-
21 cated near the premises of the hospital.

22 “(vii) The hospital does not offer a
23 physician owner or investor the oppor-
24 tunity to purchase or lease any property
25 under the control of the hospital or any

1 other owner or investor in the hospital on
2 more favorable terms than the terms of-
3 fered to a person that is not a physician
4 owner or investor.

5 “(viii) The hospital does not condition
6 any physician ownership or investment in-
7 terests either directly or indirectly on the
8 physician owner or investor making or in-
9 fluencing referrals to the hospital or other-
10 wise generating business for the hospital.

11 “(E) PATIENT SAFETY.—In the case of a
12 hospital that does not offer emergency services,
13 the hospital has the capacity to—

14 “(i) provide assessment and initial
15 treatment for medical emergencies; and

16 “(ii) if the hospital lacks additional
17 capabilities required to treat the emergency
18 involved, refer and transfer the patient
19 with the medical emergency to a hospital
20 with the required capability.

21 “(F) LIMITATION ON APPLICATION TO
22 CERTAIN CONVERTED FACILITIES.—The hos-
23 pital was not converted from an ambulatory
24 surgical center to a hospital on or after the date
25 of enactment of this subsection.

1 “(2) EXCEPTION TO PROHIBITION ON EXPAN-
2 SION OF FACILITY CAPACITY.—

3 “(A) PROCESS.—

4 “(i) ESTABLISHMENT.—The Secretary
5 shall establish and implement a process
6 under which a hospital may apply for an
7 exception from the requirement under
8 paragraph (1)(C).

9 “(ii) OPPORTUNITY FOR COMMUNITY
10 INPUT.—The process under clause (i) shall
11 provide persons and entities in the commu-
12 nity in which the hospital applying for an
13 exception is located with the opportunity to
14 provide input with respect to the applica-
15 tion.

16 “(iii) TIMING FOR IMPLEMENTA-
17 TION.—The Secretary shall implement the
18 process under clause (i) on the date that is
19 one month after the promulgation of regu-
20 lations described in clause (iv).

21 “(iv) REGULATIONS.—Not later than
22 the first day of the month beginning 18
23 months after the date of the enactment of
24 this subsection, the Secretary shall promul-
25 gate regulations to carry out the process

1 under clause (i). The Secretary may issue
2 such regulations as interim final regula-
3 tions.

4 “(B) FREQUENCY.—The process described
5 in subparagraph (A) shall permit a hospital to
6 apply for an exception up to once every 2 years.

7 “(C) PERMITTED INCREASE.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii) and subparagraph (D), a hospital
10 granted an exception under the process de-
11 scribed in subparagraph (A) may increase
12 the number of operating rooms, procedure
13 rooms, or beds of the hospital above the
14 baseline number of operating rooms, proce-
15 dure rooms, or beds, respectively, of the
16 hospital (or, if the hospital has been grant-
17 ed a previous exception under this para-
18 graph, above the number of operating
19 rooms, procedure rooms, or beds, respec-
20 tively, of the hospital after the application
21 of the most recent increase under such an
22 exception).

23 “(ii) 100 PERCENT INCREASE LIMITA-
24 TION.—The Secretary shall not permit an
25 increase in the number of operating rooms,

1 procedure rooms, or beds of a hospital
2 under clause (i) to the extent such increase
3 would result in the number of operating
4 rooms, procedure rooms, or beds of the
5 hospital exceeding 200 percent of the base-
6 line number of operating rooms, procedure
7 rooms, or beds of the hospital.

8 “(iii) BASELINE NUMBER OF OPER-
9 ATING ROOMS, PROCEDURE ROOMS, OR
10 BEDS.—In this paragraph, the term ‘base-
11 line number of operating rooms, procedure
12 rooms, or beds’ means the number of oper-
13 ating rooms, procedure rooms, or beds of a
14 hospital as of the date of enactment of this
15 subsection.

16 “(D) INCREASE LIMITED TO FACILITIES
17 ON THE MAIN CAMPUS OF THE HOSPITAL.—
18 Any increase in the number of operating rooms,
19 procedure rooms, or beds of a hospital pursuant
20 to this paragraph may only occur in facilities on
21 the main campus of the hospital.

22 “(E) CONDITIONS FOR APPROVAL OF AN
23 INCREASE IN FACILITY CAPACITY.—The Sec-
24 retary may grant an exception under the proc-

1 ess described in subparagraph (A) only to a
2 hospital—

3 “(i) that is located in a county in
4 which the percentage increase in the popu-
5 lation during the most recent 5-year period
6 for which data are available is estimated to
7 be at least 150 percent of the percentage
8 increase in the population growth of the
9 State in which the hospital is located dur-
10 ing that period, as estimated by Bureau of
11 the Census and available to the Secretary;

12 “(ii) whose annual percent of total in-
13 patient admissions that represent inpatient
14 admissions under the program under title
15 XIX is estimated to be equal to or greater
16 than the average percent with respect to
17 such admissions for all hospitals located in
18 the county in which the hospital is located;

19 “(iii) that does not discriminate
20 against beneficiaries of Federal health care
21 programs and does not permit physicians
22 practicing at the hospital to discriminate
23 against such beneficiaries;

24 “(iv) that is located in a State in
25 which the average bed capacity in the

1 State is estimated to be less than the na-
2 tional average bed capacity;

3 “(v) that has an average bed occu-
4 pancy rate that is estimated to be greater
5 than the average bed occupancy rate in the
6 State in which the hospital is located; and

7 “(vi) that meets other conditions as
8 determined by the Secretary.

9 “(F) PROCEDURE ROOMS.—In this sub-
10 section, the term ‘procedure rooms’ includes
11 rooms in which catheterizations, angiographies,
12 angiograms, and endoscopies are furnished, but
13 such term shall not include emergency rooms or
14 departments (except for rooms in which cath-
15 eterizations, angiographies, angiograms, and
16 endoscopies are furnished).

17 “(G) PUBLICATION OF FINAL DECI-
18 SIONS.—Not later than 120 days after receiving
19 a complete application under this paragraph,
20 the Secretary shall publish on the public Inter-
21 net website of the Centers for Medicare & Med-
22 icaid Services the final decision with respect to
23 such application.

24 “(H) LIMITATION ON REVIEW.—There
25 shall be no administrative or judicial review

1 under section 1869, section 1878, or otherwise
2 of the exception process under this paragraph,
3 including the establishment of such process,
4 and any determination made under such pro-
5 cess.

6 “(3) PHYSICIAN OWNER OR INVESTOR DE-
7 FINED.—For purposes of this subsection and sub-
8 section (f)(2), the term ‘physician owner or investor’
9 means a physician (or an immediate family member
10 of such physician) with a direct or an indirect own-
11 ership or investment interest in the hospital.

12 “(4) PATIENT SAFETY REQUIREMENT.—In the
13 case of a hospital to which the requirements of para-
14 graph (1) apply, insofar as the hospital admits a pa-
15 tient and does not have any physician available on
16 the premises 24 hours per day, 7 days per week, be-
17 fore admitting the patient—

18 “(A) the hospital shall disclose such fact to
19 the patient; and

20 “(B) following such disclosure, the hospital
21 shall receive from the patient a signed acknowl-
22 edgment that the patient understands such fact.

23 “(5) CLARIFICATION.—Nothing in this sub-
24 section shall be construed as preventing the Sec-
25 retary from terminating a hospital’s provider agree-

1 ment if the hospital is not in compliance with regu-
2 lations pursuant to section 1866.”.

3 (b) VERIFYING COMPLIANCE.—The Secretary of
4 Health and Human Services shall establish policies and
5 procedures to verify compliance with the requirements de-
6 scribed in subsections (i)(1) and (i)(4) of section 1877 of
7 the Social Security Act, as added by subsection (a)(5).
8 The Secretary may use unannounced site reviews of hos-
9 pitals and audits to verify compliance with such require-
10 ments.

11 (c) IMPLEMENTATION.—

12 (1) FUNDING.—For purposes of carrying out
13 the amendments made by subsection (a) and the
14 provisions of subsection (b), in addition to funds
15 otherwise available, out of any funds in the Treasury
16 not otherwise appropriated there are appropriated to
17 the Secretary of Health and Human Services for the
18 Centers for Medicare & Medicaid Services Program
19 Management Account \$5,000,000 for each fiscal
20 year beginning with fiscal year 2010. Amounts ap-
21 propriated under this paragraph for a fiscal year
22 shall be available until expended.

23 (2) ADMINISTRATION.—Chapter 35 of title 44,
24 United States Code, shall not apply to the amend-

1 ments made by subsection (a) and the provisions of
2 subsection (b).

3 **SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEO-**
4 **GRAPHIC ADJUSTMENT FACTORS UNDER**
5 **MEDICARE.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall enter into a contract with the Insti-
8 tute of Medicine of the National Academy of Science to
9 conduct a comprehensive empirical study, and provide rec-
10 ommendations as appropriate, on the accuracy of the geo-
11 graphic adjustment factors established under sections
12 1848(e) and 1886(d)(3)(E) of the Social Security Act (42
13 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)).

14 (b) MATTERS INCLUDED.—Such study shall include
15 an evaluation and assessment of the following with respect
16 to such adjustment factors:

17 (1) Empirical validity of the adjustment factors.

18 (2) Methodology used to determine the adjust-
19 ment factors.

20 (3) Measures used for the adjustment factors,
21 taking into account—

22 (A) timeliness of data and frequency of re-
23 visions to such data;

24 (B) sources of data and the degree to
25 which such data are representative of costs; and

1 (C) operational costs of providers who par-
2 ticipate in Medicare.

3 (c) EVALUATION.—Such study shall, within the con-
4 text of the United States health care marketplace, evalu-
5 ate and consider the following:

6 (1) The effect of the adjustment factors on the
7 level and distribution of the health care workforce
8 and resources, including—

9 (A) recruitment and retention that takes
10 into account workforce mobility between urban
11 and rural areas;

12 (B) ability of hospitals and other facilities
13 to maintain an adequate and skilled workforce;
14 and

15 (C) patient access to providers and needed
16 medical technologies.

17 (2) The effect of the adjustment factors on pop-
18 ulation health and quality of care.

19 (3) The effect of the adjustment factors on the
20 ability of providers to furnish efficient, high value
21 care.

22 (d) REPORT.—The contract under subsection (a)
23 shall provide for the Institute of Medicine to submit, not
24 later than 1 year after the date of the enactment of this
25 Act, to the Secretary and the Congress a report containing

1 results and recommendations of the study conducted
2 under this section.

3 (e) FUNDING.—There are authorized to be appro-
4 priated to carry out this section such sums as may be nec-
5 essary.

6 **SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO**
7 **ADDRESS GEOGRAPHIC INEQUITIES.**

8 (a) REVISION OF MEDICARE PAYMENT SYSTEMS.—
9 Taking into account the recommendations described in the
10 report under section 1157, and notwithstanding the geo-
11 graphic adjustments that would otherwise apply under sec-
12 tion 1848(e) and section 1886(d)(3)(E) of the Social Se-
13 curity Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)), the
14 Secretary of Health and Human Services shall include in
15 proposed rules applicable to the rulemaking cycle for pay-
16 ment systems for physicians' services and inpatient hos-
17 pital services under sections 1848 and section 1886(d) of
18 such Act, respectively, proposals (as the Secretary deter-
19 mines to be appropriate) to revise the geographic adjust-
20 ment factors used in such systems. Such proposals' rules
21 shall be contained in the next rulemaking cycle following
22 the submission to the Secretary of the report described
23 in section 1157.

24 (b) PAYMENT ADJUSTMENTS.—

1 (1) FUNDING FOR IMPROVEMENTS.—For years
2 before 2014, the Secretary shall ensure that the ad-
3 ditional expenditures resulting from the implementa-
4 tion of the provisions of this section, as estimated by
5 the Secretary, do not exceed \$8,000,000,000, and do
6 not exceed half of such amount in any payment year.

7 (2) HOLD HARMLESS.—In carrying out this
8 subsection—

9 (A) for payment years before 2014, the
10 Secretary shall not reduce the geographic ad-
11 justment below the factor that applied for such
12 payment system in the payment year before
13 such changes; and

14 (B) for payment years beginning with
15 2014, the Secretary shall implement the geo-
16 graphic adjustment in a manner that does not
17 result in any net change in aggregate expendi-
18 tures under title XVIII of the Social Security
19 Act from the amount of such expenditures that
20 the Secretary estimates would have occurred if
21 no geographic adjustment had occurred under
22 this section.

23 (c) MEDICARE IMPROVEMENT FUND.—

24 (1) Amounts in the Medicare Improvement
25 Fund under section 1898 of the Social Security Act,

1 as amended by paragraph (2), shall be available to
2 the Secretary to make changes to the geographic ad-
3 justments factors as described in subsections (a) and
4 (b) with respect to services furnished before January
5 1, 2014. No more than one-half of such amounts
6 shall be available with respect to services furnished
7 in any one payment year.

8 (2) Section 1898(b) of the Social Security Act
9 (42 U.S.C. 1395iii(b)) is amended—

10 (A) by amending paragraph (1)(A) to read
11 as follows:

12 “(A) the period beginning with fiscal year
13 2011 and ending with fiscal year 2019,
14 \$8,000,000,000; and”;

15 (B) by adding at the end the following new
16 paragraph:

17 “(5) ADJUSTMENT FOR UNDERFUNDING.—For
18 fiscal year 2014 or a subsequent fiscal year specified
19 by the Secretary, the amount available to the fund
20 under subsection (a) shall be increased by the Sec-
21 retary’s estimate of the amount (based on data on
22 actual expenditures) by which—

23 “(A) the additional expenditures resulting
24 from the implementation of subsection (a) of
25 section 1158 of the Affordable Health Care for

1 America Act for the period before fiscal year
2 2014, is less than

3 “(B) the maximum amount of funds avail-
4 able under subsection (a) of such section for
5 funding for such expenditures.”.

6 **SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEO-**
7 **GRAPHIC VARIATION IN HEALTH CARE**
8 **SPENDING AND PROMOTING HIGH-VALUE**
9 **HEALTH CARE.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services (in this section and the succeeding sec-
12 tion referred to as the “Secretary”) shall enter into an
13 agreement with the Institute of Medicine of the National
14 Academies (referred to in this section as the “Institute”)
15 to conduct a study on geographic variation and growth
16 in volume and intensity of services in per capita health
17 care spending among the Medicare, Medicaid, privately in-
18 sured and uninsured populations. Such study may draw
19 on recent relevant reports of the Institute and shall in-
20 clude each of the following:

21 (1) An evaluation of the extent and range of
22 such variation using various units of geographic
23 measurement, including micro areas within larger
24 areas.

1 (2) An evaluation of the extent to which geo-
2 graphic variation can be attributed to differences in
3 input prices; health status; practice patterns; access
4 to medical services; supply of medical services; socio-
5 economic factors, including race, ethnicity, gender,
6 age, income and educational status; and provider
7 and payer organizational models.

8 (3) An evaluation of the extent to which vari-
9 ations in spending are correlated with patient access
10 to care, insurance status, distribution of health care
11 resources, health care outcomes, and consensus-
12 based measures of health care quality.

13 (4) An evaluation of the extent to which vari-
14 ation can be attributed to physician and practitioner
15 discretion in making treatment decisions, and the
16 degree to which discretionary treatment decisions
17 are made that could be characterized as different
18 from the best available medical evidence.

19 (5) An evaluation of the extent to which vari-
20 ation can be attributed to patient preferences and
21 patient compliance with treatment protocols.

22 (6) An assessment of the degree to which vari-
23 ation cannot be explained by empirical evidence.

24 (7) For Medicare beneficiaries, An evaluation of
25 the extent to which variations in spending are cor-

1 related with insurance status prior to enrollment in
2 the Medicare program under title XVIII of the So-
3 cial Security Act, and institutionalization status;
4 whether beneficiaries are dually eligible for the
5 Medicare program and Medicaid under title XIX of
6 such Act; and whether beneficiaries are enrolled in
7 fee-for-service Medicare or Medicare Advantage.

8 (8) An evaluation of such other factors as the
9 Institute deems appropriate.

10 The Institute shall conduct public hearings and provide
11 an opportunity for comments prior to completion of the
12 reports under subsection (e).

13 (b) RECOMMENDATIONS.—Taking into account the
14 findings under subsection (a) and the changes to the pay-
15 ment systems made by this Act, the Institute shall rec-
16 ommend changes to payment for items and services under
17 parts A and B of title XVIII of the Social Security Act,
18 for addressing variation in Medicare per capita spending
19 for items and services (not including add-ons for graduate
20 medical education, disproportionate share payments, and
21 health information technology, as specified in sections
22 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and
23 1886(n), respectively, of such Act) by promoting high-
24 value care (as defined in subsection (f)), with particular
25 attention to high-volume, high-cost conditions. In making

1 such recommendations, the Institute shall consider each
2 of the following:

3 (1) Measurement and reporting on quality and
4 population health.

5 (2) Reducing fragmented and duplicative care.

6 (3) Promoting the practice of evidence-based
7 medicine.

8 (4) Empowering patients to make value-based
9 care decisions.

10 (5) Leveraging the use of health information
11 technology.

12 (6) The role of financial and other incentives
13 affecting provision of care.

14 (7) Variation in input costs.

15 (8) The characteristics of the patient popu-
16 lation, including socio-economic factors (including
17 race, ethnicity, gender, age, income and educational
18 status), and whether the beneficiaries are dually eli-
19 gible for the Medicare program under title XVIII of
20 the Social Security Act and Medicaid under title
21 XIX of such Act.

22 (9) Other topics the Institute deems appro-
23 priate.

24 In making such recommendations, the Institute shall con-
25 sider an appropriate phase-in that takes into account the

1 impact of payment changes on providers and facilities and
2 preserves access to care for Medicare beneficiaries.

3 (c) SPECIFIC CONSIDERATIONS.—In making the rec-
4 ommendations under subsection (b), the Institute shall
5 specifically address whether payment systems under title
6 XVIII of the Social Security Act for physicians and hos-
7 pitals should be further modified to incentivize high-value
8 care. In so doing, the Institute shall consider the adoption
9 of a value index based on a composite of appropriate meas-
10 ures of quality and cost that would adjust provider pay-
11 ments on a regional or provider-level basis. If the Institute
12 finds that application of such a value index would signifi-
13 cantly incentivize providers to furnish high-value care, it
14 shall make specific recommendations on how such an
15 index would be designed and implemented. In so doing,
16 it should identify specific measures of quality and cost ap-
17 propriate for use in such an index, and include a thorough
18 analysis (including on a geographic basis) of how pay-
19 ments and spending under such title would be affected by
20 such an index.

21 (d) ADDITIONAL CONSIDERATIONS.—The Institute
22 shall consider the experience of governmental and commu-
23 nity-based programs that promote high-value care.

24 (e) REPORTS.—

1 (1) Not later than April 15, 2011, the Institute
2 shall submit to the Secretary and each House of
3 Congress a report containing findings and rec-
4 ommendations of the study conducted under this
5 section.

6 (2) Following submission of the report under
7 paragraph (1), the Institute shall use the data col-
8 lected and analyzed in this section to issue a subse-
9 quent report, or series of reports, on how best to ad-
10 dress geographic variation or efforts to promote
11 high-value care for items and services reimbursed by
12 private insurance or other programs. Such reports
13 shall include a comparison to the Institute’s findings
14 and recommendations regarding the Medicare pro-
15 gram. Such reports, and any recommendations,
16 would not be subject to the procedures outlined in
17 section 1160.

18 (f) HIGH-VALUE CARE DEFINED.—For purposes of
19 this section, the term “high-value care” means the effi-
20 cient delivery of high quality, evidence-based, patient-cen-
21 tered care.

22 (g) APPROPRIATIONS.—There is appropriated from
23 amounts in the general fund of the Treasury not otherwise
24 appropriated \$10,000,000 to carry out this section. Such
25 sums are authorized to remain available until expended.

1 **SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL RE-**
2 **VIEW, OF PROPOSAL TO REVISE MEDICARE**
3 **PAYMENTS TO PROMOTE HIGH VALUE**
4 **HEALTH CARE.**

5 (a) PREPARATION AND SUBMISSION OF IMPLEMEN-
6 TATION PLANS.—

7 (1) FINAL IMPLEMENTATION PLAN.—Not later
8 than 240 days after the date of receipt by the Sec-
9 retary and each House of Congress of the report
10 under section 1159(e)(1), the Secretary shall submit
11 to each House of Congress a final implementation
12 plan describing proposed changes to payment for
13 items and services under parts A and B of title
14 XVIII of the Social Security Act (which may include
15 payment for inpatient and outpatient hospital serv-
16 ices for services furnished in PPS and PPS-exempt
17 hospitals, physicians' services, dialysis facility serv-
18 ices, skilled nursing facility services, home health
19 services, hospice care, clinical laboratory services,
20 durable medical equipment, and other items and
21 services, but which shall exclude add-on payments
22 for graduate medical education, disproportionate
23 share payments, and health information technology,
24 as specified in sections 1886(d)(5)(F),
25 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), re-
26 spectively, of the Social Security Act) taking into

1 consideration, as appropriate, the recommendations
2 of the report submitted under section 1159(e)(1)
3 and the changes to the payment systems made by
4 this Act. To the extent such implementation plan re-
5 quires a substantial change to the payment system,
6 it shall include a transition phase-in that takes into
7 consideration possible disruption to provider partici-
8 pation in the Medicare program under title XVIII of
9 the Social Security Act and preserves access to care
10 for Medicare beneficiaries.

11 (2) PRELIMINARY IMPLEMENTATION PLAN.—
12 Not later than 90 days after the date the Institute
13 of Medicine submits to each House of Congress the
14 report under section 1159(e)(1), the Secretary shall
15 submit to each House of Congress a preliminary
16 version of the implementation plan provided for
17 under paragraph (1)(A).

18 (3) NO INCREASE IN BUDGET EXPENDI-
19 TURES.—The Secretary shall include with the sub-
20 mission of the final implementation plan under para-
21 graph (1) a certification by the Chief Actuary of the
22 Centers for Medicare & Medicaid Services that over
23 the initial 10-year period in which the plan is imple-
24 mented, the aggregate level of net expenditures
25 under the Medicare program under title XVIII of

1 the Social Security Act will not exceed the aggregate
2 level of such expenditures that would have occurred
3 if the plan were not implemented.

4 (4) WAIVERS REQUIRED.—To the extent the
5 final implementation plan under paragraph (1) pro-
6 poses changes that are not otherwise permitted
7 under title XVIII of the Social Security Act, the
8 Secretary shall specify in the plan the specific waiv-
9 ers required under such title to implement such
10 changes. Except as provided in subsection (c), the
11 Secretary is authorized to waive the requirements so
12 specified in order to implement such changes.

13 (5) ASSESSMENT OF IMPACT.—In addition,
14 both the preliminary and final implementation plans
15 under this subsection shall include a detailed assess-
16 ment of the effects of the proposed payment changes
17 by provider or supplier type and State relative to the
18 payments that would otherwise apply.

19 (b) REVIEW BY MEDPAC AND GAO.—Not later than
20 45 days after the date the preliminary implementation
21 plan is received by each House of Congress under sub-
22 section (a)(2), the Medicare Payment Advisory Committee
23 and the Comptroller General of the United States shall
24 each evaluate such plan and submit to each House of Con-
25 gress a report containing its analysis and recommenda-

1 tions regarding implementation of the plan, including an
2 analysis of the effects of the proposed changes in the plan
3 on payments and projected spending.

4 (c) IMPLEMENTATION.—

5 (1) IN GENERAL.—The Secretary shall include,
6 in applicable proposed rules for the next rulemaking
7 cycle beginning after the Congressional action dead-
8 line, appropriate proposals to revise payments under
9 title XVIII of the Social Security Act in accordance
10 with the final implementation plan submitted under
11 subsection (a)(1), and the waivers specified in sub-
12 section (a)(4) to the extent required to carry out
13 such plan are effective, unless a joint resolution (de-
14 scribed in subsection (d)(5)(A)) with respect to such
15 plan is enacted by not later than such deadline. If
16 such a joint resolution is enacted, the Secretary is
17 not authorized to implement such plan and the waiv-
18 er authority provided under subsection (a)(4) shall
19 no longer be effective.

20 (2) CONGRESSIONAL ACTION DEADLINE.—For
21 purposes of this section, the term “Congressional ac-
22 tion deadline” means, with respect to a final imple-
23 mentation plan under subsection (a)(1), May 31,
24 2012, or, if later, the date that is 145 days after the

1 date of receipt of such plan by each House of Con-
2 gress under subsection (a).

3 (d) CONGRESSIONAL PROCEDURES.—

4 (1) INTRODUCTION.—On the day on which the
5 final implementation plan is received by the House
6 of Representatives and the Senate under subsection
7 (a), a joint resolution specified in paragraph (5)(A)
8 shall be introduced in the House of Representatives
9 by the majority leader and minority leader of the
10 House of Representatives and in the Senate by the
11 majority leader and minority leader of the Senate. If
12 either House is not in session on the day on which
13 such a plan is received, the joint resolution with re-
14 spect to such plan shall be introduced in that House,
15 as provided in the preceding sentence, on the first
16 day thereafter on which that House is in session.

17 (2) CONSIDERATION IN THE HOUSE OF REP-
18 RESENTATIVES.—

19 (A) REPORTING AND DISCHARGE.—Any
20 committee of the House of Representatives to
21 which a joint resolution introduced under para-
22 graph (1) is referred shall report such joint res-
23 olution to the House not later than 50 legisla-
24 tive days after the applicable date of introduc-
25 tion of the joint resolution. If a committee fails

1 to report such joint resolution within that pe-
2 riod, a motion to discharge the committee from
3 further consideration of the joint resolution
4 shall be in order. Such a motion shall be in
5 order only at a time designated by the Speaker
6 in the legislative schedule within two legislative
7 days after the day on which the proponent an-
8 nounces an intention to offer the motion. Notice
9 may not be given on an anticipatory basis. Such
10 a motion shall not be in order after the last
11 committee authorized to consider the joint reso-
12 lution reports it to the House or after the
13 House has disposed of a motion to discharge
14 the joint resolution. The previous question shall
15 be considered as ordered on the motion to its
16 adoption without intervening motion except 20
17 minutes of debate equally divided and controlled
18 by the proponent and an opponent. A motion to
19 reconsider the vote by which the motion is dis-
20 posed of shall not be in order.

21 (B) PROCEEDING TO CONSIDERATION.—
22 After each committee authorized to consider a
23 joint resolution reports such joint resolution to
24 the House of Representatives or has been dis-
25 charged from its consideration, a motion to pro-

1 ceed to consider such joint resolution shall be in
2 order. Such a motion shall be in order only at
3 a time designated by the Speaker in the legisla-
4 tive schedule within two legislative days after
5 the day on which the proponent announces an
6 intention to offer the motion. Notice may not be
7 given on an anticipatory basis. Such a motion
8 shall not be in order after the House of Rep-
9 resentatives has disposed of a motion to proceed
10 on the joint resolution. The previous question
11 shall be considered as ordered on the motion to
12 its adoption without intervening motion. A mo-
13 tion to reconsider the vote by which the motion
14 is disposed of shall not be in order.

15 (C) CONSIDERATION.—The joint resolution
16 shall be considered in the House and shall be
17 considered as read. All points of order against
18 a joint resolution and against its consideration
19 are waived. The previous question shall be con-
20 sidered as ordered on the joint resolution to its
21 passage without intervening motion except two
22 hours of debate equally divided and controlled
23 by the proponent and an opponent. A motion to
24 reconsider the vote on passage of a joint resolu-
25 tion shall not be in order.

1 (3) CONSIDERATION IN THE SENATE.—

2 (A) REPORTING AND DISCHARGE.—Any
3 committee of the Senate to which a joint resolu-
4 tion introduced under paragraph (1) is referred
5 shall report such joint resolution to the Senate
6 within 50 legislative days. If a committee fails
7 to report such joint resolution at the close of
8 the 15th legislative day after its receipt by the
9 Senate, such committee shall be automatically
10 discharged from further consideration of such
11 joint resolution and such joint resolution or
12 joint resolutions shall be placed on the calendar.
13 A vote on final passage of such joint resolution
14 shall be taken in the Senate on or before the
15 close of the second legislative day after such
16 joint resolution is reported by the committee or
17 committees of the Senate to which it was re-
18 ferred, or after such committee or committees
19 have been discharged from further consider-
20 ation of such joint resolution.

21 (B) PROCEEDING TO CONSIDERATION.—A
22 motion in the Senate to proceed to the consider-
23 ation of a joint resolution shall be privileged
24 and not debatable. An amendment to such a
25 motion shall not be in order, nor shall it be in

1 order to move to reconsider the vote by which
2 such a motion is agreed to or disagreed to.

3 (C) CONSIDERATION.—

4 (i) Debate in the Senate on a joint
5 resolution, and all debatable motions and
6 appeals in connection therewith, shall be
7 limited to not more than 20 hours. The
8 time shall be equally divided between, and
9 controlled by, the majority leader and the
10 minority leader or their designees.

11 (ii) Debate in the Senate on any de-
12 batable motion or appeal in connection
13 with a joint resolution shall be limited to
14 not more than 1 hour, to be equally di-
15 vided between, and controlled by, the
16 mover and the manager of the resolution,
17 except that in the event the manager of the
18 joint resolution is in favor of any such mo-
19 tion or appeal, the time in opposition
20 thereto shall be controlled by the minority
21 leader or a designee. Such leaders, or ei-
22 ther of them, may, from time under their
23 control on the passage of a joint resolu-
24 tion, allot additional time to any Senator

1 during the consideration of any debatable
2 motion or appeal.

3 (iii) A motion in the Senate to further
4 limit debate is not debatable. A motion to
5 recommit a joint resolution is not in order.

6 (4) RULES RELATING TO SENATE AND HOUSE
7 OF REPRESENTATIVES.—

8 (A) COORDINATION WITH ACTION BY
9 OTHER HOUSE.—If, before the passage by one
10 House of a joint resolution of that House, that
11 House receives from the other House a joint
12 resolution, then the following procedures shall
13 apply:

14 (i) The joint resolution of the other
15 House shall not be referred to a com-
16 mittee.

17 (ii) With respect to the joint resolu-
18 tion of the House receiving the resolution,
19 the procedure in that House shall be the
20 same as if no such joint resolution had
21 been received from the other House; but
22 the vote on passage shall be on the joint
23 resolution of the other House.

24 (B) TREATMENT OF COMPANION MEAS-
25 URES.—If, following passage of a joint resolu-

1 tion in the Senate, the Senate then receives the
2 companion measure from the House of Rep-
3 representatives, the companion measure shall not
4 be debatable.

5 (C) RULES OF HOUSE OF REPRESENTA-
6 TIVES AND SENATE.—This paragraph and the
7 preceding paragraphs are enacted by Con-
8 gress—

9 (i) as an exercise of the rulemaking
10 power of the Senate and House of Rep-
11 representatives, respectively, and as such it is
12 deemed a part of the rules of each House,
13 respectively, but applicable only with re-
14 spect to the procedure to be followed in
15 that House in the case of a joint resolu-
16 tion, and it supersedes other rules only to
17 the extent that it is inconsistent with such
18 rules; and

19 (ii) with full recognition of the con-
20 stitutional right of either House to change
21 the rules (so far as relating to the proce-
22 dure of that House) at any time, in the
23 same manner, and to the same extent as in
24 the case of any other rule of that House.

25 (5) DEFINITIONS.—In this section:

1 (A) JOINT RESOLUTION.—The term “joint
2 resolution” means only a joint resolution—

3 (i) which does not have a preamble;

4 (ii) the title of which is as follows:

5 “Joint resolution disapproving a Medicare
6 final implementation plan of the Secretary
7 of Health and Human Services submitted
8 under section 1160(a) of the Affordable
9 Health Care for America Act”; and

10 (iii) the sole matter after the resolving
11 clause of which is as follows: “That the
12 Congress disapproves the final implementa-
13 tion plan of the Secretary of Health and
14 Human Services transmitted to the Con-
15 gress on————.”, the blank space
16 being filled with the appropriate date.

17 (B) LEGISLATIVE DAY.—The term “legis-
18 lative day” means any calendar day excluding
19 any day on which that House was not in ses-
20 sion.

21 (6) BUDGETARY TREATMENT.—For the pur-
22 poses of consideration of a joint resolution, the
23 Chairmen of the House of Representatives and Sen-
24 ate Committees on the Budget shall exclude from
25 the evaluation of the budgetary effects of the meas-

1 ure, any such effects that are directly attributable to
2 disapproving a Medicare final implementation plan
3 of the Secretary submitted under subsection (a).

4 **Subtitle D—Medicare Advantage** 5 **Reforms**

6 **PART 1—PAYMENT AND ADMINISTRATION**

7 **SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-** 8 **SERVICE COSTS; QUALITY BONUS PAYMENTS.**

9 (a) PHASE-IN OF PAYMENT BASED ON FEE-FOR-
10 SERVICE COSTS.—Section 1853 of the Social Security Act
11 (42 U.S.C. 1395w–23) is amended—

12 (1) in subsection (j)(1)(A)—

13 (A) by striking “beginning with 2007” and
14 inserting “for 2007, 2008, 2009, and 2010”;
15 and

16 (B) by inserting after “(k)(1)” the fol-
17 lowing: “, or, beginning with 2011, $\frac{1}{12}$ of the
18 blended benchmark amount determined under
19 subsection (n)(1)”;

20 (2) by adding at the end the following new sub-
21 section:

22 “(n) DETERMINATION OF BLENDED BENCHMARK
23 AMOUNT.—

1 “(1) IN GENERAL.—For purposes of subsection
2 (j), subject to paragraphs (3) and (4), the term
3 ‘blended benchmark amount’ means for an area—

4 “(A) for 2011 the sum of—

5 “(i) $\frac{2}{3}$ of the applicable amount (as
6 defined in subsection (k)) for the area and
7 year; and

8 “(ii) $\frac{1}{3}$ of the amount specified in
9 paragraph (2) for the area and year;

10 “(B) for 2012 the sum of—

11 “(i) $\frac{1}{3}$ of the applicable amount for
12 the area and year; and

13 “(ii) $\frac{2}{3}$ of the amount specified in
14 paragraph (2) for the area and year; and

15 “(C) for a subsequent year the amount
16 specified in paragraph (2) for the area and
17 year.

18 “(2) SPECIFIED AMOUNT.—The amount speci-
19 fied in this paragraph for an area and year is the
20 amount specified in subsection (c)(1)(D)(i) for the
21 area and year adjusted (in a manner specified by the
22 Secretary) to take into account the phase-out in the
23 indirect costs of medical education from capitation
24 rates described in subsection (k)(4).

1 “(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In
2 no case shall the blended benchmark amount for an
3 area and year be less than the amount specified in
4 paragraph (2).

5 “(4) EXCEPTION FOR PACE PLANS.—This sub-
6 section shall not apply to payments to a PACE pro-
7 gram under section 1894.”.

8 (b) QUALITY BONUS PAYMENTS.—Section 1853 of
9 the Social Security Act (42 U.S.C. 1395w-23), as amend-
10 ed by subsection (a), is amended—

11 (1) in subsection (j), by inserting “subject to
12 subsection (o),” after “For purposes of this part,”;
13 and

14 (2) by adding at the end the following new sub-
15 section:

16 “(o) QUALITY BASED PAYMENT ADJUSTMENT.—

17 “(1) IN GENERAL.—In the case of a qualifying
18 plan in a qualifying county with respect to a year
19 beginning with 2011, the blended benchmark
20 amount under subsection (n)(1) shall be increased—

21 “(A) for 2011, by 1.5 percent;

22 “(B) for 2012, by 3.0 percent; and

23 “(C) for a subsequent year, by 5.0 percent.

24 “(2) QUALIFYING PLAN AND QUALIFYING
25 COUNTY DEFINED.—For purposes of this subsection:

1 “(A) QUALIFYING PLAN.—The term ‘quali-
2 fying plan’ means, for a year and subject to
3 paragraph (4), a plan that, in a preceding year
4 specified by the Secretary, had a quality rank-
5 ing (based on the quality ranking system estab-
6 lished by the Centers for Medicare & Medicaid
7 Services for Medicare Advantage plans) of 4
8 stars or higher.

9 “(B) QUALIFYING COUNTY.—The term
10 ‘qualifying county’ means, for a year, a coun-
11 ty—

12 “(i) that ranked within the lowest
13 third of counties in the amount specified in
14 subsection (n)(2) for a year specified by
15 the Secretary; and

16 “(ii) for which, as of June of a year
17 specified by the Secretary, of the Medicare
18 Advantage eligible individuals residing in
19 the county at least 20 percent of such indi-
20 viduals were enrolled in Medicare Advan-
21 tage plans.

22 “(3) DETERMINATIONS OF QUALITY.—

23 “(A) QUALITY PERFORMANCE.—The Sec-
24 retary shall provide for the computation of a

1 quality performance score for each Medicare
2 Advantage plan to be applied for each year.

3 “(B) COMPUTATION OF SCORE.—

4 “(i) QUALITY PERFORMANCE SCORE.—

5 For years before a year specified by the
6 Secretary, the quality performance score
7 for a Medicare Advantage plan shall be
8 computed based on a blend (as designated
9 by the Secretary) of the plan’s perform-
10 ance on—

11 “(I) HEDIS effectiveness of care
12 quality measures;

13 “(II) CAHPS quality measures;
14 and

15 “(III) such other measures of
16 clinical quality as the Secretary may
17 specify.

18 Such measures shall be risk-adjusted as
19 the Secretary deems appropriate.

20 “(ii) ESTABLISHMENT OF OUTCOME-
21 BASED MEASURES.—By not later than for
22 a year specified by the Secretary, the Sec-
23 retary shall implement reporting require-
24 ments for quality under this section on
25 measures selected under clause (iii) that

1 reflect the outcomes of care experienced by
2 individuals enrolled in Medicare Advantage
3 plans (in addition to measures described in
4 clause (i)). Such measures may include—

5 “(I) measures of rates of admis-
6 sion and readmission to a hospital;

7 “(II) measures of prevention
8 quality, such as those established by
9 the Agency for Healthcare Research
10 and Quality (that include hospital ad-
11 mission rates for specified conditions);

12 “(III) measures of patient mor-
13 tality and morbidity following surgery;

14 “(IV) measures of health func-
15 tioning (such as limitations on activi-
16 ties of daily living) and survival for
17 patients with chronic diseases;

18 “(V) measures of patient safety;

19 and

20 “(VI) other measure of outcomes
21 and patient quality of life as deter-
22 mined by the Secretary.

23 Such measures shall be risk-adjusted as
24 the Secretary deems appropriate. In deter-
25 mining the quality measures to be used

1 under this clause, the Secretary shall take
2 into consideration the recommendations of
3 the Medicare Payment Advisory Commis-
4 sion in its report to Congress under section
5 168 of the Medicare Improvements for Pa-
6 tients and Providers Act of 2008 (Public
7 Law 110–275) and shall provide pref-
8 erence to measures collected on and com-
9 parable to measures used in measuring
10 quality under parts A and B.

11 “(iii) RULES FOR SELECTION OF
12 MEASURES.—The Secretary shall select
13 measures for purposes of clause (ii) con-
14 sistent with the following:

15 “(I) The Secretary shall provide
16 preference to clinical quality measures
17 that have been endorsed by the entity
18 with a contract with the Secretary
19 under section 1890(a).

20 “(II) Prior to any measure being
21 selected under this clause, the Sec-
22 retary shall publish in the Federal
23 Register such measure and provide for
24 a period of public comment on such
25 measure.

1 “(iv) TRANSITIONAL USE OF
2 BLEND.—For payments for years specified
3 by the Secretary, the Secretary may com-
4 pute the quality performance score for a
5 Medicare Advantage plan based on a blend
6 of the measures specified in clause (i) and
7 the measures described in clause (ii) and
8 selected under clause (iii).

9 “(v) USE OF QUALITY OUTCOMES
10 MEASURES.—For payments beginning with
11 a year specified by the Secretary (begin-
12 ning after the years specified for section
13 (iv)), the preponderance of measures used
14 under this paragraph shall be quality out-
15 comes measures described in clause (ii)
16 and selected under clause (iii).

17 “(C) REPORTING OF DATA.—Each Medi-
18 care Advantage organization shall provide for
19 the reporting to the Secretary of quality per-
20 formance data described in this paragraph (in
21 order to determine a quality performance score
22 under this paragraph) in such time and manner
23 as the Secretary shall specify.

24 “(4) NOTIFICATION.—The Secretary, in the an-
25 nual announcement required under subsection

1 (b)(1)(B) in 2010 and each succeeding year, shall
2 notify the Medicare Advantage organization that is
3 offering a qualifying plan in a qualifying county of
4 such identification for the year. The Secretary shall
5 provide for publication on the website for the Medi-
6 care program of the information described in the
7 previous sentence.

8 “(5) AUTHORITY TO DISQUALIFY DEFICIENT
9 PLANS.—The Secretary may determine that a Medi-
10 care Advantage plan is not a qualifying plan if the
11 Secretary has identified deficiencies in the plan’s
12 compliance with rules for Medicare Advantage plans
13 under this part.”.

14 **SEC. 1162. AUTHORITY FOR SECRETARIAL CODING INTEN-**
15 **SITY ADJUSTMENT AUTHORITY.**

16 Section 1853(a)(1)(C)(ii) of the Social Security Act
17 (42 U.S.C. 1395w-23(a)(1)(C)(ii) is amended—

18 (1) in the matter before subclause (I), by strik-
19 ing “through 2010” and inserting “and each subse-
20 quent year”; and

21 (2) in subclause (II)—

22 (A) by inserting “periodically” before “con-
23 duct an analysis”;

24 (B) by inserting “on a timely basis” after
25 “are incorporated”; and

1 (C) by striking “only for 2008, 2009, and
2 2010” and inserting “for 2008 and subsequent
3 years”.

4 **SEC. 1163. SIMPLIFICATION OF ANNUAL BENEFICIARY**
5 **ELECTION PERIODS.**

6 (a) 2 WEEK PROCESSING PERIOD FOR ANNUAL EN-
7 ROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section
8 1851(e) of the Social Security Act (42 U.S.C. 1395w-
9 21(e)) is amended—

10 (1) by striking “and” at the end of clause (iii);

11 (2) in clause (iv)—

12 (A) by striking “and succeeding years”
13 and inserting “, 2008, 2009, and 2010”; and

14 (B) by striking the period at the end and
15 inserting “; and”; and

16 (3) by adding at the end the following new
17 clause:

18 “(v) with respect to 2011 and suc-
19 ceeding years, the period beginning on No-
20 vember 1 and ending on December 15 of
21 the year before such year.”.

22 (b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN
23 ENROLLMENT PERIOD (OEP).—Effective for plan years
24 beginning with 2011, paragraph (2) of such section is
25 amended by striking subparagraph (C).

1 **SEC. 1164. EXTENSION OF REASONABLE COST CONTRACTS.**

2 Section 1876(h)(5)(C) of the Social Security Act (42
3 U.S.C. 1395mm(h)(5)(C)) is amended—

4 (1) in clause (ii), by striking “January 1,
5 2010” and inserting “January 1, 2012”; and

6 (2) in clause (iii), by striking “the service area
7 for the year” and inserting “the portion of the
8 plan’s service area for the year that is within the
9 service area of a reasonable cost reimbursement con-
10 tract”.

11 **SEC. 1165. LIMITATION OF WAIVER AUTHORITY FOR EM-
12 PLOYER GROUP PLANS.**

13 (a) IN GENERAL.—The first sentence of each of para-
14 graphs (1) and (2) of section 1857(i) of the Social Secu-
15 rity Act (42 U.S.C. 1395w–27(i)) is amended by inserting
16 before the period at the end the following: “, but only if
17 90 percent of the Medicare Advantage eligible individuals
18 enrolled under such plan reside in a county in which the
19 MA organization offers an MA local plan”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall apply for plan years beginning on or
22 after January 1, 2011, and shall not apply to plans which
23 were in effect as of December 31, 2010.

24 **SEC. 1166. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.**

25 (a) REPORT TO CONGRESS.—Not later than 1 year
26 after the date of the enactment of this Act, the Secretary

1 of Health and Human Services shall submit to Congress
2 a report that evaluates the adequacy of the risk adjust-
3 ment system under section 1853(a)(1)(C) of the Social Se-
4 curity Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting
5 costs for beneficiaries with chronic or co-morbid condi-
6 tions, beneficiaries dually-eligible for Medicare and Med-
7 icaid, and non-Medicaid eligible low-income beneficiaries;
8 and the need and feasibility of including further gradua-
9 tions of diseases or conditions and multiple years of bene-
10 ficiary data.

11 (b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not
12 later than January 1, 2012, the Secretary shall implement
13 necessary improvements to the risk adjustment system
14 under section 1853(a)(1)(C) of the Social Security Act (42
15 U.S.C. 1395–23(a)(1)(C)), taking into account the evalua-
16 tion under subsection (a).

17 **SEC. 1167. ELIMINATION OF MA REGIONAL PLAN STA-**
18 **BILIZATION FUND.**

19 (a) IN GENERAL.—Section 1858 of the Social Secu-
20 rity Act (42 U.S.C. 1395w–27a) is amended by striking
21 subsection (e).

22 (b) TRANSITION.—Any amount contained in the MA
23 Regional Plan Stabilization Fund as of the date of the
24 enactment of this Act shall be transferred to the Federal
25 Supplementary Medical Insurance Trust Fund.

1 **SEC. 1168. STUDY REGARDING THE EFFECTS OF CALCU-**
2 **LATING MEDICARE ADVANTAGE PAYMENT**
3 **RATES ON A REGIONAL AVERAGE OF MEDI-**
4 **CARE FEE FOR SERVICE RATES.**

5 (a) IN GENERAL.—The Administrator of the Centers
6 for Medicare and Medicaid Services shall conduct a study
7 to determine the potential effects of calculating Medicare
8 Advantage payment rates on a more aggregated geo-
9 graphic basis (such as metropolitan statistical areas or
10 other regional delineations) rather than using county
11 boundaries. In conducting such study, the Administrator
12 shall consider the effect of such alternative geographic
13 basis on the following:

14 (1) The quality of care received by Medicare
15 Advantage enrollees.

16 (2) The networks of Medicare Advantage plans,
17 including any implications for providers contracting
18 with Medicare Advantage plans.

19 (3) The predictability of benchmark amounts
20 for Medicare advantage plans.

21 (b) CONSULTATIONS.—In conducting the study, the
22 Administrator shall consult with the following:

23 (1) Experts in health care financing.

24 (2) Representatives of foundations and other
25 nonprofit entities that have conducted or supported
26 research on Medicare financing issues.

1 (3) Representatives from Medicare Advantage
2 plans.

3 (4) Such other entities or people as determined
4 by the Secretary.

5 (c) REPORT.—Not later than one year after the date
6 of the enactment of this Act, the Administrator shall
7 transmit a report to the Congress on the study conducted
8 under this section. The report shall contain a detailed
9 statement of findings and conclusions of the study, to-
10 gether with its recommendations for such legislation and
11 administrative actions as the Administrator considers ap-
12 propriate.

13 **PART 2—BENEFICIARY PROTECTIONS AND ANTI-**
14 **FRAUD**

15 **SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL**
16 **HEALTH SERVICES.**

17 (a) IN GENERAL.—Section 1852(a)(1) of the Social
18 Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

19 (1) in subparagraph (A), by inserting before the
20 period at the end the following: “with cost-sharing
21 that is no greater (and may be less) than the cost-
22 sharing that would otherwise be imposed under such
23 program option”;

1 (2) in subparagraph (B)(i), by striking “or an
2 actuarially equivalent level of cost-sharing as deter-
3 mined in this part”; and

4 (3) by amending clause (ii) of subparagraph
5 (B) to read as follows:

6 “(ii) PERMITTING USE OF FLAT CO-
7 PAYMENT OR PER DIEM RATE.—Nothing in
8 clause (i) shall be construed as prohibiting
9 a Medicare Advantage plan from using a
10 flat copayment or per diem rate, in lieu of
11 the cost-sharing that would be imposed
12 under part A or B, so long as the amount
13 of the cost-sharing imposed does not ex-
14 ceed the amount of the cost-sharing that
15 would be imposed under the respective part
16 if the individual were not enrolled in a plan
17 under this part.”.

18 (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-
19 FIED MEDICARE BENEFICIARIES.—Section 1852(a)(7) of
20 such Act is amended to read as follows:

21 “(7) LIMITATION ON COST-SHARING FOR DUAL
22 ELIGIBLES AND QUALIFIED MEDICARE BENE-
23 FICIARIES.—In the case of a individual who is a full-
24 benefit dual eligible individual (as defined in section
25 1935(e)(6)) or a qualified medicare beneficiary (as

1 defined in section 1905(p)(1)) who is enrolled in a
2 Medicare Advantage plan, the plan may not impose
3 cost-sharing that exceeds the amount of cost-sharing
4 that would be permitted with respect to the indi-
5 vidual under this title and title XIX if the individual
6 were not enrolled with such plan.”.

7 (c) EFFECTIVE DATES.—

8 (1) The amendments made by subsection (a)
9 shall apply to plan years beginning on or after Janu-
10 ary 1, 2011.

11 (2) The amendments made by subsection (b)
12 shall apply to plan years beginning on or after Janu-
13 ary 1, 2011.

14 **SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLL-**
15 **EES IN PLANS WITH ENROLLMENT SUSPEN-**
16 **SION.**

17 Section 1851(e)(4) of the Social Security Act (42
18 U.S.C. 1395w(e)(4)) is amended—

19 (1) in subparagraph (C), by striking at the end
20 “or”;

21 (2) in subparagraph (D)—

22 (A) by inserting “, taking into account the
23 health or well-being of the individual” before
24 the period; and

1 (B) by redesignating such subparagraph as
2 subparagraph (E); and

3 (3) by inserting after subparagraph (C) the fol-
4 lowing new subparagraph:

5 “(D) the individual is enrolled in an MA
6 plan and enrollment in the plan is suspended
7 under paragraph (2)(B) or (3)(C) of section
8 1857(g) because of a failure of the plan to meet
9 applicable requirements; or”.

10 **SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN**

11 **ADMINISTRATIVE COSTS.**

12 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND
13 OTHER EXPENSE DATA.—Section 1851 of the Social Se-
14 curity Act (42 U.S.C. 1395w–21), as previously amended
15 by this subtitle, is amended by adding at the end the fol-
16 lowing new subsection:

17 “(p) PUBLICATION OF MEDICAL LOSS RATIOS AND
18 OTHER COST-RELATED INFORMATION.—

19 “(1) IN GENERAL.—The Secretary shall pub-
20 lish, not later than November 1 of each year (begin-
21 ning with 2011), for each MA plan contract, the
22 medical loss ratio of the plan in the previous year.

23 “(2) SUBMISSION OF DATA.—

24 “(A) IN GENERAL.—Each MA organization
25 shall submit to the Secretary, in a form and

1 manner specified by the Secretary, data nec-
2 essary for the Secretary to publish the medical
3 loss ratio on a timely basis.

4 “(B) DATA FOR 2010 AND 2011.—The data
5 submitted under subparagraph (A) for 2010
6 and for 2011 shall be consistent in content with
7 the data reported as part of the MA plan bid
8 in June 2009 for 2010.

9 “(C) USE OF STANDARDIZED ELEMENTS
10 AND DEFINITIONS.—The data to be submitted
11 under subparagraph (A) relating to medical loss
12 ratio for a year, beginning with 2012, shall be
13 submitted based on the standardized elements
14 and definitions developed under paragraph (3).

15 “(3) DEVELOPMENT OF DATA REPORTING
16 STANDARDS.—

17 “(A) IN GENERAL.—The Secretary shall
18 develop and implement standardized data ele-
19 ments and definitions for reporting under this
20 subsection, for contract years beginning with
21 2012, of data necessary for the calculation of
22 the medical loss ratio for MA plans. Not later
23 than December 31, 2010, the Secretary shall
24 publish a report describing the elements and
25 definitions so developed.

1 “(B) CONSULTATION.—The Secretary
2 shall consult with the Health Choices Commis-
3 sioner, representatives of MA organizations, ex-
4 perts on health plan accounting systems, and
5 representatives of the National Association of
6 Insurance Commissioners, in the development
7 of such data elements and definitions.

8 “(4) MEDICAL LOSS RATIO TO BE DEFINED.—
9 For purposes of this part, the term ‘medical loss
10 ratio’ has the meaning given such term by the Sec-
11 retary, taking into account the meaning given such
12 term by the Health Choices Commissioner under
13 section 116 of the Affordable Health Care for Amer-
14 ica Act.”.

15 (b) MINIMUM MEDICAL LOSS RATIO.—Section
16 1857(e) of the Social Security Act (42 U.S.C. 1395w-
17 27(e)) is amended by adding at the end the following new
18 paragraph:

19 “(4) REQUIREMENT FOR MINIMUM MEDICAL
20 LOSS RATIO.—If the Secretary determines for a con-
21 tract year (beginning with 2014) that an MA plan
22 has failed to have a medical loss ratio (as defined in
23 section 1851(p)(4)) of at least .85—

24 “(A) the Secretary shall require the Medi-
25 care Advantage organization offering the plan

1 to give enrollees a rebate (in the second suc-
2 ceeding contract year) of premiums under this
3 part (or part B or part D, if applicable) by
4 such amount as would provide for a benefits
5 ratio of at least .85;

6 “(B) for 3 consecutive contract years, the
7 Secretary shall not permit the enrollment of
8 new enrollees under the plan for coverage dur-
9 ing the second succeeding contract year; and

10 “(C) the Secretary shall terminate the plan
11 contract if the plan fails to have such a medical
12 loss ratio for 5 consecutive contract years.”.

13 **SEC. 1174. STRENGTHENING AUDIT AUTHORITY.**

14 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—
15 Section 1857(d)(1) of the Social Security Act (42 U.S.C.
16 1395w–27(d)(1)) is amended by inserting after “section
17 1858(c)” the following: “, and data submitted with re-
18 spect to risk adjustment under section 1853(a)(3)”.

19 (b) ENFORCEMENT OF AUDITS AND DEFICI-
20 CIENCIES.—

21 (1) IN GENERAL.—Section 1857(e) of such Act,
22 as amended by section 1173, is amended by adding
23 at the end the following new paragraph:

24 “(5) ENFORCEMENT OF AUDITS AND DEFICI-
25 CIENCIES.—

1 “(A) INFORMATION IN CONTRACT.—The
2 Secretary shall require that each contract with
3 an MA organization under this section shall in-
4 clude terms that inform the organization of the
5 provisions in subsection (d).

6 “(B) ENFORCEMENT AUTHORITY.—The
7 Secretary is authorized, in connection with con-
8 ducting audits and other activities under sub-
9 section (d), to take such actions, including pur-
10 suit of financial recoveries, necessary to address
11 deficiencies identified in such audits or other
12 activities.”.

13 (2) APPLICATION UNDER PART D.—For provi-
14 sion applying the amendment made by paragraph
15 (1) to prescription drug plans under part D, see sec-
16 tion 1860D–12(b)(3)(D) of the Social Security Act.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect on the date of the enactment
19 of this Act and shall apply to audits and activities con-
20 ducted for contract years beginning on or after January
21 1, 2011.

22 **SEC. 1175. AUTHORITY TO DENY PLAN BIDS.**

23 (a) IN GENERAL.—Section 1854(a)(5) of the Social
24 Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by
25 adding at the end the following new subparagraph:

1 “(C) REJECTION OF BIDS.—Nothing in
2 this section shall be construed as requiring the
3 Secretary to accept any or every bid by an MA
4 organization under this subsection.”.

5 (b) APPLICATION UNDER PART D.—Section 1860D–
6 11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended
7 by adding at the end the following new paragraph:

8 “(3) REJECTION OF BIDS.—Paragraph (5)(C)
9 of section 1854(a) shall apply with respect to bids
10 under this section in the same manner as it applies
11 to bids by an MA organization under such section.”.

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to bids for contract years begin-
14 ning on or after January 1, 2011.

15 **SEC. 1175A. STATE AUTHORITY TO ENFORCE STANDARD-**
16 **IZED MARKETING REQUIREMENTS.**

17 Section 1856(b)(3) of the Social Security Act (42
18 U.S.C. 1395w–26(b)(3)) is amended—

19 (1) by striking “The standards” and inserting
20 “(A) IN GENERAL.—The standards” with appro-
21 priate indentation that is the same as for the sub-
22 paragraph (B) added by paragraph (2); and

23 (2) by adding at the end the following new sub-
24 paragraph:

1 “(B) ENFORCEMENT OF FEDERAL STAND-
2 ARDS PERMITTED.—

3 “(i) IN GENERAL.—Subject to the
4 subsequent provision of this subparagraph,
5 nothing in this title shall be construed to
6 prohibit a State from conducting a market
7 conduct examination or from imposing civil
8 monetary penalties, in accordance with
9 laws and procedures of the State, against
10 Medicare Advantage organizations, PDP
11 sponsors, or agents or brokers of such or-
12 ganizations or sponsors for violations of
13 the marketing requirements under sub-
14 sections (h)(4), (h)(6), and (j) of section
15 1851 and section 1857(g)(1)(E).

16 “(ii) ADDITIONAL REMEDIES RESULT-
17 ING FROM FEDERAL-STATE COOPERA-
18 TION.—

19 “(I) STATE RECOMMENDA-
20 TION.—A State may recommend to
21 the Secretary the imposition of an in-
22 termediate sanction not described in
23 clause (i) (such as those available
24 under section 1857(g)) against a
25 Medicare Advantage organization,

1 PDP sponsor, or agent or broker of
2 such an organization or sponsor for a
3 violation described in such clause.

4 “(II) RESPONSE TO REC-
5 OMMENDATION.—Not later than 30
6 days after receipt of a recommenda-
7 tion under subclause (I) from a State,
8 with respect to a violation described in
9 clause (i), the Secretary shall respond
10 in writing to the State indicating the
11 progress of any investigation involving
12 such violation, whether the Secretary
13 intends to pursue the recommendation
14 from the State, and in the case the
15 Secretary does not intend to pursue
16 such recommendation, the reason for
17 such decision.

18 “(iii) NON-DUPLICATION OF PEN-
19 ALTIES.—In the case that an action has
20 been initiated against a Medicare Advan-
21 tage organization, PDP sponsor, or agent
22 or broker of such an organization or spon-
23 sor for a violation of a marketing require-
24 ment under subsection (h)(4), (h)(6), or (j)
25 of section 1851 or section 1857(g)(1)(E)—

1 “(I) in the case such action has
2 been initiated by the Secretary, no
3 State may bring an action under such
4 applicable subsection or section
5 against such organization, sponsor,
6 agent, or broker with respect to such
7 violation during the pendency period
8 of the action initiated by the Sec-
9 retary and, if a penalty is imposed
10 pursuant to such action, after such
11 period; and

12 “(II) in the case such action has
13 been initiated by a State, the Sec-
14 retary may not bring an action under
15 such applicable subsection or section
16 against such organization, sponsor,
17 agent, or broker with respect to such
18 violation during the pendency period
19 of the action initiated by the Sec-
20 retary and, if a penalty is imposed
21 pursuant to such action, after such
22 period.

23 Nothing in this clause shall be construed
24 as limiting the ability of the Secretary to
25 impose any sanction other than a civil

1 monetary penalty under section 1857
2 against a Medicare Advantage organiza-
3 tion, PDP sponsor, or agent or broker of
4 such an organization or sponsor for a vio-
5 lation described in clause (i).

6 “(iv) CONSTRUCTION.—Nothing in
7 this subparagraph shall be construed as af-
8 fecting any State authority to regulate bro-
9 kers described in this paragraph or any
10 other conduct of a Medicare Advantage or-
11 ganization or PDP sponsor.”.

12 **PART 3—TREATMENT OF SPECIAL NEEDS PLANS**

13 **SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN**
14 **ENROLLMENT PERIOD OF INDIVIDUALS INTO**
15 **CHRONIC CARE SPECIALIZED MA PLANS FOR**
16 **SPECIAL NEEDS INDIVIDUALS.**

17 Section 1859(f)(4) of the Social Security Act (42
18 U.S.C. 1395w-28(f)(4)) is amended by adding at the end
19 the following new subparagraph:

20 “(C) The plan does not enroll an individual
21 on or after January 1, 2011, other than—

22 “(i) during an annual, coordinated
23 open enrollment period; or

24 “(ii) during a special election period
25 consisting of the period for which the indi-

1 vidual has a chronic condition that quali-
2 fies the individual as an individual de-
3 scribed in subsection (b)(6)(B)(iii) for such
4 plan and ending on the date on which the
5 individual enrolls in such a plan on the
6 basis of such condition.

7 If an individual is enrolled in such a plan on
8 the basis of a chronic condition and becomes el-
9 igible for another such plan on the basis of an-
10 other chronic condition, the other plan may en-
11 roll the individual on the basis of such other
12 chronic condition during a special enrollment
13 period described in clause (ii). An individual is
14 eligible to apply such clause only once on the
15 basis of any specific chronic condition.”.

16 **SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS**
17 **PLANS TO RESTRICT ENROLLMENT; SERVICE**
18 **AREA MORATORIUM FOR CERTAIN SNPS.**

19 (a) IN GENERAL.—Section 1859(f)(1) of the Social
20 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by
21 striking “January 1, 2011” and inserting “January 1,
22 2013 (or January 1, 2016, in the case of a plan described
23 in section 1177(b)(1) of the Affordable Health Care for
24 America Act)”.

25 (b) EXTENSION OF CERTAIN PLANS.—

1 (1) PLANS DESCRIBED.—For purposes of Sec-
2 tion 1859(f)(1) of the Social Security Act (42
3 U.S.C. 1395w-28(f)(1)), a plan described in this
4 paragraph is a Medicare Advantage dual eligible spe-
5 cial needs plan that—

6 (A) whose sponsoring Medicare Advantage
7 organization, as of the date enactment of the
8 Affordable Health Care for America Act, has a
9 contract with a State Medicaid Agency that
10 participated in the “Demonstrations Serving
11 Those Dually-Eligible for Medicare and Med-
12 icaid” under the Medicare program; and

13 (B) that has been approved by the Centers
14 for Medicare & Medicaid Services as a dual eli-
15 gible special needs plan and that offers inte-
16 grated Medicare and Medicaid services under a
17 contract with the State Medicaid agency.

18 (2) ANALYSIS; REPORT.—

19 (A) ANALYSIS.—The Secretary of Health
20 and Human Services shall provide, through a
21 contract with an independent health services
22 evaluation organization, for an analysis of the
23 plans described in paragraph (1) with regard to
24 the impact of such plans on cost, quality of
25 care, patient satisfaction, and other subjects

1 specified by the Secretary. Such report also will
2 identify statutory changes needed to simplify
3 access to needed services, improve coordination
4 of benefits and services and ensure protection
5 for dual eligibles as appropriate.

6 (B) REPORT.—Not later than December
7 31, 2011, the Secretary shall submit to the
8 Congress a report on the analysis under sub-
9 paragraph (A) and shall include in such report
10 such recommendations with regard to the treat-
11 ment of such plans as the Secretary deems ap-
12 propriate.

13 (c) EXTENSION OF SERVICE AREA MORATORIUM FOR
14 CERTAIN SNPs.—Section 164(c)(2) of the Medicare Im-
15 provements for Patients and Providers Act of 2008 is
16 amended by striking “December 31, 2010” and inserting
17 “December 31, 2012”.

18 **SEC. 1178. EXTENSION OF MEDICARE SENIOR HOUSING**
19 **PLANS.**

20 Section 1859 of the Social Security Act (42 U.S.C.
21 1395w-28) is amended by adding at the end the following
22 new subsection:

23 “(g) SPECIAL RULES FOR SENIOR HOUSING FACIL-
24 ITY PLANS.—

1 “(1) IN GENERAL.—Notwithstanding any other
2 provision of this part, in the case of a Medicare Ad-
3 vantage senior housing facility plan described in
4 paragraph (2) and for periods before January 1,
5 2013—

6 “(A) the service area of such plan may be
7 limited to a senior housing facility in a geo-
8 graphic area;

9 “(B) the service area of such plan may not
10 be expanded; and

11 “(C) additional senior housing facilities
12 may not be serviced by such plan.

13 “(2) MEDICARE ADVANTAGE SENIOR HOUSING
14 FACILITY PLAN DESCRIBED.—For purposes of this
15 subsection, a Medicare Advantage senior housing fa-
16 cility plan is a Medicare Advantage plan that—

17 “(A)(i) restricts enrollment of individuals
18 under this part to individuals who reside in a
19 continuing care retirement community (as de-
20 fined in section 1852(l)(4)(B));

21 “(ii) provides primary care services onsite
22 and has a ratio of accessible providers to bene-
23 ficiaries that the Secretary determines is ade-
24 quate, taking into consideration the number of
25 residents onsite, the health needs of those resi-

1 dents, and the accessibility of providers offsite;
2 and

3 “(iii) provides transportation services for
4 beneficiaries to providers outside of the facility;
5 and

6 “(B) is offered by a Medicare Advantage
7 organization that has offered at least 1 plan de-
8 scribed in subparagraph (A) for at least 1 year
9 prior to January 1, 2010, under a demonstra-
10 tion project established by the Secretary.”.

11 **Subtitle E—Improvements to**
12 **Medicare Part D**

13 **SEC. 1181. ELIMINATION OF COVERAGE GAP.**

14 (a) IMMEDIATE REDUCTION IN COVERAGE GAP IN
15 2010.—Section 1860D–2(b) of the Social Security Act
16 (42 U.S.C. 1395w–102(b)) is amended—

17 (1) in paragraph (3)(A), by striking “paragraph
18 (4)” and inserting “paragraphs (4) and (7)”; and

19 (2) by adding at the end the following new
20 paragraph:

21 “(7) INCREASE IN INITIAL COVERAGE LIMIT IN
22 2010.—

23 “(A) IN GENERAL.—For plan years begin-
24 ning during 2010, the initial coverage limit de-

1 scribed in paragraph (3)(B) otherwise applica-
2 ble shall be increased by \$500.

3 “(B) APPLICATION.—In applying subpara-
4 graph (A)—

5 “(i) except as otherwise provided in
6 this subparagraph, there shall be no
7 change in the premiums, bids, or any other
8 parameters under this part or part C;

9 “(ii) costs that would be treated as in-
10 curred costs for purposes of applying para-
11 graph (4) but for the application of sub-
12 paragraph (A) shall continue to be treated
13 as incurred costs;

14 “(iii) the Secretary shall establish pro-
15 cedures, which may include a reconciliation
16 process, to fully reimburse PDP sponsors
17 with respect to prescription drug plans and
18 MA organizations with respect to MA-PD
19 plans for the reduction in beneficiary cost
20 sharing associated with the application of
21 subparagraph (A);

22 “(iv) the Secretary shall develop an
23 estimate of the additional increased costs
24 attributable to the application of this para-
25 graph for increased drug utilization and fi-

1 financing and administrative costs and shall
2 use such estimate to adjust payments to
3 PDP sponsors with respect to prescription
4 drug plans under this part and MA organi-
5 zations with respect to MA-PD plans
6 under part C; and

7 “(v) the Secretary shall establish pro-
8 cedures for retroactive reimbursement of
9 part D eligible individuals who are covered
10 under such a plan for costs which are in-
11 curred before the date of initial implemen-
12 tation of subparagraph (A) and which
13 would be reimbursed under such a plan if
14 such implementation occurred as of Janu-
15 ary 1, 2010.”.

16 (b) ADDITIONAL CLOSURE IN GAP BEGINNING IN
17 2011.—Section 1860D–2(b) of such Act (42 U.S.C.
18 1395w–102(b)) as amended by subsection (a), is further
19 amended—

20 (1) in paragraph (3)(A), by striking “and (7)”
21 and inserting “, (7), and (8)” ;

22 (2) in paragraph (4)(B)(i), by inserting “sub-
23 ject to paragraph (8)” after “purposes of this part”;
24 and

1 (3) by adding at the end the following new
2 paragraph:

3 “(8) PHASED-IN ELIMINATION OF COVERAGE
4 GAP.—

5 “(A) IN GENERAL.—For each year begin-
6 ning with 2011, the Secretary shall consistent
7 with this paragraph progressively increase the
8 initial coverage limit (described in subsection
9 (b)(3)) and decrease the annual out-of-pocket
10 threshold from the amounts otherwise computed
11 until, beginning in 2019, there is a continuation
12 of coverage from the initial coverage limit for
13 expenditures incurred through the total amount
14 of expenditures at which benefits are available
15 under paragraph (4).

16 “(B) INCREASE IN INITIAL COVERAGE
17 LIMIT.—

18 “(i) IN GENERAL.—For a year begin-
19 ning with 2011, subject to clause (ii), the
20 initial coverage limit otherwise computed
21 without regard to this paragraph shall be
22 increased by the cumulative ICL phase-in
23 percentage (as defined in clause (iii) for
24 the year) times the out-of-pocket gap

1 amount (as defined in subparagraph (D))
2 for the year.

3 “(ii) MAINTENANCE OF 2010 INITIAL
4 COVERAGE LIMIT LEVEL.—If for a year the
5 initial coverage limit otherwise computed
6 under this paragraph would be less than
7 the initial coverage limit applied during
8 2010, taking into account paragraph (7),
9 the initial coverage limit for that year shall
10 be such initial coverage limit as so applied
11 during 2010.

12 “(iii) CUMULATIVE PHASE-IN PER-
13 CENTAGE.—

14 “(I) IN GENERAL.—For purposes
15 of this paragraph, subject to sub-
16 clause (II), the term ‘cumulative ICL
17 phase-in percentage’ means for a year
18 the sum of the annual ICL phase-in
19 percentage (as defined in clause (iv))
20 for the year and the annual ICL
21 phase-in percentages for each previous
22 year beginning with 2011.

23 “(II) LIMITATION.—If the sum
24 of the cumulative ICL phase-in per-
25 centage and the cumulative OPT

1 phase-in percentage (as defined in
2 subparagraph (C)(iii)) for a year
3 would otherwise exceed 100 percent,
4 each such percentage shall be reduced
5 in a proportional amount so the sum
6 does not exceed 100 percent.

7 “(iv) ANNUAL ICL PHASE-IN PER-
8 CENTAGE.—For purposes of this para-
9 graph, the term ‘annual ICL phase-in per-
10 centage’ means—

11 “(I) for 2011, 8.25 percent;

12 “(II) for 2012, 2013, and 2014,
13 4.5 percent;

14 “(III) for 2015 and 2016, 6 per-
15 cent;

16 “(IV) for 2017, 7.5 percent;

17 “(V) for 2018, 8 percent; and

18 “(VI) for 2019, 8 percent, or
19 such other percent as may be nec-
20 essary to provide for a full continu-
21 ation of coverage as described in sub-
22 paragraph (A) in that year.

23 “(C) DECREASE IN ANNUAL OUT-OF-POCK-
24 ET THRESHOLD.—

1 “(i) IN GENERAL.—For a year begin-
2 ning with 2011, subject to clause (ii), the
3 annual out-of-pocket threshold otherwise
4 computed without regard to this paragraph
5 shall be decreased by the cumulative OPT
6 phase-in percentage (as defined in clause
7 (iii) for the year) of the out-of-pocket gap
8 amount for the year multiplied by 1.75.

9 “(ii) MAINTENANCE.—The Secretary
10 shall adjust the annual out-of-pocket
11 threshold for a year to the extent nec-
12 essary to ensure that the sum of the initial
13 coverage limit described in subparagraph
14 (A) and the out-of-pocket gap amount (de-
15 fined in subparagraph (D)), as determined
16 for the year pursuant to the provisions of
17 this paragraph for such year, does not ex-
18 ceed such sum that would have applied if
19 this paragraph did not apply.

20 “(iii) CUMULATIVE OPT PHASE-IN
21 PERCENTAGE.—For purposes of this para-
22 graph, subject to subparagraph (B)(iii)(II),
23 the term ‘cumulative OPT phase-in per-
24 centage’ means for a year the sum of the
25 annual OPT phase-in percentage (as de-

1 fined in clause (iv)) for the year and the
2 annual OPT phase-in percentages for each
3 previous year beginning with 2011.

4 “(iv) ANNUAL OPT PHASE-IN PER-
5 CENTAGE.—For purposes of this para-
6 graph, the term ‘annual OPT phase-in per-
7 centage’ means—

8 “(I) for 2011, 0 percent;

9 “(II) for 2012, 2013, and 2014,
10 4.5 percent;

11 “(III) for 2015 and 2016, 6 per-
12 cent;

13 “(IV) for 2017, 7.5 percent; and

14 “(V) for 2018 and 2019, 8 per-
15 cent.

16 “(D) OUT-OF-POCKET GAP AMOUNT.—For
17 purposes of this paragraph, the term ‘out-of-
18 pocket gap amount’ means for a year the
19 amount by which—

20 “(i) the annual out-of-pocket thresh-
21 old specified in paragraph (4)(B) for the
22 year (as determined as if this paragraph
23 did not apply), exceeds

24 “(ii) the sum of—

1 “(I) the annual deductible under
2 paragraph (1) for the year; and

3 “(II) $\frac{1}{4}$ of the amount by which
4 the initial coverage limit under para-
5 graph (3) for the year (as determined
6 as if this paragraph did not apply) ex-
7 ceeds such annual deductible.

8 “(E) RELATION TO AAHCA TRANSITIONAL
9 INCREASE.—Except as otherwise specifically
10 provided, this paragraph shall be applied as if
11 no increase had been made in the initial cov-
12 erage limit under paragraph (7).”.

13 (c) REQUIRING DRUG MANUFACTURERS TO PROVIDE
14 DRUG REBATES FOR REBATE ELIGIBLE INDIVIDUALS.—

15 (1) IN GENERAL.—Section 1860D–2 of the So-
16 cial Security Act (42 U.S.C. 1395w–102) is amend-
17 ed—

18 (A) in subsection (e)(1), in the matter be-
19 fore subparagraph (A), by inserting “and sub-
20 section (f)” after “this subsection”; and

21 (B) by adding at the end the following new
22 subsection:

23 “(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR
24 REBATE ELIGIBLE INDIVIDUALS.—

25 “(1) REQUIREMENT.—

1 “(A) IN GENERAL.—For plan years begin-
2 ning on or after January 1, 2011, in this part,
3 the term ‘covered part D drug’ does not include
4 any drug or biological product that is manufac-
5 tured by a manufacturer that has not entered
6 into and have in effect a rebate agreement de-
7 scribed in paragraph (2).

8 “(B) 2010 PLAN YEAR REQUIREMENT.—
9 Any drug or biological product manufactured by
10 a manufacturer that declines to enter into a re-
11 bate agreement described in paragraph (2) for
12 the period beginning on January 1, 2010, and
13 ending on December 31, 2010, shall not be in-
14 cluded as a ‘covered part D drug ‘ for the sub-
15 sequent plan year.

16 “(2) REBATE AGREEMENT.—A rebate agree-
17 ment under this subsection shall require the manu-
18 facturer to provide to the Secretary a rebate for
19 each rebate period (as defined in paragraph (6)(B))
20 ending after December 31, 2009, in the amount
21 specified in paragraph (3) for any covered part D
22 drug of the manufacturer dispensed after December
23 31, 2009, to any rebate eligible individual (as de-
24 fined in paragraph (6)(A)) for which payment was
25 made by a PDP sponsor under part D or a MA or-

1 organization under part C for such period, including
2 payments passed through the low-income and rein-
3 surance subsidies under sections 1860D–14 and
4 1860D–15(b), respectively. Such rebate shall be paid
5 by the manufacturer to the Secretary not later than
6 30 days after the date of receipt of the information
7 described in section 1860D–12(b)(7), including as
8 such section is applied under section 1857(f)(3), or
9 30 days after the receipt of information under sub-
10 paragraph (D) of paragraph (3), as determined by
11 the Secretary. Insofar as not inconsistent with this
12 subsection, the Secretary shall establish terms and
13 conditions of such agreement relating to compliance,
14 penalties, and program evaluations, investigations,
15 and audits that are similar to the terms and condi-
16 tions for rebate agreements under paragraphs (3)
17 and (4) of section 1927(b).

18 “(3) REBATE FOR REBATE ELIGIBLE MEDICARE
19 DRUG PLAN ENROLLEES.—

20 “(A) IN GENERAL.—The amount of the re-
21 bate specified under this paragraph for a manu-
22 facturer for a rebate period, with respect to
23 each dosage form and strength of any covered
24 part D drug provided by such manufacturer

1 and dispensed to a rebate eligible individual,
2 shall be equal to the product of—

3 “(i) the total number of units of such
4 dosage form and strength of the drug so
5 provided and dispensed for which payment
6 was made by a PDP sponsor under part D
7 or a MA organization under part C for the
8 rebate period, including payments passed
9 through the low-income and reinsurance
10 subsidies under sections 1860D–14 and
11 1860D–15(b), respectively; and

12 “(ii) the amount (if any) by which—

13 “(I) the Medicaid rebate amount
14 (as defined in subparagraph (B)) for
15 such form, strength, and period, ex-
16 ceeds

17 “(II) the average Medicare drug
18 program rebate eligible rebate amount
19 (as defined in subparagraph (C)) for
20 such form, strength, and period.

21 “(B) MEDICAID REBATE AMOUNT.—For
22 purposes of this paragraph, the term ‘Medicaid
23 rebate amount’ means, with respect to each
24 dosage form and strength of a covered part D

1 drug provided by the manufacturer for a rebate
2 period—

3 “(i) in the case of a single source
4 drug or an innovator multiple source drug,
5 the amount specified in paragraph
6 (1)(A)(ii) of section 1927(c) plus the
7 amount, if any, specified in paragraph
8 (2)(A)(ii) of such section, for such form,
9 strength, and period; or

10 “(ii) in the case of any other covered
11 outpatient drug, the amount specified in
12 paragraph (3)(A)(i) of such section for
13 such form, strength, and period.

14 “(C) AVERAGE MEDICARE DRUG PROGRAM
15 REBATE ELIGIBLE REBATE AMOUNT.—For pur-
16 poses of this subsection, the term ‘average
17 Medicare drug program rebate eligible rebate
18 amount’ means, with respect to each dosage
19 form and strength of a covered part D drug
20 provided by a manufacturer for a rebate period,
21 the sum, for all PDP sponsors under part D
22 and MA organizations administering a MA-PD
23 plan under part C, of—

24 “(i) the product, for each such spon-
25 sor or organization, of—

1 “(I) the sum of all rebates, dis-
2 counts, or other price concessions (not
3 taking into account any rebate pro-
4 vided under paragraph (2) for such
5 dosage form and strength of the drug
6 dispensed, calculated on a per-unit
7 basis, but only to the extent that any
8 such rebate, discount, or other price
9 concession applies equally to drugs
10 dispensed to rebate eligible Medicare
11 drug plan enrollees and drugs dis-
12 pensed to PDP and MA-PD enrollees
13 who are not rebate eligible individuals;
14 and

15 “(II) the number of the units of
16 such dosage and strength of the drug
17 dispensed during the rebate period to
18 rebate eligible individuals enrolled in
19 the prescription drug plans adminis-
20 tered by the PDP sponsor or the MA-
21 PD plans administered by the MA or-
22 ganization; divided by

23 “(ii) the total number of units of such
24 dosage and strength of the drug dispensed
25 during the rebate period to rebate eligible

1 individuals enrolled in all prescription drug
2 plans administered by PDP sponsors and
3 all MA-PD plans administered by MA or-
4 ganizations.

5 “(D) USE OF ESTIMATES.—The Secretary
6 may establish a methodology for estimating the
7 average Medicare drug program rebate eligible
8 rebate amounts for each rebate period based on
9 bid and utilization information under this part
10 and may use these estimates as the basis for
11 determining the rebates under this section. If
12 the Secretary elects to estimate the average
13 Medicare drug program rebate eligible rebate
14 amounts, the Secretary shall establish a rec-
15 onciliation process for adjusting manufacturer
16 rebate payments not later than 3 months after
17 the date that manufacturers receive the infor-
18 mation collected under section 1860D-
19 12(b)(7)(B).

20 “(4) LENGTH OF AGREEMENT.—The provisions
21 of paragraph (4) of section 1927(b) (other than
22 clauses (iv) and (v) of subparagraph (B)) shall apply
23 to rebate agreements under this subsection in the
24 same manner as such paragraph applies to a rebate
25 agreement under such section.

1 “(5) OTHER TERMS AND CONDITIONS.—The
2 Secretary shall establish other terms and conditions
3 of the rebate agreement under this subsection, in-
4 cluding terms and conditions related to compliance,
5 that are consistent with this subsection.

6 “(6) DEFINITIONS.—In this subsection and sec-
7 tion 1860D–12(b)(7):

8 “(A) REBATE ELIGIBLE INDIVIDUAL.—The
9 term ‘rebate eligible individual’—

10 “(i) means a full-benefit dual eligible
11 individual (as defined in section
12 1935(c)(6)); and

13 “(ii) includes, for drugs dispensed
14 after December 31, 2014, a subsidy eligi-
15 ble individual (as defined in section
16 1860D–14(a)(3)(A)).

17 “(B) REBATE PERIOD.—The term ‘rebate
18 period’ has the meaning given such term in sec-
19 tion 1927(k)(8).

20 “(7) WAIVER.—Chapter 35 of title 44, United
21 States Code, shall not apply to the requirements
22 under this subsection for the period beginning on
23 January 1, 2010, and ending on December 31,
24 2010.”.

1 (2) REPORTING REQUIREMENT FOR THE DE-
2 TERMINATION AND PAYMENT OF REBATES BY MANU-
3 FACTURES RELATED TO REBATE FOR REBATE ELIGI-
4 BLE MEDICARE DRUG PLAN ENROLLEES.—

5 (A) REQUIREMENTS FOR PDP SPON-
6 SORS.—Section 1860D–12(b) of the Social Se-
7 curity Act (42 U.S.C. 1395w–112(b)) is amend-
8 ed by adding at the end the following new para-
9 graph:

10 “(7) REPORTING REQUIREMENT FOR THE DE-
11 TERMINATION AND PAYMENT OF REBATES BY MANU-
12 FACTURERS RELATED TO REBATE FOR REBATE ELI-
13 GIBLE MEDICARE DRUG PLAN ENROLLEES.—

14 “(A) IN GENERAL.—For purposes of the
15 rebate under section 1860D–2(f) for contract
16 years beginning on or after January 1, 2011,
17 each contract entered into with a PDP sponsor
18 under this part with respect to a prescription
19 drug plan shall require that the sponsor comply
20 with subparagraphs (B) and (C).

21 “(B) REPORT FORM AND CONTENTS.—Not
22 later than a date specified by the Secretary, a
23 PDP sponsor of a prescription drug plan under
24 this part shall report to each manufacturer—

1 “(i) information (by National Drug
2 Code number) on the total number of units
3 of each dosage, form, and strength of each
4 drug of such manufacturer dispensed to re-
5 bate eligible Medicare drug plan enrollees
6 under any prescription drug plan operated
7 by the PDP sponsor during the rebate pe-
8 riod;

9 “(ii) information on the price dis-
10 counts, price concessions, and rebates for
11 such drugs for such form, strength, and
12 period;

13 “(iii) information on the extent to
14 which such price discounts, price conces-
15 sions, and rebates apply equally to rebate
16 eligible Medicare drug plan enrollees and
17 PDP enrollees who are not rebate eligible
18 Medicare drug plan enrollees; and

19 “(iv) any additional information that
20 the Secretary determines is necessary to
21 enable the Secretary to calculate the aver-
22 age Medicare drug program rebate eligible
23 rebate amount (as defined in paragraph
24 (3)(C) of such section), and to determine
25 the amount of the rebate required under

1 this section, for such form, strength, and
2 period.

3 Such report shall be in a form consistent with
4 a standard reporting format established by the
5 Secretary.

6 “(C) SUBMISSION TO SECRETARY.—Each
7 PDP sponsor shall promptly transmit a copy of
8 the information reported under subparagraph
9 (B) to the Secretary for the purpose of audit
10 oversight and evaluation.

11 “(D) CONFIDENTIALITY OF INFORMA-
12 TION.—The provisions of subparagraph (D) of
13 section 1927(b)(3), relating to confidentiality of
14 information, shall apply to information reported
15 by PDP sponsors under this paragraph in the
16 same manner that such provisions apply to in-
17 formation disclosed by manufacturers or whole-
18 salers under such section, except—

19 “(i) that any reference to ‘this sec-
20 tion’ in clause (i) of such subparagraph
21 shall be treated as being a reference to this
22 section;

23 “(ii) the reference to the Director of
24 the Congressional Budget Office in clause
25 (iii) of such subparagraph shall be treated

1 as including a reference to the Medicare
2 Payment Advisory Commission; and

3 “(iii) clause (iv) of such subparagraph
4 shall not apply.

5 “(E) OVERSIGHT.—Information reported
6 under this paragraph may be used by the In-
7 spector General of the Department of Health
8 and Human Services for the statutorily author-
9 ized purposes of audit, investigation, and eval-
10 uations.

11 “(F) PENALTIES FOR FAILURE TO PRO-
12 VIDE TIMELY INFORMATION AND PROVISION OF
13 FALSE INFORMATION.—In the case of a PDP
14 sponsor—

15 “(i) that fails to provide information
16 required under subparagraph (B) on a
17 timely basis, the sponsor is subject to a
18 civil money penalty in the amount of
19 \$10,000 for each day in which such infor-
20 mation has not been provided; or

21 “(ii) that knowingly (as defined in
22 section 1128A(i)) provides false informa-
23 tion under such subparagraph, the sponsor
24 is subject to a civil money penalty in an

1 amount not to exceed \$100,000 for each
2 item of false information.

3 Such civil money penalties are in addition to
4 other penalties as may be prescribed by law.
5 The provisions of section 1128A (other than
6 subsections (a) and (b)) shall apply to a civil
7 money penalty under this subparagraph in the
8 same manner as such provisions apply to a pen-
9 alty or proceeding under section 1128A(a).”.

10 (B) APPLICATION TO MA ORGANIZA-
11 TIONS.—Section 1857(f)(3) of the Social Secu-
12 rity Act (42 U.S.C. 1395w–27(f)(3)) is amend-
13 ed by adding at the end the following:

14 “(D) REPORTING REQUIREMENT RELATED
15 TO REBATE FOR REBATE ELIGIBLE MEDICARE
16 DRUG PLAN ENROLLEES.—Section 1860D–
17 12(b)(7).”.

18 (3) DEPOSIT OF REBATES INTO MEDICARE PRE-
19 SCRIPTON DRUG ACCOUNT.—Section 1860D–16(c)
20 of such Act (42 U.S.C. 1395w–116(c)) is amended
21 by adding at the end the following new paragraph:

22 “(6) REBATE FOR REBATE ELIGIBLE MEDICARE
23 DRUG PLAN ENROLLEES.—Amounts paid under a re-
24 bate agreement under section 1860D–2(f) shall be
25 deposited into the Account and shall be used to pay

1 for all or part of the gradual elimination of the cov-
2 erage gap under section 1860D–2(b)(7).”.

3 **SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN**
4 **ORIGINAL COVERAGE GAP.**

5 Section 1860D–2 of the Social Security Act (42
6 U.S.C. 1395w–102), as amended by section 1181, is
7 amended—

8 (1) in subsection (b)(4)(C)(ii), by inserting
9 “subject to subsection (g)(2)(C),” after “(ii)”;

10 (2) in subsection (e)(1), in the matter before
11 subparagraph (A), by striking “subsection (f)” and
12 inserting “subsections (f) and (g)” after “this sub-
13 section”; and

14 (3) by adding at the end the following new sub-
15 section:

16 “(g) REQUIREMENT FOR MANUFACTURER DISCOUNT
17 AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

18 “(1) IN GENERAL.—In this part, the term ‘cov-
19 ered part D drug’ does not include any drug or bio-
20 logical product that is manufactured by a manufac-
21 turer that has not entered into and have in effect for
22 all qualifying drugs (as defined in paragraph (5)(A))
23 a discount agreement described in paragraph (2).

24 “(2) DISCOUNT AGREEMENT.—

1 “(A) PERIODIC DISCOUNTS.—A discount
2 agreement under this paragraph shall require
3 the manufacturer involved to provide, to each
4 PDP sponsor with respect to a prescription
5 drug plan or each MA organization with respect
6 to each MA–PD plan, a discount in an amount
7 specified in paragraph (3) for qualifying drugs
8 (as defined in paragraph (5)(A)) of the manu-
9 facturer dispensed to a qualifying enrollee after
10 January 1, 2010, insofar as the individual is in
11 the original gap in coverage (as defined in para-
12 graph (5)(E)).

13 “(B) DISCOUNT AGREEMENT.—Insofar as
14 not inconsistent with this subsection, the Sec-
15 retary shall establish terms and conditions of
16 such agreement, including terms and conditions
17 relating to compliance, similar to the terms and
18 conditions for rebate agreements under para-
19 graphs (2), (3), and (4) of section 1927(b), ex-
20 cept that—

21 “(i) discounts shall be applied under
22 this subsection to prescription drug plans
23 and MA–PD plans instead of State plans
24 under title XIX;

1 “(ii) PDP sponsors and MA organiza-
2 tions shall be responsible, instead of
3 States, for provision of necessary utiliza-
4 tion information to drug manufacturers;
5 and

6 “(iii) sponsors and MA organizations
7 shall be responsible for reporting informa-
8 tion on drug-component negotiated price.

9 “(C) COUNTING DISCOUNT TOWARD TRUE
10 OUT-OF-POCKET COSTS.—Under the discount
11 agreement, in applying subsection (b)(4), with
12 regard to subparagraph (C)(i) of such sub-
13 section, if a qualified enrollee purchases the
14 qualified drug insofar as the enrollee is in an
15 actual gap of coverage (as defined in paragraph
16 (5)(D)), the amount of the discount under the
17 agreement shall be treated and counted as costs
18 incurred by the plan enrollee.

19 “(3) DISCOUNT AMOUNT.—The amount of the
20 discount specified in this paragraph for a discount
21 period for a plan is equal to 50 percent of the
22 amount of the drug-component negotiated price (as
23 defined in paragraph (5)(C)) for qualifying drugs for
24 the period involved.

1 “(4) ADDITIONAL TERMS.—In the case of a dis-
2 count provided under this subsection with respect to
3 a prescription drug plan offered by a PDP sponsor
4 or an MA–PD plan offered by an MA organization,
5 if a qualified enrollee purchases the qualified drug—

6 “(A) insofar as the enrollee is in an actual
7 gap of coverage (as defined in paragraph
8 (5)(D)), the sponsor or plan shall provide the
9 discount to the enrollee at the time the enrollee
10 pays for the drug; and

11 “(B) insofar as the enrollee is in the por-
12 tion of the original gap in coverage (as defined
13 in paragraph (5)(E)) that is not in the actual
14 gap in coverage, the discount shall not be ap-
15 plied against the negotiated price (as defined in
16 subsection (d)(1)(B)) for the purpose of calcu-
17 lating the beneficiary payment.

18 “(5) DEFINITIONS.—In this subsection:

19 “(A) QUALIFYING DRUG.—The term
20 ‘qualifying drug’ means, with respect to a pre-
21 scription drug plan or MA–PD plan, a drug or
22 biological product that—

23 “(i)(I) is a drug produced or distrib-
24 uted under an original new drug applica-
25 tion approved by the Food and Drug Ad-

1 ministration, including a drug product
2 marketed by any cross-licensed producers
3 or distributors operating under the new
4 drug application;

5 “(II) is a drug that was originally
6 marketed under an original new drug ap-
7 plication approved by the Food and Drug
8 Administration; or

9 “(III) is a biological product as ap-
10 proved under Section 351(a) of the Public
11 Health Services Act;

12 “(ii) is covered under the formulary of
13 the plan or is treated as covered under the
14 formulary of the plan as a result of a cov-
15 erage determination or appeal under sub-
16 section (g) or (h) of section 1860D-4; and

17 “(iii) is dispensed to an individual
18 who is in the original gap in coverage.

19 “(B) QUALIFYING ENROLLEE.—The term
20 ‘qualifying enrollee’ means an individual en-
21 rolled in a prescription drug plan or MA-PD
22 plan other than such an individual who is a
23 subsidy-eligible individual (as defined in section
24 1860D-14(a)(3)).

1 “(C) DRUG-COMPONENT NEGOTIATED
2 PRICE.—The term ‘drug-component negotiated
3 price’ means, with respect to a qualifying drug,
4 the negotiated price (as defined in section
5 423.100 of title 42, Code of Federal Regula-
6 tions, as in effect on the date of enactment of
7 this subsection), as determined without regard
8 to any dispensing fee, of the drug under the
9 prescription drug plan or MA–PD plan in-
10 volved.

11 “(D) ACTUAL GAP IN COVERAGE.—The
12 term ‘actual gap in coverage’ means the gap in
13 prescription drug coverage that occurs between
14 the initial coverage limit (as modified under
15 paragraph (7) and subparagraph (B) of para-
16 graph (8) of subsection (b)) and the annual
17 out-of-pocket threshold (as modified under sub-
18 paragraph (C) of such subsection).

19 “(E) ORIGINAL GAP IN COVERAGE.—The
20 term ‘original in gap coverage’ means the gap
21 in prescription drug coverage that would occur
22 between the initial coverage limit (described in
23 subsection (b)(3)) and the out-of-pocket thresh-
24 old (as defined in subsection (b)(4)(B)) if sub-
25 sections (b)(7) and (b)(8) did not apply.

1 “(6) SPECIAL RULE FOR 2010.—For the period
2 beginning January 1, 2010, and ending December
3 31, 2010, the Secretary may—

4 “(A) enter into agreements with manufac-
5 turers to directly receive the discount amount
6 described in paragraph (3);

7 “(B) collect the necessary information
8 from prescription drug plans and MA-PD plans
9 to calculate the discount amount described in
10 such paragraph; and

11 “(C) provide the discount described in such
12 paragraph to beneficiaries as close as prac-
13 ticable after the point of sale.

14 “(7) WAIVER.—Chapter 35 of title 44, United
15 States Code, shall not apply to the requirements
16 under this subsection for the period beginning on
17 January 1, 2010, and ending on December 31,
18 2010.”.

19 **SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMIS-**
20 **SION OF CLAIMS BY PHARMACIES LOCATED**
21 **IN OR CONTRACTING WITH LONG-TERM CARE**
22 **FACILITIES.**

23 (a) PART D SUBMISSION.—Section 1860D–12(b) of
24 the Social Security Act (42 U.S.C. 1395w–112(b)), as
25 amended by section 172(a)(1) of Public Law 110–275, is

1 amended by striking paragraph (5) and redesignating
2 paragraph (6) and paragraph (7), as added by section
3 1181(c)(2)(A), as paragraph (5) and paragraph (6), re-
4 spectively.

5 (b) SUBMISSION TO MA-PD PLANS.—Section
6 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-
7 27(f)(3)), as added by section 171(b) of Public Law 110-
8 275 and amended by section 172(a)(2) of such Public Law
9 and section 1181 of this Act, is amended by striking sub-
10 paragraph (B) and redesignating subparagraphs (C) and
11 (D) as subparagraphs (B) and (C) respectively.

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply for contract years beginning with
14 2010.

15 **SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
16 **SISTANCE PROGRAMS AND INDIAN HEALTH**
17 **SERVICE IN PROVIDING PRESCRIPTION**
18 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**
19 **ET THRESHOLD UNDER PART D.**

20 (a) IN GENERAL.—Section 1860D-2(b)(4)(C) of the
21 Social Security Act (42 U.S.C. 1395w-102(b)(4)(C)) is
22 amended—

- 23 (1) in clause (i), by striking “and” at the end;
24 (2) in clause (ii)—

1 (A) by striking “such costs shall be treated
2 as incurred only if” and inserting “and subject
3 to clause (iii), such costs shall be treated as in-
4 curred only if”;

5 (B) by striking “, under section 1860D-
6 14, or under a State Pharmaceutical Assistance
7 Program”; and

8 (C) by striking the period at the end and
9 inserting “; and”; and

10 (3) by inserting after clause (ii) the following
11 new clause:

12 “(iii) such costs shall be treated as in-
13 curred and shall not be considered to be
14 reimbursed under clause (ii) if such costs
15 are borne or paid—

16 “(I) under section 1860D-14;

17 “(II) under a State Pharma-
18 ceutical Assistance Program;

19 “(III) by the Indian Health Serv-
20 ice, an Indian tribe or tribal organiza-
21 tion, or an urban Indian organization
22 (as defined in section 4 of the Indian
23 Health Care Improvement Act); or

24 “(IV) under an AIDS Drug As-
25 sistance Program under part B of

1 title XXVI of the Public Health Serv-
2 ice Act.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply to costs incurred on or after
5 January 1, 2011.

6 **SEC. 1185. NO MID-YEAR FORMULARY CHANGES PER-**
7 **MITTED.**

8 (a) IN GENERAL.—Section 1860D–4(b)(3)(E) of the
9 Social Security Act (42 U.S.C. 1395w–104(b)(3)(E)) is
10 amended—

11 (1) in the heading, by inserting “; CERTAIN
12 FORMULARY CHANGES ONLY BEFORE INITIATING
13 MARKETING FOR A PLAN YEAR” after “STATUS OF
14 DRUG”;

15 (2) by striking “Any removal” and inserting
16 “(i) NOTICE.—Any removal” with the same indenta-
17 tion as the clause added by paragraph (2);

18 (3) by adding at the end the following new
19 clause:

20 “(ii) CERTAIN CHANGES IN FOR-
21 MULARY ONLY BEFORE INITIATING MAR-
22 KETING FOR A PLAN YEAR.—Any removal
23 of a covered part D drug from a formulary
24 used by a PDP sponsor of a prescription
25 drug plan (or MA organization of a MA-

1 PD plan) or any other material change to
2 the formulary so as to reduce the coverage
3 (or increase the cost-sharing) of the drug
4 under the plan for a plan year shall take
5 effect by a date specified by the Secretary
6 but no later than the start of plan mar-
7 keting activities for the plan year. In addi-
8 tion to any exceptions to the previous sen-
9 tence specified by the Secretary, the pre-
10 vious sentence shall not apply in the case
11 that a drug is removed from the formulary
12 of a plan because of a recall or withdrawal
13 of the drug issued by the Food and Drug
14 Administration, because the drug is re-
15 placed with a generic drug that is a thera-
16 peutic equivalent, or because of utilization
17 management applied to—

18 “(I) a drug whose labeling in-
19 cludes a boxed warning required by
20 the Food and Drug Administration
21 under section 201.57(c)(1) of title 21,
22 Code of Federal Regulations (or a
23 successor regulation); or

24 “(II) a drug required under sub-
25 section (c)(2) of section 505–1 of the

1 Federal Food, Drug, and Cosmetic
2 Act to have a Risk Evaluation and
3 Management Strategy that includes
4 elements under subsection (f) of such
5 section.”.

6 (b) EFFECTIVE DATE.—The amendments made by
7 subsection (a) shall apply to contract years beginning on
8 or after January 1, 2011.

9 **SEC. 1186. NEGOTIATION OF LOWER COVERED PART D**
10 **DRUG PRICES ON BEHALF OF MEDICARE**
11 **BENEFICIARIES.**

12 (a) NEGOTIATION BY SECRETARY.—Section 1860D–
13 11 of the Social Security Act (42 U.S.C. 1395w–111) is
14 amended by striking subsection (i) (relating to noninter-
15 ference) and inserting the following:

16 “(i) NEGOTIATION OF LOWER DRUG PRICES.—

17 “(1) IN GENERAL.—Notwithstanding any other
18 provision of law, the Secretary shall negotiate with
19 pharmaceutical manufacturers the prices (including
20 discounts, rebates, and other price concessions) that
21 may be charged to PDP sponsors and MA organiza-
22 tions for covered part D drugs for part D eligible in-
23 dividuals who are enrolled under a prescription drug
24 plan or under an MA-PD plan.

1 “(2) NO CHANGE IN RULES FOR
2 FORMULARIES.—

3 “(A) IN GENERAL.—Nothing in paragraph
4 (1) shall be construed to authorize the Sec-
5 retary to establish or require a particular for-
6 mulary.

7 “(B) CONSTRUCTION.—Subparagraph (A)
8 shall not be construed as affecting the Sec-
9 retary’s authority to ensure appropriate and
10 adequate access to covered part D drugs under
11 prescription drug plans and under MA-PD
12 plans, including compliance of such plans with
13 formulary requirements under section 1860D-
14 4(b)(3).

15 “(3) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as preventing the sponsor
17 of a prescription drug plan, or an organization offer-
18 ing an MA-PD plan, from obtaining a discount or
19 reduction of the price for a covered part D drug
20 below the price negotiated under paragraph (1).

21 “(4) ANNUAL REPORTS TO CONGRESS.—Not
22 later than June 1, 2011, and annually thereafter,
23 the Secretary shall submit to the Committees on
24 Ways and Means, Energy and Commerce, and Over-
25 sight and Government Reform of the House of Rep-

1 representatives and the Committee on Finance of the
2 Senate a report on negotiations conducted by the
3 Secretary to achieve lower prices for Medicare bene-
4 ficiaries, and the prices and price discounts achieved
5 by the Secretary as a result of such negotiations.”.

6 (b) **EFFECTIVE DATE.**—The amendment made by
7 subsection (a) shall take effect on the date of the enact-
8 ment of this Act and shall first apply to negotiations and
9 prices for plan years beginning on January 1, 2011.

10 **SEC. 1187. ACCURATE DISPENSING IN LONG-TERM CARE**
11 **FACILITIES.**

12 Section 1860D–4(c) of the Social Security Act (42
13 U.S.C. 1395w–104(c)) is amended by adding at the end
14 the following new paragraph:

15 “(3) **REDUCTION OF WASTEFUL DISPENSING.**—

16 “(A) **IN GENERAL.**—For plan years begin-
17 ning on or after January 1, 2012, a PDP spon-
18 sor offering a prescription drug plan and MA
19 organization offering a MA–PD plan under part
20 C shall have in place the utilization manage-
21 ment techniques established under subpara-
22 graph (B).

23 “(B) **REQUIREMENTS.**—The Secretary
24 shall establish utilization management tech-
25 niques, such as daily, weekly, or automated

1 dose dispensing, to apply to PDP sponsors and
2 MA organizations to reduce the quantities of
3 covered part D drugs dispensed to enrollees
4 who are residing in long-term care facilities in
5 order to reduce waste associated with unused
6 medications.

7 “(C) CONSULTATION.—In establishing the
8 requirements under subparagraph (A), the Sec-
9retary shall consult with the Administrator of
10 the Environmental Protection Agency, Adminis-
11trator of the Food and Drug Administration,
12 Administrator of the Drug Enforcement Admin-
13stration, State Boards of Pharmacy, pharmacy
14and physician organizations, and other appro-
15priate stakeholders to study and determine ad-
16ditional methods for prescription drug plans to
17reduce waste associated with unused prescrip-
18tion drugs.”.

19 **SEC. 1188. FREE GENERIC FILL.**

20 (a) IN GENERAL.—Section 1128A(i)(6) of the Social
21 Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

22 (1) in subparagraph (C), by striking “of 1996”
23 and all that follows and inserting “of 1996;”;

1 (2) in the first subparagraph (D), by striking
2 “promulgated” and all that follows and inserting
3 “promulgated;”;

4 (3) by redesignating the second subparagraph
5 (D) as a subparagraph (E) and by striking the pe-
6 riod at the end of such subparagraph and inserting
7 “; and”; and

8 (4) by adding at the end the following new sub-
9 paragraph:

10 “(F) with regard to a prescription drug
11 plan offered by a PDP sponsor or an MA–PD
12 plan offered by an MA organization, a reduc-
13 tion in or waiver of the copayment amount
14 under the plan given to an individual to induce
15 the individual to switch to a generic, bioequiva-
16 lent drug, or biosimilar.”.

17 (b) **EFFECTIVE DATE.**—The amendments made by
18 this subsection shall take effect on the date of the enact-
19 ment of this Act and shall first apply with respect to remu-
20 neration offered, paid, solicited, or received on or after
21 January 1, 2011.

1 **SEC. 1189. STATE CERTIFICATION PRIOR TO WAIVER OF LI-**
2 **CENSURE REQUIREMENTS UNDER MEDICARE**
3 **PRESCRIPTION DRUG PROGRAM.**

4 (a) IN GENERAL.—Section 1860D–12(c) of the So-
5 cial Security Act (42 U.S.C. 1395w–112(c)) is amended—

6 (1) in paragraph (1)(A), by striking “In the
7 case” and inserting “Subject to paragraph (5), in
8 the case”; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(5) STATE CERTIFICATION REQUIRED.—

12 “(A) IN GENERAL.—Except as provided in
13 section 1860D–21(f)(4), the Secretary may only
14 grant a waiver under paragraph (1)(A) if the
15 Secretary has received a certification from the
16 State insurance commissioner that the prescrip-
17 tion drug plan has a substantially complete ap-
18 plication pending in the State.

19 “(B) REVOCATION OF WAIVER UPON FIND-
20 ING OF FRAUD AND ABUSE.—The Secretary
21 shall revoke a waiver granted under paragraph
22 (1)(A) if the State insurance commissioner sub-
23 mits a certification to the Secretary that the re-
24 cipient of such a waiver—

25 “(i) has committed fraud or abuse
26 with respect to such waiver;

1 “(ii) has failed to make a good faith
2 effort to satisfy State licensing require-
3 ments; or

4 “(iii) was determined ineligible for li-
5 censure by the State.”.

6 (b) EXCEPTION FOR PACE PROGRAMS.—Section
7 1860D–21(f) of such Act (42 U.S.C. 1395w–131(f)) is
8 amended—

9 (1) in paragraph (1), by striking “paragraphs
10 (2) and (3)” and inserting “the succeeding para-
11 graphs”; and

12 (2) by adding at the end the following new
13 paragraph:

14 “(4) INAPPLICABILITY OF CERTAIN LICENSURE
15 WAIVER REQUIREMENTS.—The provisions of para-
16 graph (1) of section 1860D–12(c) (relating to waiver
17 of licensure under certain circumstances) shall apply
18 without regard to paragraph (5) of such section in
19 the case of a PACE program that elects to provide
20 qualified prescription drug coverage to a part D eli-
21 gible individual who is enrolled under such pro-
22 gram.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 this section shall apply with respect to plan years begin-
25 ning on or after January 1, 2010.

1 **Subtitle F—Medicare Rural Access**
2 **Protections**

3 **SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.**

4 (a) **ADDITIONAL TELEHEALTH SITE.**—

5 (1) **IN GENERAL.**—Paragraph (4)(C)(ii) of sec-
6 tion 1834(m) of the Social Security Act (42 U.S.C.
7 1395m(m)) is amended by adding at the end the fol-
8 lowing new subclause:

9 “(IX) A renal dialysis facility.”

10 (2) **EFFECTIVE DATE.**—The amendment made
11 by paragraph (1) shall apply to services furnished on
12 or after January 1, 2011.

13 (b) **TELEHEALTH ADVISORY COMMITTEE.**—

14 (1) **ESTABLISHMENT.**—Section 1868 of the So-
15 cial Security Act (42 U.S.C. 1395ee) is amended—

16 (A) in the heading, by adding at the end
17 the following: “TELEHEALTH ADVISORY COM-
18 MITTEE”; and

19 (B) by adding at the end the following new
20 subsection:

21 “(c) **TELEHEALTH ADVISORY COMMITTEE.**—

22 “(1) **IN GENERAL.**—The Secretary shall appoint
23 a Telehealth Advisory Committee (in this subsection
24 referred to as the ‘Advisory Committee’) to make
25 recommendations to the Secretary on policies of the

1 Centers for Medicare & Medicaid Services regarding
2 telehealth services as established under section
3 1834(m), including the appropriate addition or dele-
4 tion of services (and HCPCS codes) to those speci-
5 fied in paragraphs (4)(F)(i) and (4)(F)(ii) of such
6 section and for authorized payment under paragraph
7 (1) of such section.

8 “(2) MEMBERSHIP; TERMS.—

9 “(A) MEMBERSHIP.—

10 “(i) IN GENERAL.—The Advisory
11 Committee shall be composed of 9 mem-
12 bers, to be appointed by the Secretary, of
13 whom—

14 “(I) 5 shall be practicing physi-
15 cians;

16 “(II) 2 shall be practicing non-
17 physician health care practitioners;
18 and

19 “(III) 2 shall be administrators
20 of telehealth programs.

21 “(ii) REQUIREMENTS FOR APPOINT-
22 ING MEMBERS.—In appointing members of
23 the Advisory Committee, the Secretary
24 shall—

1 “(I) ensure that each member
2 has prior experience with the practice
3 of telemedicine or telehealth;

4 “(II) give preference to individ-
5 uals who are currently providing tele-
6 medicine or telehealth services or who
7 are involved in telemedicine or tele-
8 health programs;

9 “(III) ensure that the member-
10 ship of the Advisory Committee rep-
11 resents a balance of specialties and
12 geographic regions; and

13 “(IV) take into account the rec-
14 ommendations of stakeholders.

15 “(B) TERMS.—The members of the Advi-
16 sory Committee shall serve for such term as the
17 Secretary may specify.

18 “(C) CONFLICTS OF INTEREST.—An advi-
19 sory committee member may not participate
20 with respect to a particular matter considered
21 in an advisory committee meeting if such mem-
22 ber (or an immediate family member of such
23 member) has a financial interest that could be
24 affected by the advice given to the Secretary
25 with respect to such matter.

1 “(3) MEETINGS.—The Advisory Committee
2 shall meet twice each calendar year and at such
3 other times as the Secretary may provide.

4 “(4) PERMANENT COMMITTEE.—Section 14 of
5 the Federal Advisory Committee Act (5 U.S.C.
6 App.) shall not apply to the Advisory Committee.”

7 (2) FOLLOWING RECOMMENDATIONS.—Section
8 1834(m)(4)(F) of such Act (42 U.S.C.
9 1395m(m)(4)(F)) is amended by adding at the end
10 the following new clause:

11 “(iii) RECOMMENDATIONS OF THE
12 TELEHEALTH ADVISORY COMMITTEE.—In
13 making determinations under clauses (i)
14 and (ii), the Secretary shall take into ac-
15 count the recommendations of the Tele-
16 health Advisory Committee (established
17 under section 1868(c)) when adding or de-
18 leting services (and HCPCS codes) and in
19 establishing policies of the Centers for
20 Medicare & Medicaid Services regarding
21 the delivery of telehealth services. If the
22 Secretary does not implement such a rec-
23 ommendation, the Secretary shall publish
24 in the Federal Register a statement re-

1 garding the reason such recommendation
2 was not implemented.”

3 (3) WAIVER OF ADMINISTRATIVE LIMITA-
4 TION.—The Secretary of Health and Human Serv-
5 ices shall establish the Telehealth Advisory Com-
6 mittee under the amendment made by paragraph (1)
7 notwithstanding any limitation that may apply to
8 the number of advisory committees that may be es-
9 tablished (within the Department of Health and
10 Human Services or otherwise).

11 (c) HOSPITAL CREDENTIALING OF TELEMEDICINE
12 PHYSICIANS AND PRACTITIONERS.—

13 (1) IN GENERAL.—Not later than 60 days after
14 the date of the enactment of this Act, the Secretary
15 of Health and Human Services shall issue guidance
16 for hospitals (as defined in paragraph (4)) to sim-
17 plify requirements regarding compiling practitioner
18 credentials for the purpose of rendering a medical
19 staff privileging decision (under bylaws of the type
20 described in section 1861(e)(3) of the Social Secu-
21 rity Act) for physicians and practitioners (as defined
22 in paragraph (4)) delivering telehealth services that
23 are furnished via a telecommunications system.

1 (2) FLEXIBILITY IN ACCEPTING
2 CREDENTIALING BY ANOTHER MEDICARE PARTICI-
3 PATING HOSPITAL.—

4 (A) IN GENERAL.—Such guidance shall
5 permit a hospital to accept credentialing pack-
6 ages compiled by another hospital participating
7 under Medicare with regard to physicians and
8 practitioners who seek medical staff privileges
9 in the hospital to provide telehealth services via
10 a telecommunications system from a site other
11 than the hospital where the patient is located.

12 (B) CONSTRUCTION.—Nothing in this sub-
13 section shall be construed to require a hospital
14 to accept the credentialing package compiled by
15 another facility.

16 (C) NO OVERSIGHT REQUIRED.—If a hos-
17 pital does accept the credentialing materials
18 prepared by another hospital, the hospital shall
19 not be required to exercise oversight over the
20 other hospital's process for compiling and
21 verifying credentials.

22 (D) PRIVILEGING.—This paragraph shall
23 only apply to credentialing and does not relieve
24 a hospital from any applicable privileging re-
25 quirements.

1 (3) CONSTRUCTION.—This subsection shall not
2 be construed as limiting the ability of the Secretary
3 to issue additional guidance regarding the require-
4 ments for the compilation of credentials for physi-
5 cians and practitioners not described in paragraph
6 (1).

7 (4) DEFINITIONS.—In this subsection:

8 (A) The term “hospital” has the meaning
9 given such term in subsection (e) of section
10 1861 of the Social Security Act (42 U.S.C.
11 1395x) and includes a critical access hospital
12 (as defined in subsection (mm)(1) of such sec-
13 tion).

14 (B) The term “physician” has the meaning
15 given such term in subsection (r) of such sec-
16 tion.

17 (C) The term “practitioner” means a prac-
18 titioner described in section 1842(b)(18)(C) of
19 the Social Security Act (42 U.S.C.
20 1395u(b)(18)(C)).

21 **SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS**
22 **PROVISION.**

23 Section 1833(t)(7)(D)(i) of the Social Security Act
24 (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

25 (1) in subclause (II)—

1 (A) in the first sentence, by striking
2 “2010” and inserting “2012”; and

3 (B) in the second sentence, by striking “or
4 2009” and inserting “, 2009, 2010, or 2011”;
5 and

6 (2) in subclause (III), by striking “January 1,
7 2010” and inserting “January 1, 2012”.

8 **SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLAS-**
9 **SIFICATIONS.**

10 (a) IN GENERAL.—Subsection (a) of section 106 of
11 division B of the Tax Relief and Health Care Act of 2006
12 (42 U.S.C. 1395 note), as amended by section 117 of the
13 Medicare, Medicaid, and SCHIP Extension Act of 2007
14 (Public Law 110–173) and section 124 of the Medicare
15 Improvements for Patients and Providers Act of 2008
16 (Public Law 110–275), is amended by striking “Sep-
17 tember 30, 2009” and inserting “September 30, 2011”.

18 (b) USE OF PARTICULAR WAGE INDEX FOR FISCAL
19 YEAR 2010.—For purposes of implementation of the
20 amendment made by subsection (a) for fiscal year 2010,
21 the Secretary shall use the hospital wage index that was
22 promulgated by the Secretary in the Federal Register on
23 August 27, 2009 (74 Fed. Reg. 43754), and any subse-
24 quent corrections.

1 **SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.**

2 Section 1848(e)(1)(E) of the Social Security Act (42
3 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “before
4 January 1, 2010” and inserting “before January 1,
5 2012”.

6 **SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COM-**
7 **PONENT OF CERTAIN PHYSICIAN PATHOL-**
8 **OGY SERVICES.**

9 Section 542(c) of the Medicare, Medicaid, and
10 SCHIP Benefits Improvement and Protection Act of 2000
11 (as enacted into law by section 1(a)(6) of Public Law 106-
12 554), as amended by section 732 of the Medicare Prescrip-
13 tion Drug, Improvement, and Modernization Act of 2003
14 (42 U.S.C. 1395w-4 note), section 104 of division B of
15 the Tax Relief and Health Care Act of 2006 (42 U.S.C.
16 1395w-4 note), section 104 of the Medicare, Medicaid,
17 and SCHIP Extension Act of 2007 (Public Law 110-
18 173), and section 136 of the Medicare Improvements for
19 Patients and Providers Act of 1008 (Public Law 110-
20 275), is amended by striking “and 2009” and inserting
21 “2009, 2010, and 2011”.

22 **SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.**

23 (a) IN GENERAL.—Section 1834(l)(13) of the Social
24 Security Act (42 U.S.C. 1395m(l)(13)) is amended—

25 (1) in subparagraph (A)—

1 (A) in the matter preceding clause (i), by
2 striking “before January 1, 2010” and insert-
3 ing “before January 1, 2012”; and

4 (B) in each of clauses (i) and (ii), by strik-
5 ing “before January 1, 2010” and inserting
6 “before January 1, 2012”.

7 (b) AIR AMBULANCE IMPROVEMENTS.—Section
8 146(b)(1) of the Medicare Improvements for Patients and
9 Providers Act of 2008 (Public Law 110–275) is amended
10 by striking “ending on December 31, 2009” and inserting
11 “ending on December 31, 2011”.

12 **TITLE II—MEDICARE**
13 **BENEFICIARY IMPROVEMENTS**
14 **Subtitle A—Improving and Simpli-**
15 **fyng Financial Assistance for**
16 **Low Income Medicare Bene-**
17 **ficiaries**

18 **SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**
19 **INGS PROGRAM AND LOW-INCOME SUBSIDY**
20 **PROGRAM.**

21 (a) APPLICATION OF HIGHEST LEVEL PERMITTED
22 UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.—

23 (1) IN GENERAL.—Section 1860D–14(a)(1) of
24 the Social Security Act (42 U.S.C. 1395w–
25 114(a)(1)) is amended in the matter before subpara-

1 graph (A), by inserting “(or, beginning with 2012,
2 paragraph (3)(E))” after “paragraph (3)(D)”.

3 (2) ANNUAL INCREASE IN LIS RESOURCE
4 TEST.—Section 1860D–14(a)(3)(E)(i) of such Act
5 (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

6 (A) by striking “and” at the end of sub-
7 clause (I);

8 (B) in subclause (II), by inserting “(before
9 2012)” after “subsequent year”;

10 (C) by striking the period at the end of
11 subclause (II) and inserting a semicolon;

12 (D) by inserting after subclause (II) the
13 following new subclauses:

14 “(III) for 2012, \$17,000 (or
15 \$34,000 in the case of the combined
16 value of the individual’s assets or re-
17 sources and the assets or resources of
18 the individual’s spouse); and

19 “(IV) for a subsequent year, the
20 dollar amounts specified in this sub-
21 clause (or subclause (III)) for the pre-
22 vious year increased by the annual
23 percentage increase in the consumer
24 price index (all items; U.S. city aver-

1 age) as of September of such previous
2 year.”; and

3 (E) in the last sentence, by inserting “or
4 (IV)” after “subclause (II)”.

5 (3) APPLICATION OF LIS TEST UNDER MEDI-
6 CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of
7 such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

8 (A) by striking “effective beginning with
9 January 1, 2010” and inserting “effective for
10 the period beginning with January 1, 2010, and
11 ending with December 31, 2011”; and

12 (B) by inserting before the period at the
13 end the following: “or, effective beginning with
14 January 1, 2012, whose resources (as so deter-
15 mined) do not exceed the maximum resource
16 level applied for the year under subparagraph
17 (E) of section 1860D–14(a)(3) (determined
18 without regard to the life insurance policy ex-
19 clusion provided under subparagraph (G) of
20 such section) applicable to an individual or to
21 the individual and the individual’s spouse (as
22 the case may be)”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply to eligibility determinations for

1 income-related subsidies and medicare cost-sharing fur-
2 nished for periods beginning on or after January 1, 2012.

3 **SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR**
4 **CERTAIN NON-INSTITUTIONALIZED FULL-**
5 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

6 (a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of
7 the Social Security Act (42 U.S.C. 1395w–
8 114(a)(1)(D)(i)) is amended—

9 (1) by striking “INSTITUTIONALIZED INDIVID-
10 UALS.—In” and inserting “ELIMINATION OF COST-
11 SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGI-
12 BLE INDIVIDUALS.—

13 “(I) INSTITUTIONALIZED INDI-
14 VIDUALS.—In”; and

15 (2) by adding at the end the following new sub-
16 clause:

17 “(II) CERTAIN OTHER INDIVID-
18 UALS.—In the case of an individual
19 who is a full-benefit dual eligible indi-
20 vidual and with respect to whom there
21 has been a determination that but for
22 the provision of home and community
23 based care (whether under section
24 1915, 1932, or under a waiver under
25 section 1115) the individual would re-

1 quire the level of care provided in a
2 hospital or a nursing facility or inter-
3 mediate care facility for the mentally
4 retarded the cost of which could be re-
5 imbursed under the State plan under
6 title XIX, the elimination of any bene-
7 ficiary coinsurance described in sec-
8 tion 1860D–2(b)(2) (for all amounts
9 through the total amount of expendi-
10 tures at which benefits are available
11 under section 1860D–2(b)(4)).”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to drugs dispensed on or after
14 January 1, 2011.

15 **SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.**

16 (a) ADMINISTRATIVE VERIFICATION OF INCOME AND
17 RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-
18 GRAM.—

19 (1) IN GENERAL.—Clause (iii) of section
20 1860D–14(a)(3)(E) of the Social Security Act (42
21 U.S.C. 1395w–114(a)(3)(E)) is amended to read as
22 follows:

23 “(iii) CERTIFICATION OF INCOME AND
24 RESOURCES.—For purposes of applying
25 this section—

1 “(I) an individual shall be per-
2 mitted to apply on the basis of self-
3 certification of income and resources;
4 and

5 “(II) matters attested to in the
6 application shall be subject to appro-
7 priate methods of verification without
8 the need of the individual to provide
9 additional documentation, except in
10 extraordinary situations as determined
11 by the Commissioner.”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall apply beginning January 1,
14 2010.

15 (b) DISCLOSURES TO FACILITATE IDENTIFICATION
16 OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE
17 LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRE-
18 SCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY
19 ADMINISTRATION’S OUTREACH TO ELIGIBLE INDIVID-
20 UALS.—For provision authorizing disclosure of return in-
21 formation to facilitate identification of individuals likely
22 to be ineligible for low-income subsidies under Medicare
23 prescription drug program, see section 1801.

1 **SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIM-**
2 **BURSEMENTS FOR RETROACTIVE LOW IN-**
3 **COME SUBSIDY ENROLLMENT.**

4 (a) IN GENERAL.—In the case of a retroactive LIS
5 enrollment beneficiary who is enrolled under a prescription
6 drug plan under part D of title XVIII of the Social Secu-
7 rity Act (or an MA–PD plan under part C of such title),
8 the beneficiary (or any eligible third party) is entitled to
9 reimbursement by the plan for covered drug costs incurred
10 by the beneficiary during the retroactive coverage period
11 of the beneficiary in accordance with subsection (b) and
12 in the case of such a beneficiary described in subsection
13 (c)(4)(A)(i), such reimbursement shall be made automati-
14 cally by the plan upon receipt of appropriate notice the
15 beneficiary is eligible for assistance described in such sub-
16 section (c)(4)(A)(i) without further information required
17 to be filed with the plan by the beneficiary.

18 (b) ADMINISTRATIVE REQUIREMENTS RELATING TO
19 REIMBURSEMENTS.—

20 (1) LINE-ITEM DESCRIPTION.—Each reimburse-
21 ment made by a prescription drug plan or MA–PD
22 plan under subsection (a) shall include a line-item
23 description of the items for which the reimbursement
24 is made.

25 (2) TIMING OF REIMBURSEMENTS.—A prescrip-
26 tion drug plan or MA–PD plan must make a reim-

1 bursement under subsection (a) to a retroactive LIS
2 enrollment beneficiary, with respect to a claim, not
3 later than 45 days after—

4 (A) in the case of a beneficiary described
5 in subsection (c)(4)(A)(i), the date on which the
6 plan receives notice from the Secretary that the
7 beneficiary is eligible for assistance described in
8 such subsection; or

9 (B) in the case of a beneficiary described
10 in subsection (c)(4)(A)(ii), the date on which
11 the beneficiary files the claim with the plan.

12 (3) REPORTING REQUIREMENT.—For each
13 month beginning with January 2011, each prescrip-
14 tion drug plan and each MA–PD plan shall report
15 to the Secretary the following:

16 (A) The number of claims the plan has re-
17 adjudicated during the month due to a bene-
18 ficiary becoming retroactively eligible for sub-
19 sidies available under section 1860D–14 of the
20 Social Security Act.

21 (B) The total value of the readjudicated
22 claim amount for the month.

23 (C) The Medicare Health Insurance Claims
24 Number of beneficiaries for whom claims were
25 readjudicated.

1 (D) For the claims described in subpara-
2 graphs (A) and (B), an attestation to the Ad-
3 ministrator of the Centers for Medicare & Med-
4 icaid Services of the total amount of reimburse-
5 ment the plan has provided to beneficiaries for
6 premiums and cost-sharing that the beneficiary
7 overpaid for which the plan received payment
8 from the Centers for Medicare & Medicaid Serv-
9 ices.

10 (c) DEFINITIONS.—For purposes of this section:

11 (1) COVERED DRUG COSTS.—The term “cov-
12 ered drug costs” means, with respect to a retroactive
13 LIS enrollment beneficiary enrolled under a pre-
14 scription drug plan under part D of title XVIII of
15 the Social Security Act (or an MA–PD plan under
16 part C of such title), the amount by which—

17 (A) the costs incurred by such beneficiary
18 during the retroactive coverage period of the
19 beneficiary for covered part D drugs, premiums,
20 and cost-sharing under such title; exceeds

21 (B) such costs that would have been in-
22 curred by such beneficiary during such period if
23 the beneficiary had been both enrolled in the
24 plan and recognized by such plan as qualified
25 during such period for the low income subsidy

1 under section 1860D–14 of the Social Security
2 Act to which the individual is entitled.

3 (2) ELIGIBLE THIRD PARTY.—The term “eligi-
4 ble third party” means, with respect to a retroactive
5 LIS enrollment beneficiary, an organization or other
6 third party that is owed payment on behalf of such
7 beneficiary for covered drug costs incurred by such
8 beneficiary during the retroactive coverage period of
9 such beneficiary.

10 (3) RETROACTIVE COVERAGE PERIOD.—The
11 term “retroactive coverage period” means—

12 (A) with respect to a retroactive LIS en-
13 rollment beneficiary described in paragraph
14 (4)(A)(i), the period—

15 (i) beginning on the effective date of
16 the assistance described in such paragraph
17 for which the individual is eligible; and

18 (ii) ending on the date the plan effec-
19 tuates the status of such individual as so
20 eligible; and

21 (B) with respect to a retroactive LIS en-
22 rollment beneficiary described in paragraph
23 (4)(A)(ii), the period—

24 (i) beginning on the date the indi-
25 vidual is both entitled to benefits under

1 part A, or enrolled under part B, of title
2 XVIII of the Social Security Act and eligi-
3 ble for medical assistance under a State
4 plan under title XIX of such Act; and

5 (ii) ending on the date the plan effec-
6 tuates the status of such individual as a
7 full-benefit dual eligible individual (as de-
8 fined in section 1935(c)(6) of such Act).

9 (4) RETROACTIVE LIS ENROLLMENT BENE-
10 FICIARY.—

11 (A) IN GENERAL.—The term “retroactive
12 LIS enrollment beneficiary” means an indi-
13 vidual who—

14 (i) is enrolled in a prescription drug
15 plan under part D of title XVIII of the So-
16 cial Security Act (or an MA–PD plan
17 under part C of such title) and subse-
18 quently becomes eligible as a full-benefit
19 dual eligible individual (as defined in sec-
20 tion 1935(c)(6) of such Act), an individual
21 receiving a low-income subsidy under sec-
22 tion 1860D–14 of such Act, an individual
23 receiving assistance under the Medicare
24 Savings Program implemented under
25 clauses (i), (iii), and (iv) of section

1 1902(a)(10)(E) of such Act, or an indi-
2 vidual receiving assistance under the sup-
3 plemental security income program under
4 section 1611 of such Act; or

5 (ii) subject to subparagraph (B)(i), is
6 a full-benefit dual eligible individual (as
7 defined in section 1935(c)(6) of such Act)
8 who is automatically enrolled in such a
9 plan under section 1860D-1(b)(1)(C) of
10 such Act.

11 (B) EXCEPTION FOR BENEFICIARIES EN-
12 ROLLED IN RFP PLAN.—

13 (i) IN GENERAL.—In no case shall an
14 individual described in subparagraph
15 (A)(ii) include an individual who is en-
16 rolled, pursuant to a RFP contract de-
17 scribed in clause (ii), in a prescription
18 drug plan offered by the sponsor of such
19 plan awarded such contract.

20 (ii) RFP CONTRACT DESCRIBED.—
21 The RFP contract described in this section
22 is a contract entered into between the Sec-
23 retary and a sponsor of a prescription drug
24 plan pursuant to the Centers for Medicare
25 & Medicaid Services' request for proposals

1 issued on February 17, 2009, relating to
2 Medicare part D retroactive coverage for
3 certain low income beneficiaries, or a simi-
4 lar subsequent request for proposals.

5 **SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

6 (a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the
7 Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is
8 amended by adding after “PDP region” the following: “or
9 through use of an intelligent assignment process that is
10 designed to maximize the access of such individual to nec-
11 essary prescription drugs while minimizing costs to such
12 individual and to the program under this part to the great-
13 est extent possible. In the case the Secretary enrolls such
14 individuals through use of an intelligent assignment proc-
15 ess, such process shall take into account the extent to
16 which prescription drugs necessary for the individual are
17 covered in the case of a PDP sponsor of a prescription
18 drug plan that uses a formulary, the use of prior author-
19 ization or other restrictions on access to coverage of such
20 prescription drugs by such a sponsor, and the overall qual-
21 ity of a prescription drug plan as measured by quality rat-
22 ings established by the Secretary”

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall take effect for contract years begin-
25 ning with 2012.

1 **SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC**
2 **ENROLLMENT PROCESS FOR CERTAIN SUB-**
3 **SIDY ELIGIBLE INDIVIDUALS.**

4 (a) SPECIAL ENROLLMENT PERIOD.—Section
5 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C.
6 1395w–101(b)(3)(D)) is amended to read as follows:

7 “(D) SUBSIDY ELIGIBLE INDIVIDUALS.—
8 In the case of an individual (as determined by
9 the Secretary) who is determined under sub-
10 paragraph (B) of section 1860D–14(a)(3) to be
11 a subsidy eligible individual.”.

12 (b) AUTOMATIC ENROLLMENT.—Section 1860D–
13 1(b)(1) of the Social Security Act (42 U.S.C. 1395w–
14 101(b)(1)) is amended by adding at the end the following
15 new subparagraph:

16 “(D) SPECIAL RULE FOR SUBSIDY ELIGI-
17 BLE INDIVIDUALS.—The process established
18 under subparagraph (A) shall include, in the
19 case of an individual described in section
20 1860D–1(b)(3)(D) who fails to enroll in a pre-
21 scription drug plan or an MA–PD plan during
22 the special enrollment established under such
23 section applicable to such individual, the appli-
24 cation of the assignment process described in
25 subparagraph (C) to such individual in the
26 same manner as such assignment process ap-

1 plies to a part D eligible individual described in
2 such subparagraph (C). Nothing in the previous
3 sentence shall prevent an individual described in
4 such sentence from declining enrollment in a
5 plan determined appropriate by the Secretary
6 (or in the program under this part) or from
7 changing such enrollment.”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to subsidy determinations made
10 for months beginning with January 2011.

11 **SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO RE-**
12 **BATE AND QUALITY BONUS PAYMENTS IN**
13 **CALCULATION OF LOW INCOME SUBSIDY**
14 **BENCHMARK.**

15 (a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii)
16 of the Social Security Act (42 U.S.C. 1395w–
17 114(b)(2)(B)(iii)) is amended by inserting before the pe-
18 riod the following: “before the application of the monthly
19 rebate computed under section 1854(b)(1)(C)(i) for that
20 plan and year involved and, in the case of a qualifying
21 plan in a qualifying county, before the application of the
22 increase under section 1853(o) for that plan and year in-
23 volved”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to subsidy determinations made
3 for months beginning with January 2011.

4 **Subtitle B—Reducing Health**
5 **Disparities**

6 **SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN**
7 **MEDICARE.**

8 (a) ENSURING EFFECTIVE COMMUNICATION BY THE
9 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

10 (1) STUDY ON MEDICARE PAYMENTS FOR LAN-
11 GUAGE SERVICES.—The Secretary of Health and
12 Human Services shall conduct a study that examines
13 the extent to which Medicare service providers uti-
14 lize, offer, or make available language services for
15 beneficiaries who are limited English proficient and
16 ways that Medicare should develop payment systems
17 for language services.

18 (2) ANALYSES.—The study shall include an
19 analysis of each of the following:

20 (A) How to develop and structure appro-
21 priate payment systems for language services
22 for all Medicare service providers.

23 (B) The feasibility of adopting a payment
24 methodology for on-site interpreters, including
25 interpreters who work as independent contrac-

1 tors and interpreters who work for agencies
2 that provide on-site interpretation, pursuant to
3 which such interpreters could directly bill Medi-
4 care for services provided in support of physi-
5 cian office services for an LEP Medicare pa-
6 tient.

7 (C) The feasibility of Medicare contracting
8 directly with agencies that provide off-site inter-
9 pretation including telephonic and video inter-
10 pretation pursuant to which such contractors
11 could directly bill Medicare for the services pro-
12 vided in support of physician office services for
13 an LEP Medicare patient.

14 (D) The feasibility of modifying the exist-
15 ing Medicare resource-based relative value scale
16 (RBRVS) by using adjustments (such as multi-
17 pliers or add-ons) when a patient is LEP.

18 (E) How each of options described in a
19 previous paragraph would be funded and how
20 such funding would affect physician payments,
21 a physician's practice, and beneficiary cost-
22 sharing.

23 (F) The extent to which providers under
24 parts A and B of title XVIII of the Social Secu-
25 rity Act, MA organizations offering Medicare

1 Advantage plans under part C of such title and
2 PDP sponsors of a prescription drug plan
3 under part D of such title utilize, offer, or make
4 available language services for beneficiaries with
5 limited English proficiency.

6 (G) The nature and type of language serv-
7 ices provided by States under title XIX of the
8 Social Security Act and the extent to which
9 such services could be utilized by beneficiaries
10 and providers under title XVIII of such Act.

11 (H) The extent to which interpreters and
12 translators providing services to Medicare bene-
13 ficiaries under title XVIII of such Act are
14 trained or accredited.

15 (3) VARIATION IN PAYMENT SYSTEM DE-
16 SCRIBED.—The payment systems described in para-
17 graph (2)(A) may allow variations based upon types
18 of service providers, available delivery methods, and
19 costs for providing language services including such
20 factors as—

21 (A) the type of language services provided
22 (such as provision of health care or health care
23 related services directly in a non-English lan-
24 guage by a bilingual provider or use of an inter-
25 preter);

1 (B) type of interpretation services provided
2 (such as in-person, telephonic, video interpreta-
3 tion);

4 (C) the methods and costs of providing
5 language services (including the costs of pro-
6 viding language services with internal staff or
7 through contract with external independent con-
8 tractors or agencies, or both);

9 (D) providing services for languages not
10 frequently encountered in the United States;
11 and

12 (E) providing services in rural areas.

13 (4) REPORT.—The Secretary shall submit a re-
14 port on the study conducted under subsection (a) to
15 appropriate committees of Congress not later than
16 12 months after the date of the enactment of this
17 Act.

18 (5) EXEMPTION FROM PAPERWORK REDUCTION
19 ACT.—Chapter 35 of title 44, United States Code
20 (commonly known as the “Paperwork Reduction
21 Act”), shall not apply for purposes of carrying out
22 this subsection.

23 (6) AUTHORIZATION OF APPROPRIATIONS.—
24 The Secretary shall provide for the transfer, from
25 the Federal Supplementary Medical Insurance Trust

1 Fund under section 1841 of the Social Security Act
2 (42 U.S.C. 1395t) of \$2,000,000 for purposes of
3 carrying out this subsection.

4 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-
5 cial Security Act (42 U.S.C. 1395w–27(g)(1)) is amend-
6 ed—

7 (1) by striking “or” at the end of subparagraph
8 (F);

9 (2) by adding “or” at the end of subparagraph
10 (G); and

11 (3) by inserting after subparagraph (G) the fol-
12 lowing new subparagraph:

13 “(H) fails substantially to provide lan-
14 guage services to limited English proficient
15 beneficiaries enrolled in the plan that are re-
16 quired under law;”.

17 **SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR**
18 **MEDICARE BENEFICIARIES WITH LIMITED**
19 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
20 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
21 **TICALLY APPROPRIATE SERVICES.**

22 (a) IN GENERAL.—Not later than 6 months after the
23 date of the completion of the study described in section
24 1221(a) of this Act, the Secretary, acting through the
25 Centers for Medicare & Medicaid Services and the Center

1 for Medicare and Medicaid Innovation established under
2 section 1115A of the Social Security Act (as added by sec-
3 tion 1907) and consistent with the applicable provisions
4 of such section, shall carry out a demonstration program
5 under which the Secretary shall award not fewer than 24
6 3-year grants to eligible Medicare service providers (as de-
7 scribed in subsection (b)(1)) to improve effective commu-
8 nication between such providers and Medicare bene-
9 ficiaries who are living in communities where racial and
10 ethnic minorities, including populations that face language
11 barriers, are underserved with respect to such services. In
12 designing and carrying out the demonstration the Sec-
13 retary shall take into consideration the results of the study
14 conducted under section 1221(a) of this Act and adjust,
15 as appropriate, the distribution of grants so as to better
16 target Medicare beneficiaries who are in the greatest need
17 of language services. The Secretary shall not authorize a
18 grant larger than \$500,000 over three years for any grant-
19 ee.

20 (b) ELIGIBILITY; PRIORITY.—

21 (1) ELIGIBILITY.—To be eligible to receive a
22 grant under subsection (a) an entity shall—

23 (A) be—

24 (i) a provider of services under part A
25 of title XVIII of the Social Security Act;

1 (ii) a service provider under part B of
2 such title;

3 (iii) a part C organization offering a
4 Medicare part C plan under part C of such
5 title; or

6 (iv) a PDP sponsor of a prescription
7 drug plan under part D of such title; and

8 (B) prepare and submit to the Secretary
9 an application, at such time, in such manner,
10 and accompanied by such additional informa-
11 tion as the Secretary may require.

12 (2) PRIORITY.—

13 (A) DISTRIBUTION.—To the extent fea-
14 sible, in awarding grants under this section, the
15 Secretary shall award—

16 (i) at least 6 grants to providers of
17 services described in paragraph (1)(A)(i);

18 (ii) at least 6 grants to service pro-
19 viders described in paragraph (1)(A)(ii);

20 (iii) at least 6 grants to organizations
21 described in paragraph (1)(A)(iii); and

22 (iv) at least 6 grants to sponsors de-
23 scribed in paragraph (1)(A)(iv).

24 (B) FOR COMMUNITY ORGANIZATIONS.—

25 The Secretary shall give priority to applicants

1 that have developed partnerships with commu-
2 nity organizations or with agencies with experi-
3 ence in language access.

4 (C) VARIATION IN GRANTEES.—The Sec-
5 retary shall also ensure that the grantees under
6 this section represent, among other factors—

7 (i) different types of language services
8 provided and of service providers and orga-
9 nizations under parts A through D of title
10 XVIII of the Social Security Act;

11 (ii) variations in languages needed
12 and their frequency of use;

13 (iii) urban and rural settings;

14 (iv) at least two geographic regions,
15 as defined by the Secretary; and

16 (v) at least two large metropolitan
17 statistical areas with diverse populations.

18 (c) USE OF FUNDS.—

19 (1) IN GENERAL.—A grantee shall use grant
20 funds received under this section to pay for the pro-
21 vision of competent language services to Medicare
22 beneficiaries who are limited English proficient.
23 Competent interpreter services may be provided
24 through on-site interpretation, telephonic interpreta-
25 tion, or video interpretation or direct provision of

1 health care or health care related services by a bilin-
2 gual health care provider. A grantee may use bilin-
3 gual providers, staff, or contract interpreters. A
4 grantee may use grant funds to pay for competent
5 translation services. A grantee may use up to 10
6 percent of the grant funds to pay for administrative
7 costs associated with the provision of competent lan-
8 guage services and for reporting required under sub-
9 section (e).

10 (2) ORGANIZATIONS.—Grantees that are part C
11 organizations or PDP sponsors must ensure that
12 their network providers receive at least 50 percent of
13 the grant funds to pay for the provision of com-
14 petent language services to Medicare beneficiaries
15 who are limited English proficient, including physi-
16 cians and pharmacies.

17 (3) DETERMINATION OF PAYMENTS FOR LAN-
18 GUAGE SERVICES.—Payments to grantees shall be
19 calculated based on the estimated numbers of lim-
20 ited English proficient Medicare beneficiaries in a
21 grantee’s service area utilizing—

22 (A) data on the numbers of limited
23 English proficient individuals who speak
24 English less than “very well” from the most re-
25 cently available data from the Bureau of the

1 Census or other State-based study the Sec-
2 retary determines likely to yield accurate data
3 regarding the number of such individuals served
4 by the grantee; or

5 (B) the grantee's own data if the grantee
6 routinely collects data on Medicare bene-
7 ficiaries' primary language in a manner deter-
8 mined by the Secretary to yield accurate data
9 and such data shows greater numbers of limited
10 English proficient individuals than the data list-
11 ed in subparagraph (A).

12 (4) LIMITATIONS.—

13 (A) REPORTING.—Payments shall only be
14 provided under this section to grantees that re-
15 port their costs of providing language services
16 as required under subsection (e) and may be
17 modified annually at the discretion of the Sec-
18 retary. If a grantee fails to provide the reports
19 under such section for the first year of a grant,
20 the Secretary may terminate the grant and so-
21 licit applications from new grantees to partici-
22 pate in the subsequent two years of the dem-
23 onstration program.

24 (B) TYPE OF SERVICES.—

1 (i) IN GENERAL.—Subject to clause
2 (ii), payments shall be provided under this
3 section only to grantees that utilize com-
4 petent bilingual staff or competent inter-
5 preter or translation services which—

6 (I) if the grantee operates in a
7 State that has statewide health care
8 interpreter standards, meet the State
9 standards currently in effect; or

10 (II) if the grantee operates in a
11 State that does not have statewide
12 health care interpreter standards, uti-
13 lizes competent interpreters who fol-
14 low the National Council on Inter-
15 preting in Health Care’s Code of Eth-
16 ics and Standards of Practice.

17 (ii) EXEMPTIONS.—The requirements
18 of clause (i) shall not apply—

19 (I) in the case of a Medicare ben-
20 eficiary who is limited English pro-
21 ficient (who has been informed in the
22 beneficiary’s primary language of the
23 availability of free interpreter and
24 translation services) and who requests
25 the use of family, friends, or other

1 persons untrained in interpretation or
2 translation and the grantee documents
3 the request in the beneficiary's record;
4 and

5 (II) in the case of a medical
6 emergency where the delay directly as-
7 sociated with obtaining a competent
8 interpreter or translation services
9 would jeopardize the health of the pa-
10 tient.

11 Nothing in clause (ii)(II) shall be con-
12 strued to exempt emergency rooms or simi-
13 lar entities that regularly provide health
14 care services in medical emergencies from
15 having in place systems to provide com-
16 petent interpreter and translation services
17 without undue delay.

18 (d) ASSURANCES.—Grantees under this section
19 shall—

20 (1) ensure that appropriate clinical and support
21 staff receive ongoing education and training in lin-
22 guistically appropriate service delivery;

23 (2) ensure the linguistic competence of bilingual
24 providers;

1 (3) offer and provide appropriate language serv-
2 ices at no additional charge to each patient with lim-
3 ited English proficiency at all points of contact, in
4 a timely manner during all hours of operation;

5 (4) notify Medicare beneficiaries of their right
6 to receive language services in their primary lan-
7 guage;

8 (5) post signage in the languages of the com-
9 monly encountered group or groups present in the
10 service area of the organization; and

11 (6) ensure that—

12 (A) primary language data are collected
13 for recipients of language services and are con-
14 sistent with standards developed under section
15 1709(b)(3)(B)(iv) of the Public Health Service
16 Act, as added by section 2402 of this Act, to
17 the extent such standards are available upon
18 the initiation of the demonstration; and

19 (B) consistent with the privacy protections
20 provided under the regulations promulgated
21 pursuant to section 264(e) of the Health Insur-
22 ance Portability and Accountability Act of 1996
23 (42 U.S.C. 1320d–2 note), if the recipient of
24 language services is a minor or is incapacitated,

1 the primary language of the parent or legal
2 guardian is collected and utilized.

3 (e) REPORTING REQUIREMENTS.—Grantees under
4 this section shall provide the Secretary with reports at the
5 conclusion of the each year of a grant under this section.
6 Each report shall include at least the following informa-
7 tion:

8 (1) The number of Medicare beneficiaries to
9 whom language services are provided.

10 (2) The languages of those Medicare bene-
11 ficiaries.

12 (3) The types of language services provided
13 (such as provision of services directly in non-English
14 language by a bilingual health care provider or use
15 of an interpreter).

16 (4) Type of interpretation (such as in-person,
17 telephonic, or video interpretation).

18 (5) The methods of providing language services
19 (such as staff or contract with external independent
20 contractors or agencies).

21 (6) The length of time for each interpretation
22 encounter.

23 (7) The costs of providing language services
24 (which may be actual or estimated, as determined by
25 the Secretary).

1 (8) An account of the training or accreditation
2 of bilingual staff, interpreters, or translators pro-
3 viding services under this demonstration.

4 (f) NO COST SHARING.—Limited English proficient
5 Medicare beneficiaries shall not have to pay cost-sharing
6 or co-pays for language services provided through this
7 demonstration program.

8 (g) EVALUATION AND REPORT.—The Secretary shall
9 conduct an evaluation of the demonstration program
10 under this section and shall submit to the appropriate
11 committees of Congress a report not later than 1 year
12 after the completion of the program. The report shall in-
13 clude the following:

14 (1) An analysis of the patient outcomes and
15 costs of furnishing care to the limited English pro-
16 ficient Medicare beneficiaries participating in the
17 project as compared to such outcomes and costs for
18 limited English proficient Medicare beneficiaries not
19 participating.

20 (2) The effect of delivering culturally and lin-
21 guistically appropriate services on beneficiary access
22 to care, utilization of services, efficiency and cost-ef-
23 fectiveness of health care delivery, patient satisfac-
24 tion, and select health outcomes.

1 (3) The extent to which bilingual staff, inter-
2 preters, and translators providing services under
3 such demonstration were trained or accredited and
4 the nature of accreditation or training needed by
5 type of provider, service, or other category as deter-
6 mined by the Secretary to ensure the provision of
7 high-quality interpretation, translation, or other lan-
8 guage services to Medicare beneficiaries if such serv-
9 ices are expanded pursuant to subsection (c) of sec-
10 tion 1907 of this Act.

11 (4) Recommendations, if any, regarding the ex-
12 tension of such project to the entire Medicare pro-
13 gram.

14 (h) ACCREDITATION OR TRAINING FOR PROVIDERS
15 OF INTERPRETATION, TRANSLATION OR LANGUAGE
16 SERVICES IN MEDICARE.—

17 (1) IN GENERAL.—

18 (A) DESIGNATION OF STANDARDS.—If the
19 Secretary, pursuant to section 1907(c) of this
20 Act, expands the model initially developed
21 through the demonstration program under this
22 section, the Secretary shall use the results of
23 the study under section 1221 and the dem-
24 onstration under this section to designate
25 standards for training or accreditation. The

1 Secretary may designate one or more training
2 or accreditation organizations, as appropriate
3 for the nature and type of interpretation and
4 translation services provided to Medicare bene-
5 ficiaries to ensure that payments are made only
6 for approved services by trained or accredited
7 language services providers.

8 (B) ALTERNATIVES TO TRAINING OR AC-
9 CREDITATION.—If the Secretary designates one
10 or more training or accreditation organiza-
11 tions but determines that accreditation is not
12 available in all languages for which payments
13 may be initiated, the Secretary shall provide
14 payments for and accept alternatives to train-
15 ing or accreditation for certain languages, in-
16 cluding languages of lesser diffusion. The Sec-
17 retary must ensure that the alternatives to
18 training or accreditation provide, at a min-
19 imum—

20 (i) a determination that the inter-
21 preter is proficient and able to commu-
22 nicate information accurately in both
23 English and in the language for which in-
24 terpreting is needed;

1 (ii) an attestation from the interpreter
2 to comply with and adhere to the role of
3 an interpreter as defined by the National
4 Code of Ethics and National Standards of
5 Practice as published by the National
6 Council on Interpreting in Health Care;
7 and

8 (iii) an attestation to adhere to
9 HIPAA privacy and security law, as de-
10 fined in section 3009(a)(2) of the Public
11 Health Service Act, to the same extent as
12 the healthcare provider for whom inter-
13 preting is provided.

14 (C) MODIFIERS, ADD-ONS, AND OTHER
15 FORMS OF PAYMENT.—If the Secretary decides
16 that modifiers, add-ons, or other forms of pay-
17 ment may be made for the provision of services
18 directly by bilingual providers, the Secretary
19 shall designate standards to ensure the com-
20 petency of such providers delivering such serv-
21 ices in a non-English language.

22 (2) CONSULTATION WITH STAKEHOLDERS AND
23 CONSIDERATIONS FOR ACCREDITATION OR TRAIN-
24 ING.—

1 (A) CONSULTATION.—In designating ac-
2 creditation or training requirements under this
3 subsection, the Secretary shall consult with pa-
4 tients, providers, organizations that advocate on
5 behalf of limited English proficient individuals,
6 and other individuals or entities determined ap-
7 propriate by the Secretary.

8 (B) CONSIDERATIONS.—In designating ac-
9 creditation or training requirements under this
10 section, the Secretary shall consider, as appro-
11 priate—

12 (i) standards for qualifications of
13 health care interpreters who interpret in-
14 frequently encountered languages;

15 (ii) standards for qualifications of
16 health care interpreters who interpret in
17 languages of lesser diffusion;

18 (iii) standards for training of inter-
19 preters; and

20 (iv) standards for continuing edu-
21 cation of interpreters.

22 (i) GENERAL PROVISIONS.—Nothing in this section
23 shall be construed to limit otherwise existing obligations
24 of recipients of Federal financial assistance under title VI

1 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et
2 seq.) or any other statute.

3 (j) APPROPRIATIONS.—There are appropriated to
4 carry out this section, in equal parts from the Federal
5 Hospital Insurance Trust Fund and the Federal Supple-
6 mentary Medical Insurance Trust Fund, \$16,000,000 for
7 each fiscal year of the demonstration program.

8 **SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**
9 **SERVICES.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services shall enter into an arrangement with the
12 Institute of Medicine under which the Institute will pre-
13 pare and publish, not later than 3 years after the date
14 of the enactment of this Act, a report on the impact of
15 language access services on the health and health care of
16 limited English proficient populations.

17 (b) CONTENTS.—Such report shall include—

18 (1) recommendations on the development and
19 implementation of policies and practices by health
20 care organizations and providers for limited English
21 proficient patient populations;

22 (2) a description of the effect of providing lan-
23 guage access services on quality of health care and
24 access to care and reduced medical error; and

1 (3) a description of the costs associated with or
2 savings related to provision of language access serv-
3 ices.

4 **SEC. 1224. DEFINITIONS.**

5 In this subtitle:

6 (1) **BILINGUAL.**—The term “bilingual” with re-
7 spect to an individual means a person who has suffi-
8 cient degree of proficiency in two languages and can
9 ensure effective communication can occur in both
10 languages.

11 (2) **COMPETENT INTERPRETER SERVICES.**—The
12 term “competent interpreter services” means a
13 trans-language rendition of a spoken message in
14 which the interpreter comprehends the source lan-
15 guage and can speak comprehensively in the target
16 language to convey the meaning intended in the
17 source language. The interpreter knows health and
18 health-related terminology and provides accurate in-
19 terpretations by choosing equivalent expressions that
20 convey the best matching and meaning to the source
21 language and captures, to the greatest possible ex-
22 tent, all nuances intended in the source message.

23 (3) **COMPETENT TRANSLATION SERVICES.**—The
24 term “competent translation services” means a
25 trans-language rendition of a written document in

1 which the translator comprehends the source lan-
2 guage and can write comprehensively in the target
3 language to convey the meaning intended in the
4 source language. The translator knows health and
5 health-related terminology and provides accurate
6 translations by choosing equivalent expressions that
7 convey the best matching and meaning to the source
8 language and captures, to the greatest possible ex-
9 tent, all nuances intended in the source document.

10 (4) **EFFECTIVE COMMUNICATION.**—The term
11 “effective communication” means an exchange of in-
12 formation between the provider of health care or
13 health care-related services and the limited English
14 proficient recipient of such services that enables lim-
15 ited English proficient individuals to access, under-
16 stand, and benefit from health care or health care-
17 related services.

18 (5) **INTERPRETING/INTERPRETATION.**—The
19 terms “interpreting” and “interpretation” mean the
20 transmission of a spoken message from one language
21 into another, faithfully, accurately, and objectively.

22 (6) **HEALTH CARE SERVICES.**—The term
23 “health care services” means services that address
24 physical as well as mental health conditions in all
25 care settings.

1 (7) HEALTH CARE-RELATED SERVICES.—The
2 term “health care-related services” means human or
3 social services programs or activities that provide ac-
4 cess, referrals or links to health care.

5 (8) LANGUAGE ACCESS.—The term “language
6 access” means the provision of language services to
7 an LEP individual designed to enhance that individ-
8 ual’s access to, understanding of or benefit from
9 health care or health care-related services.

10 (9) LANGUAGE SERVICES.—The term “lan-
11 guage services” means provision of health care serv-
12 ices directly in a non-English language, interpreta-
13 tion, translation, and non-English signage.

14 (10) LIMITED ENGLISH PROFICIENT.—The
15 term “limited English proficient” or “LEP” with re-
16 spect to an individual means an individual who
17 speaks a primary language other than English and
18 who cannot speak, read, write or understand the
19 English language at a level that permits the indi-
20 vidual to effectively communicate with clinical or
21 nonclinical staff at an entity providing health care or
22 health care related services.

23 (11) MEDICARE BENEFICIARY.—The term
24 “Medicare beneficiary” means an individual entitled

1 to benefits under part A of title XVIII of the Social
2 Security Act or enrolled under part B of such title.

3 (12) MEDICARE PROGRAM.—The term “Medi-
4 care program” means the programs under parts A
5 through D of title XVIII of the Social Security Act.

6 (13) SERVICE PROVIDER.—The term “service
7 provider” includes all suppliers, providers of services,
8 or entities under contract to provide coverage, items
9 or services under any part of title XVIII of the So-
10 cial Security Act.

11 **Subtitle C—Miscellaneous** 12 **Improvements**

13 **SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS** 14 **PROCESS.**

15 Section 1833(g)(5) of the Social Security Act (42
16 U.S.C. 1395l(g)(5)), as amended by section 141 of the
17 Medicare Improvements for Patients and Providers Act of
18 2008 (Public Law 110–275), is amended by striking “De-
19 cember 31, 2009” and inserting “December 31, 2011”.

1 **SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNO-**
2 **SUPPRESSIVE DRUGS FOR KIDNEY TRANS-**
3 **PLANT PATIENTS AND OTHER RENAL DIALY-**
4 **SIS PROVISIONS.**

5 (a) PROVISION OF APPROPRIATE COVERAGE OF IM-
6 MUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PRO-
7 GRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

8 (1) CONTINUED ENTITLEMENT TO IMMUNO-
9 SUPPRESSIVE DRUGS.—

10 (A) KIDNEY TRANSPLANT RECIPIENTS.—

11 Section 226A(b)(2) of the Social Security Act
12 (42 U.S.C. 426–1(b)(2)) is amended by insert-
13 ing “(except for coverage of immunosuppressive
14 drugs under section 1861(s)(2)(J))” before “,
15 with the thirty-sixth month”.

16 (B) APPLICATION.—Section 1836 of such
17 Act (42 U.S.C. 1395o) is amended—

18 (i) by striking “Every individual who”
19 and inserting “(a) IN GENERAL.—Every
20 individual who”; and

21 (ii) by adding at the end the following
22 new subsection:

23 “(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS
24 ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE
25 DRUGS.—

1 “(1) IN GENERAL.—In the case of an individual
2 whose eligibility for benefits under this title has
3 ended on or after January 1, 2012, except for the
4 coverage of immunosuppressive drugs by reason of
5 section 226A(b)(2), the following rules shall apply:

6 “(A) The individual shall be deemed to be
7 enrolled under this part for purposes of receiv-
8 ing coverage of such drugs.

9 “(B) The individual shall be responsible
10 for providing for payment of the portion of the
11 premium under section 1839 which is not cov-
12 ered under the Medicare savings program (as
13 defined in section 1144(c)(7)) in order to re-
14 ceive such coverage.

15 “(C) The provision of such drugs shall be
16 subject to the application of—

17 “(i) the deductible under section
18 1833(b); and

19 “(ii) the coinsurance amount applica-
20 ble for such drugs (as determined under
21 this part).

22 “(D) If the individual is an inpatient of a
23 hospital or other entity, the individual is enti-
24 tled to receive coverage of such drugs under
25 this part.

1 “(2) ESTABLISHMENT OF PROCEDURES IN
2 ORDER TO IMPLEMENT COVERAGE.—The Secretary
3 shall establish procedures for—

4 “(A) identifying individuals that are enti-
5 tled to coverage of immunosuppressive drugs by
6 reason of section 226A(b)(2); and

7 “(B) distinguishing such individuals from
8 individuals that are enrolled under this part for
9 the complete package of benefits under this
10 part.”.

11 (C) TECHNICAL AMENDMENT TO CORRECT
12 DUPLICATE SUBSECTION DESIGNATION.—Sub-
13 section (c) of section 226A of such Act (42
14 U.S.C. 426–1), as added by section
15 201(a)(3)(D)(ii) of the Social Security Inde-
16 pendence and Program Improvements Act of
17 1994 (Public Law 103–296; 108 Stat. 1497), is
18 redesignated as subsection (d).

19 (2) EXTENSION OF SECONDARY PAYER RE-
20 QUIREMENTS FOR ESRD BENEFICIARIES.—Section
21 1862(b)(1)(C) of such Act (42 U.S.C.
22 1395y(b)(1)(C)) is amended by adding at the end
23 the following new sentence: “With regard to im-
24 munosuppressive drugs furnished on or after the
25 date of the enactment of the Affordable Health Care

1 for America Act, this subparagraph shall be applied
2 without regard to any time limitation.”.

3 (b) MEDICARE COVERAGE FOR ESRD PATIENTS.—

4 Section 1881 of such Act is further amended—

5 (1) in subsection (b)(14)(B)(iii), by inserting “,
6 including oral drugs that are not the oral equivalent
7 of an intravenous drug (such as oral phosphate bind-
8 ers and calcimimetics),” after “other drugs and
9 biologicals”;

10 (2) in subsection (b)(14)(E)(ii)—

11 (A) in the first sentence—

12 (i) by striking “a one-time election to
13 be excluded from the phase-in” and insert-
14 ing “an election, with respect to 2011,
15 2012, or 2013, to be excluded from the
16 phase-in (or the remainder of the phase-
17 in)”;

18 (ii) by adding before the period at the
19 end the following: “for such year and for
20 each subsequent year during the phase-in
21 described in clause (i)”;

22 (B) in the second sentence—

23 (i) by striking “January 1, 2011” and
24 inserting “the first date of such year”; and

1 (ii) by inserting “and at a time” after
2 “form and manner”; and
3 (3) in subsection (h)(4)(E), by striking “lesser”
4 and inserting “greater”.

5 **SEC. 1233. VOLUNTARY ADVANCE CARE PLANNING CON-**
6 **SULTATION.**

7 (a) IN GENERAL.—Section 1861 of the Social Secu-
8 rity Act (42 U.S.C. 1395x) is amended—

9 (1) in subsection (s)(2)—

10 (A) by striking “and” at the end of sub-
11 paragraph (DD);

12 (B) by adding “and” at the end of sub-
13 paragraph (EE); and

14 (C) by adding at the end the following new
15 subparagraph:

16 “(FF) voluntary advance care planning con-
17 sultation (as defined in subsection (hhh)(1));” and

18 (2) by adding at the end the following new sub-
19 section:

20 “Voluntary Advance Care Planning Consultation

21 “(hhh)(1) Subject to paragraphs (3) and (4), the
22 term ‘voluntary advance care planning consultation’
23 means an optional consultation between the individual and
24 a practitioner described in paragraph (2) regarding ad-

1 vance care planning. Such consultation may include the
2 following, as specified by the Secretary:

3 “(A) An explanation by the practitioner of ad-
4 vance care planning, including a review of key ques-
5 tions and considerations, advance directives (includ-
6 ing living wills and durable powers of attorney) and
7 their uses.

8 “(B) An explanation by the practitioner of the
9 role and responsibilities of a health care proxy and
10 of the continuum of end-of-life services and supports
11 available, including palliative care and hospice, and
12 benefits for such services and supports that are
13 available under this title.

14 “(C) An explanation by the practitioner of phy-
15 sician orders regarding life sustaining treatment or
16 similar orders, in States where such orders or simi-
17 lar orders exist.

18 “(2) A practitioner described in this paragraph is—

19 “(A) a physician (as defined in subsection
20 (r)(1)); and

21 “(B) another health care professional (as speci-
22 fied by the Secretary and who has the authority
23 under State law to sign orders for life sustaining
24 treatments, such as a nurse practitioner or physician
25 assistant).

1 “(3) An individual may receive the voluntary advance
2 care planning care planning consultation provided for
3 under this subsection no more than once every 5 years
4 unless there is a significant change in the health or health-
5 related condition of the individual.

6 “(4) For purposes of this section, the term ‘order re-
7 garding life sustaining treatment’ means, with respect to
8 an individual, an actionable medical order relating to the
9 treatment of that individual that effectively communicates
10 the individual’s preferences regarding life sustaining treat-
11 ment, is signed and dated by a practitioner, and is in a
12 form that permits it to be followed by health care profes-
13 sionals across the continuum of care.”.

14 (b) CONSTRUCTION.—The voluntary advance care
15 planning consultation described in section 1861(hhh) of
16 the Social Security Act, as added by subsection (a), shall
17 be completely optional. Nothing in this section shall—

18 (1) require an individual to complete an ad-
19 vance directive, an order for life sustaining treat-
20 ment, or other advance care planning document;

21 (2) require an individual to consent to restric-
22 tions on the amount, duration, or scope of medical
23 benefits an individual is entitled to receive under
24 this title; or

1 (3) encourage the promotion of suicide or as-
2 sisted suicide.

3 (c) PAYMENT.—Section 1848(j)(3) of such Act (42
4 U.S.C. 1395w-4(j)(3)) is amended by inserting “(2)(FF),”
5 after “(2)(EE),”.

6 (d) FREQUENCY LIMITATION.—Section 1862(a) of
7 such Act (42 U.S.C. 1395y(a)) is amended—

8 (1) in paragraph (1)—

9 (A) in subparagraph (N), by striking
10 “and” at the end;

11 (B) in subparagraph (O) by striking the
12 semicolon at the end and inserting “, and”; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(P) in the case of voluntary advance care
16 planning consultations (as defined in paragraph
17 (1) of section 1861(hhh)), which are performed
18 more frequently than is covered under such sec-
19 tion;”; and

20 (2) in paragraph (7), by striking “or (K)” and
21 inserting “(K), or (P)”.

22 (e) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to consultations furnished on or
24 after January 1, 2011.

1 **SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND**
2 **WAIVER OF LIMITED ENROLLMENT PENALTY**
3 **FOR TRICARE BENEFICIARIES.**

4 (a) PART B SPECIAL ENROLLMENT PERIOD.—

5 (1) IN GENERAL.—Section 1837 of the Social
6 Security Act (42 U.S.C. 1395p) is amended by add-
7 ing at the end the following new subsection:

8 “(1)(1) In the case of any individual who is a covered
9 beneficiary (as defined in section 1072(5) of title 10,
10 United States Code) at the time the individual is entitled
11 to hospital insurance benefits under part A under section
12 226(b) or section 226A and who is eligible to enroll but
13 who has elected not to enroll (or to be deemed enrolled)
14 during the individual’s initial enrollment period, there
15 shall be a special enrollment period described in paragraph
16 (2).

17 “(2) The special enrollment period described in this
18 paragraph, with respect to an individual, is the 12-month
19 period beginning on the day after the last day of the initial
20 enrollment period of the individual or, if later, the 12-
21 month period beginning with the month the individual is
22 notified of enrollment under this section.

23 “(3) In the case of an individual who enrolls during
24 the special enrollment period provided under paragraph
25 (1), the coverage period under this part shall begin on the
26 first day of the month in which the individual enrolls or,

1 at the option of the individual, on the first day of the sec-
2 ond month following the last month of the individual's ini-
3 tial enrollment period.

4 “(4) The Secretary of Defense shall establish a meth-
5 od for identifying individuals described in paragraph (1)
6 and providing notice to them of their eligibility for enroll-
7 ment during the special enrollment period described in
8 paragraph (2).”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to elections made on or
11 after the date of the enactment of this Act.

12 (b) WAIVER OF INCREASE OF PREMIUM.—

13 (1) IN GENERAL.—Section 1839(b) of the So-
14 cial Security Act (42 U.S.C. 1395r(b)) is amended
15 by striking “section 1837(i)(4)” and inserting “sub-
16 section (i)(4) or (l) of section 1837”.

17 (2) EFFECTIVE DATE.—

18 (A) IN GENERAL.—The amendment made
19 by paragraph (1) shall apply with respect to
20 elections made on or after the date of the en-
21 actment of this Act.

22 (B) REBATES FOR CERTAIN DISABLED
23 AND ESRD BENEFICIARIES.—

24 (i) IN GENERAL.—With respect to
25 premiums for months on or after January

1 2005 and before the month of the enact-
2 ment of this Act, no increase in the pre-
3 mium shall be effected for a month in the
4 case of any individual who is a covered
5 beneficiary (as defined in section 1072(5)
6 of title 10, United States Code) at the time
7 the individual is entitled to hospital insur-
8 ance benefits under part A of title XVIII
9 of the Social Security Act under section
10 226(b) or 226A of such Act, and who is el-
11 igible to enroll, but who has elected not to
12 enroll (or to be deemed enrolled), during
13 the individual's initial enrollment period,
14 and who enrolls under this part within the
15 12-month period that begins on the first
16 day of the month after the month of notifi-
17 cation of entitlement under this part.

18 (ii) CONSULTATION WITH DEPART-
19 MENT OF DEFENSE.—The Secretary of
20 Health and Human Services shall consult
21 with the Secretary of Defense in identi-
22 fying individuals described in this para-
23 graph.

24 (iii) REBATES.—The Secretary of
25 Health and Human Services shall establish

1 a method for providing rebates of premium
2 increases paid for months on or after Jan-
3 uary 1, 2005, and before the month of the
4 enactment of this Act for which a penalty
5 was applied and collected.

6 **SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX**
7 **YEAR IN CASE OF GAINS FROM SALE OF PRI-**
8 **MARY RESIDENCE IN COMPUTING PART B IN-**
9 **COME-RELATED PREMIUM.**

10 (a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of
11 the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II))
12 is amended by inserting “sale of primary residence,” after
13 “divorce of such individual.”

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply to premiums and payments for
16 years beginning with 2011.

17 **SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PA-**
18 **TIENT DECISIONS AIDS.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services , acting through the Center for Medicare
21 and Medicaid Innovation established under section 1115A
22 of the Social Security Act (as added by section 1907) and
23 consistent with the applicable provisions of such section,
24 shall establish a shared decision making demonstration
25 program (in this subsection referred to as the “program”)

1 under the Medicare program using patient decision aids
2 to meet the objective of improving the understanding by
3 Medicare beneficiaries of their medical treatment options,
4 as compared to comparable Medicare beneficiaries who do
5 not participate in a shared decision making process using
6 patient decision aids.

7 (b) SITES.—

8 (1) ENROLLMENT.—The Secretary shall enroll
9 in the program not more than 30 eligible providers
10 who have experience in implementing, and have in-
11 vested in the necessary infrastructure to implement,
12 shared decision making using patient decision aids.

13 (2) APPLICATION.—An eligible provider seeking
14 to participate in the program shall submit to the
15 Secretary an application at such time and containing
16 such information as the Secretary may require.

17 (3) PREFERENCE.—In enrolling eligible pro-
18 viders in the program, the Secretary shall give pref-
19 erence to eligible providers that—

20 (A) have documented experience in using
21 patient decision aids for the conditions identi-
22 fied by the Secretary and in using shared deci-
23 sion making;

24 (B) have the necessary information tech-
25 nology infrastructure to collect the information

1 required by the Secretary for reporting pur-
2 poses; and

3 (C) are trained in how to use patient deci-
4 sion aids and shared decision making.

5 (c) FOLLOW-UP COUNSELING VISIT.—

6 (1) IN GENERAL.—An eligible provider partici-
7 pating in the program shall routinely schedule Medi-
8 care beneficiaries for a counseling visit after the
9 viewing of such a patient decision aid to answer any
10 questions the beneficiary may have with respect to
11 the medical care of the condition involved and to as-
12 sist the beneficiary in thinking through how their
13 preferences and concerns relate to their medical
14 care.

15 (2) PAYMENT FOR FOLLOW-UP COUNSELING
16 VISIT.—The Secretary shall establish procedures for
17 making payments for such counseling visits provided
18 to Medicare beneficiaries under the program. Such
19 procedures shall provide for the establishment—

20 (A) of a code (or codes) to represent such
21 services; and

22 (B) of a single payment amount for such
23 service that includes the professional time of
24 the health care provider and a portion of the
25 reasonable costs of the infrastructure of the eli-

1 gible provider such as would be made under the
2 applicable payment systems to that provider for
3 similar covered services.

4 (d) COSTS OF AIDS.—An eligible provider partici-
5 pating in the program shall be responsible for the costs
6 of selecting, purchasing, and incorporating such patient
7 decision aids into the provider’s practice, and reporting
8 data on quality and outcome measures under the program.

9 (e) FUNDING.—The Secretary shall provide for the
10 transfer from the Federal Supplementary Medical Insur-
11 ance Trust Fund established under section 1841 of the
12 Social Security Act (42 U.S.C. 1395t) of such funds as
13 are necessary for the costs of carrying out the program.

14 (f) WAIVER AUTHORITY.—The Secretary may waive
15 such requirements of titles XI and XVIII of the Social
16 Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.)
17 as may be necessary for the purpose of carrying out the
18 program.

19 (g) REPORT.—Not later than 12 months after the
20 date of completion of the program, the Secretary shall sub-
21 mit to Congress a report on such program, together with
22 recommendations for such legislation and administrative
23 action as the Secretary determines to be appropriate. The
24 final report shall include an evaluation of the impact of
25 the use of the program on health quality, utilization of

1 health care services, and on improving the quality of life
2 of such beneficiaries.

3 (h) DEFINITIONS.—In this section:

4 (1) ELIGIBLE PROVIDER.—The term “eligible
5 provider” means the following:

6 (A) A primary care practice.

7 (B) A specialty practice.

8 (C) A multispecialty group practice.

9 (D) A hospital.

10 (E) A rural health clinic.

11 (F) A Federally qualified health center (as
12 defined in section 1861(aa)(4) of the Social Se-
13 curity Act (42 U.S.C. 1395x(aa)(4)).

14 (G) An integrated delivery system.

15 (H) A State cooperative entity that in-
16 cludes the State government and at least one
17 other health care provider which is set up for
18 the purpose of testing shared decision making
19 and patient decision aids.

20 (2) PATIENT DECISION AID.—The term “pa-
21 tient decision aid” means an educational tool (such
22 as the Internet, a video, or a pamphlet) that helps
23 patients (or, if appropriate, the family caregiver of
24 the patient) understand and communicate their be-
25 liefs and preferences related to their treatment op-

1 tions, and to decide with their health care provider
2 what treatments are best for them based on their
3 treatment options, scientific evidence, circumstances,
4 beliefs, and preferences.

5 (3) SHARED DECISION MAKING.—The term
6 “shared decision making” means a collaborative
7 process between patient and clinician that engages
8 the patient in decision making, provides patients
9 with information about trade-offs among treatment
10 options, and facilitates the incorporation of patient
11 preferences and values into the medical plan.

12 **TITLE III—PROMOTING PRI-**
13 **MARY CARE, MENTAL**
14 **HEALTH SERVICES, AND CO-**
15 **ORDINATED CARE**

16 **SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT**
17 **PROGRAM.**

18 Title XVIII of the Social Security Act is amended by
19 inserting after section 1866D, as added by section
20 1152(f), the following new section:

21 “ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

22 “SEC. 1866E. (a) ESTABLISHMENT.—

23 “(1) IN GENERAL.— The Secretary shall conduct a
24 pilot program (in this section referred to as the ‘pilot pro-
25 gram’) to test different payment incentive models, includ-
26 ing (to the extent practicable) the specific payment incen-

1 tive models described in subsection (c), designed to reduce
2 the growth of expenditures and improve health outcomes
3 in the provision of items and services under this title to
4 applicable beneficiaries (as defined in subsection (e)) by
5 qualifying accountable care organizations (as defined in
6 subsection (b)(1)) in order to—

7 “(A) promote accountability for a patient popu-
8 lation and coordinate items and services under parts
9 A and B (and may include Part D, if the Secretary
10 determines appropriate);

11 “(B) encourage investment in infrastructure
12 and redesigned care processes for high quality and
13 efficient service delivery; and

14 “(C) reward physician practices and other phy-
15 sician organizational models for the provision of high
16 quality and efficient health care services.

17 “(2) SCOPE.—The Secretary shall set specific goals
18 for the number of accountable care organizations, partici-
19 pating practitioners, and patients served in the initial tests
20 under the pilot program to ensure that the pilot program
21 is of sufficient size and scope to—

22 “(A) test the approach involved in a variety of
23 settings, including urban, rural, and underserved
24 areas; and

1 “(B) subject to subsection (g)(1), disseminate
2 such approach rapidly on a national basis.

3 To the extent that the Secretary finds a qualifying ac-
4 countable care organization model to be successful in im-
5 proving quality and reducing costs, the Secretary shall
6 seek to implement such models on as large a geographic
7 scale as practical and economical.

8 “(b) QUALIFYING ACCOUNTABLE CARE ORGANIZA-
9 TIONS (ACOs).—

10 “(1) QUALIFYING ACO DEFINED.—In this sec-
11 tion:

12 “(A) IN GENERAL.—The terms ‘qualifying
13 accountable care organization’ and ‘qualifying
14 ACO’ mean a group of physicians or other phy-
15 sician organizational model (as defined in sub-
16 paragraph (D)) that—

17 “(i) is organized at least in part for
18 the purpose of providing physicians’ serv-
19 ices; and

20 “(ii) meets such criteria as the Sec-
21 retary determines to be appropriate to par-
22 ticipate in the pilot program, including the
23 criteria specified in paragraph (2).

24 “(B) INCLUSION OF OTHER PROVIDERS OF
25 SERVICES AND SUPPLIERS.—Nothing in this

1 subsection shall be construed as preventing a
2 qualifying ACO from including a hospital or
3 any other provider of services or supplier fur-
4 nishing items or services for which payment
5 may be made under this title that is affiliated
6 with the ACO under an arrangement structured
7 so that such provider or supplier participates in
8 the pilot program and shares in any incentive
9 payments under the pilot program.

10 “(C) PHYSICIAN.—The term ‘physician’ in-
11 cludes, except as the Secretary may otherwise
12 provide, any individual who furnishes services
13 for which payment may be made as physicians’
14 services under this title.

15 “(D) OTHER PHYSICIAN ORGANIZATIONAL
16 MODEL.—The term ‘other physician organiza-
17 tion model’ means, with respect to a qualifying
18 ACO any model of organization under which
19 physicians enter into agreements with other
20 providers of services for the purposes of partici-
21 pation in the pilot program in order to provide
22 high quality and efficient health care services
23 and share in any incentive payments under such
24 program

1 “(E) OTHER SERVICES.—Nothing in this
2 paragraph shall be construed as preventing a
3 qualifying ACO from furnishing items or serv-
4 ices, for which payment may not be made under
5 this title, for purposes of achieving performance
6 goals under the pilot program.

7 “(2) QUALIFYING CRITERIA.—The following are
8 criteria described in this paragraph for an organized
9 group of physicians to be a qualifying ACO:

10 “(A) The group has a legal structure that
11 would allow the group to receive and distribute
12 incentive payments under this section.

13 “(B) The group includes a sufficient num-
14 ber of primary care physicians (regardless of
15 specialty) for the applicable beneficiaries for
16 whose care the group is accountable (as deter-
17 mined by the Secretary).

18 “(C) The group reports on quality meas-
19 ures in such form, manner, and frequency as
20 specified by the Secretary (which may be for
21 the group, for providers of services and sup-
22 pliers, or both).

23 “(D) The group reports to the Secretary
24 (in a form, manner and frequency as specified
25 by the Secretary) such data as the Secretary

1 determines appropriate to monitor and evaluate
2 the pilot program.

3 “(E) The group provides notice to applica-
4 ble beneficiaries regarding the pilot program (as
5 determined appropriate by the Secretary).

6 “(F) The group contributes to a best prac-
7 tices network or website, that shall be main-
8 tained by the Secretary for the purpose of shar-
9 ing strategies on quality improvement, care co-
10 ordination, and efficiency that the groups be-
11 lieve are effective.

12 “(G) The group utilizes patient-centered
13 processes of care, including those that empha-
14 size patient and caregiver involvement in plan-
15 ning and monitoring of ongoing care manage-
16 ment plan.

17 “(H) The group meets other criteria deter-
18 mined to be appropriate by the Secretary.

19 “(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The
20 specific payment incentive models described in this sub-
21 section are the following:

22 “(1) PERFORMANCE TARGET MODEL.—Under
23 the performance target model under this paragraph
24 (in this paragraph referred to as the ‘performance
25 target model’):

1 “(A) IN GENERAL.—A qualifying ACO
2 qualifies to receive an incentive payment if ex-
3 penditures for items and services for applicable
4 beneficiaries are less than a target spending
5 level or a target rate of growth. The incentive
6 payment shall be made only if savings are
7 greater than would result from normal variation
8 in expenditures for items and services covered
9 under parts A and B (and may include Part D,
10 if the Secretary determines appropriate).

11 “(B) COMPUTATION OF PERFORMANCE
12 TARGET.—

13 “(i) IN GENERAL.—The Secretary
14 shall establish a performance target for
15 each qualifying ACO comprised of a base
16 amount (described in clause (ii)) increased
17 to the current year by an adjustment fac-
18 tor (described in clause (iii)). Such a tar-
19 get may be established on a per capita
20 basis or adjusted for risk, as the Secretary
21 determines to be appropriate.

22 “(ii) BASE AMOUNT.—For purposes of
23 clause (i), the base amount in this sub-
24 paragraph is equal to the average total
25 payments (or allowed charges) under parts

1 A and B (and may include part D, if the
2 Secretary determines appropriate) for ap-
3 plicable beneficiaries for whom the quali-
4 fying ACO furnishes items and services in
5 a base period determined by the Secretary.
6 Such base amount may be determined on
7 a per capita basis or adjusted for risk.

8 “(iii) ADJUSTMENT FACTOR.—For
9 purposes of clause (i), the adjustment fac-
10 tor in this clause may equal an annual per
11 capita amount that reflects changes in ex-
12 penditures from the period of the base
13 amount to the current year that would rep-
14 resent an appropriate performance target
15 for applicable beneficiaries (as determined
16 by the Secretary).

17 “(iv) REBASING.—Under this model
18 the Secretary shall periodically rebase the
19 base expenditure amount described in
20 clause (ii).

21 “(C) MEETING TARGET.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), a qualifying ACO that meets or ex-
24 ceeds annual quality and performance tar-
25 gets for a year shall receive an incentive

1 payment for such year equal to a portion
2 (as determined appropriate by the Sec-
3 retary) of the amount by which payments
4 under this title for such year are estimated
5 to be below the performance target for
6 such year, as determined by the Secretary.
7 The Secretary may establish a cap on in-
8 centive payments for a year for a quali-
9 fying ACO.

10 “(ii) LIMITATION.— The Secretary
11 shall limit incentive payments to each
12 qualifying ACO under this paragraph as
13 necessary to ensure that the aggregate ex-
14 penditures with respect to applicable bene-
15 ficiaries for such ACOs under this title (in-
16 clusive of incentive payments described in
17 this subparagraph) do not exceed the
18 amount that the Secretary estimates would
19 be expended for such ACO for such bene-
20 ficiaries if the pilot program under this
21 section were not implemented.

22 “(D) REPORTING AND OTHER REQUIRE-
23 MENTS.—In carrying out such model, the Sec-
24 retary may (as the Secretary determines to be
25 appropriate) incorporate reporting require-

1 ments, incentive payments, and penalties re-
2 lated to the physician quality reporting initia-
3 tive (PQRI), electronic prescribing, electronic
4 health records, and other similar initiatives
5 under section 1848, and may use alternative
6 criteria than would otherwise apply under such
7 section for determining whether to make such
8 payments. The incentive payments described in
9 this subparagraph shall not be included in the
10 limit described in subparagraph (C)(ii) or in the
11 performance target model described in this
12 paragraph.

13 “(2) PARTIAL CAPITATION MODEL.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), a partial capitation model described
16 in this paragraph (in this paragraph referred to
17 as a ‘partial capitation model’) is a model in
18 which a qualifying ACO would be at financial
19 risk for some, but not all, of the items and serv-
20 ices covered under parts A and B (and may in-
21 clude part D, if the Secretary determines ap-
22 propriate), such as at risk for some or all physi-
23 cians’ services or all items and services under
24 part B. The Secretary may limit a partial capi-
25 tation model to ACOs that are highly integrated

1 systems of care and to ACOs capable of bearing
2 risk, as determined to be appropriate by the
3 Secretary.

4 “(B) NO ADDITIONAL PROGRAM EXPENDI-
5 TURES.—Payments to a qualifying ACO for
6 items and services under this title for applicable
7 beneficiaries for a year under the partial capita-
8 tion model shall be established in a manner that
9 does not result in spending more for such ACO
10 for such beneficiaries than would otherwise be
11 expended for such ACO for such beneficiaries
12 for such year if the pilot program were not im-
13 plemented, as estimated by the Secretary.

14 “(3) OTHER PAYMENT MODELS.—

15 “(A) IN GENERAL.—Subject to subpara-
16 graph (B), the Secretary may develop other
17 payment models that meet the goals of this
18 pilot program to improve quality and efficiency.

19 “(B) NO ADDITIONAL PROGRAM EXPENDI-
20 TURES.—Subparagraph (B) of paragraph (2)
21 shall apply to a payment model under subpara-
22 graph (A) in a similar manner as such subpara-
23 graph (B) applies to the payment model under
24 paragraph (2).

25 “(d) ANNUAL QUALITY TARGETS.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish annual quality targets that qualifying ACOs
3 must meet to receive incentive payments, operate at
4 financial risk, or otherwise participate in alternative
5 financing models under this section. The Secretary
6 shall establish a process for developing annual tar-
7 gets based on ACO reporting of multiple quality
8 measures. In selecting measures the Secretary
9 shall—

10 “(A) for years one and two of each ACOs
11 participation in the pilot program established
12 by this section, require reporting of a starter
13 set of measures focused on clinical care, care
14 coordination and patient experience of care; and

15 “(B) for each subsequent year, require re-
16 porting of a more comprehensive set of clinical
17 outcomes measures, care coordination measures
18 and patient experience of care measures.

19 “(2) MEASURE SELECTION.—To the extent fea-
20 sible, the Secretary shall select measures that reflect
21 national priorities for quality improvement and pa-
22 tient-centered care consistent with the measures de-
23 veloped under section 1192(c)(1).

24 “(e) APPLICABLE BENEFICIARIES.—

1 “(1) IN GENERAL.—In this section, the term
2 ‘applicable beneficiary’ means, with respect to a
3 qualifying ACO, an individual who—

4 “(A) is enrolled under part B and entitled
5 to benefits under part A;

6 “(B) is not enrolled in a Medicare Advan-
7 tage plan under part C or a PACE program
8 under section 1894; and

9 “(C) meets such other criteria as the Sec-
10 retary determines appropriate, which may in-
11 clude criteria relating to frequency of contact
12 with physicians in the ACO

13 “(2) FOLLOWING APPLICABLE BENE-
14 FICIARIES.—The Secretary may monitor data on ex-
15 penditures and quality of services under this title
16 after an applicable beneficiary discontinues receiving
17 services under this title through a qualifying ACO.

18 “(f) IMPLEMENTATION.—

19 “(1) STARTING DATE.—The pilot program shall
20 begin no later than January 1, 2012. An agreement
21 with a qualifying ACO under the pilot program may
22 cover a multi-year period of between 3 and 5 years.

23 “(2) WAIVER.—The Secretary may waive such
24 provisions of this title (including section 1877) and

1 title XI in the manner the Secretary determines nec-
2 essary in order implement the pilot program.

3 “(3) PERFORMANCE RESULTS REPORTS.—The
4 Secretary shall report performance results to quali-
5 fying ACOs under the pilot program at least annu-
6 ally.

7 “(4) LIMITATIONS ON REVIEW.—There shall be
8 no administrative or judicial review under section
9 1869, section 1878, or otherwise of—

10 “(A) the elements, parameters, scope, and
11 duration of the pilot program;

12 “(B) the selection of qualifying ACOs for
13 the pilot program;

14 “(C) the establishment of targets, meas-
15 urement of performance, determinations with
16 respect to whether savings have been achieved
17 and the amount of savings;

18 “(D) determinations regarding whether, to
19 whom, and in what amounts incentive payments
20 are paid; and

21 “(E) decisions about the extension of the
22 program under subsection (h), expansion of the
23 program under subsection (i) or extensions
24 under subsections (j) or (k).

1 “(5) ADMINISTRATION.—Chapter 35 of title 44,
2 United States Code shall not apply to this section.

3 “(g) EVALUATION; MONITORING.—

4 “(1) IN GENERAL.—The Secretary shall evalu-
5 ate the payment incentive model for each qualifying
6 ACO under the pilot program to assess impacts on
7 beneficiaries, providers of services, suppliers and the
8 program under this title. The Secretary shall make
9 such evaluation publicly available within 60 days of
10 the date of completion of such report.

11 “(2) MONITORING.—The Inspector General of
12 the Department of Health and Human Services shall
13 provide for monitoring of the operation of ACOs
14 under the pilot program with regard to violations of
15 section 1877 (popularly known as the ‘Stark law’).

16 “(h) EXTENSION OF PILOT AGREEMENT WITH SUC-
17 CESSFUL ORGANIZATIONS.—

18 “(1) REPORTS TO CONGRESS.—Not later than
19 2 years after the date the first agreement is entered
20 into under this section, and biennially thereafter for
21 six years, the Secretary shall submit to Congress
22 and make publicly available a report on the use of
23 ACO payment models under the pilot program. Each
24 report shall address the impact of the use of those

1 models on expenditures, access, and quality under
2 this title.

3 “(2) EXTENSION.—Subject to the report pro-
4 vided under paragraph (1), with respect to a quali-
5 fying ACO, the Secretary may extend the duration
6 of the agreement for such ACO under the pilot pro-
7 gram as the Secretary determines appropriate if—

8 “(A) the ACO receives incentive payments
9 with respect to any of the first 4 years of the
10 pilot agreement and is consistently meeting
11 quality standards or

12 “(B) the ACO is consistently exceeding
13 quality standards and is not increasing spend-
14 ing under the program.

15 “(3) TERMINATION.—The Secretary may termi-
16 nate an agreement with a qualifying ACO under the
17 pilot program if such ACO did not receive incentive
18 payments or consistently failed to meet quality
19 standards in any of the first 3 years under the pro-
20 gram.

21 “(i) EXPANSION TO ADDITIONAL ACOS.—

22 “(1) TESTING AND REFINEMENT OF PAYMENT
23 INCENTIVE MODELS.—Subject to the evaluation de-
24 scribed in subsection (g), the Secretary may enter
25 into agreements under the pilot program with addi-

1 tional qualifying ACOs to further test and refine
2 payment incentive models with respect to qualifying
3 ACOs.

4 “(2) EXPANDING USE OF SUCCESSFUL MODELS
5 TO PROGRAM IMPLEMENTATION.—

6 “(A) IN GENERAL.—Subject to subpara-
7 graph (B), the Secretary may issue regulations
8 to implement, on a permanent basis, 1 or more
9 models if, and to the extent that, such models
10 are beneficial to the program under this title, as
11 determined by the Secretary.

12 “(B) CERTIFICATION.—The Chief Actuary
13 of the Centers for Medicare & Medicaid Serv-
14 ices shall certify that 1 or more of such models
15 described in subparagraph (A) would result in
16 estimated spending that would be less than
17 what spending would otherwise be estimated to
18 be in the absence of such expansion.

19 “(j) TREATMENT OF PHYSICIAN GROUP PRACTICE
20 DEMONSTRATION.—

21 “(1) EXTENSION.—The Secretary may enter in
22 to an agreement with a qualifying ACO under the
23 demonstration under section 1866A, subject to re-
24 basing and other modifications deemed appropriate

1 by the Secretary, until the pilot program under this
2 section is operational.

3 “(2) TRANSITION.—For purposes of extension
4 of an agreement with a qualifying ACO under sub-
5 section (h)(2), the Secretary shall treat receipt of an
6 incentive payment for a year by an organization
7 under the physician group practice demonstration
8 pursuant to section 1866A as a year for which an
9 incentive payment is made under such subsection, as
10 long as such practice group practice organization
11 meets the criteria under subsection (b)(2).

12 “(k) ADDITIONAL PROVISIONS.—

13 “(1) AUTHORITY FOR SEPARATE INCENTIVE
14 ARRANGEMENTS.—The Secretary may create sepa-
15 rate incentive arrangements (including using mul-
16 tiple years of data, varying thresholds, varying
17 shared savings amounts, and varying shared savings
18 limits) for different categories of qualifying ACOs to
19 reflect variation in average annual attributable ex-
20 penditures and other matters the Secretary deems
21 appropriate.

22 “(2) ENCOURAGEMENT OF PARTICIPATION OF
23 SMALLER ORGANIZATIONS.—In order to encourage
24 the participation of smaller accountable care organi-
25 zations under the pilot program, the Secretary may

1 limit a qualifying ACO's exposure to high cost pa-
2 tients under the program.

3 “(3) INVOLVEMENT IN PRIVATE PAYER AND
4 OTHER THIRD PARTY ARRANGEMENTS.—The Sec-
5 retary may give preference to ACOs who are partici-
6 pating in similar arrangements with other payers.

7 “(4) ANTIDISCRIMINATION LIMITATION.—The
8 Secretary shall not enter into an agreement with an
9 entity to provide health care items or services under
10 the pilot program, or with an entity to administer
11 the program, unless such entity guarantees that it
12 will not deny, limit, or condition the coverage or pro-
13 vision of benefits under the program, for individuals
14 eligible to be enrolled under such program, based on
15 any health status-related factor described in section
16 2702(a)(1) of the Public Health Service Act.

17 “(5) FUNDING.—For purposes of administering
18 and carrying out the pilot program, other than for
19 payments for items and services furnished under this
20 title and incentive payments under subsection (c)(1),
21 in addition to funds otherwise appropriated, there
22 are appropriated to the Secretary for the Center for
23 Medicare & Medicaid Services Program Management
24 Account \$25,000,000 for each of fiscal years 2010
25 through 2014 and \$20,000,000 for fiscal year 2015.

1 Amounts appropriated under this paragraph for a
2 fiscal year shall be available until expended.

3 “(6) NO DUPLICATION IN PAYMENTS TO PHYSI-
4 CIANS IN MULTIPLE PILOTS.—The Secretary shall
5 not make payments under this section to any physi-
6 cian group that is paid under section 1866F (relat-
7 ing to medical homes) or section 1866G (relating to
8 independence at home).”.

9 **SEC. 1302. MEDICAL HOME PILOT PROGRAM.**

10 (a) IN GENERAL.—Title XVIII of the Social Security
11 Act is amended by inserting after section 1866E, as in-
12 serted by section 1301, the following new section:

13 “MEDICAL HOME PILOT PROGRAM

14 “SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL
15 HOME MODELS.—

16 “(1) ESTABLISHMENT OF PILOT PROGRAM.—
17 The Secretary shall establish a medical home pilot
18 program (in this section referred to as the ‘pilot pro-
19 gram’) for the purpose of evaluating the feasibility
20 and advisability of reimbursing qualified patient-cen-
21 tered medical homes for furnishing medical home
22 services (as defined under subsection (b)(1)) to
23 beneficiaries (as defined in subsection (b)(4)) and to
24 targeted high need beneficiaries (as defined in sub-
25 section (c)(1)(C)).

1 “(2) SCOPE.—Subject to subsection (g), the
2 Secretary shall set specific goals for the number of
3 practices and communities, and the number of pa-
4 tients served, under the pilot program in the initial
5 tests to ensure that the pilot program is of sufficient
6 size and scope to—

7 “(A) test the approach involved in a vari-
8 ety of settings, including urban, rural, and un-
9 derserved areas; and

10 “(B) subject to subsection (e)(1), dissemi-
11 nate such approach rapidly on a national basis.

12 To the extent that the Secretary finds a medical
13 home model to be successful in improving quality
14 and reducing costs, the Secretary shall implement
15 such model on as large a geographic scale as prac-
16 tical and economical.

17 “(3) MODELS OF MEDICAL HOMES IN THE
18 PILOT PROGRAM.—The pilot program shall evaluate
19 each of the following medical home models:

20 “(A) INDEPENDENT PATIENT-CENTERED
21 MEDICAL HOME MODEL.—Independent patient-
22 centered medical home model under subsection
23 (c).

1 “(B) COMMUNITY-BASED MEDICAL HOME
2 MODEL.—Community-based medical home
3 model under subsection (d).

4 “(4) PARTICIPATION OF NURSE PRACTITIONERS
5 AND PHYSICIAN ASSISTANTS.—

6 “(A) Nothing in this section shall be con-
7 strued as preventing a nurse practitioner from
8 leading a patient centered medical home so long
9 as—

10 “(i) all the requirements of this sec-
11 tion are met; and

12 “(ii) the nurse practitioner is acting
13 in a manner that is consistent with State
14 law.

15 “(B) Nothing in this section shall be con-
16 strued as preventing a physician assistant from
17 participating in a patient centered medical
18 home so long as—

19 “(i) all the requirements of this sec-
20 tion are met; and

21 “(ii) the physician assistant is acting
22 in a manner that is consistent with State
23 law.

24 “(b) DEFINITIONS.—For purposes of this section:

1 “(1) PATIENT-CENTERED MEDICAL HOME
2 SERVICES.—The term ‘patient-centered medical
3 home services’ means services that—

4 “(A) provide beneficiaries with direct and
5 ongoing access to a primary care or principal
6 care physician or nurse practitioner who accepts
7 responsibility for providing first contact, contin-
8 uous and comprehensive care to such bene-
9 ficiary;

10 “(B) coordinate the care provided to a ben-
11 efiary by a team of individuals at the practice
12 level across office, provider of services, and
13 home settings led by a primary care or principal
14 care physician or nurse practitioner, as needed
15 and appropriate;

16 “(C) provide for all the patient’s health
17 care needs or take responsibility for appro-
18 priately arranging care with other qualified
19 physicians or providers for all stages of life;

20 “(D) provide continuous access to care and
21 communication with participating beneficiaries;

22 “(E) provide support for patient self-man-
23 agement, proactive and regular patient moni-
24 toring, support for family caregivers, use pa-

1 tient-centered processes, and coordination with
2 community resources;

3 “(F) integrate readily accessible, clinically
4 useful information on participating patients
5 that enables the practice to treat such patients
6 comprehensively and systematically; and

7 “(G) implement evidence-based guidelines
8 and apply such guidelines to the identified
9 needs of beneficiaries over time and with the in-
10 tensity needed by such beneficiaries.

11 “(2) PRIMARY CARE.—The term ‘primary care’
12 means health care that is provided by a physician,
13 nurse practitioner, or physician assistant who prac-
14 tices in the field of family medicine, general internal
15 medicine, geriatric medicine, or pediatric medicine.

16 “(3) PRINCIPAL CARE.—The term ‘principal
17 care’ means integrated, accessible health care that is
18 provided by a physician who is a medical specialist
19 or subspecialist that addresses the majority of the
20 personal health care needs of patients with chronic
21 conditions requiring the specialist’s or subspecialist’s
22 expertise, and for whom the specialist or sub-
23 specialist assumes care management.

1 “(4) BENEFICIARIES.—The term ‘beneficiaries’
2 means, with respect to a qualifying medical home,
3 an individual who—

4 “(A) is enrolled under part B and entitled
5 to benefits under part A;

6 “(B) is not enrolled in a Medicare Advan-
7 tage plan under part C or a PACE program
8 under section 1894; and

9 “(C) meets such other criteria as the Sec-
10 retary determines appropriate.

11 “(c) INDEPENDENT PATIENT-CENTERED MEDICAL
12 HOME MODEL.—

13 “(1) IN GENERAL.—

14 “(A) PAYMENT AUTHORITY.—Under the
15 independent patient-centered medical home
16 model under this subsection, the Secretary shall
17 make payments for medical home services fur-
18 nished by an independent patient-centered med-
19 ical home (as defined in subparagraph (B))
20 pursuant to paragraph (3) for targeted high
21 need beneficiaries (as defined in subparagraph
22 (C)).

23 “(B) INDEPENDENT PATIENT-CENTERED
24 MEDICAL HOME DEFINED.—In this section, the
25 term ‘independent patient-centered medical

1 home' means a physician-directed or nurse-
2 practitioner-directed practice that is qualified
3 under paragraph (2) as—

4 “(i) providing beneficiaries with pa-
5 tient-centered medical home services; and

6 “(ii) meets such other requirements as
7 the Secretary may specify.

8 “(C) TARGETED HIGH NEED BENEFICIARY
9 DEFINED.—For purposes of this subsection, the
10 term ‘targeted high need beneficiary’ means a
11 beneficiary who, based on a risk score as speci-
12 fied by the Secretary, is generally within the
13 upper 50th percentile of Medicare beneficiaries.

14 “(D) BENEFICIARY ELECTION TO PARTICI-
15 PATE.—The Secretary shall determine an ap-
16 propriate method of ensuring that beneficiaries
17 have agreed to participate in the pilot program.

18 “(E) IMPLEMENTATION.—The pilot pro-
19 gram under this subsection shall begin no later
20 than 12 months after the date of the enactment
21 of this section and shall operate for 5 years.

22 “(2) QUALIFICATION PROCESS FOR PATIENT-
23 CENTERED MEDICAL HOMES.—The Secretary shall
24 establish a process for practices to qualify as med-
25 ical homes.

1 “(3) PAYMENT.—

2 “(A) ESTABLISHMENT OF METHOD-
3 LOGY.—The Secretary shall establish a meth-
4 odology for the payment for medical home serv-
5 ices furnished by independent patient-centered
6 medical homes. Under such methodology, the
7 Secretary shall adjust payments to medical
8 homes based on beneficiary risk scores to en-
9 sure that higher payments are made for higher
10 risk beneficiaries.

11 “(B) PER BENEFICIARY PER MONTH PAY-
12 MENTS.—Under such payment methodology, the
13 Secretary shall pay independent patient-cen-
14 tered medical homes a monthly fee for each tar-
15 geted high need beneficiary who consents to re-
16 ceive medical home services through such med-
17 ical home.

18 “(C) PROSPECTIVE PAYMENT.—The fee
19 under subparagraph (B) shall be paid on a pro-
20 spective basis.

21 “(D) AMOUNT OF PAYMENT.—In deter-
22 mining the amount of such fee, the Secretary
23 shall consider the following:

24 “(i) The clinical work and practice ex-
25 penses involved in providing the medical

1 home services provided by the independent
2 patient-centered medical home (such as
3 providing increased access, care coordina-
4 tion, population disease management, and
5 teaching self-care skills for managing
6 chronic illnesses) for which payment is not
7 made under this title as of the date of the
8 enactment of this section.

9 “(ii) Allow for differential payments
10 based on capabilities of the independent
11 patient-centered medical home.

12 “(iii) Use appropriate risk-adjustment
13 in determining the amount of the per bene-
14 ficiary per month payment under this
15 paragraph in a manner that ensures that
16 higher payments are made for higher risk
17 beneficiaries.

18 “(4) ENCOURAGING PARTICIPATION OF VARI-
19 ETY OF PRACTICES.—The pilot program under this
20 subsection shall be designed to include the partici-
21 pation of physicians in practices with fewer than 10
22 full-time equivalent physicians, as well as physicians
23 in larger practices, particularly in underserved and
24 rural areas, as well as federally qualified health cen-
25 ters, and rural health centers.

1 “(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

2 “(1) IN GENERAL.—

3 “(A) AUTHORITY FOR PAYMENTS.—Under
4 the community-based medical home model
5 under this subsection (in this section referred to
6 as the ‘CBMH model’), the Secretary shall
7 make payments for the furnishing of medical
8 home services by a community-based medical
9 home (as defined in subparagraph (B)) pursu-
10 ant to paragraph (5)(B) for beneficiaries.

11 “(B) COMMUNITY-BASED MEDICAL HOME
12 DEFINED.—In this section, the term ‘commu-
13 nity-based medical home’ means a nonprofit
14 community-based or State-based organization or
15 a State that is certified under paragraph (2) as
16 meeting the following requirements:

17 “(i) The organization provides bene-
18 ficiaries with medical home services.

19 “(ii) The organization provides med-
20 ical home services under the supervision of
21 and in close collaboration with the primary
22 care or principal care physician, nurse
23 practitioner, or physician assistant des-
24 igned by the beneficiary as his or her
25 community-based medical home provider.

1 “(iii) The organization employs com-
2 munity health workers, including nurses or
3 other non-physician practitioners, lay
4 health workers, or other persons as deter-
5 mined appropriate by the Secretary, that
6 assist the primary or principal care physi-
7 cian, nurse practitioner, or physician as-
8 sistant in chronic care management activi-
9 ties such as teaching self-care skills for
10 managing chronic illnesses, transitional
11 care services, care plan setting, nutritional
12 counseling, medication therapy manage-
13 ment services for patients with multiple
14 chronic diseases, or help beneficiaries ac-
15 cess the health care and community-based
16 resources in their local geographic area.

17 “(iv) The organization meets such
18 other requirements as the Secretary may
19 specify.

20 “(2) QUALIFICATION PROCESS FOR COMMU-
21 NITY-BASED MEDICAL HOMES.—The Secretary shall
22 establish a process to provide for the review and
23 qualification of community-based medical homes
24 pursuant to criteria established by the Secretary.

1 “(3) DURATION.—The pilot program for com-
2 munity-based medical homes under this subsection
3 shall start no later than 2 years after the date of the
4 enactment of this section. Each demonstration site
5 under the pilot program shall operate for a period
6 of up to 5 years after the initial implementation
7 phase, without regard to the receipt of a initial im-
8 plementation funding under paragraph (6).

9 “(4) PREFERENCE.—In selecting sites for the
10 CBMH model, the Secretary shall give preference to
11 applications which seek to eliminate health dispari-
12 ties, as defined in section 3171 of the Public Health
13 Service Act and may give preference to any of the
14 following:

15 “(A) Applications that propose to coordi-
16 nate health care items and services under this
17 title for chronically ill beneficiaries who rely, for
18 primary care, on small physician or nurse prac-
19 titioner practices, federally qualified health cen-
20 ters, rural health clinics, or other settings with
21 limited resources and scope of services.

22 “(B) Applications that include other third-
23 party payors that furnish medical home services
24 for chronically ill patients covered by such
25 third-party payors.

1 “(C) Applications from States that propose
2 to use the medical home model to coordinate
3 health care services for—

4 “(i) individuals enrolled under this
5 title;

6 “(ii) individuals enrolled under title
7 XIX; and

8 “(iii) full-benefit dual eligible individ-
9 uals (as defined in section 1935(c)(6)),
10 with chronic diseases across a variety of health
11 care settings.

12 “(5) PAYMENTS.—

13 “(A) ESTABLISHMENT OF METHOD-
14 ODOLOGY.—The Secretary shall establish a meth-
15 odology for the payment for medical home serv-
16 ices furnished under the CBMH model.

17 “(B) PER BENEFICIARY PER MONTH PAY-
18 MENTS.—Under such payment methodology, the
19 Secretary shall make two separate monthly pay-
20 ments for each beneficiary who consents to re-
21 ceive medical home services through such med-
22 ical home, as follows:

23 “(i) PAYMENT TO COMMUNITY-BASED
24 ORGANIZATION.—One monthly payment to

1 a community-based or State-based organi-
2 zation or State.

3 “(ii) PAYMENT TO PRIMARY OR PRIN-
4 CIPAL CARE PRACTICE.—One monthly pay-
5 ment to the primary or principal care prac-
6 tice for such beneficiary.

7 “(C) PROSPECTIVE PAYMENT.—The pay-
8 ments under subparagraph (B) shall be paid on
9 a prospective basis.

10 “(D) AMOUNT OF PAYMENT.—In deter-
11 mining the amount of such payment under sub-
12 paragraph (B), the Secretary shall consider the
13 following:

14 “(i) The clinical work and practice ex-
15 penses involved in providing the medical
16 home services provided by the primary or
17 principal care practice (such as providing
18 increased access, care coordination, care
19 planning, population disease management,
20 and teaching self-care skills for managing
21 chronic illnesses) for which payment is not
22 made under this title as of the date of the
23 enactment of this section.

24 “(ii) Use appropriate risk-adjustment
25 in determining the amount of the per bene-

1 ficiary per month payment under this
2 paragraph.

3 “(iii) In the case of the models de-
4 scribed in subparagraphs (B) and (C) of
5 paragraph (4), the Secretary may deter-
6 mine an appropriate payment amount.

7 “(6) INITIAL IMPLEMENTATION FUNDING.—
8 The Secretary may make available initial implemen-
9 tation funding to a non-profit community based or
10 State-based organization or a State that is partici-
11 pating in the pilot program under this subsection.
12 Such organization shall provide the Secretary with a
13 detailed implementation plan that includes how such
14 funds will be used. The Secretary shall select a terri-
15 tory of the United States as one of the locations in
16 which to implement the pilot program under this
17 subsection, unless no organization in a territory is
18 able to comply with the requirements under para-
19 graph (1)(B).

20 “(e) EXPANSION OF PROGRAM.—

21 “(1) EVALUATION OF COST AND QUALITY.—
22 The Secretary shall evaluate the pilot program to
23 determine—

24 “(A) the extent to which medical homes re-
25 sult in—

- 1 “(i) improvement in the quality and
2 coordination of items and services under
3 this title, particularly with regard to the
4 care of complex patients;
- 5 “(ii) improvement in reducing health
6 disparities;
- 7 “(iii) reductions in preventable hos-
8 pitalizations;
- 9 “(iv) prevention of readmissions;
- 10 “(v) reductions in emergency room
11 visits;
- 12 “(vi) improvement in health outcomes,
13 including patient functional status where
14 applicable;
- 15 “(vii) improvement in patient satisfac-
16 tion;
- 17 “(viii) improved efficiency of care such
18 as reducing duplicative diagnostic tests and
19 laboratory tests; and
- 20 “(ix) reductions in health care ex-
21 penditures; and
- 22 “(B) the feasibility and advisability of re-
23 imbursing medical homes for medical home
24 services under this title on a permanent basis.

1 “(2) REPORT.—Not later than 60 days after
2 the date of completion of the evaluation under para-
3 graph (1), the Secretary shall submit to Congress
4 and make available to the public a report on the
5 findings of the evaluation under paragraph (1) and
6 the extent to which standards for the certification of
7 medical homes need to be periodically updated.

8 “(3) EXPANSION OF PROGRAM.—

9 “(A) IN GENERAL.—Subject to the results
10 of the evaluation under paragraph (1) and sub-
11 paragraph (B), the Secretary may issue regula-
12 tions to implement, on a permanent basis, one
13 or more models, if, and to the extent that such
14 model or models, are beneficial to the program
15 under this title, including that such implemen-
16 tation will improve quality of care, as deter-
17 mined by the Secretary.

18 “(B) CERTIFICATION REQUIREMENT.—The
19 Secretary may not issue such regulations unless
20 the Chief Actuary of the Centers for Medicare
21 & Medicaid Services certifies that the expansion
22 of the components of the pilot program de-
23 scribed in subparagraph (A) would result in es-
24 timated spending under this title that would be
25 no more than the level of spending that the

1 Secretary estimates would otherwise be spent
2 under this title in the absence of such expan-
3 sion.

4 “(C) UPDATED STANDARDS.—The Sec-
5 retary shall periodically review and update the
6 standards for qualification as an independent
7 patient centered medical home and as a com-
8 munity based medical home and shall establish
9 a process for ensuring that medical homes meet
10 such updated standards, as applicable

11 “(f) ADMINISTRATIVE PROVISIONS.—

12 “(1) NO DUPLICATION IN PAYMENTS FOR INDI-
13 VIDUALS IN MEDICAL HOMES.—During any month,
14 the Secretary may not make payments under this
15 section under more than one model or through more
16 than one medical home under any model for the fur-
17 nishing of medical home services to an individual.

18 “(2) NO EFFECT ON PAYMENT FOR MEDICAL
19 VISITS.—Payments made under this section are in
20 addition to, and have no effect on the amount of,
21 payment for medical visits made under this title

22 “(3) ADMINISTRATION.—Chapter 35 of title 44,
23 United States Code shall not apply to this section.

24 “(4) NO DUPLICATION IN PHYSICIAN PILOT
25 PARTICIPATION.—The Secretary shall not make pay-

1 ments to an independent or community based med-
2 ical home both under this section and section 1866E
3 or 1866G, unless the pilot program under this sec-
4 tion has been implemented on a permanent basis
5 under subsection (e)(3).

6 “(5) WAIVER.—The Secretary may waive such
7 provisions of this title and title XI in the manner the
8 Secretary determines necessary in order to imple-
9 ment this section.

10 “(g) FUNDING.—

11 “(1) OPERATIONAL COSTS.—For purposes of
12 administering and carrying out the pilot program
13 (including the design, implementation, technical as-
14 sistance for and evaluation of such program), in ad-
15 dition to funds otherwise available, there shall be
16 transferred from the Federal Supplementary Medical
17 Insurance Trust Fund under section 1841 to the
18 Secretary for the Centers for Medicare & Medicaid
19 Services Program Management Account \$6,000,000
20 for each of fiscal years 2010 through 2014.
21 Amounts appropriated under this paragraph for a
22 fiscal year shall be available until expended.

23 “(2) PATIENT-CENTERED MEDICAL HOME
24 SERVICES.—In addition to funds otherwise available,
25 there shall be available to the Secretary for the Cen-

1 ters for Medicare & Medicaid Services, from the
2 Federal Supplementary Medical Insurance Trust
3 Fund under section 1841—

4 “(A) \$200,000,000 for each of fiscal years
5 2010 through 2014 for payments for medical
6 home services under subsection (c)(3); and

7 “(B) \$125,000,000 for each of fiscal years
8 2012 through 2016, for payments under sub-
9 section (d)(5).

10 Amounts available under this paragraph for a fiscal
11 year shall be available until expended.

12 “(3) INITIAL IMPLEMENTATION.—In addition
13 to funds otherwise available, there shall be available
14 to the Secretary for the Centers for Medicare &
15 Medicaid Services, from the Federal Supplementary
16 Medical Insurance Trust Fund under section 1841,
17 \$2,500,000 for each of fiscal years 2010 through
18 2012, under subsection (d)(6). Amounts available
19 under this paragraph for a fiscal year shall be avail-
20 able until expended.

21 “(h) TREATMENT OF TRHCA MEDICARE MEDICAL
22 HOME DEMONSTRATION FUNDING.—

23 “(1) In addition to funds otherwise available for
24 payment of medical home services under subsection
25 (c)(3), there shall also be available the amount pro-

1 vided in subsection (g) of section 204 of division B
2 of the Tax Relief and Health Care Act of 2006 (42
3 U.S.C. 1395b–1 note), as added by section 133 of
4 the Medicare Improvements for Patients and Pro-
5 viders Act of 2008 (Public Law 110-275).

6 “(2) Notwithstanding section 1302(c) of the Af-
7 fordable Health Care for America Act, in addition to
8 funds provided in paragraph (1) and subsection
9 (g)(2)(A), the funding for medical home services
10 that would otherwise have been available if such sec-
11 tion 204 medical home demonstration had been im-
12 plemented (without regard to subsection (g) of such
13 section) shall be available to the independent pa-
14 tient-centered medical home model described in sub-
15 section (c).”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 this section shall apply to services furnished on or after
18 the date of the enactment of this Act.

19 (c) CONFORMING REPEAL.—Section 204 of division
20 B of the Tax Relief and Health Care Act of 2006 (42
21 U.S.C. 1395b–1 note), as amended by section 133(a)(2)
22 of the Medicare Improvements for Patients and Providers
23 Act of 2008 (Public Law 110–275), is repealed.

1 **SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY**
2 **CARE SERVICES.**

3 (a) IN GENERAL.—Section 1833 of the Social Secu-
4 rity Act is amended by inserting after subsection (o) the
5 following new subsection:

6 “(p) PRIMARY CARE PAYMENT INCENTIVES.—

7 “(1) IN GENERAL.—In the case of primary care
8 services (as defined in paragraph (2)) furnished on
9 or after January 1, 2011, by a primary care practi-
10 tioner (as defined in paragraph (3)) for which
11 amounts are payable under section 1848, in addition
12 to the amount otherwise paid under this part there
13 shall also be paid to the practitioner (or to an em-
14 ployer or facility in the cases described in clause (A)
15 of section 1842(b)(6)) (on a monthly or quarterly
16 basis) from the Federal Supplementary Medical In-
17 surance Trust Fund an amount equal 5 percent (or
18 10 percent if the practitioner predominately fur-
19 nishes such services in an area that is designated
20 (under section 332(a)(1)(A) of the Public Health
21 Service Act) as a primary care health professional
22 shortage area.

23 “(2) PRIMARY CARE SERVICES DEFINED.—In
24 this subsection, the term ‘primary care services’—

25 “(A) mean evaluation and management
26 services, without regard to the specialty of the

1 physician furnishing the services, that are pro-
2 cedure codes (for services covered under this
3 title) for—

4 “(i) services in the category des-
5 ignated Evaluation and Management in the
6 Health Care Common Procedure Coding
7 System (established by the Secretary under
8 section 1848(c)(5) as of December 31,
9 2009, and as subsequently modified by the
10 Secretary); and

11 “(ii) preventive services (as defined in
12 section 1861(iii) for which payment is
13 made under this section; and

14 “(B) includes services furnished by another
15 health care professional that would be described
16 in subparagraph (A) if furnished by a physi-
17 cian.

18 “(3) PRIMARY CARE PRACTITIONER DE-
19 FINED.—In this subsection, the term ‘primary care
20 practitioner’—

21 “(A) means a physician or other health
22 care practitioner (including a nurse practi-
23 tioner) who—

24 “(i) specializes in family medicine,
25 general internal medicine, general pediat-

1 rics, geriatrics, or obstetrics and gyne-
2 cology; and

3 “(ii) has allowed charges for primary
4 care services that account for at least 50
5 percent of the physician’s or practitioner’s
6 total allowed charges under section 1848,
7 as determined by the Secretary for the
8 most recent period for which data are
9 available; and

10 “(B) includes a physician assistant who is
11 under the supervision of a physician described
12 in subparagraph (A).

13 “(4) LIMITATION ON REVIEW.—There shall be
14 no administrative or judicial review under section
15 1869, section 1878, or otherwise, respecting—

16 “(A) any determination or designation
17 under this subsection;

18 “(B) the identification of services as pri-
19 mary care services under this subsection; and

20 “(C) the identification of a practitioner as
21 a primary care practitioner under this sub-
22 section.

23 “(5) COORDINATION WITH OTHER PAY-
24 MENTS.—

1 “(A) WITH OTHER PRIMARY CARE INCEN-
2 TIVES.—The provisions of this subsection shall
3 not be taken into account in applying sub-
4 sections (m) and (u) and any payment under
5 such subsections shall not be taken into account
6 in computing payments under this subsection.

7 “(B) WITH QUALITY INCENTIVES.—Pay-
8 ments under this subsection shall not be taken
9 into account in determining the amounts that
10 would otherwise be paid under this part for
11 purposes of section 1834(g)(2)(B).”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Section 1833(m) of such Act (42 U.S.C.
14 1395l(m)) is amended by redesignating paragraph
15 (4) as paragraph (5) and by inserting after para-
16 graph (3) the following new paragraph:

17 “(4) The provisions of this subsection shall not be
18 taken into account in applying subsections (m) or (u) and
19 any payment under such subsections shall not be taken
20 into account in computing payments under this sub-
21 section.”.

22 (2) Section 1848(m)(5)(B) of such Act (42
23 U.S.C. 1395w-4(m)(5)(B)) is amended by inserting
24 “, (p),” after “(m)”.

1 (3) Section 1848(o)(1)(B)(iv) of such Act (42
2 U.S.C. 1395w-4(o)(1)(B)(iv)) is amended by insert-
3 ing “primary care” before “health professional
4 shortage area”.

5 **SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CER-**
6 **TIFIED NURSE-MIDWIVES.**

7 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-
8 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended
9 by striking “(but in no event” and all that follows through
10 “performed by a physician)”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to services furnished on or after
13 January 1, 2011.

14 **SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR**
15 **PREVENTIVE SERVICES.**

16 (a) MEDICARE COVERED PREVENTIVE SERVICES DE-
17 FINED.—Section 1861 of the Social Security Act (42
18 U.S.C. 1395x), as amended by section 1233(a)(1)(B), is
19 amended by adding at the end the following new sub-
20 section:

21 “Medicare Covered Preventive Services
22 “(iii)(1) Subject to the succeeding provisions of this
23 subsection, the term ‘Medicare covered preventive services’
24 means the following:

1 “(A) Prostate cancer screening tests (as defined
2 in subsection (oo)).

3 “(B) Colorectal cancer screening tests (as de-
4 fined in subsection (pp)).

5 “(C) Diabetes outpatient self-management
6 training services (as defined in subsection (qq)).

7 “(D) Screening for glaucoma for certain indi-
8 viduals (as described in subsection (s)(2)(U)).

9 “(E) Medical nutrition therapy services for cer-
10 tain individuals (as described in subsection
11 (s)(2)(V)).

12 “(F) An initial preventive physical examination
13 (as defined in subsection (ww)).

14 “(G) Cardiovascular screening blood tests (as
15 defined in subsection (xx)(1)).

16 “(H) Diabetes screening tests (as defined in
17 subsection (yy)).

18 “(I) Ultrasound screening for abdominal aortic
19 aneurysm for certain individuals (as described in
20 subsection (s)(2)(AA)).

21 “(J) Federally approved and recommended vac-
22 cines and their administration as described in sub-
23 section (s)(10).

24 “(K) Screening mammography (as defined in
25 subsection (jj)).

1 “(L) Screening pap smear and screening pelvic
2 exam (as defined in subsection (nn)).

3 “(M) Bone mass measurement (as defined in
4 subsection (rr)).

5 “(N) Kidney disease education services (as de-
6 fined in subsection (ggg)).

7 “(O) Additional preventive services (as defined
8 in subsection (ddd)).

9 “(2) With respect to specific Medicare covered pre-
10 ventive services, the limitations and conditions described
11 in the provisions referenced in paragraph (1) with respect
12 to such services shall apply.”.

13 (b) PAYMENT AND ELIMINATION OF COST-SHAR-
14 ING.—

15 (1) IN GENERAL.—

16 (A) IN GENERAL.—Section 1833(a) of the
17 Social Security Act (42 U.S.C. 1395l(a)) is
18 amended by adding after and below paragraph
19 (9) the following:

20 “With respect to Medicare covered preventive services, in
21 any case in which the payment rate otherwise provided
22 under this part is computed as a percent of less than 100
23 percent of an actual charge, fee schedule rate, or other
24 rate, such percentage shall be increased to 100 percent.”.

1 (B) APPLICATION TO SIGMOIDOSCOPIES
2 AND COLONOSCOPIES.—Section 1834(d) of such
3 Act (42 U.S.C. 1395m(d)) is amended—

4 (i) in paragraph (2)(C), by amending
5 clause (ii) to read as follows:

6 “(ii) NO COINSURANCE.—In the case
7 of a beneficiary who receives services de-
8 scribed in clause (i), there shall be no coin-
9 surance applied.”; and

10 (ii) in paragraph (3)(C), by amending
11 clause (ii) to read as follows:

12 “(ii) NO COINSURANCE.—In the case
13 of a beneficiary who receives services de-
14 scribed in clause (i), there shall be no coin-
15 surance applied.”.

16 (2) ELIMINATION OF COINSURANCE IN OUT-
17 PATIENT HOSPITAL SETTINGS.—

18 (A) EXCLUSION FROM OPD FEE SCHED-
19 ULE.—Section 1833(t)(1)(B)(iv) of the Social
20 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
21 amended by striking “screening mammography
22 (as defined in section 1861(jj)) and diagnostic
23 mammography” and inserting “diagnostic
24 mammograms and Medicare covered preventive
25 services (as defined in section 1861(iii)(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” after the semicolon at the end;

6 (ii) in subparagraph (G), by adding
7 “and” at the end; and

8 (iii) by adding at the end the fol-
9 lowing new subparagraph:

10 “(H) with respect to additional preventive
11 services (as defined in section 1861(ddd)) fur-
12 nished by an outpatient department of a hos-
13 pital, the amount determined under paragraph
14 (1)(W);”.

15 (3) WAIVER OF APPLICATION OF DEDUCTIBLE
16 FOR ALL PREVENTIVE SERVICES.—The first sen-
17 tence of section 1833(b) of the Social Security Act
18 (42 U.S.C. 1395l(b)) is amended—

19 (A) in clause (1), by striking “items and
20 services described in section 1861(s)(10)(A)”
21 and inserting “Medicare covered preventive
22 services (as defined in section 1861(iii))”;

23 (B) by inserting “and” before “(4)”; and

24 (C) by striking clauses (5) through (8).

1 (4) APPLICATION TO PROVIDERS OF SERV-
2 ICES.—Section 1866(a)(2)(A)(ii) of such Act (42
3 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting
4 “other than for Medicare covered preventive services
5 and” after “for such items and services (”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to services furnished on or after
8 January 1, 2011.

9 (d) PREVENTIVE SERVICES.—

10 (1) REPORT TO CONGRESS ON BARRIERS TO
11 PREVENTIVE SERVICES.—Not later than 12 months
12 after the date of the enactment of this Act, the Sec-
13 retary of Health and Human Services shall report to
14 Congress on barriers, if any, facing Medicare bene-
15 ficiaries in accessing the benefit to abdominal aortic
16 aneurysm screening and other preventative services
17 through the Welcome to Medicare Physical Exam.

18 (2) ABDOMINAL AORTIC ANEURYSM SCREEN AC-
19 CESS.—The Secretary shall, to the extent practical,
20 identify and implement policies promoting proper
21 use of abdominal aortic aneurysm screening among
22 Medicare beneficiaries at risk for such aneurysms.

1 **SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL**
2 **CANCER SCREENING TESTS REGARDLESS OF**
3 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**
4 **LARY TISSUE REMOVAL.**

5 (a) **IN GENERAL.**—Section 1833 of the Social Secu-
6 rity Act (42 U.S.C. 1395l(b)), as amended by section
7 1305(b), is further amended—

8 (1) in subsection (a), in the sentence added by
9 section 1305(b)(1)(A), by inserting “(including serv-
10 ices described in the last sentence of section
11 1833(b))” after “preventive services”; and

12 (2) in subsection (b), by adding at the end the
13 following new sentence: “Clause (1) of the first sen-
14 tence of this subsection shall apply with respect to
15 a colorectal cancer screening test regardless of the
16 code that is billed for the establishment of a diag-
17 nosis as a result of the test, or for the removal of
18 tissue or other matter or other procedure that is fur-
19 nished in connection with, as a result of, and in the
20 same clinical encounter as, the screening test.”.

21 (b) **EFFECTIVE DATE.**—The amendment made by
22 subsection (a) shall apply to items and services furnished
23 on or after January 1, 2011.

1 **SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERV-**
2 **ICES FROM COVERAGE UNDER THE MEDI-**
3 **CARE SKILLED NURSING FACILITY PROSPEC-**
4 **TIVE PAYMENT SYSTEM AND CONSOLIDATED**
5 **PAYMENT.**

6 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the
7 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is
8 amended by inserting “clinical social worker services,”
9 after “qualified psychologist services,”.

10 (b) CONFORMING AMENDMENT.—Section
11 1861(hh)(2) of the Social Security Act (42 U.S.C.
12 1395x(hh)(2)) is amended by striking “and other than
13 services furnished to an inpatient of a skilled nursing facil-
14 ity which the facility is required to provide as a require-
15 ment for participation”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to items and services furnished on
18 or after October 1, 2010.

19 **SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERA-**
20 **PIST SERVICES AND MENTAL HEALTH COUN-**
21 **SELOR SERVICES.**

22 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
23 PIST SERVICES.—

24 (1) COVERAGE OF SERVICES.—Section
25 1861(s)(2) of the Social Security Act (42 U.S.C.

1 1395x(s)(2)), as amended by section 1235, is
2 amended—

3 (A) in subparagraph (EE), by striking
4 “and” at the end;

5 (B) in subparagraph (FF), by adding
6 “and” at the end; and

7 (C) by adding at the end the following new
8 subparagraph:

9 “(GG) marriage and family therapist serv-
10 ices (as defined in subsection (jjj));”.

11 (2) DEFINITION.—Section 1861 of the Social
12 Security Act (42 U.S.C. 1395x), as amended by sec-
13 tions 1233 and 1305, is amended by adding at the
14 end the following new subsection:

15 “Marriage and Family Therapist Services
16 “(jjj)(1) The term ‘marriage and family therapist
17 services’ means services performed by a marriage and
18 family therapist (as defined in paragraph (2)) for the diag-
19 nosis and treatment of mental illnesses, which the mar-
20 riage and family therapist is legally authorized to perform
21 under State law (or the State regulatory mechanism pro-
22 vided by State law) of the State in which such services
23 are performed, as would otherwise be covered if furnished
24 by a physician or as incident to a physician’s professional
25 service, but only if no facility or other provider charges

1 or is paid any amounts with respect to the furnishing of
2 such services.

3 “(2) The term ‘marriage and family therapist’ means
4 an individual who—

5 “(A) possesses a master’s or doctoral degree
6 which qualifies for licensure or certification as a
7 marriage and family therapist pursuant to State
8 law;

9 “(B) after obtaining such degree has performed
10 at least 2 years of clinical supervised experience in
11 marriage and family therapy; and

12 “(C) is licensed or certified as a marriage and
13 family therapist in the State in which marriage and
14 family therapist services are performed.”.

15 (3) PROVISION FOR PAYMENT UNDER PART
16 B.—Section 1832(a)(2)(B) of the Social Security
17 Act (42 U.S.C. 1395k(a)(2)(B)) is amended by add-
18 ing at the end the following new clause:

19 “(v) marriage and family therapist
20 services;”.

21 (4) AMOUNT OF PAYMENT.—

22 (A) IN GENERAL.—Section 1833(a)(1) of
23 the Social Security Act (42 U.S.C. 1395l(a)(1))
24 is amended—

1 (i) by striking “and” before “(W)”;

2 and

3 (ii) by inserting before the semicolon
4 at the end the following: “, and (X) with
5 respect to marriage and family therapist
6 services under section 1861(s)(2)(GG), the
7 amounts paid shall be 80 percent of the
8 lesser of the actual charge for the services
9 or 75 percent of the amount determined
10 for payment of a psychologist under clause
11 (L)”.

12 (B) DEVELOPMENT OF CRITERIA WITH RE-
13 SPECT TO CONSULTATION WITH A HEALTH
14 CARE PROFESSIONAL.—The Secretary of Health
15 and Human Services shall, taking into consider-
16 ation concerns for patient confidentiality, de-
17 velop criteria with respect to payment for mar-
18 riage and family therapist services for which
19 payment may be made directly to the marriage
20 and family therapist under part B of title
21 XVIII of the Social Security Act (42 U.S.C.
22 1395j et seq.) under which such a therapist
23 must agree to consult with a patient’s attending
24 or primary care physician or nurse practitioner
25 in accordance with such criteria.

1 (5) EXCLUSION OF MARRIAGE AND FAMILY
2 THERAPIST SERVICES FROM SKILLED NURSING FA-
3 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section
4 1888(e)(2)(A)(ii) of the Social Security Act (42
5 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section
6 1307(a), is amended by inserting “marriage and
7 family therapist services (as defined in subsection
8 (jjj)(1)),” after “clinical social worker services,”.

9 (6) COVERAGE OF MARRIAGE AND FAMILY
10 THERAPIST SERVICES PROVIDED IN RURAL HEALTH
11 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
12 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
13 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by
14 striking “or by a clinical social worker (as defined
15 in subsection (hh)(1)),” and inserting “, by a clinical
16 social worker (as defined in subsection (hh)(1)), or
17 by a marriage and family therapist (as defined in
18 subsection (jjj)(2)),”.

19 (7) INCLUSION OF MARRIAGE AND FAMILY
20 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT
21 OF CLAIMS.—Section 1842(b)(18)(C) of the Social
22 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-
23 ed by adding at the end the following new clause:

24 “(vii) A marriage and family therapist (as de-
25 fined in section 1861(jjj)(2)).”.

1 (b) COVERAGE OF MENTAL HEALTH COUNSELOR
2 SERVICES.—

3 (1) COVERAGE OF SERVICES.—Section
4 1861(s)(2) of the Social Security Act (42 U.S.C.
5 1395x(s)(2)), as previously amended, is further
6 amended—

7 (A) in subparagraph (FF), by striking
8 “and” at the end;

9 (B) in subparagraph (GG), by inserting
10 “and” at the end; and

11 (C) by adding at the end the following new
12 subparagraph:

13 “(HH) mental health counselor services (as de-
14 fined in subsection (kkk)(1));”.

15 (2) DEFINITION.—Section 1861 of the Social
16 Security Act (42 U.S.C. 1395x), as previously
17 amended, is amended by adding at the end the fol-
18 lowing new subsection:

19 “Mental Health Counselor Services

20 “(kkk)(1) The term ‘mental health counselor services’
21 means services performed by a mental health counselor (as
22 defined in paragraph (2)) for the diagnosis and treatment
23 of mental illnesses which the mental health counselor is
24 legally authorized to perform under State law (or the
25 State regulatory mechanism provided by the State law) of

1 the State in which such services are performed, as would
2 otherwise be covered if furnished by a physician or as inci-
3 dent to a physician's professional service, but only if no
4 facility or other provider charges or is paid any amounts
5 with respect to the furnishing of such services.

6 “(2) The term ‘mental health counselor’ means an
7 individual who—

8 “(A) possesses a master's or doctor's degree
9 which qualifies the individual for licensure or certifi-
10 cation for the practice of mental health counseling in
11 the State in which the services are performed;

12 “(B) after obtaining such a degree has per-
13 formed at least 2 years of supervised mental health
14 counselor practice; and

15 “(C) is licensed or certified as a mental health
16 counselor or professional counselor by the State in
17 which the services are performed.”.

18 (3) PROVISION FOR PAYMENT UNDER PART
19 B.—Section 1832(a)(2)(B) of the Social Security
20 Act (42 U.S.C. 1395k(a)(2)(B)), as amended by
21 subsection (a)(3), is further amended—

22 (A) by striking “and” at the end of clause
23 (iv);

24 (B) by adding “and” at the end of clause
25 (v); and

1 (C) by adding at the end the following new
2 clause:

3 “(vi) mental health counselor serv-
4 ices;”.

5 (4) AMOUNT OF PAYMENT.—

6 (A) IN GENERAL.—Section 1833(a)(1) of
7 the Social Security Act (42 U.S.C.
8 1395l(a)(1)), as amended by subsection (a), is
9 further amended—

10 (i) by striking “and” before “(X)”;

11 and

12 (ii) by inserting before the semicolon
13 at the end the following: “, and (Y), with
14 respect to mental health counselor services
15 under section 1861(s)(2)(HH), the
16 amounts paid shall be 80 percent of the
17 lesser of the actual charge for the services
18 or 75 percent of the amount determined
19 for payment of a psychologist under clause
20 (L)”.

21 (B) DEVELOPMENT OF CRITERIA WITH RE-
22 SPECT TO CONSULTATION WITH A PHYSICIAN.—

23 The Secretary of Health and Human Services
24 shall, taking into consideration concerns for pa-
25 tient confidentiality, develop criteria with re-

1 spect to payment for mental health counselor
2 services for which payment may be made di-
3 rectly to the mental health counselor under part
4 B of title XVIII of the Social Security Act (42
5 U.S.C. 1395j et seq.) under which such a coun-
6 selor must agree to consult with a patient’s at-
7 tending or primary care physician in accordance
8 with such criteria.

9 (5) EXCLUSION OF MENTAL HEALTH COUN-
10 SELOR SERVICES FROM SKILLED NURSING FACILITY
11 PROSPECTIVE PAYMENT SYSTEM.—Section
12 1888(e)(2)(A)(ii) of the Social Security Act (42
13 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section
14 1307(a) and subsection (a), is amended by inserting
15 “mental health counselor services (as defined in sec-
16 tion 1861(kkk)(1)),” after “marriage and family
17 therapist services (as defined in subsection
18 (jjj)(1)),”.

19 (6) COVERAGE OF MENTAL HEALTH COUN-
20 SELOR SERVICES PROVIDED IN RURAL HEALTH
21 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
22 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
23 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended
24 by subsection (a), is amended by striking “or by a
25 marriage and family therapist (as defined in sub-

1 section (jjj)(2)),” and inserting “by a marriage and
2 family therapist (as defined in subsection (jjj)(2)),
3 or a mental health counselor (as defined in sub-
4 section (kkk)(2)),”.

5 (7) INCLUSION OF MENTAL HEALTH COUN-
6 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF
7 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-
8 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended
9 by subsection (a)(7), is amended by adding at the
10 end the following new clause:

11 “(viii) A mental health counselor (as defined in
12 section 1861(kkk)(2)).”.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to items and services furnished on
15 or after January 1, 2011.

16 **SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**
17 **TAL HEALTH ADD-ON.**

18 Section 138(a)(1) of the Medicare Improvements for
19 Patients and Providers Act of 2008 (Public Law 110–275)
20 is amended by striking “December 31, 2009” and insert-
21 ing “December 31, 2011”.

22 **SEC. 1310. EXPANDING ACCESS TO VACCINES.**

23 (a) IN GENERAL.—Paragraph (10) of section
24 1861(s) of the Social Security Act (42 U.S.C. 1395w(s))
25 is amended to read as follows:

1 “(10) federally approved and recommended vac-
2 cines (as defined in subsection (III)) and their re-
3 spective administration;”.

4 (b) **FEDERALLY APPROVED AND RECOMMENDED**
5 **VACCINES DEFINED.**—Section 1861 of such Act is further
6 amended by adding at the end the following new sub-
7 section:

8 “Federally Approved and Recommended Vaccines

9 “(III) The term ‘federally approved and recommended
10 vaccine’ means a vaccine that—

11 “(1) is licensed under section 351 of the Public
12 Health Service Act, approved under the Federal
13 Food, Drug, and Cosmetic Act, or authorized for
14 emergency use under section 564 of the Federal,
15 Food, Drug, and Cosmetic Act; and

16 “(2) is recommended by the Director of the
17 Centers for Disease Control and Prevention.”.

18 (c) **CONFORMING AMENDMENTS.**—

19 (1) Section 1833 of such Act (42 U.S.C. 1395l)
20 is amended, in each of subsections (a)(1)(B),
21 (a)(2)(G), and (a)(3)(A), by striking
22 “1861(s)(10)(A)” and inserting “1861(s)(10)” each
23 place it appears.

24 (2) Section 1842(o)(1)(A)(iv) of such Act (42
25 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

1 (A) by striking “subparagraph (A) or (B)
2 of”; and

3 (B) by inserting before the period the fol-
4 lowing: “and before January 1, 2011, and influ-
5 enza vaccines furnished on or after January 1,
6 2011”.

7 (3) Section 1847A(c)(6) of such Act (42 U.S.C.
8 1395w-3a(e)(6)) is amended—

9 (A) in subparagraph (D)(i), by inserting “,
10 including a vaccine furnished on or after Janu-
11 ary 1, 2010”; and

12 (B) by the following new paragraph:

13 “(H) IMPLEMENTATION.—Chapter 35 of
14 title 44, United States Code shall not apply to
15 manufacturer provision of information pursuant
16 to section 1927(b)(3)(A)(iii) or subsection
17 (f)(2) for purposes of implementation of this
18 section.”.

19 (4) Section 1860D-2(e)(1) of such Act (42
20 U.S.C. 1395w-102(e)(1)) is amended by striking
21 “such term includes a vaccine” and all that follows
22 through “its administration) and”.

23 (5) Section 1861(ww)(2)(A) of such Act (42
24 U.S.C. 1395x(ww)(2)(A))) is amended by striking
25 “Pneumococcal, influenza, and hepatitis B vaccine

1 and administration” and inserting “federally ap-
2 proved or authorized vaccines (as defined in sub-
3 section (III)) and their respective administration”.

4 (6) Section 1927(b)(3)(A)(iii) of such Act (42
5 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the
6 matter following subclause (III), by inserting
7 “(A)(iv) (including influenza vaccines furnished on
8 or after January 1, 2011),” after “described in sub-
9 paragraph”.

10 (7) Section 1847A(f) of such Act (42 U.S.C.
11 1395w–3a(f)) is amended—

12 (A) by striking “For” and inserting “(1)
13 IN GENERAL.—For”;

14 (B) by indenting paragraph (1), as redes-
15 igned in subparagraph (A), 2 ems to the left;
16 and—

17 (C) by adding at the end the following new
18 paragraph:

19 “(2) TREATMENT OF CERTAIN MANUFACTUR-
20 ERS.—In the case of a manufacturer of a drug or
21 biological described in subparagraphs (A)(iv), (C),
22 (D), (E), or (G) of section 1842(o)(1) that does not
23 have a rebate agreement under section 1927(a), no
24 payment may be made under this part for such drug
25 or biological if such manufacturer does not submit

1 the information described in section
2 1927(b)(3)(A)(iii) in the same manner as if the
3 manufacturer had such a rebate agreement in effect.
4 Subparagraphs (C) and (D) of section 1927(b)(3)
5 shall apply to information reported pursuant to the
6 previous sentence in the same manner as such sub-
7 paragraphs apply with respect to information re-
8 ported pursuant to such section.”.”.

9 (d) EFFECTIVE DATES.—The amendments made—

10 (1) by this section (other than by subsection
11 (c)(6)) shall apply to vaccines administered on or
12 after January 1, 2011; and

13 (2) by subsection (c)(6) shall apply to calendar
14 quarters beginning on or after January 1, 2010.

15 **SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVEN-**
16 **TIVE SERVICES AT FEDERALLY QUALIFIED**
17 **HEALTH CENTERS.**

18 (a) IN GENERAL.—Section 1861(aa)(3)(A) of the So-
19 cial Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amend-
20 ed to read as follows:

21 “(A) services of the type described sub-
22 paragraphs (A) through (C) of paragraph (1)
23 and services described in section 1861(iii);
24 and”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply not later than January 1, 2011.

3 **SEC. 1312. INDEPENDENCE AT HOME DEMONSTRATION**
4 **PROGRAM.**

5 Title XVIII of the Social Security Act is amended by
6 inserting after section 1866F, as inserted by section 1302,
7 the following new section:

8 “INDEPENDENCE AT HOME MEDICAL PRACTICE
9 DEMONSTRATION PROGRAM

10 “SEC. 1866G. (a) ESTABLISHMENT.—

11 “(1) IN GENERAL.—The Secretary shall con-
12 duct a demonstration program (in this section re-
13 ferred to as the ‘demonstration program’) to test a
14 payment incentive and service delivery model that
15 utilizes physician and nurse practitioner directed
16 home-based primary care teams designed to reduce
17 expenditures and improve health outcomes in the
18 provision of items and services under this title to ap-
19 plicable beneficiaries (as defined in subsection (d)).

20 “(2) REQUIREMENT.—The demonstration pro-
21 gram shall test whether a model described in para-
22 graph (1), which is accountable for providing com-
23 prehensive, coordinated, continuous, and accessible
24 care to high-need populations at home and coordi-
25 nating health care across all treatment settings, re-
26 sults in—

1 “(A) reducing preventable hospitalizations;

2 “(B) preventing hospital readmissions;

3 “(C) reducing emergency room visits;

4 “(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic
5 illness;

6 “(E) improving the efficiency of care, such
7 as by reducing duplicative diagnostic and laboratory tests;

8 “(F) reducing the cost of health care services covered under this title; and

9 “(G) achieving beneficiary and family caregiver satisfaction.

10 “(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

11 “(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

12 “(A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal
13 entity that—

14 “(i) is comprised of an individual physician or nurse practitioner or group of
15 physicians and nurse practitioners that provides care as part of a team that includes
16 physicians, nurses, physician assist-

1 ants, pharmacists, and other health and
2 social services staff as appropriate who
3 have experience providing home-based pri-
4 mary care to applicable beneficiaries, make
5 in-home visits, and are available 24 hours
6 per day, 7 days per week to carry out
7 plans of care that are tailored to the indi-
8 vidual beneficiary's chronic conditions and
9 designed to achieve the results in sub-
10 section (a);

11 “(ii) is organized at least in part for
12 the purpose of providing physicians' serv-
13 ices;

14 “(iii) has documented experience in
15 providing home-based primary care serv-
16 ices to high cost chronically ill bene-
17 ficiaries, as determined appropriate by the
18 Secretary;

19 “(iv) includes at least 200 applicable
20 beneficiaries as defined in subsection (d);

21 “(v) has entered into an agreement
22 with the Secretary;

23 “(vi) uses electronic health informa-
24 tion systems, remote monitoring, and mo-
25 bile diagnostic technology; and

1 “(vii) meets such other criteria as the
2 Secretary determines to be appropriate to
3 participate in the demonstration program.

4 “(B) PHYSICIAN.—The term ‘physician’ in-
5 cludes, except as the Secretary may otherwise
6 provide, any individual who furnishes services
7 for which payment may be made as physicians’
8 services and has the medical training or experi-
9 ence to fulfill the physician’s role described in
10 subparagraph (A)(i).

11 “(2) PARTICIPATION OF NURSE PRACTITIONERS
12 AND PHYSICIAN ASSISTANTS.—Nothing in this sec-
13 tion shall be construed to prevent a nurse practi-
14 tioner or physician assistant from participating in,
15 or leading, a home-based primary care team as part
16 of an independence at home medical practice if—

17 “(A) all the requirements of this section
18 are met;

19 “(B) the nurse practitioner or physician
20 assistant, as the case may be, is acting con-
21 sistent with State law; and

22 “(C) the nurse practitioner or physician
23 assistant has the medical training or experience
24 to fulfill the nurse practitioner or physician as-
25 sistant role described in paragraph (1)(A)(i).

1 “(3) INCLUSION OF PROVIDERS AND PRACTI-
2 TIONERS.—Nothing in this subsection shall be con-
3 strued as preventing an independence at home med-
4 ical practice from including a provider of services or
5 a participating practitioner described in section
6 1842(b)(18)(C) that is affiliated with the practice
7 under an arrangement structured so that such pro-
8 vider of services or practitioner participates in the
9 demonstration program and shares in any savings
10 under the demonstration program.

11 “(4) QUALITY AND PERFORMANCE STAND-
12 ARDS.—

13 “(A) IN GENERAL.—An independence at
14 home medical practice participating in the dem-
15 onstration program shall report on quality
16 measures (in such form, manner, and frequency
17 as specified by the Secretary, which may be for
18 the group, for providers of services and sup-
19 pliers, or both) and report to the Secretary (in
20 a form, manner, and frequency as specified by
21 the Secretary) such data as the Secretary deter-
22 mines appropriate to monitor and evaluate the
23 demonstration program.

24 “(B) DEVELOPMENT OF QUALITY PER-
25 FORMANCE STANDARDS.—The Secretary shall

1 develop quality performance standards for inde-
2 pendence at home medical practices partici-
3 pating in the demonstration program.

4 “(c) SHARED SAVINGS PAYMENT METHODOLOGY.—

5 “(1) ESTABLISHMENT OF TARGET SPENDING
6 LEVEL.—The Secretary shall establish annual target
7 spending levels for items and services covered under
8 parts A and B furnished to applicable beneficiaries
9 by qualifying independence at home medical prac-
10 tices under this section. The Secretary may set an
11 aggregate target spending level for all qualifying
12 practices, or may set different target spending levels
13 for groups of practices or a single practice. Such
14 target spending levels may be determined on a per
15 capita basis and shall take into account normal vari-
16 ation in expenditures for items and services covered
17 under parts A and B furnished to such beneficiaries.
18 The target shall also be adjusted for the size of the
19 practice, number of practices included in the target
20 spending level, characteristics of applicable bene-
21 ficiaries and such other factors as the Secretary de-
22 termines appropriate. The Secretary may periodi-
23 cally adjust or rebase the target spending level
24 under this paragraph.

25 “(2) SHARED SAVINGS AMOUNTS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), qualifying independence at home
3 medical practices are eligible to receive an in-
4 centive payment under this section if aggregate
5 expenditures for a year for applicable bene-
6 ficiaries are less than the target spending level
7 for qualifying independence at home medical
8 practices for such year. An incentive payment
9 for such year shall be equal to a portion (as de-
10 termined by the Secretary) of the amount by
11 which total payments for applicable bene-
12 ficiaries under parts A and B for such year are
13 estimated to be less than 5 percent less than
14 the target spending level for such year, as de-
15 termined by the Secretary.

16 “(B) APPORTIONMENT OF SAVINGS.—The
17 Secretary shall designate how, and to what ex-
18 tent, an incentive payment under this section is
19 to be apportioned among qualifying independ-
20 ence at home medical practices, taking into ac-
21 count the size of the practice, characteristics of
22 the individuals enrolled in each practice, per-
23 formance on quality performance measures, and
24 such other factors as the Secretary determines
25 appropriate.

1 “(3) SAVINGS TO THE MEDICARE PROGRAM.—

2 The Secretary shall limit incentive payments to each
3 qualifying independence at home medical practice
4 under this paragraph, with respect to a year, as nec-
5 essary to ensure that the aggregate expenditures for
6 items and services under parts A and B with respect
7 to applicable beneficiaries for such independence at
8 home medical practice (inclusive of shared savings
9 payments) do not exceed the amount that the Sec-
10 retary estimates would be expended for such items
11 and services for such beneficiaries during such year
12 (taking into account normal variation in expendi-
13 tures and other factors the Secretary deems appro-
14 priate) if the demonstration program under this sec-
15 tion were not implemented, minus 5 percent.

16 “(d) APPLICABLE BENEFICIARIES.—

17 “(1) DEFINITION.—In this section, the term
18 ‘applicable beneficiary’ means, with respect to a
19 qualifying independence at home medical practice,
20 an individual who the practice has determined—

21 “(A) is entitled to benefits under part A
22 and enrolled for benefits under part B;

23 “(B) is not enrolled in a Medicare Advan-
24 tage plan under part C or a PACE program
25 under section 1894;

1 “(C) has 2 or more chronic illnesses, such
2 as congestive heart failure, diabetes, other de-
3 mentias designated by the Secretary, chronic
4 obstructive pulmonary disease, ischemic heart
5 disease, stroke, Alzheimer’s Disease and
6 neurodegenerative diseases, and other diseases
7 and conditions designated by the Secretary
8 which result in high costs under this title;

9 “(D) within the past 12 months has had a
10 nonelective hospital admission;

11 “(E) within the past 12 months has re-
12 ceived acute or subacute rehabilitation services;

13 “(F) has 2 or more functional depend-
14 encies requiring the assistance of another per-
15 son (such as bathing, dressing, toileting, walk-
16 ing, or feeding); and

17 “(G) meets such other criteria as the Sec-
18 retary determines appropriate.

19 “(2) PATIENT ELECTION TO PARTICIPATE.—
20 The Secretary shall determine an appropriate meth-
21 od of ensuring that applicable beneficiaries have
22 agreed to enroll in an independence at home medical
23 practice under the demonstration program. Enroll-
24 ment in the demonstration program shall be vol-
25 untary.

1 “(3) BENEFICIARY ACCESS TO SERVICES.—
2 Nothing in this section shall be construed as encour-
3 aging physicians or nurse practitioners to limit ap-
4 plicable beneficiary access to services covered under
5 this title and applicable beneficiaries shall not be re-
6 quired to relinquish access to any benefit under this
7 title as a condition of receiving services from an
8 independence at home medical practice.

9 “(e) IMPLEMENTATION.—

10 “(1) STARTING DATE.—The demonstration pro-
11 gram shall begin not later than January 1, 2012. An
12 agreement with an independence at home medical
13 practice under the demonstration program may
14 cover not more than a 3-year period.

15 “(2) NO PHYSICIAN DUPLICATION IN DEM-
16 ONSTRATION PARTICIPATION.—The Secretary shall
17 not pay an independence at home medical practice
18 under this section that participates in section 1866D
19 or section 1866E.

20 “(3) NO BENEFICIARY DUPLICATION IN DEM-
21 ONSTRATION PARTICIPATION.—The Secretary shall
22 ensure that no applicable beneficiary enrolled in an
23 independence at home medical practice under this
24 section is participating in the programs under sec-
25 tion 1866D or section 1866E.

1 “(4) PREFERENCE.—In approving an independ-
2 ence at home medical practice, the Secretary shall
3 give preference to practices that are—

4 “(A) located in high-cost areas of the
5 country;

6 “(B) have experience in furnishing health
7 care services to applicable beneficiaries in the
8 home; and

9 “(C) use electronic medical records, health
10 information technology, and individualized plans
11 of care.

12 “(5) NUMBER OF PRACTICES.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the Secretary shall enter into agree-
15 ments with as many independence at home me-
16 dial practices as practicable and consistent with
17 this subsection to test the potential of the inde-
18 pendence at home medical practice model under
19 this section in order to achieve the results de-
20 scribed in subsection (a) across practices serv-
21 ing varying numbers of applicable beneficiaries.

22 “(B) LIMITATION.—In selecting qualified
23 independence at home medial practices to par-
24 ticipate under the demonstration program, the
25 Secretary shall limit the number of applicable

1 beneficiaries that may participate in the dem-
2 onstration program to 10,000.

3 “(6) WAIVER.—The Secretary may waive such
4 provisions of this title and title XI as the Secretary
5 determines necessary in order to implement the dem-
6 onstration program.

7 “(7) ADMINISTRATION.—Chapter 35 of title 44,
8 United States Code, shall not apply to this section.

9 “(f) EVALUATION AND MONITORING.—

10 “(1) IN GENERAL.—The Secretary shall evalu-
11 ate each independence at home medical practice
12 under the demonstration program to assess whether
13 the practice achieved the results described in sub-
14 section (a).

15 “(2) FOLLOWING APPLICABLE BENE-
16 FICIARIES.—The Secretary may monitor data on ex-
17 penditures and quality of services under this title
18 after an applicable beneficiary discontinues receiving
19 services under this title through a qualifying inde-
20 pendence at home medical practice.

21 “(g) REPORTS TO CONGRESS.—The Secretary shall
22 conduct an independent evaluation of the demonstration
23 program and submit to Congress a final report, including
24 best practices under the demonstration program. Such re-
25 port shall include an analysis of the demonstration pro-

1 gram on coordination of care, expenditures under this
2 title, applicable beneficiary access to services, and the
3 quality of health care services provided to applicable bene-
4 ficiaries.

5 “(h) FUNDING.—For purposes of administering and
6 carrying out the demonstration program, other than for
7 payments for items and services furnished under this title
8 and shared savings under subsection (c), in addition to
9 funds otherwise appropriated, there shall be transferred
10 to the Secretary for the Center for Medicare & Medicaid
11 Services Program Management Account from the Federal
12 Hospital Insurance Trust Fund under section 1817 and
13 the Federal Supplementary Medical Insurance Trust
14 Fund under section 1841 \$5,000,000 for each of fiscal
15 years 2010 through 2015. Amounts transferred under this
16 subsection for a fiscal year shall be available until ex-
17 pended.

18 “(i) ANTIDISCRIMINATION LIMITATION.—The Sec-
19 retary shall not enter into an agreement with an entity
20 to provide health care items or services under the dem-
21 onstration program unless such entity guarantees that for
22 individuals eligible to be enrolled in such program, the en-
23 tity will not deny, limit, or condition the coverage or provi-
24 sion of benefits to which the individual would have other-

1 wise been entitled to on the basis of health status if not
2 included in this program.

3 “(j) **TERMINATION.**—The Secretary may terminate
4 an agreement with an independence at home medical prac-
5 tice if such practice does not receive incentive payments
6 under subsection (c)(2) or consistently fails to meet qual-
7 ity standards.”.

8 **SEC. 1313. RECOGNITION OF CERTIFIED DIABETES EDU-**
9 **CATORS AS CERTIFIED PROVIDERS FOR PUR-**
10 **POSES OF MEDICARE DIABETES OUTPATIENT**
11 **SELF-MANAGEMENT TRAINING SERVICES.**

12 (a) **IN GENERAL.**—Section 1861(qq) of the Social Se-
13 curity Act (42 U.S.C. 1395x(qq)) is amended—

14 (1) in paragraph (1), by inserting “or by a cer-
15 tified diabetes educator (as defined in paragraph
16 (3))” after “paragraph (2)(B)”; and

17 (2) by adding at the end the following new
18 paragraphs:

19 “(3) For purposes of paragraph (1), the term
20 ‘certified diabetes educator’ means an individual
21 who—

22 “(A) is licensed or registered by the State
23 in which the services are performed as a health
24 care professional;

1 “(B) specializes in teaching individuals
2 with diabetes to develop the necessary skills and
3 knowledge to manage the individual’s diabetic
4 condition; and

5 “(C) is certified as a diabetes educator by
6 a recognized certifying body (as defined in
7 paragraph (4)).

8 “(4)(A) For purposes of paragraph (3)(C), the
9 term ‘recognized certifying body’ means—

10 “(i) the National Certification Board for
11 Diabetes Educators, or

12 “(ii) a certifying body for diabetes edu-
13 cators, which is recognized by the Secretary as
14 authorized to grant certification of diabetes
15 educators for purposes of this subsection pursu-
16 ant to standards established by the Secretary,
17 if the Secretary determines such Board or body,
18 respectively, meets the requirement of subpara-
19 graph (B).

20 “(B) The National Certification Board for Dia-
21 betes Educators or a certifying body for diabetes
22 educators meets the requirement of this subpara-
23 graph, with respect to the certification of an indi-
24 vidual, if the Board or body, respectively, is incor-
25 porated and registered to do business in the United

1 States and requires as a condition of such certifi-
2 cation each of the following:

3 “(i) The individual has a qualifying cre-
4 dential in a specified health care profession.

5 “(ii) The individual has professional prac-
6 tice experience in diabetes self-management
7 training that includes a minimum number of
8 hours and years of experience in such training.

9 “(iii) The individual has successfully com-
10 pleted a national certification examination of-
11 fered by such entity.

12 “(iv) The individual periodically renews
13 certification status following initial certifi-
14 cation.”.

15 (b) **EFFECTIVE DATE.**—The amendments made by
16 subsection (a) shall apply to diabetes outpatient self-man-
17 agement training services furnished on or after the first
18 day of the first calendar year that is at least 6 months
19 after the date of the enactment of this Act.

20 **TITLE IV—QUALITY**
21 **Subtitle A—Comparative**
22 **Effectiveness Research**

23 **SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.**

24 (a) **IN GENERAL.**—Title XI of the Social Security Act
25 is amended by adding at the end the following new part:

1 “PART D—COMPARATIVE EFFECTIVENESS RESEARCH

2 “COMPARATIVE EFFECTIVENESS RESEARCH

3 “SEC. 1181. (a) CENTER FOR COMPARATIVE EFFEC-
4 TIVENESS RESEARCH ESTABLISHED.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish within the Agency for Healthcare Research and
7 Quality a Center for Comparative Effectiveness Re-
8 search (in this section referred to as the ‘Center’) to
9 conduct, support, and synthesize research (including
10 research conducted or supported under section 1013
11 of the Medicare Prescription Drug, Improvement,
12 and Modernization Act of 2003) with respect to the
13 outcomes, effectiveness, and appropriateness of
14 health care services and procedures in order to iden-
15 tify the manner in which diseases, disorders, and
16 other health conditions can most effectively and ap-
17 propriately be prevented, diagnosed, treated, and
18 managed clinically.

19 “(2) DUTIES.—The Center shall—

20 “(A) conduct, support, and synthesize re-
21 search relevant to the comparative effectiveness
22 of the full spectrum of health care items, serv-
23 ices and systems, including pharmaceuticals,
24 medical devices, medical and surgical proce-
25 dures, and other medical interventions;

1 “(B) conduct and support systematic re-
2 views of clinical research, including original re-
3 search conducted subsequent to the date of the
4 enactment of this section;

5 “(C) continuously develop rigorous sci-
6 entific methodologies for conducting compara-
7 tive effectiveness studies, and use such meth-
8 odologies appropriately;

9 “(D) submit to the Comparative Effective-
10 ness Research Commission, the Secretary, and
11 Congress appropriate relevant reports described
12 in subsection (d)(2);

13 “(E) not later than one year after the date
14 of the enactment of this section, enter into an
15 arrangement under which the Institute of Medi-
16 cine of the National Academy of Sciences shall
17 conduct an evaluation and report on standards
18 of evidence for highly credible research;

19 “(F) encourage, as appropriate, the devel-
20 opment and use of clinical registries and the de-
21 velopment of clinical effectiveness research data
22 networks from electronic health records, post
23 marketing drug and medical device surveillance
24 efforts, and other forms of electronic health
25 data; and

1 “(G) appoint clinical perspective advisory
2 panels for research priorities under this section,
3 which shall consult with patients and other
4 stakeholders and advise the Center on research
5 questions, methods, and evidence gaps in terms
6 of clinical outcomes for the specific research in-
7 quiry to be examined with respect to such pri-
8 ority to ensure that the information produced
9 from such research is clinically relevant to deci-
10 sions made by clinicians and patients at the
11 point of care.

12 “(3) POWERS.—

13 “(A) OBTAINING OFFICIAL DATA.—The
14 Center may secure directly from any depart-
15 ment or agency of the United States informa-
16 tion necessary to enable it to carry out this sec-
17 tion. Upon request of the Center, the head of
18 such department or agency shall furnish that
19 information to the Center on an agreed upon
20 schedule.

21 “(B) DATA COLLECTION.—In order to
22 carry out its functions, the Center shall—

23 “(i) utilize existing information, both
24 published and unpublished, where possible,
25 collected and assessed either by its own

1 staff or under other arrangements made in
2 accordance with this section;

3 “(ii) carry out, or award grants or
4 contracts for, original research and experi-
5 mentation, where existing information is
6 inadequate; and

7 “(iii) adopt procedures allowing any
8 interested party to submit information for
9 the use by the Center in making reports
10 and recommendations.

11 In carrying out clause (ii), the Center may
12 award grants or contracts (or provide for inter-
13 governmental transfers, as applicable) to pri-
14 vate entities and governmental agencies with
15 experience in conducting comparative effective-
16 ness research, such as the National Institutes
17 of Health and other relevant Federal health
18 agencies.

19 “(C) ACCESS OF GAO TO INFORMATION.—
20 The Comptroller General shall have unrestricted
21 access to all deliberations, records, and non-
22 proprietary data of the Center and Commission
23 under subsection (b), immediately upon request.

24 “(D) PERIODIC AUDIT.—The Center and
25 Commission under subsection (b) shall be sub-

1 ject to periodic audit by the Comptroller Gen-
2 eral.

3 “(b) COMPARATIVE EFFECTIVENESS RESEARCH
4 COMMISSION.—

5 “(1) IN GENERAL.—There is established an
6 independent Comparative Effectiveness Research
7 Commission (in this section referred to as the ‘Com-
8 mission’) to advise the Center and evaluate the ac-
9 tivities carried out by the Center under subsection
10 (a) to ensure such activities result in highly credible
11 research and information resulting from such re-
12 search.

13 “(2) DUTIES.—The Commission shall—

14 “(A)(i) recommend to the Center national
15 priorities for research described in subsection
16 (a) which shall take into account—

17 “(I) disease incidence, prevalence, and
18 burden in the United States;

19 “(II) evidence gaps in terms of clinical
20 outcomes;

21 “(III) variations in practice, delivery,
22 and outcomes by geography, treatment
23 site, provider type, disability, variation in
24 age group (including children, adolescents,
25 adults, and seniors), racial and ethnic

1 background, gender, genetic and molecular
2 subtypes, and other appropriate popu-
3 lations or subpopulations; and

4 “(IV) the potential for new evidence
5 concerning certain categories, health care
6 services, or treatments to improve patient
7 health and well-being, and the quality of
8 care; and

9 “(ii) in making such recommendations con-
10 sult with a broad array of public and private
11 stakeholders, including patients and health care
12 providers and payers;

13 “(B) monitor the appropriateness of use of
14 the CERTF described in subsection (g) with re-
15 spect to the timely production of comparative
16 effectiveness research recommended to be a na-
17 tional priority under subparagraph (A);

18 “(C) identify highly credible research
19 methods and standards of evidence for such re-
20 search to be considered by the Center;

21 “(D) review the methodologies developed
22 by the center under subsection (a)(2)(C);

23 “(E) support forums to increase stake-
24 holder awareness and permit stakeholder feed-
25 back on the efforts of the Center to advance

1 methods and standards that promote highly
2 credible research;

3 “(F) make recommendations to the Center
4 for policies that would allow for public access of
5 data produced under this section, in accordance
6 with appropriate privacy and proprietary prac-
7 tices, while ensuring that the information pro-
8 duced through such data is timely and credible;

9 “(G) make recommendations to the Center
10 for the priority for periodic reviews of previous
11 comparative effectiveness research and studies
12 conducted by the Center under subsection (a);

13 “(H) at least annually review the processes
14 of the Center and make reports to Congress
15 and the President regarding research con-
16 ducted, supported, or synthesized by the Center
17 to confirm that the information produced by
18 such research is objective, credible, consistent
19 with standards of evidence developed under this
20 section, and developed through a transparent
21 process that includes consultations with appro-
22 priate stakeholders;

23 “(I) make recommendations to the Center
24 for the broad dissemination, consistent with
25 subsection (e), of the findings of research con-

1 ducted and supported under this section that
2 enables clinicians, patients, consumers, and
3 payers to make more informed health care deci-
4 sions that improve quality and value; and

5 “(J) at least twice each year, hold a public
6 meeting with an opportunity for stakeholder
7 input.

8 The reports under subparagraph (H) shall not be
9 submitted to the Office of Management and Budget
10 or to any other Federal agency or executive depart-
11 ment for any purpose prior to transmittal to Con-
12 gress and the President. Such reports shall be pub-
13 lished on the public internet website of the Commis-
14 sion after the date of such transmittal.

15 “(3) COMPOSITION OF COMMISSION.—

16 “(A) IN GENERAL.—The members of the
17 Commission shall consist of—

18 “(i) the Director of the Agency for
19 Healthcare Research and Quality or their
20 designee;

21 “(ii) the Chief Medical Officer of the
22 Centers for Medicare & Medicaid Services
23 or their designee;

24 “(iii) the Director of the National In-
25 stitutes of Health or their designee; and

1 “(iv) 16 additional members who shall
2 represent broad constituencies of stake-
3 holders including clinicians, patients, re-
4 searchers, third-party payers, and con-
5 sumers of Federal and State beneficiary
6 programs.

7 Of such members, at least 10 shall be prac-
8 ticing physicians, health care practitioners, con-
9 sumers, or patients.

10 “(B) QUALIFICATIONS.—

11 “(i) DIVERSE REPRESENTATION OF
12 PERSPECTIVES.—The members of the
13 Commission shall represent a broad range
14 of perspectives and shall collectively have
15 experience in the following areas:

16 “(I) Epidemiology.

17 “(II) Health services research.

18 “(III) Bioethics.

19 “(IV) Decision sciences.

20 “(V) Health disparities.

21 “(VI) Health economics.

22 “(ii) DIVERSE REPRESENTATION OF
23 HEALTH CARE COMMUNITY.—At least one
24 member shall represent each of the fol-
25 lowing health care communities:

1 “(I) Patients.

2 “(II) Health care consumers.

3 “(III) Practicing Physicians, in-
4 cluding surgeons.

5 “(IV) Other health care practi-
6 tioners engaged in clinical care.

7 “(V) Organizations with proven
8 expertise in racial and ethnic minority
9 health research.

10 “(VI) Employers.

11 “(VII) Public payers.

12 “(VIII) Insurance plans.

13 “(IX) Clinical researchers who
14 conduct research on behalf of pharma-
15 ceutical or device manufacturers.

16 “(C) LIMITATION.—No more than 3 of the
17 Members of the Commission may be representa-
18 tives of pharmaceutical or device manufacturers
19 and such representatives shall be clinical re-
20 searchers described under subparagraph
21 (B)(ii)(IX).

22 “(4) APPOINTMENT.—The Comptroller General
23 shall appoint the members of the Commission.

24 “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-
25 troller General shall designate a member of the

1 Commission, at the time of appointment of the mem-
2 ber, as Chairman and a member as Vice Chairman
3 for that term of appointment, except that in the case
4 of vacancy of the Chairmanship or Vice Chairman-
5 ship, the Comptroller General may designate another
6 member for the remainder of that member's term.
7 The Chairman shall serve as an ex officio member
8 of the National Advisory Council of the Agency for
9 Health Care Research and Quality under section
10 931(c)(3)(B) of the Public Health Service Act.

11 “(6) TERMS.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), each member of the Com-
14 mission shall be appointed for a term of 4
15 years.

16 “(B) TERMS OF INITIAL APPOINTEES.—Of
17 the members first appointed—

18 “(i) 8 shall be appointed for a term of
19 4 years; and

20 “(ii) 8 shall be appointed for a term
21 of 3 years.

22 “(7) COMPENSATION.—While serving on the
23 business of the Commission (including travel time),
24 a member of the Commission shall be entitled to
25 compensation at the per diem equivalent of the rate

1 provided for level IV of the Executive Schedule
2 under section 5315 of title 5, United States Code;
3 and while so serving away from home and the mem-
4 ber's regular place of business, a member may be al-
5 lowed travel expenses, as authorized by the Director
6 of the Commission.

7 “(8) DIRECTOR AND STAFF; EXPERTS AND
8 CONSULTANTS.—Subject to such review as the
9 Comptroller General deems necessary to assure the
10 efficient administration of the Commission, the Com-
11 mission may—

12 “(A) appoint and set the compensation for
13 an Executive Director (subject to the approval
14 of the Comptroller General) and such other per-
15 sonnel as Federal employees under section 2105
16 of title 5, United States Code, as may be nec-
17 essary to carry out its duties (without regard to
18 the provisions of title 5, United States Code,
19 governing appointments in the competitive serv-
20 ice);

21 “(B) seek such assistance and support as
22 may be required in the performance of its du-
23 ties from appropriate Federal departments and
24 agencies;

1 “(C) enter into contracts or make other ar-
2 rangements, as may be necessary for the con-
3 duct of the work of the Commission (without
4 regard to section 3709 of the Revised Statutes
5 (41 U.S.C. 5));

6 “(D) make advance, progress, and other
7 payments which relate to the work of the Com-
8 mission;

9 “(E) provide transportation and subsist-
10 ence for persons serving without compensation;
11 and

12 “(F) prescribe such rules and regulations
13 as it deems necessary with respect to the inter-
14 nal organization and operation of the Commis-
15 sion.

16 “(9) 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 the Commission to carry out this section.
20 Upon request of the Chairman of the Commission,
21 the head of such department or agency shall furnish
22 the information to the Commission on an agreed
23 upon schedule.

24 “(10) AVAILABILITY OF REPORTS.—The Com-
25 mission shall transmit to the Secretary a copy of

1 each report submitted under this subsection and
2 shall make such reports available to the public.

3 “(11) COORDINATION.—To enhance effective-
4 ness and coordination, the Secretary is encouraged,
5 to the greatest extent possible, to seek coordination
6 between the Commission and the National Advisory
7 Council of the Agency for Healthcare Research and
8 Quality.

9 “(12) CONFLICTS OF INTEREST.—

10 “(A) IN GENERAL.—In appointing the
11 members of the Commission or a clinical per-
12 spective advisory panel described in subsection
13 (a)(2)(G), the Comptroller General or the Sec-
14 retary, respectively, shall take into consider-
15 ation any financial interest (as defined in sub-
16 paragraph (D)), consistent with this paragraph,
17 and develop a plan for managing any identified
18 conflicts.

19 “(B) EVALUATION AND CRITERIA.—When
20 considering an appointment to the Commission
21 or a clinical perspective advisory panel de-
22 scribed subsection (a)(2)(G), the Comptroller
23 General or the Secretary, respectively, shall re-
24 view the expertise of the individual and the fi-
25 nancial disclosure report filed by the individual

1 pursuant to the Ethics in Government Act of
2 1978 for each individual under consideration
3 for the appointment, so as to reduce the likeli-
4 hood that an appointed individual will later re-
5 quire a written determination as referred to in
6 section 208(b)(1) of title 18, United States
7 Code, a written certification as referred to in
8 section 208(b)(3) of title 18, United States
9 Code, or a waiver as referred to in subpara-
10 graph (D)(iii) for service on the Commission at
11 a meeting of the Commission.

12 “(C) DISCLOSURES; PROHIBITIONS ON
13 PARTICIPATION; WAIVERS.—

14 “(i) DISCLOSURE OF FINANCIAL IN-
15 TEREST.—Prior to a meeting of the Com-
16 mission or a clinical perspective advisory
17 panel described in subsection (a)(2)(G) re-
18 garding a ‘particular matter’ (as that term
19 is used in section 208 of title 18, United
20 States Code), each member of the Commis-
21 sion or the clinical perspective advisory
22 panel who is a full-time Government em-
23 ployee or special Government employee
24 shall disclose to the Comptroller General or
25 Secretary, respectively, financial interests

1 in accordance with requiring a waiver
2 under section 208(b) of title 18, United
3 States Code, or other interests as deemed
4 relevant by the Secretary.

5 “(ii) PROHIBITIONS ON PARTICIPA-
6 TION.—Except as provided under clause
7 (iii), a member of the Commission or a
8 clinical perspective advisory panel de-
9 scribed in subsection (a)(2)(G) may not
10 participate with respect to a particular
11 matter considered in meeting of the Com-
12 mission or the clinical perspective advisory
13 panel if such member has a financial inter-
14 est that could be affected by the advice
15 given to the Secretary with respect to such
16 matter, excluding interests exempted in
17 regulations issued by the Director of the
18 Office of Government Ethics as too remote
19 or inconsequential to affect the integrity of
20 the services of the Government officers or
21 employees to which such regulations apply.

22 “(iii) WAIVER.—If the Comptroller
23 General or Secretary, as applicable, deter-
24 mines it necessary to afford the Commis-
25 sion or a clinical perspective advisory panel

1 described in subsection (a)(2)(G) essential
2 expertise, the Comptroller General or Sec-
3 retary, respectively, may grant a waiver of
4 the prohibition in clause (ii) to permit a
5 member described in such subparagraph
6 to—

7 “(I) participate as a non-voting
8 member with respect to a particular
9 matter considered in a meeting of the
10 Commission or a clinical perspective
11 advisory panel, respectively; or

12 “(II) participate as a voting
13 member with respect to a particular
14 matter considered in a meeting of the
15 Commission.

16 “(iv) LIMITATION ON WAIVERS AND
17 OTHER EXCEPTIONS.—

18 “(I) DETERMINATION OF ALLOW-
19 ABLE EXCEPTIONS FOR THE COMMIS-
20 SION.—The number of waivers grant-
21 ed to members of the Commission
22 cannot exceed one-half of the total
23 number of members for the Commis-
24 sion.

1 “(II) PROHIBITION ON VOTING
2 STATUS ON CLINICAL PERSPECTIVE
3 ADVISORY PANELS.—No voting mem-
4 ber of any clinical perspective advisory
5 panel shall be in receipt of a waiver.
6 No more than two nonvoting members
7 of any clinical perspective advisory
8 panel shall receive a waiver.

9 “(D) FINANCIAL INTEREST DEFINED.—
10 For purposes of this paragraph, the term ‘fi-
11 nancial interest’ means a financial interest
12 under section 208(a) of title 18, United States
13 Code.

14 “(13) APPLICATION OF FACA.—The Federal
15 Advisory Committee Act (other than section 14 of
16 such Act) shall apply to the Commission to the ex-
17 tent that the provisions of such Act do not conflict
18 with the requirements of this subsection.

19 “(c) RESEARCH REQUIREMENTS.—Any research con-
20 ducted, supported, or synthesized under this section shall
21 meet the following requirements:

22 “(1) ENSURING TRANSPARENCY, CREDIBILITY,
23 AND ACCESS.—

24 “(A) The establishment of a research agen-
25 da by the Center shall be informed by the na-

1 tional priorities for research recommended
2 under subsection (b)(2)(A).

3 “(B) The establishment of the agenda and
4 conduct of the research shall be insulated from
5 inappropriate political or stakeholder influence.

6 “(C) Methods of conducting such research
7 shall be scientifically based.

8 “(D) Consistent with applicable law, all as-
9 pects of the prioritization of research, conduct
10 of the research, and development of conclusions
11 based on the research shall be transparent to
12 all stakeholders.

13 “(E) Consistent with applicable law, the
14 process and methods for conducting such re-
15 search shall be publicly documented and avail-
16 able to all stakeholders.

17 “(F) Throughout the process of such re-
18 search, the Center shall provide opportunities
19 for all stakeholders involved to review and pro-
20 vide public comment on the methods and find-
21 ings of such research.

22 “(G) Such research shall consider advice
23 given to the Center by the clinical perspective
24 advisory panel for the particular national re-
25 search priority.

1 “(2) STAKEHOLDER INPUT.—

2 “(A) IN GENERAL.—The Commission shall
3 consult with patients, health care providers,
4 health care consumer representatives, and other
5 appropriate stakeholders with an interest in the
6 research through a transparent process rec-
7 ommended by the Commission.

8 “(B) SPECIFIC AREAS OF CONSULTA-
9 TION.—Consultation shall include where
10 deemed appropriate by the Commission—

11 “(i) recommending research priorities
12 and questions;

13 “(ii) recommending research meth-
14 odologies; and

15 “(iii) advising on and assisting with
16 efforts to disseminate research findings.

17 “(C) OMBUDSMAN.—The Secretary shall
18 designate a patient ombudsman. The ombuds-
19 man shall—

20 “(i) serve as an available point of con-
21 tact for any patients with an interest in
22 proposed comparative effectiveness studies
23 by the Center; and

24 “(ii) ensure that any comments from
25 patients regarding proposed comparative

1 effectiveness studies are reviewed by the
2 Center.

3 “(3) TAKING INTO ACCOUNT POTENTIAL DIF-
4 FERENCES.—Research shall—

5 “(A) be designed, as appropriate, to take
6 into account the potential for differences in the
7 effectiveness of health care items, services, and
8 systems used with various subpopulations such
9 as racial and ethnic minorities, women, dif-
10 ferent age groups (including children, adoles-
11 cents, adults, and seniors), individuals with dis-
12 abilities, and individuals with different
13 comorbidities and genetic and molecular
14 subtypes; and—

15 “(B) seek, as feasible and appropriate, to
16 include members of such subpopulations as sub-
17 jects in the research.

18 “(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-
19 NESS INFORMATION.—

20 “(1) IN GENERAL.—Not later than 90 days
21 after receipt by the Center or Commission, as appli-
22 cable, of a relevant report described in paragraph
23 (2) made by the Center, Commission, or clinical per-
24 spective advisory panel under this section, appro-
25 priate information contained in such report shall be

1 posted on the official public Internet site of the Cen-
2 ter and of the Commission, as applicable.

3 “(2) RELEVANT REPORTS DESCRIBED.—For
4 purposes of this section, a relevant report is each of
5 the following submitted by the Center or a grantee
6 or contractor of the Center:

7 “(A) Any interim or progress reports as
8 deemed appropriate by the Secretary.

9 “(B) Stakeholder comments.

10 “(C) A final report.

11 “(e) DISSEMINATION AND INCORPORATION OF COM-
12 PARATIVE EFFECTIVENESS INFORMATION.—

13 “(1) DISSEMINATION.—The Center shall pro-
14 vide for the dissemination of appropriate findings
15 produced by research supported, conducted, or syn-
16 thesized under this section to health care providers,
17 patients, vendors of health information technology
18 focused on clinical decision support, relevant expert
19 organizations (as defined in subsection (i)(3)(A)),
20 and Federal and private health plans, and other rel-
21 evant stakeholders. In disseminating such findings
22 the Center shall—

23 “(A) convey findings of research so that
24 they are comprehensible and useful to patients
25 and providers in making health care decisions;

1 “(B) discuss findings and other consider-
2 ations specific to certain sub-populations, risk
3 factors, and comorbidities as appropriate;

4 “(C) include considerations such as limita-
5 tions of research and what further research
6 may be needed, as appropriate;

7 “(D) not include any data that the dis-
8 semination of which would violate the privacy of
9 research participants or violate any confiden-
10 tiality agreements made with respect to the use
11 of data under this section; and

12 “(E) assist the users of health information
13 technology focused on clinical decision support
14 to promote the timely incorporation of such
15 findings into clinical practices and promote the
16 ease of use of such incorporation.

17 “(2) DISSEMINATION PROTOCOLS AND STRATE-
18 GIES.—The Center shall develop protocols and strat-
19 egies for the appropriate dissemination of research
20 findings in order to ensure effective communication
21 of findings and the use and incorporation of such
22 findings into relevant activities for the purpose of in-
23 forming higher quality and more effective and effi-
24 cient decisions regarding medical items and services.
25 In developing and adopting such protocols and strat-

1 egies, the Center shall consult with stakeholders con-
2 cerning the types of dissemination that will be most
3 useful to the end users of information and may pro-
4 vide for the utilization of multiple formats for con-
5 veying findings to different audiences, including dis-
6 semination to individuals with limited English pro-
7 ficiency.

8 “(f) REPORTS TO CONGRESS.—

9 “(1) ANNUAL REPORTS.—Beginning not later
10 than one year after the date of the enactment of this
11 section, the Director of the Agency of Healthcare
12 Research and Quality shall submit to Congress an
13 annual report on the activities of the Center, as well
14 as the research, conducted under this section. Each
15 such report shall include a discussion of the Center’s
16 compliance with subsection (c)(3)(B), including any
17 reasons for lack of compliance with such subsection.

18 “(2) RECOMMENDATION FOR FAIR SHARE PER
19 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-
20 ginning not later than December 31, 2011, the Sec-
21 retary shall submit to Congress an annual rec-
22 ommendation for a fair share per capita amount de-
23 scribed in subsection (c)(1) of section 9511 of the
24 Internal Revenue Code of 1986 for purposes of
25 funding the CERTF under such section.

1 “(3) ANALYSIS AND REVIEW.—Not later than
2 December 31, 2013, the Secretary, in consultation
3 with the Commission, shall submit to Congress a re-
4 port on all activities conducted or supported under
5 this section as of such date. Such report shall in-
6 clude an evaluation of the overall costs of such ac-
7 tivities and an analysis of the backlog of any re-
8 search proposals approved by the Center but not
9 funded.

10 “(g) FUNDING OF COMPARATIVE EFFECTIVENESS
11 RESEARCH.—For fiscal year 2010 and each subsequent
12 fiscal year, amounts in the Comparative Effectiveness Re-
13 search Trust Fund (referred to in this section as the
14 ‘CERTF’) under section 9511 of the Internal Revenue
15 Code of 1986 shall be available in accordance with such
16 section, without the need for further appropriations and
17 without fiscal year limitation, to carry out this section.

18 “(h) CONSTRUCTION.—

19 “(1) COVERAGE.—Nothing in this section shall
20 be construed—

21 “(A) to permit the Center or Commission
22 to mandate coverage, reimbursement, or other
23 policies for any public or private payer; or

24 “(B) as preventing the Secretary from cov-
25 ering the routine costs of clinical care received

1 by an individual entitled to, or enrolled for, ben-
2 efits under title XVIII, XIX, or XXI in the case
3 where such individual is participating in a clin-
4 ical trial and such costs would otherwise be cov-
5 ered under such title with respect to the bene-
6 ficiary.

7 “(2) REPORTS AND FINDINGS.—None of the re-
8 ports submitted under this section or research find-
9 ings disseminated by the Center or Commission shall
10 be construed as mandates, for payment, coverage, or
11 treatment.

12 “(3) PROTECTING THE PHYSICIAN-PATIENT RE-
13 LATIONSHIP.—Nothing in this section shall be con-
14 strued to authorize any Federal officer or employee
15 to exercise any supervision or control over the prac-
16 tice of medicine.

17 “(i) CONSULTATION WITH RELEVANT EXPERT OR-
18 GANIZATIONS.—

19 “(1) CONSULTATION PRIOR TO INITIATION OF
20 RESEARCH.—Prior to recommending priorities or
21 initiating research described in this section, the
22 Commission or the Center shall consult with the rel-
23 evant expert organizations responsible for standards
24 and protocols of clinical excellence. Such consulta-

1 tion shall be consistent with the processes estab-
2 lished under subsection (c)(2).

3 “(2) CONSULTATION IN DISSEMINATION OF RE-
4 SEARCH.—Any dissemination of research from the
5 Commission or the Center and findings made by the
6 Commission or the Center shall be consistent with
7 processes established under subsection (e) and
8 shall—

9 “(A) be based upon evidence-based medi-
10 cine; and

11 “(B) take into consideration standards and
12 protocols of clinical excellence developed by rel-
13 evant expert organizations.

14 “(3) DEFINITIONS.—For purposes of this sub-
15 section:

16 “(A) RELEVANT EXPERT ORGANIZA-
17 TIONS.—The term ‘relevant expert organization’
18 means an organization with expertise in the rig-
19 orous application of evidence-based scientific
20 methods for the design of clinical studies, the
21 interpretation of clinical data, and the develop-
22 ment of national clinical practice guidelines, in-
23 cluding a voluntary health organization, clinical
24 specialty, or other professional organization
25 that represents physicians based on the field of

1 medicine in which each such physician practices
2 or is board certified.

3 “(B) STANDARDS AND PROTOCOLS OF
4 CLINICAL EXCELLENCE.—The term ‘standards
5 and protocols of clinical excellence’ means clin-
6 ical or practice guidelines that consist of a set
7 of directions or principles that is based on evi-
8 dence and is designed to assist a health care
9 practitioner with decisions about appropriate di-
10 agnostic, therapeutic, or other clinical proce-
11 dures for specific clinical circumstances.

12 “(j) RESEARCH MAY NOT BE USED TO DENY OR RA-
13 TION CARE.—Nothing in this section shall be construed
14 to make more stringent or otherwise change the standards
15 or requirements for coverage of items and services under
16 this Act.”.

17 (b) COMPARATIVE EFFECTIVENESS RESEARCH
18 TRUST FUND; FINANCING FOR THE TRUST FUND.—For
19 the provision establishing a Comparative Effectiveness Re-
20 search Trust Fund and financing such Trust Fund, see
21 section 1802.

1 **Subtitle B—Nursing Home**
2 **Transparency**

3 **PART 1—IMPROVING TRANSPARENCY OF INFOR-**
4 **MATION ON SKILLED NURSING FACILITIES,**
5 **NURSING FACILITIES, AND OTHER LONG-**
6 **TERM CARE FACILITIES**

7 **SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND**
8 **ADDITIONAL DISCLOSABLE PARTIES INFOR-**
9 **MATION.**

10 (a) IN GENERAL.—Section 1124 of the Social Secu-
11 rity Act (42 U.S.C. 1320a–3) is amended by adding at
12 the end the following new subsection:

13 “(c) REQUIRED DISCLOSURE OF OWNERSHIP AND
14 ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

15 “(1) DISCLOSURE.—A facility (as defined in
16 paragraph (6)(B)) shall have the information de-
17 scribed in paragraph (3) available—

18 “(A) during the period beginning on the
19 date of the enactment of this subsection and
20 ending on the date such information is made
21 available to the public under section 1411(b) of
22 the Affordable Health Care for America Act,
23 for submission to the Secretary, the Inspector
24 General of the Department of Health and
25 Human Services, the State in which the facility

1 is located, and the State long-term care om-
2 budsman in the case where the Secretary, the
3 Inspector General, the State, or the State long-
4 term care ombudsman requests such informa-
5 tion; and

6 “(B) beginning on the effective date of the
7 final regulations promulgated under paragraph
8 (4)(A), for reporting such information in ac-
9 cordance with such final regulations.

10 Nothing in subparagraph (A) shall be construed as
11 authorizing a facility to dispose of or delete informa-
12 tion described in such subparagraph after the effec-
13 tive date of the final regulations promulgated under
14 paragraph (4)(A).

15 “(2) PUBLIC AVAILABILITY OF INFORMATION.—
16 During the period described in paragraph (1)(A), a
17 facility shall—

18 “(A) make the information described in
19 paragraph (3) available to the public upon re-
20 quest and update such information as may be
21 necessary to reflect changes in such informa-
22 tion; and

23 “(B) post a notice of the availability of
24 such information in the lobby of the facility in
25 a prominent manner.

1 “(3) INFORMATION DESCRIBED.—

2 “(A) IN GENERAL.—The following infor-
3 mation is described in this paragraph:

4 “(i) The information described in sub-
5 sections (a) and (b), subject to subpara-
6 graph (C).

7 “(ii) The identity of and information
8 on—

9 “(I) each member of the gov-
10 erning body of the facility, including
11 the name, title, and period of service
12 of each such member;

13 “(II) each person or entity who is
14 an officer, director, member, partner,
15 trustee, or managing employee of the
16 facility, including the name, title, and
17 date of start of service of each such
18 person or entity; and

19 “(III) each person or entity who
20 is an additional disclosable party of
21 the facility.

22 “(iii) A description of the organiza-
23 tional structure and the relationship of
24 each person and entity described in sub-

1 clauses (II) and (III) of clause (ii) to the
2 facility and to one another.

3 “(B) SPECIAL RULE WHERE INFORMATION
4 IS ALREADY REPORTED OR SUBMITTED.—To
5 the extent that information reported by a facil-
6 ity to the Internal Revenue Service on Form
7 990, information submitted by a facility to the
8 Securities and Exchange Commission, or infor-
9 mation otherwise submitted to the Secretary or
10 any other Federal agency contains the informa-
11 tion described in clauses (i), (ii), or (iii) of sub-
12 paragraph (A), the Secretary may allow, to the
13 extent practicable, such Form or such informa-
14 tion to meet the requirements of paragraph (1)
15 and to be submitted in a manner specified by
16 the Secretary.

17 “(C) SPECIAL RULE.—In applying sub-
18 paragraph (A)(i)—

19 “(i) with respect to subsections (a)
20 and (b), ‘ownership or control interest’
21 shall include direct or indirect interests, in-
22 cluding such interests in intermediate enti-
23 ties; and

24 “(ii) subsection (a)(3)(A)(ii) shall in-
25 clude the owner of a whole or part interest

1 in any mortgage, deed of trust, note, or
2 other obligation secured, in whole or in
3 part, by the entity or any of the property
4 or assets thereof, if the interest is equal to
5 or exceeds 5 percent of the total property
6 or assets of the entirety.

7 “(4) REPORTING.—

8 “(A) IN GENERAL.—Not later than the
9 date that is 2 years after the date of the enact-
10 ment of this subsection, the Secretary shall pro-
11 mulgate regulations requiring a facility to re-
12 port the information described in paragraph (3)
13 to the Secretary in a standardized format, and
14 such other regulations as are necessary to carry
15 out this subsection. Such regulations shall
16 specify the frequency of reporting, as deter-
17 mined by the Secretary. Such final regulations
18 shall also require—

19 “(i) the reporting of such information
20 on or after the first day of the first cal-
21 endar quarter beginning after the date
22 that is 90 days after the date on which
23 such final regulations are published in the
24 Federal Register; and—

1 “(ii) the certification, as a condition
2 of participation under the program under
3 title XVIII or XIX, that such information
4 is accurate and current.

5 “(B) GUIDANCE.—The Secretary shall pro-
6 vide guidance and technical assistance to States
7 on how to adopt the standardized format under
8 subparagraph (A).

9 “(5) NO EFFECT ON EXISTING REPORTING RE-
10 QUIREMENTS.—Nothing in this subsection shall re-
11 duce, diminish, or alter any reporting requirement
12 for a facility that is in effect as of the date of the
13 enactment of this subsection.

14 “(6) DEFINITIONS.—In this subsection:

15 “(A) ADDITIONAL DISCLOSABLE PARTY.—
16 The term ‘additional disclosable party’ means,
17 with respect to a facility, any person or entity
18 who, through ownership interest, partnership
19 interest, contract, or otherwise—

20 “(i) directly or indirectly exercises
21 operational, financial, administrative, or
22 managerial control or direction over the fa-
23 cility or a part thereof, or provides policies
24 or procedures for any of the operations of

1 the facility, or provides financial or cash
2 management services to the facility;

3 “(ii) leases or subleases real property
4 to the facility, or owns a whole or part in-
5 terest equal to or exceeding 5 percent of
6 the total value of such real property;

7 “(iii) lends funds or provides a finan-
8 cial guarantee to the facility in an amount
9 which is equal to or exceeds \$50,000; or

10 “(iv) provides management or admin-
11 istrative services, clinical consulting serv-
12 ices, or accounting or financial services to
13 the facility.

14 “(B) FACILITY.—The term ‘facility’ means
15 a disclosing entity which is—

16 “(i) a skilled nursing facility (as de-
17 fined in section 1819(a)); or

18 “(ii) a nursing facility (as defined in
19 section 1919(a)).

20 “(C) MANAGING EMPLOYEE.—The term
21 ‘managing employee’ means, with respect to a
22 facility, an individual (including a general man-
23 ager, business manager, administrator, director,
24 or consultant) who directly or indirectly man-

1 ages, advises, or supervises any element of the
2 practices, finances, or operations of the facility.

3 “(D) ORGANIZATIONAL STRUCTURE.—The
4 term ‘organizational structure’ means, in the
5 case of—

6 “(i) a corporation, the officers, direc-
7 tors, and shareholders of the corporation
8 who have an ownership interest in the cor-
9 poration which is equal to or exceeds 5
10 percent;

11 “(ii) a limited liability company, the
12 members and managers of the limited li-
13 ability company (including, as applicable,
14 what percentage each member and man-
15 ager has of the ownership interest in the
16 limited liability company);

17 “(iii) a general partnership, the part-
18 ners of the general partnership;

19 “(iv) a limited partnership, the gen-
20 eral partners and any limited partners of
21 the limited partnership who have an own-
22 ership interest in the limited partnership
23 which is equal to or exceeds 10 percent;

24 “(v) a trust, the trustees of the trust;

1 “(vi) an individual, contact informa-
2 tion for the individual; and

3 “(vii) any other person or entity, such
4 information as the Secretary determines
5 appropriate.”.

6 (b) PUBLIC AVAILABILITY OF INFORMATION.—Not
7 later than the date that is 1 year after the date on which
8 the final regulations promulgated under section
9 1124(c)(4)(A) of the Social Security Act, as added by sub-
10 section (a), are published in the Federal Register, the in-
11 formation reported in accordance with such final regula-
12 tions shall be made available to the public in accordance
13 with procedures established by the Secretary of Health
14 and Human Services.

15 (a) CONFORMING AMENDMENTS.—

16 (1) SKILLED NURSING FACILITIES.—Section
17 1819(d)(1) of the Social Security Act (42 U.S.C.
18 1395i–3(d)(1)) is amended by striking subparagraph
19 (B) and redesignating subparagraph (C) as subpara-
20 graph (B).

21 (2) NURSING FACILITIES.—Section 1919(d)(1)
22 of the Social Security Act (42 U.S.C. 1396r(d)(1))
23 is amended by striking subparagraph (B) and redesi-
24 gnating subparagraph (C) as subparagraph (B).

1 **SEC. 1412. ACCOUNTABILITY REQUIREMENTS.**

2 (a) EFFECTIVE COMPLIANCE AND ETHICS PRO-
3 GRAMS.—

4 (1) SKILLED NURSING FACILITIES.—Section
5 1819(d)(1) of the Social Security Act (42 U.S.C.
6 1395i–3(d)(1)), as amended by section 1411(c)(1),
7 is amended by adding at the end the following new
8 subparagraph:

9 “(C) COMPLIANCE AND ETHICS PRO-
10 GRAMS.—

11 “(i) REQUIREMENT.—On or after the
12 first day of the first calendar quarter be-
13 ginning after the date that is 1 year after
14 the date on which regulations developed
15 under clause (ii) are published in the Fed-
16 eral Register, a skilled nursing facility
17 shall, with respect to the entity that oper-
18 ates or controls the facility (in this sub-
19 paragraph referred to as the ‘operating or-
20 ganization’ or ‘organization’), have in oper-
21 ation a compliance and ethics program
22 that is effective in preventing and detect-
23 ing criminal, civil, and administrative viola-
24 tions under this Act and in promoting
25 quality of care consistent with such regula-
26 tions.

1 “(ii) DEVELOPMENT OF REGULA-
2 TIONS.—

3 “(I) IN GENERAL.—Not later
4 than the date that is 2 years after the
5 date of the enactment of this subpara-
6 graph, the Secretary, in consultation
7 with the Inspector General of the De-
8 partment of Health and Human Serv-
9 ices, shall promulgate regulations for
10 an effective compliance and ethics
11 program for operating organizations,
12 which may include a model compliance
13 program.

14 “(II) DESIGN OF REGULA-
15 TIONS.—Such regulations with respect
16 to specific elements or formality of a
17 program may vary with the size of the
18 organization, such that larger organi-
19 zations should have a more formal
20 and rigorous program and include es-
21 tablished written policies defining the
22 standards and procedures to be fol-
23 lowed by its employees. Such require-
24 ments shall specifically apply to the

1 corporate level management of multi-
2 unit nursing home chains.

3 “(III) EVALUATION.—Not later
4 than 3 years after the date on which
5 compliance and ethics programs estab-
6 lished under this subparagraph are in
7 operation pursuant to clause (i), the
8 Secretary shall complete an evaluation
9 of such programs. Such evaluation
10 shall determine if such programs led
11 to changes in deficiency citations,
12 changes in quality performance, or
13 changes in other metrics of resident
14 quality of care. The Secretary shall
15 submit to Congress a report on such
16 evaluation and shall include in such
17 report such recommendations regard-
18 ing changes in the requirements for
19 such programs as the Secretary deter-
20 mines appropriate.

21 “(iii) REQUIREMENTS FOR COMPLI-
22 ANCE AND ETHICS PROGRAMS.—In this
23 subparagraph, the term ‘compliance and
24 ethics program’ means, with respect to a

1 skilled nursing facility, a program of the
2 operating organization that—

3 “(I) has been reasonably de-
4 signed, implemented, and enforced so
5 that it generally will be effective in
6 preventing and detecting criminal,
7 civil, and administrative violations
8 under this Act and in promoting qual-
9 ity of care; and

10 “(II) includes at least the re-
11 quired components specified in clause
12 (iv).

13 “(iv) REQUIRED COMPONENTS OF
14 PROGRAM.—The required components of a
15 compliance and ethics program of an orga-
16 nization are the following:

17 “(I) The organization must have
18 established compliance standards and
19 procedures to be followed by its em-
20 ployees, contractors, and other agents
21 that are reasonably capable of reduc-
22 ing the prospect of criminal, civil, and
23 administrative violations under this
24 Act.

1 “(II) Specific individuals within
2 high-level personnel of the organiza-
3 tion must have been assigned overall
4 responsibility to oversee compliance
5 with such standards and procedures
6 and have sufficient resources and au-
7 thority to assure such compliance.

8 “(III) The organization must
9 have used due care not to delegate
10 substantial discretionary authority to
11 individuals whom the organization
12 knew, or should have known through
13 the exercise of due diligence, had a
14 propensity to engage in criminal, civil,
15 and administrative violations under
16 this Act.

17 “(IV) The organization must
18 have taken steps to communicate ef-
19 fectively its standards and procedures
20 to all employees and other agents,
21 such as by requiring participation in
22 training programs or by disseminating
23 publications that explain in a practical
24 manner what is required.

1 “(V) The organization must have
2 taken reasonable steps to achieve com-
3 pliance with its standards, such as by
4 utilizing monitoring and auditing sys-
5 tems reasonably designed to detect
6 criminal, civil, and administrative vio-
7 lations under this Act by its employ-
8 ees and other agents and by having in
9 place and publicizing a reporting sys-
10 tem whereby employees and other
11 agents could report violations by oth-
12 ers within the organization without
13 fear of retribution.

14 “(VI) The standards must have
15 been consistently enforced through ap-
16 propriate disciplinary mechanisms, in-
17 cluding, as appropriate, discipline of
18 individuals responsible for the failure
19 to detect an offense.

20 “(VII) After an offense has been
21 detected, the organization must have
22 taken all reasonable steps to respond
23 appropriately to the offense and to
24 prevent further similar offenses, in-
25 cluding repayment of any funds to

1 which it was not entitled and any nec-
2 essary modification to its program to
3 prevent and detect criminal, civil, and
4 administrative violations under this
5 Act.

6 “(VIII) The organization must
7 periodically undertake reassessment of
8 its compliance program to identify
9 changes necessary to reflect changes
10 within the organization and its facili-
11 ties.

12 “(v) COORDINATION.—The provisions
13 of this subparagraph shall apply with re-
14 spect to a skilled nursing facility in lieu of
15 section 1874(d).”.

16 (2) NURSING FACILITIES.—Section 1919(d)(1)
17 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
18 as amended by section 1411(c)(2), is amended by
19 adding at the end the following new subparagraph:

20 “(C) COMPLIANCE AND ETHICS PRO-
21 GRAM.—

22 “(i) REQUIREMENT.—On or after the
23 first day of the first calendar quarter be-
24 ginning after the date that is 1 year after
25 the date on which regulations developed

1 under clause (ii) are published in the Fed-
2 eral Register, a skilled nursing facility
3 shall, with respect to the entity that oper-
4 ates or controls the facility (in this sub-
5 paragraph referred to as the ‘operating or-
6 ganization’ or ‘organization’), have in oper-
7 ation a compliance and ethics program
8 that is effective in preventing and detect-
9 ing criminal, civil, and administrative viola-
10 tions under this Act and in promoting
11 quality of care consistent with such regula-
12 tions.

13 “(iii) DEVELOPMENT OF REGULA-
14 TIONS.—

15 “(I) IN GENERAL.—Not later
16 than the date that is 2 years after the
17 date of the enactment of this subpara-
18 graph, the Secretary, in consultation
19 with the Inspector General of the De-
20 partment of Health and Human Serv-
21 ices, shall promulgate regulations for
22 an effective compliance and ethics
23 program for operating organizations,
24 which may include a model compliance
25 program.

1 “(II) DESIGN OF REGULA-
2 TIONS.—Such regulations with respect
3 to specific elements or formality of a
4 program may vary with the size of the
5 organization, such that larger organi-
6 zations should have a more formal
7 and rigorous program and include es-
8 tablished written policies defining the
9 standards and procedures to be fol-
10 lowed by its employees. Such require-
11 ments shall specifically apply to the
12 corporate level management of multi-
13 unit nursing home chains.

14 “(III) EVALUATION.—Not later
15 than 3 years after the date on which
16 compliance and ethics programs estab-
17 lished under this subparagraph are in
18 operation pursuant to clause (i), the
19 Secretary shall complete an evaluation
20 of such programs. Such evaluation
21 shall determine if such programs led
22 to changes in deficiency citations,
23 changes in quality performance, or
24 changes in other metrics of resident
25 quality of care. The Secretary shall

1 submit to Congress a report on such
2 evaluation and shall include in such
3 report such recommendations regard-
4 ing changes in the requirements for
5 such programs as the Secretary deter-
6 mines appropriate.

7 “(v) REQUIREMENTS FOR COMPLI-
8 ANCE AND ETHICS PROGRAMS.—In this
9 subparagraph, the term ‘compliance and
10 ethics program’ means, with respect to a
11 nursing facility, a program of the oper-
12 ating organization that—

13 “(I) has been reasonably de-
14 signed, implemented, and enforced so
15 that it generally will be effective in
16 preventing and detecting criminal,
17 civil, and administrative violations
18 under this Act and in promoting qual-
19 ity of care; and

20 “(II) includes at least the re-
21 quired components specified in clause
22 (iv).

23 “(vi) REQUIRED COMPONENTS OF
24 PROGRAM.—The required components of a

1 compliance and ethics program of an orga-
2 nization are the following:

3 “(I) The organization must have
4 established compliance standards and
5 procedures to be followed by its em-
6 ployees and other agents that are rea-
7 sonably capable of reducing the pros-
8 pect of criminal, civil, and administra-
9 tive violations under this Act.

10 “(II) Specific individuals within
11 high-level personnel of the organiza-
12 tion must have been assigned overall
13 responsibility to oversee compliance
14 with such standards and procedures
15 and has sufficient resources and au-
16 thority to assure such compliance.

17 “(III) The organization must
18 have used due care not to delegate
19 substantial discretionary authority to
20 individuals whom the organization
21 knew, or should have known through
22 the exercise of due diligence, had a
23 propensity to engage in criminal, civil,
24 and administrative violations under
25 this Act.

1 “(IV) The organization must
2 have taken steps to communicate ef-
3 fectively its standards and procedures
4 to all employees and other agents,
5 such as by requiring participation in
6 training programs or by disseminating
7 publications that explain in a practical
8 manner what is required.

9 “(V) The organization must have
10 taken reasonable steps to achieve com-
11 pliance with its standards, such as by
12 utilizing monitoring and auditing sys-
13 tems reasonably designed to detect
14 criminal, civil, and administrative vio-
15 lations under this Act by its employ-
16 ees and other agents and by having in
17 place and publicizing a reporting sys-
18 tem whereby employees and other
19 agents could report violations by oth-
20 ers within the organization without
21 fear of retribution.

22 “(VI) The standards must have
23 been consistently enforced through ap-
24 propriate disciplinary mechanisms, in-
25 cluding, as appropriate, discipline of

1 individuals responsible for the failure
2 to detect an offense.

3 “(VII) After an offense has been
4 detected, the organization must have
5 taken all reasonable steps to respond
6 appropriately to the offense and to
7 prevent further similar offenses, in-
8 cluding repayment of any funds to
9 which it was not entitled and any nec-
10 essary modification to its program to
11 prevent and detect criminal, civil, and
12 administrative violations under this
13 Act.

14 “(VIII) The organization must
15 periodically undertake reassessment of
16 its compliance program to identify
17 changes necessary to reflect changes
18 within the organization and its facili-
19 ties.

20 “(vii) COORDINATION.—The provi-
21 sions of this subparagraph shall apply with
22 respect to a nursing facility in lieu of sec-
23 tion 1902(a)(77).”.

24 (b) QUALITY ASSURANCE AND PERFORMANCE IM-
25 PROVEMENT PROGRAM.—

1 (1) SKILLED NURSING FACILITIES.—Section
2 1819(b)(1)(B) of the Social Security Act (42 U.S.C.
3 1396r(b)(1)(B)) is amended—

4 (A) by striking “ASSURANCE” and insert-
5 ing “ASSURANCE AND QUALITY ASSURANCE
6 AND PERFORMANCE IMPROVEMENT PROGRAM”;

7 (B) by designating the matter beginning
8 with “A skilled nursing facility” as a clause (i)
9 with the heading “IN GENERAL.—” and the ap-
10 propriate indentation;

11 (C) in clause (i) (as so designated by sub-
12 paragraph (B)), by redesignating clauses (i)
13 and (ii) as subclauses (I) and (II), respectively;
14 and

15 (D) by adding at the end the following new
16 clause:

17 “(ii) QUALITY ASSURANCE AND PER-
18 FORMANCE IMPROVEMENT PROGRAM.—

19 “(I) IN GENERAL.—Not later
20 than December 31, 2011, the Sec-
21 retary shall establish and implement a
22 quality assurance and performance
23 improvement program (in this clause
24 referred to as the ‘QAPI program’)
25 for skilled nursing facilities, including

1 multi-unit chains of such facilities.
2 Under the QAPI program, the Sec-
3 retary shall establish standards relat-
4 ing to such facilities and provide tech-
5 nical assistance to such facilities on
6 the development of best practices in
7 order to meet such standards. Not
8 later than 1 year after the date on
9 which the regulations are promulgated
10 under subclause (II), a skilled nursing
11 facility must submit to the Secretary
12 a plan for the facility to meet such
13 standards and implement such best
14 practices, including how to coordinate
15 the implementation of such plan with
16 quality assessment and assurance ac-
17 tivities conducted under clause (i).

18 “(II) REGULATIONS.—The Sec-
19 retary shall promulgate regulations to
20 carry out this clause.”.

21 (2) NURSING FACILITIES.—Section
22 1919(b)(1)(B) of the Social Security Act (42 U.S.C.
23 1396r(b)(1)(B)) is amended—

1 (A) by striking “ASSURANCE” and insert-
2 ing “ASSURANCE AND QUALITY ASSURANCE
3 AND PERFORMANCE IMPROVEMENT PROGRAM”;

4 (B) by designating the matter beginning
5 with “A nursing facility” as a clause (i) with
6 the heading “IN GENERAL.—” and the appro-
7 priate indentation; and

8 (C) by adding at the end the following new
9 clause:

10 “(ii) QUALITY ASSURANCE AND PER-
11 FORMANCE IMPROVEMENT PROGRAM.—

12 “(I) IN GENERAL.—Not later
13 than December 31, 2011, the Sec-
14 retary shall establish and implement a
15 quality assurance and performance
16 improvement program (in this clause
17 referred to as the ‘QAPI program’)
18 for nursing facilities, including multi-
19 unit chains of such facilities. Under
20 the QAPI program, the Secretary
21 shall establish standards relating to
22 such facilities and provide technical
23 assistance to such facilities on the de-
24 velopment of best practices in order to
25 meet such standards. Not later than 1

1 year after the date on which the regu-
2 lations are promulgated under sub-
3 clause (II), a nursing facility must
4 submit to the Secretary a plan for the
5 facility to meet such standards and
6 implement such best practices, includ-
7 ing how to coordinate the implementa-
8 tion of such plan with quality assess-
9 ment and assurance activities con-
10 ducted under clause (i).

11 “(II) REGULATIONS.—The Sec-
12 retary shall promulgate regulations to
13 carry out this clause.”.

14 (3) PROPOSAL TO REVISE QUALITY ASSURANCE
15 AND PERFORMANCE IMPROVEMENT PROGRAMS.—
16 The Secretary shall implement policies that modify
17 and strengthen quality assurance and performance
18 improvement programs in skilled nursing facilities
19 and nursing facilities on a periodic basis, as deter-
20 mined by the Secretary.

21 (4) FACILITY PLAN.—Not later than 1 year
22 after the date on which the regulations are promul-
23 gated under subclause (II) of clause (ii) of sections
24 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Se-
25 curity Act, as added by paragraphs (1) and (2), a

1 skilled nursing facility and a nursing facility must
2 submit to the Secretary a plan for the facility to
3 meet the standards under such regulations and im-
4 plement such best practices, including how to coordi-
5 nate the implementation of such plan with quality
6 assessment and assurance activities conducted under
7 clause (i) of such sections.

8 (c) GAO STUDY ON NURSING FACILITY UNDER-
9 CAPITALIZATION.—

10 (1) IN GENERAL.—The Comptroller General of
11 the United States shall conduct a study that exam-
12 ines the following:

13 (A) The extent to which corporations that
14 own or operate large numbers of nursing facili-
15 ties, taking into account ownership type (includ-
16 ing private equity and control interests), are
17 undercapitalizing such facilities.

18 (B) The effects of such undercapitalization
19 on quality of care, including staffing and food
20 costs, at such facilities.

21 (C) Options to address such undercapital-
22 ization, such as requirements relating to surety
23 bonds, liability insurance, or minimum capital-
24 ization.

1 (2) REPORT.—Not later than 18 months after
2 the date of the enactment of this Act, the Comp-
3 troller General shall submit to Congress a report on
4 the study conducted under paragraph (1).

5 (3) NURSING FACILITY.—In this subsection, the
6 term “nursing facility” includes a skilled nursing fa-
7 cility.

8 **SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.**

9 (a) SKILLED NURSING FACILITIES.—

10 (1) IN GENERAL.—Section 1819 of the Social
11 Security Act (42 U.S.C. 1395i-3) is amended—

12 (A) by redesignating subsection (i) as sub-
13 section (j); and

14 (B) by inserting after subsection (h) the
15 following new subsection:

16 “(i) NURSING HOME COMPARE WEBSITE.—

17 “(1) INCLUSION OF ADDITIONAL INFORMA-
18 TION.—

19 “(A) IN GENERAL.—The Secretary shall
20 ensure that the Department of Health and
21 Human Services includes, as part of the infor-
22 mation provided for comparison of nursing
23 homes on the official Internet website of the
24 Federal Government for Medicare beneficiaries
25 (commonly referred to as the ‘Nursing Home

1 Compare' Medicare website) (or a successor
2 website), the following information in a manner
3 that is prominent, easily accessible, readily un-
4 derstandable to consumers of long-term care
5 services, and searchable:

6 “(i) Information that is reported to
7 the Secretary under section 1124(c)(4).

8 “(ii) Information on the ‘Special
9 Focus Facility program’ (or a successor
10 program) established by the Centers for
11 Medicare and Medicaid Services, according
12 to procedures established by the Secretary.
13 Such procedures shall provide for the in-
14 clusion of information with respect to, and
15 the names and locations of, those facilities
16 that, since the previous quarter—

17 “(I) were newly enrolled in the
18 program;

19 “(II) are enrolled in the program
20 and have failed to significantly im-
21 prove;

22 “(III) are enrolled in the pro-
23 gram and have significantly improved;

24 “(IV) have graduated from the
25 program; and

1 “(V) have closed voluntarily or
2 no longer participate under this title.

3 “(iii) Staffing data for each facility
4 (including resident census data and data
5 on the hours of care provided per resident
6 per day) based on data submitted under
7 subsection (b)(8)(C), including information
8 on staffing turnover and tenure, in a for-
9 mat that is clearly understandable to con-
10 sumers of long-term care services and al-
11 lows such consumers to compare dif-
12 ferences in staffing between facilities and
13 State and national averages for the facili-
14 ties. Such format shall include—

15 “(I) concise explanations of how
16 to interpret the data (such as a plain
17 English explanation of data reflecting
18 ‘nursing home staff hours per resident
19 day’);

20 “(II) differences in types of staff
21 (such as training associated with dif-
22 ferent categories of staff);

23 “(III) the relationship between
24 nurse staffing levels and quality of
25 care; and

1 “(IV) an explanation that appro-
2 priate staffing levels vary based on
3 patient case mix.

4 “(iv) Links to State internet websites
5 with information regarding State survey
6 and certification programs, links to Form
7 2567 State inspection reports (or a suc-
8 cessor form) on such websites, information
9 to guide consumers in how to interpret and
10 understand such reports, and the facility
11 plan of correction or other response to
12 such report.

13 “(v) The standardized complaint form
14 developed under subsection (f)(8), includ-
15 ing explanatory material on what com-
16 plaint forms are, how they are used, and
17 how to file a complaint with the State sur-
18 vey and certification program and the
19 State long-term care ombudsman program.

20 “(vi) Summary information on the
21 number, type, severity, and outcome of
22 substantiated complaints.

23 “(vii) The number of adjudicated in-
24 stances of criminal violations by employees
25 of a nursing facility—

1 “(I) that were committed inside
2 the facility;

3 “(II) with respect to such in-
4 stances of violations or crimes com-
5 mitted inside of the facility that were
6 the violations or crimes of abuse, ne-
7 glect, and exploitation, criminal sexual
8 abuse, or other violations or crimes
9 that resulted in serious bodily injury;
10 and

11 “(viii) The number of civil monetary
12 penalties levied against the facility, em-
13 ployees, contractors, and other agents.

14 “(ix) Any other information that the
15 Secretary determines appropriate.

16 The facility shall not make available under
17 clause (iv) identifying information on complain-
18 ants or residents.

19 “(B) DEADLINE FOR PROVISION OF INFOR-
20 MATION.—

21 “(i) IN GENERAL.—Except as pro-
22 vided in clause (ii), the Secretary shall en-
23 sure that the information described in sub-
24 paragraph (A) is included on such website
25 (or a successor website) not later than 1

1 year after the date of the enactment of this
2 subsection.

3 “(ii) EXCEPTION.—The Secretary
4 shall ensure that the information described
5 in subparagraph (A)(i) and (A)(iii) is in-
6 cluded on such website (or a successor
7 website) not later than 1 year after the
8 dates on which the data are submitted to
9 the Secretary pursuant to section
10 1124(c)(4) and subsection (b)(8)(C), re-
11 spectively.

12 “(2) REVIEW AND MODIFICATION OF
13 WEBSITE.—

14 “(A) IN GENERAL.—The Secretary shall
15 establish a process—

16 “(i) to review the accuracy, clarity of
17 presentation, timeliness, and comprehen-
18 siveness of information reported on such
19 website as of the day before the date of the
20 enactment of this subsection; and

21 “(ii) not later than 1 year after the
22 date of the enactment of this subsection, to
23 modify or revamp such website in accord-
24 ance with the review conducted under
25 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; and

8 “(iv) any other representatives of pro-
9 grams or groups the Secretary determines
10 appropriate.”.

11 (2) TIMELINESS OF SUBMISSION OF SURVEY
12 AND CERTIFICATION INFORMATION.—

13 (A) IN GENERAL.—Section 1819(g)(5) of
14 the Social Security Act (42 U.S.C. 1395i-
15 3(g)(5)) is amended by adding at the end the
16 following new subparagraph:

17 “(E) SUBMISSION OF SURVEY AND CER-
18 TIFICATION INFORMATION TO THE SEC-
19 RETARY.—In order to improve the timeliness of
20 information made available to the public under
21 subparagraph (A) and provided on the Nursing
22 Home Compare Medicare website under sub-
23 section (i), each State shall submit information
24 respecting any survey or certification rec-
25 ommendation made respecting a skilled nursing

1 facility (including any enforcement actions
2 taken by the State or any Federal enforcement
3 action recommended by the State) to the Sec-
4 retary 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 1819(f) of such Act is amended by adding at
17 the end the following new paragraph:

18 “(8) SPECIAL FOCUS FACILITY PROGRAM.—

19 “(A) IN GENERAL.—The Secretary shall
20 conduct a special focus facility program for en-
21 forcement of requirements for skilled nursing
22 facilities that the Secretary has identified as
23 having a poor compliance history or that sub-
24 stantially failed to meet applicable requirements
25 of this Act

1 “(B) PERIODIC SURVEYS.—Under such
2 program the Secretary shall conduct surveys of
3 each facility in the program not less than once
4 every 6 months.”.

5 (b) NURSING FACILITIES.—

6 (1) IN GENERAL.—Section 1919 of the Social
7 Security Act (42 U.S.C. 1396r) is amended—

8 (A) by redesignating subsection (i) as sub-
9 section (j); and

10 (B) by inserting after subsection (h) the
11 following new subsection:

12 “(i) NURSING HOME COMPARE WEBSITE.—

13 “(1) INCLUSION OF ADDITIONAL INFORMA-
14 TION.—

15 “(A) IN GENERAL.—The Secretary shall
16 ensure that the Department of Health and
17 Human Services includes, as part of the infor-
18 mation provided for comparison of nursing
19 homes on the official internet website of the
20 Federal Government for Medicare beneficiaries
21 (commonly referred to as the ‘Nursing Home
22 Compare’ Medicare website) (or a successor
23 website), the following information in a manner
24 that is prominent, easily accessible, readily un-

1 derstandable to consumers of long-term care
2 services, and searchable:

3 “(i) Information that is reported to
4 the Secretary under section 1124(c)(4)

5 “(ii) Information on the ‘Special
6 Focus Facility program’ (or a successor
7 program) established by the Centers for
8 Medicare & Medicaid Services, according to
9 procedures established by the Secretary.
10 Such procedures shall provide for the in-
11 clusion of information with respect to, and
12 the names and locations of, those facilities
13 that, since the previous quarter—

14 “(I) were newly enrolled in the
15 program;

16 “(II) are enrolled in the program
17 and have failed to significantly im-
18 prove;

19 “(III) are enrolled in the pro-
20 gram and have significantly improved;

21 “(IV) have graduated from the
22 program; and

23 “(V) have closed voluntarily or
24 no longer participate under this title.

1 “(iii) Staffing data for each facility
2 (including resident census data and data
3 on the hours of care provided per resident
4 per day) based on data submitted under
5 subsection (b)(8)(C)(ii), including informa-
6 tion on staffing turnover and tenure, in a
7 format that is clearly understandable to
8 consumers of long-term care services and
9 allows such consumers to compare dif-
10 ferences in staffing between facilities and
11 State and national averages for the facili-
12 ties. Such format shall include—

13 “(I) concise explanations of how
14 to interpret the data (such as plain
15 English explanation of data reflecting
16 ‘nursing home staff hours per resident
17 day’);

18 “(II) differences in types of staff
19 (such as training associated with dif-
20 ferent categories of staff);

21 “(III) the relationship between
22 nurse staffing levels and quality of
23 care; and

1 “(IV) an explanation that appro-
2 priate staffing levels vary based on
3 patient case mix.

4 “(iv) Links to State internet websites
5 with information regarding State survey
6 and certification programs, links to Form
7 2567 State inspection reports (or a suc-
8 cessor form) on such websites, information
9 to guide consumers in how to interpret and
10 understand such reports, and the facility
11 plan of correction or other response to
12 such report.

13 “(v) The standardized complaint form
14 developed under subsection (f)(10), includ-
15 ing explanatory material on what com-
16 plaint forms are, how they are used, and
17 how to file a complaint with the State sur-
18 vey and certification program and the
19 State long-term care ombudsman program.

20 “(vi) Summary information on the
21 number, type, severity, and outcome of
22 substantiated complaints.

23 “(vii) The number of adjudicated in-
24 stances of criminal violations by employees
25 of a nursing facility—

1 “(I) that were committed inside
2 of the facility; and

3 “(II) with respect to such in-
4 stances of violations or crimes com-
5 mitted inside of the facility that were
6 the violations or crimes of abuse, ne-
7 glect, and exploitation, criminal sexual
8 abuse, or other violations or crimes
9 that resulted in serious bodily injury.

10 “(viii) the number of civil monetary
11 penalties levied against the facility, em-
12 ployees, contractors, and other agents.

13 “(ix) Any other information that the
14 Secretary determines appropriate.

15 The facility shall not make available under
16 clause (ii) identifying information about com-
17 plainants or residents.

18 “(B) DEADLINE FOR PROVISION OF INFOR-
19 MATION.—

20 “(i) IN GENERAL.—Except as pro-
21 vided in clause (ii), the Secretary shall en-
22 sure that the information described in sub-
23 paragraph (A) is included on such website
24 (or a successor website) not later than 1

1 year after the date of the enactment of this
2 subsection.

3 “(ii) EXCEPTION.—The Secretary
4 shall ensure that the information described
5 in subparagraph (A)(i) and (A)(iii) is in-
6 cluded on such website (or a successor
7 website) not later than 1 year after the
8 dates on which the data are submitted to
9 the Secretary pursuant to section
10 1124(c)(4) and subsection (b)(8)(C), re-
11 spectively.

12 “(2) REVIEW AND MODIFICATION OF
13 WEBSITE.—

14 “(A) IN GENERAL.—The Secretary shall
15 establish a process—

16 “(i) to review the accuracy, clarity of
17 presentation, timeliness, and comprehen-
18 siveness of information reported on such
19 website as of the day before the date of the
20 enactment of this subsection; and

21 “(ii) not later than 1 year after the
22 date of the enactment of this subsection, to
23 modify or revamp such website in accord-
24 ance with the review conducted under
25 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 rec-
2 ommendation made respecting a nursing facility
3 (including any enforcement actions taken by the
4 State or any Federal enforcement action rec-
5 ommended by the State) to the Secretary not
6 later than the date on which the State sends
7 such information to the facility. The Secretary
8 shall use the information submitted under the
9 preceding sentence to update the information
10 provided on the Nursing Home Compare Medi-
11 care website as expeditiously as practicable but
12 not less frequently than quarterly.”.

13 (B) EFFECTIVE DATE.—The amendment
14 made by this paragraph shall take effect 1 year
15 after the date of the enactment of this Act.

16 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
17 tion 1919(f) of such Act is amended by adding at
18 the end of the following new paragraph:

19 “(10) SPECIAL FOCUS FACILITY PROGRAM.—

20 “(A) IN GENERAL.—The Secretary shall
21 conduct a special focus facility program for en-
22 forcement of requirements for nursing facilities
23 that the Secretary has identified as having a
24 poor compliance history or that substantially

1 failed to meet applicable requirements of this
2 Act

3 “(B) PERIODIC SURVEYS.—Under such
4 program the Secretary shall conduct surveys of
5 each facility in the program not less often than
6 once every 6 months.”.

7 (c) AVAILABILITY OF REPORTS ON SURVEYS, CER-
8 TIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

9 (1) SKILLED NURSING FACILITIES.—Section
10 1819(d)(1) of the Social Security Act (42 U.S.C.
11 1395i–3(d)(1)), as amended by sections 1411 and
12 1412, is amended by adding at the end the following
13 new subparagraph:

14 “(D) AVAILABILITY OF SURVEY, CERTIFI-
15 CATION, AND COMPLAINT INVESTIGATION RE-
16 PORTS.—A skilled nursing facility must—

17 “(i) have reports with respect to any
18 surveys, certifications, and complaint in-
19 vestigations made respecting the facility
20 during the 3 preceding years available for
21 any individual to review upon request; and

22 “(ii) post notice of the availability of
23 such reports in areas of the facility that
24 are prominent and accessible to the public.

1 The facility shall not make available under
2 clause (i) identifying information about com-
3 plainants or residents.”.

4 (2) NURSING FACILITIES.—Section 1919(d)(1)
5 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
6 as amended by sections 1411 and 1412, is amended
7 by adding at the end the following new subpara-
8 graph:

9 “(D) AVAILABILITY OF SURVEY, CERTIFI-
10 CATION, AND COMPLAINT INVESTIGATION RE-
11 PORTS.—A nursing facility must—

12 “(i) have reports with respect to any
13 surveys, certifications, and complaint in-
14 vestigations made respecting the facility
15 during the 3 preceding years available for
16 any individual to review upon request; and

17 “(ii) post notice of the availability of
18 such reports in areas of the facility that
19 are prominent and accessible to the public.

20 The facility shall not make available under
21 clause (i) identifying information about com-
22 plainants or residents.”.

23 (3) EFFECTIVE DATE.—The amendments made
24 by this subsection shall take effect 1 year after the
25 date of the enactment of this Act.

1 (d) GUIDANCE TO STATES ON FORM 2567 STATE IN-
2 SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-
3 PORTS.—

4 (1) GUIDANCE.—The Secretary of Health and
5 Human Services (in this subtitle referred to as the
6 “Secretary”) shall provide guidance to States on
7 how States can establish electronic links to Form
8 2567 State inspection reports (or a successor form),
9 complaint investigation reports, and a facility’s plan
10 of correction or other response to such Form 2567
11 State inspection reports (or a successor form) on the
12 Internet website of the State that provides informa-
13 tion on skilled nursing facilities and nursing facili-
14 ties and the Secretary shall, if possible, include such
15 information on Nursing Home Compare.

16 (2) REQUIREMENT.—Section 1902(a)(9) of the
17 Social Security Act (42 U.S.C. 1396a(a)(9)) is
18 amended—

19 (A) by striking “and” at the end of sub-
20 paragraph (B);

21 (B) by striking the semicolon at the end of
22 subparagraph (C) and inserting “, and”; and

23 (C) by adding at the end the following new
24 subparagraph:

1 “(D) that the State maintain a consumer-
2 oriented website providing useful information to
3 consumers regarding all skilled nursing facili-
4 ties and all nursing facilities in the State, in-
5 cluding for each facility, Form 2567 State in-
6 spection reports (or a successor form), com-
7 plaint investigation reports, the facility’s plan of
8 correction, and such other information that the
9 State or the Secretary considers useful in as-
10 sisting the public to assess the quality of long
11 term care options and the quality of care pro-
12 vided by individual facilities;”.

13 (3) DEFINITIONS.—In this subsection:

14 (A) NURSING FACILITY.—The term “nurs-
15 ing facility” has the meaning given such term
16 in section 1919(a) of the Social Security Act
17 (42 U.S.C. 1396r(a)).

18 (B) SECRETARY.—The term “Secretary”
19 means the Secretary of Health and Human
20 Services.

21 (C) SKILLED NURSING FACILITY.—The
22 term “skilled nursing facility” has the meaning
23 given such term in section 1819(a) of the Social
24 Security Act (42 U.S.C. 1395i–3(a)).

1 **SEC. 1414. REPORTING OF EXPENDITURES.**

2 Section 1888 of the Social Security Act (42 U.S.C.
3 1395yy) is amended by adding at the end the following
4 new subsection:

5 “(f) REPORTING OF DIRECT CARE EXPENDI-
6 TURES.—

7 “(1) IN GENERAL.—For cost reports submitted
8 under this title for cost reporting periods beginning
9 on or after the date that is no more than two years
10 after the redesign of the report specified in subpara-
11 graph (2), skilled nursing facilities shall—

12 “(A) separately report expenditures for
13 wages and benefits for direct care staff (break-
14 ing out (at a minimum) registered nurses, li-
15 censed professional nurses, certified nurse as-
16 sistants, and other medical and therapy staff);
17 and

18 “(B) take into account agency and con-
19 tract staff in a manner to be determined by the
20 Administrator.

21 “(2) MODIFICATION OF FORM.—The Secretary,
22 in consultation with private sector accountants expe-
23 rienced with skilled nursing facility cost reports,
24 shall redesign such reports to meet the requirement
25 of paragraph (1) not later than 2 years after the
26 date of the enactment of this subsection.

1 “(3) CATEGORIZATION BY FUNCTIONAL AC-
2 COUNTS.—Beginning with cost reports submitted
3 under paragraph (1) , the Secretary, working in con-
4 sultation with the Medicare Payment Advisory Com-
5 mission, the Inspector General of the Department of
6 Health and Human Services, and other expert par-
7 ties the Secretary determines appropriate, shall cat-
8 egorize the expenditures listed on cost reports, as
9 modified under paragraph (1), submitted by skilled
10 nursing facilities, regardless of any source of pay-
11 ment for such expenditures, for each skilled nursing
12 facility into the following functional accounts on an
13 annual basis:

14 “(A) Spending on direct care services (in-
15 cluding nursing, therapy, and medical services).

16 “(B) Spending on indirect care (including
17 housekeeping and dietary services).

18 “(C) Capital assets (including building and
19 land costs).

20 “(D) Administrative services costs.

21 “(4) AVAILABILITY OF INFORMATION SUB-
22 MITTED.—The Secretary shall establish procedures
23 to make information on expenditures submitted
24 under this subsection readily available to interested
25 parties upon request, subject to such requirements

1 as the Secretary may specify under the procedures
2 established under this paragraph.”.

3 **SEC. 1415. STANDARDIZED COMPLAINT FORM.**

4 (a) SKILLED NURSING FACILITIES.—

5 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
6 tion 1819(f) of the Social Security Act (42 U.S.C.
7 1395i–3(f)), as amended by section 1413(a)(3), is
8 amended by adding at the end the following new
9 paragraph:

10 “(9) STANDARDIZED COMPLAINT FORM.—The
11 Secretary shall develop a standardized complaint
12 form for use by a resident (or a person acting on the
13 resident’s behalf) in filing a complaint with a State
14 survey and certification agency and a State long-
15 term care ombudsman program with respect to a
16 skilled nursing facility.”.

17 (2) STATE REQUIREMENTS.—Section 1819(e)
18 of the Social Security Act (42 U.S.C. 1395i–3(e)) is
19 amended by adding at the end the following new
20 paragraph:

21 “(6) COMPLAINT PROCESSES AND WHISTLE-
22 BLOWER PROTECTION.—

23 “(A) COMPLAINT FORMS.—The State must
24 make the standardized complaint form devel-

1 oped under subsection (f)(9) available upon re-
2 quest to—

3 “(i) a resident of a skilled nursing fa-
4 cility;

5 “(ii) any person acting on the resi-
6 dent’s behalf; and

7 “(iii) any person who works at a
8 skilled nursing facility or is a representa-
9 tive of such a worker.

10 “(B) COMPLAINT RESOLUTION PROCESS.—

11 The State must establish a complaint resolution
12 process in order to ensure that a resident, the
13 legal representative of a resident of a skilled
14 nursing facility, or other responsible party is
15 not retaliated against if the resident, legal rep-
16 resentative, or responsible party has com-
17 plained, in good faith, about the quality of care
18 or other issues relating to the skilled nursing
19 facility, that the legal representative of a resi-
20 dent of a skilled nursing facility or other re-
21 sponsible party is not denied access to such
22 resident or otherwise retaliated against if such
23 representative party has complained, in good
24 faith, about the quality of care provided by the
25 facility or other issues relating to the facility,

1 and that a person who works at a skilled nurs-
2 ing facility is not retaliated against if the work-
3 er has complained, in good faith, about quality
4 of care or services or an issue relating to the
5 quality of care or services provided at the facil-
6 ity, whether the resident, legal representative,
7 other responsible party, or worker used the
8 form developed under subsection (f)(9) or some
9 other method for submitting the complaint.
10 Such complaint resolution process shall in-
11 clude—

12 “(i) procedures to assure accurate
13 tracking of complaints received, including
14 notification to the complainant that a com-
15 plaint has been received;

16 “(ii) procedures to determine the like-
17 ly severity of a complaint and for the in-
18 vestigation of the complaint;

19 “(iii) deadlines for responding to a
20 complaint and for notifying the complain-
21 ant of the outcome of the investigation;
22 and

23 “(iv) procedures to ensure that the
24 identity of the complainant will be kept
25 confidential.

1 “(C) WHISTLEBLOWER PROTECTION.—

2 “(i) PROHIBITION AGAINST RETALIA-
3 TION.—No person who works at a skilled
4 nursing facility may be penalized, discrimi-
5 nated, or retaliated against with respect to
6 any aspect of employment, including dis-
7 charge, promotion, compensation, terms,
8 conditions, or privileges of employment, or
9 have a contract for services terminated, be-
10 cause the person (or anyone acting at the
11 person’s request) complained, in good
12 faith, about the quality of care or services
13 provided by a skilled nursing facility or
14 about other issues relating to quality of
15 care or services, whether using the form
16 developed under subsection (f)(9) or some
17 other method for submitting the complaint.

18 “(ii) RETALIATORY REPORTING.—A
19 skilled nursing facility may not file a com-
20 plaint or a report against a person who
21 works (or has worked at the facility) with
22 the appropriate State professional discipli-
23 nary agency because the person (or anyone
24 acting at the person’s request) complained
25 in good faith, as described in clause (i).

1 “(iii) RELIEF.—Any person aggrieved
2 by a violation of clause (i) or clause (ii)
3 may, in a civil action, obtain all appro-
4 priate relief, including reinstatement, reim-
5 bursement of lost wages, compensation,
6 and benefits, and exemplary damages
7 where warranted, and such other relief as
8 the court deems appropriate, as well as
9 costs of suit and reasonable attorney and
10 expert witness fees.

11 “(iv) RIGHTS NOT WAIVABLE.—The
12 rights protected by this paragraph may not
13 be diminished by contract or other agree-
14 ment, and nothing in this paragraph shall
15 be construed to diminish any greater or
16 additional protection provided by Federal
17 or State law or by contract or other agree-
18 ment.

19 “(v) REQUIREMENT TO POST NOTICE
20 OF EMPLOYEE RIGHTS.—Each skilled
21 nursing facility shall post conspicuously in
22 an appropriate location a sign (in a form
23 specified by the Secretary) specifying the
24 rights of persons under this paragraph and
25 including a statement that an employee

1 may file a complaint with the Secretary
2 against a skilled nursing facility that vio-
3 lates the provisions of this paragraph and
4 information with respect to the manner of
5 filing such a complaint.

6 “(D) RULE OF CONSTRUCTION.—Nothing
7 in this paragraph shall be construed as pre-
8 venting a resident of a skilled nursing facility
9 (or a person acting on the resident’s behalf)
10 from submitting a complaint in a manner or
11 format other than by using the standardized
12 complaint form developed under subsection
13 (f)(9) (including submitting a complaint orally).

14 “(E) GOOD FAITH DEFINED.—For pur-
15 poses of this paragraph, an individual shall be
16 deemed to be acting in good faith with respect
17 to the filing of a complaint if the individual rea-
18 sonably believes—

19 “(i) the information reported or dis-
20 closed in the complaint is true; and

21 “(ii) the violation of this title has oc-
22 curred or may occur in relation to such in-
23 formation.”.

24 (b) NURSING FACILITIES.—

1 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
2 tion 1919(f) of the Social Security Act (42 U.S.C.
3 1395i–3(f)), as amended by section 1413(b), is
4 amended by adding at the end the following new
5 paragraph:

6 “(11) STANDARDIZED COMPLAINT FORM.—The
7 Secretary shall develop a standardized complaint
8 form for use by a resident (or a person acting on the
9 resident’s behalf) in filing a complaint with a State
10 survey and certification agency and a State long-
11 term care ombudsman program with respect to a
12 nursing facility.”.

13 (2) STATE REQUIREMENTS.—Section 1919(e)
14 of the Social Security Act (42 U.S.C. 1395i–3(e)) is
15 amended by adding at the end the following new
16 paragraph:

17 “(8) COMPLAINT PROCESSES AND WHISTLE-
18 BLOWER PROTECTION.—

19 “(A) COMPLAINT FORMS.—The State must
20 make the standardized complaint form devel-
21 oped under subsection (f)(11) available upon re-
22 quest to—

23 “(i) a resident of a nursing facility;

24 “(ii) any person acting on the resi-
25 dent’s behalf; and

1 “(iii) any person who works at a nurs-
2 ing facility or a representative of such a
3 worker.

4 “(B) COMPLAINT RESOLUTION PROCESS.—
5 The State must establish a complaint resolution
6 process in order to ensure that a resident, the
7 legal representative of a resident of a nursing
8 facility, or other responsible party is not retali-
9 ated against if the resident, legal representa-
10 tive, or responsible party has complained, in
11 good faith, about the quality of care or other
12 issues relating to the nursing facility, that the
13 legal representative of a resident of a nursing
14 facility or other responsible party is not denied
15 access to such resident or otherwise retaliated
16 against if such representative party has com-
17 plained, in good faith, about the quality of care
18 provided by the facility or other issues relating
19 to the facility, and that a person who works at
20 a nursing facility is not retaliated against if the
21 worker has complained, in good faith, about
22 quality of care or services or an issue relating
23 to the quality of care or services provided at the
24 facility, whether the resident, legal representa-
25 tive, other responsible party, or worker used the

1 form developed under subsection (f)(11) or
2 some other method for submitting the com-
3 plaint. Such complaint resolution process shall
4 include—

5 “(i) procedures to assure accurate
6 tracking of complaints received, including
7 notification to the complainant that a com-
8 plaint has been received;

9 “(ii) procedures to determine the like-
10 ly severity of a complaint and for the in-
11 vestigation of the complaint;

12 “(iii) deadlines for responding to a
13 complaint and for notifying the complain-
14 ant of the outcome of the investigation;
15 and

16 “(iv) procedures to ensure that the
17 identity of the complainant will be kept
18 confidential.

19 “(C) WHISTLEBLOWER PROTECTION.—

20 “(i) PROHIBITION AGAINST RETALIA-
21 TION.—No person who works at a nursing
22 facility may be penalized, discriminated, or
23 retaliated against with respect to any as-
24 pect of employment, including discharge,
25 promotion, compensation, terms, condi-

1 tions, or privileges of employment, or have
2 a contract for services terminated, because
3 the person (or anyone acting at the per-
4 son's request) complained, in good faith,
5 about the quality of care or services pro-
6 vided by a nursing facility or about other
7 issues relating to quality of care or serv-
8 ices, whether using the form developed
9 under subsection (f)(11) or some other
10 method for submitting the complaint.

11 “(ii) RETALIATORY REPORTING.—A
12 nursing facility may not file a complaint or
13 a report against a person who works (or
14 has worked at the facility with the appro-
15 priate State professional disciplinary agen-
16 cy because the person (or anyone acting at
17 the person's request) complained in good
18 faith, as described in clause (i).

19 “(iii) RELIEF.—Any person aggrieved
20 by a violation of clause (i) or clause (ii)
21 may, in a civil action, obtain all appro-
22 priate relief, including reinstatement, reim-
23 bursement of lost wages, compensation,
24 and benefits, and exemplary damages
25 where warranted, and such other relief as

1 the court deems appropriate, as well as
2 costs of suit and reasonable attorney and
3 expert witness fees.

4 “(iv) RIGHTS NOT WAIVABLE.—The
5 rights protected by this paragraph may not
6 be diminished by contract or other agree-
7 ment, and nothing in this paragraph shall
8 be construed to diminish any greater or
9 additional protection provided by Federal
10 or State law or by contract or other agree-
11 ment.

12 “(v) REQUIREMENT TO POST NOTICE
13 OF EMPLOYEE RIGHTS.—Each nursing fa-
14 cility shall post conspicuously in an appro-
15 priate location a sign (in a form specified
16 by the Secretary) specifying the rights of
17 persons under this paragraph and includ-
18 ing a statement that an employee may file
19 a complaint with the Secretary against a
20 nursing facility that violates the provisions
21 of this paragraph and information with re-
22 spect to the manner of filing such a com-
23 plaint.

24 “(D) RULE OF CONSTRUCTION.—Nothing
25 in this paragraph shall be construed as pre-

1 venting a resident of a nursing facility (or a
2 person acting on the resident's behalf) from
3 submitting a complaint in a manner or format
4 other than by using the standardized complaint
5 form developed under subsection (f)(11) (in-
6 cluding submitting a complaint orally).

7 “(E) GOOD FAITH DEFINED.—For pur-
8 poses of this paragraph, an individual shall be
9 deemed to be acting in good faith with respect
10 to the filing of a complaint if the individual rea-
11 sonably believes—

12 “(i) the information reported or dis-
13 closed in the complaint is true; and

14 “(ii) the violation of this title has oc-
15 curred or may occur in relation to such in-
16 formation.”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect 1 year after the date of the
19 enactment of this Act.

20 **SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.**

21 (a) SKILLED NURSING FACILITIES.—Section
22 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i-
23 3(b)(8)) is amended by adding at the end the following
24 new subparagraph:

1 “(C) SUBMISSION OF STAFFING INFORMA-
2 TION BASED ON PAYROLL DATA IN A UNIFORM
3 FORMAT.—On and after the first day of the
4 first calendar quarter beginning after the date
5 that is 2 years after the date of enactment of
6 this subparagraph, and after consulting with
7 State long-term care ombudsman programs,
8 consumer advocacy groups, provider stakeholder
9 groups, employees and their representatives,
10 and other parties the Secretary deems appro-
11 priate, the Secretary shall require a skilled
12 nursing facility to electronically submit to the
13 Secretary direct care staffing information (in-
14 cluding information with respect to agency and
15 contract staff) based on payroll and other
16 verifiable and auditable data in a uniform for-
17 mat (according to specifications established by
18 the Secretary in consultation with such pro-
19 grams, groups, and parties). Such specifications
20 shall require that the information submitted
21 under the preceding sentence—

22 “(i) specify the category of work a
23 certified employee performs (such as
24 whether the employee is a registered nurse,
25 licensed practical nurse, licensed vocational

1 nurse, certified nursing assistant, thera-
2 pist, or other medical personnel);

3 “(ii) include resident census data and
4 information on resident case mix;

5 “(iii) include a regular reporting
6 schedule; and

7 “(iv) include information on employee
8 turnover and tenure and on the hours of
9 care provided by each category of certified
10 employees referenced in clause (i) per resi-
11 dent per day.

12 Nothing in this subparagraph shall be con-
13 strued as preventing the Secretary from requir-
14 ing submission of such information with respect
15 to specific categories, such as nursing staff, be-
16 fore other categories of certified employees. In-
17 formation under this subparagraph with respect
18 to agency and contract staff shall be kept sepa-
19 rate from information on employee staffing.”.

20 (b) NURSING FACILITIES.—Section 1919(b)(8) of the
21 Social Security Act (42 U.S.C. 1396r(b)(8)) is amended
22 by adding at the end the following new subparagraph:

23 “(C) SUBMISSION OF STAFFING INFORMA-
24 TION BASED ON PAYROLL DATA IN A UNIFORM
25 FORMAT.—On and after the first day of the

1 first calendar quarter beginning after the date
2 that is 2 years after the date of enactment of
3 this subparagraph, and after consulting with
4 State long-term care ombudsman programs,
5 consumer advocacy groups, provider stakeholder
6 groups, employees and their representatives,
7 and other parties the Secretary deems appro-
8 priate, the Secretary shall require a nursing fa-
9 cility to electronically submit to the Secretary
10 direct care staffing information (including in-
11 formation with respect to agency and contract
12 staff) based on payroll and other verifiable and
13 auditable data in a uniform format (according
14 to specifications established by the Secretary in
15 consultation with such programs, groups, and
16 parties). Such specifications shall require that
17 the information submitted under the preceding
18 sentence—

19 “(i) specify the category of work a
20 certified employee performs (such as
21 whether the employee is a registered nurse,
22 licensed practical nurse, licensed vocational
23 nurse, certified nursing assistant, thera-
24 pist, or other medical personnel);

1 “(ii) include resident census data and
2 information on resident case mix;

3 “(iii) include a regular reporting
4 schedule; and

5 “(iv) include information on employee
6 turnover and tenure and on the hours of
7 care provided by each category of certified
8 employees referenced in clause (i) per resi-
9 dent per day.

10 Nothing in this subparagraph shall be con-
11 strued as preventing the Secretary from requir-
12 ing submission of such information with respect
13 to specific categories, such as nursing staff, be-
14 fore other categories of certified employees. In-
15 formation under this subparagraph with respect
16 to agency and contract staff shall be kept sepa-
17 rate from information on employee staffing.”.

18 **SEC. 1417. NATIONWIDE PROGRAM FOR NATIONAL AND**
19 **STATE BACKGROUND CHECKS ON DIRECT PA-**
20 **TIENT ACCESS EMPLOYEES OF LONG-TERM**
21 **CARE FACILITIES AND PROVIDERS.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services (in this section referred to as the “Sec-
24 retary”), shall establish a program to identify efficient, ef-
25 fective, and economical procedures for long term care fa-

1 cilities or providers to conduct background checks on pro-
2 spective direct patient access employees on a nationwide
3 basis (in this subsection, such program shall be referred
4 to as the “nationwide program”). The Secretary shall
5 carry out the nationwide program under similar terms and
6 conditions as the pilot program under section 307 of the
7 Medicare Prescription Drug, Improvement, and Mod-
8 ernization Act of 2003 (Public Law 108–173; 117 Stat.
9 2257), including the prohibition on hiring abusive workers
10 and the authorization of the imposition of penalties by a
11 participating State under subsections (b)(3)(A) and
12 (b)(6), respectively, of such section 307. The program
13 under this subsection shall contain the following modifica-
14 tions to such pilot program:

15 (1) AGREEMENTS.—

16 (A) NEWLY PARTICIPATING STATES.—The
17 Secretary shall enter into agreements with each
18 State—

19 (i) that the Secretary has not entered
20 into an agreement with under subsection
21 (c)(1) of such section 307;

22 (ii) that agrees to conduct background
23 checks under the nationwide program on a
24 Statewide basis; and

1 (iii) that submits an application to the
2 Secretary containing such information and
3 at such time as the Secretary may specify.

4 (B) CERTAIN PREVIOUSLY PARTICIPATING
5 STATES.—The Secretary shall enter into agree-
6 ments with each State—

7 (i) that the Secretary has entered into
8 an agreement with under such subsection
9 (c)(1);

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 (2) NONAPPLICATION OF SELECTION CRI-
17 TERIA.—The selection criteria required under sub-
18 section (c)(3)(B) of such section 307 shall not apply.

19 (3) REQUIRED FINGERPRINT CHECK AS PART
20 OF CRIMINAL BACKGROUND CHECK.—The proce-
21 dures established under subsection (b)(1) of such
22 section 307 shall—

23 (A) require that the long-term care facility
24 or provider (or the designated agent of the
25 long-term care facility or provider) obtain State

1 and national criminal or other background
2 checks on the prospective employee through
3 such means as the Secretary determines appro-
4 priate that utilize a search of State-based abuse
5 and neglect registries and databases, including
6 the abuse and neglect registries of another
7 State in the case where a prospective employee
8 previously resided in that State, State criminal
9 history records, the records of any proceedings
10 in the State that may contain disqualifying in-
11 formation about prospective employees (such as
12 proceedings conducted by State professional li-
13 censing and disciplinary boards and State Med-
14 icaid Fraud Control Units), and Federal crimi-
15 nal history records, including a fingerprint
16 check using the Integrated Automated Finger-
17 print Identification System of the Federal Bu-
18 reau of Investigation; and

19 (B) require States to describe and test
20 methods that reduce duplicative fingerprinting,
21 including providing for the development of “rap
22 back” capability by the State such that, if a di-
23 rect patient access employee of a long-term care
24 facility or provider is convicted of a crime fol-
25 lowing the initial criminal history background

1 check conducted with respect to such employee,
2 and the employee's fingerprints match the
3 prints on file with the State law enforcement
4 department, the department will immediately
5 inform the State and the State will immediately
6 inform the long-term care facility or provider
7 which employs the direct patient access em-
8 ployee of such conviction.

9 (4) STATE REQUIREMENTS.—An agreement en-
10 tered into under paragraph (1) shall require that a
11 participating State—

12 (A) be responsible for monitoring compli-
13 ance with the requirements of the nationwide
14 program;

15 (B) have procedures in place to—

16 (i) conduct screening and criminal or
17 other background checks under the nation-
18 wide program in accordance with the re-
19 quirements of this section;

20 (ii) monitor compliance by long-term
21 care facilities and providers with the proce-
22 dures and requirements of the nationwide
23 program;

24 (iii) as appropriate, provide for a pro-
25 visional period of employment by a long-

1 term care facility or provider of a direct
2 patient access employee, not to exceed 60
3 days, pending completion of the required
4 criminal history background check and, in
5 the case where the employee has appealed
6 the results of such background check,
7 pending completion of the appeals process,
8 during which the employee shall be subject
9 to direct on-site supervision (in accordance
10 with procedures established by the State to
11 ensure that a long-term care facility or
12 provider furnishes such direct on-site su-
13 pervision);

14 (iv) provide an independent process by
15 which a provisional employee or an em-
16 ployee may appeal or dispute the accuracy
17 of the information obtained in a back-
18 ground check performed under the nation-
19 wide program, including the specification
20 of criteria for appeals for direct patient ac-
21 cess employees found to have disqualifying
22 information which shall include consider-
23 ation of the passage of time, extenuating
24 circumstances, demonstration of rehabilita-
25 tion, and relevancy of the particular dis-

1 qualifying information with respect to the
2 current employment of the individual;

3 (v) provide for the designation of a
4 single State agency as responsible for—

5 (I) overseeing the coordination of
6 any State and national criminal his-
7 tory background checks requested by
8 a long-term care facility or provider
9 (or the designated agent of the long-
10 term care facility or provider) utilizing
11 a search of State and Federal crimi-
12 nal history records, including a finger-
13 print check of such records;

14 (II) overseeing the design of ap-
15 propriate privacy and security safe-
16 guards for use in the review of the re-
17 sults of any State or national criminal
18 history background checks conducted
19 regarding a prospective direct patient
20 access employee to determine whether
21 the employee has any conviction for a
22 relevant crime;

23 (III) immediately reporting to
24 the long-term care facility or provider
25 that requested the criminal history

1 background check the results of such
2 review; and

3 (IV) in the case of an employee
4 with a conviction for a relevant crime
5 that is subject to reporting under sec-
6 tion 1128E of the Social Security Act
7 (42 U.S.C. 1320a-7e), reporting the
8 existence of such conviction to the
9 database established under that sec-
10 tion;

11 (vi) determine which individuals are
12 direct patient access employees (as defined
13 in paragraph (6)(B)) for purposes of the
14 nationwide program;

15 (vii) as appropriate, specify offenses,
16 including convictions for violent crimes, for
17 purposes of the nationwide program; and

18 (viii) describe and test methods that
19 reduce duplicative fingerprinting, including
20 providing for the development of “rap
21 back” capability such that, if a direct pa-
22 tient access employee of a long-term care
23 facility or provider is convicted of a crime
24 following the initial criminal history back-
25 ground check conducted with respect to

1 such employee, and the employee's finger-
2 prints match the prints on file with the
3 State law enforcement department—

4 (I) the department will imme-
5 diately inform the State agency des-
6 ignated under clause (v) and such
7 agency will immediately inform the fa-
8 cility or provider which employs the
9 direct patient access employee of such
10 conviction; and

11 (II) the State will provide, or will
12 require the facility to provide, to the
13 employee a copy of the results of the
14 criminal history background check
15 conducted with respect to the em-
16 ployee at no charge in the case where
17 the individual requests such a copy.

18 Background checks and screenings under
19 this subsection shall be valid for a period
20 of no longer than 2 years, as determined
21 by the State and approved by the Sec-
22 retary.

23 (5) PAYMENTS.—

24 (A) NEWLY PARTICIPATING STATES.—

1 (i) IN GENERAL.—As part of the ap-
2 plication submitted by a State under para-
3 graph (1)(A)(iii), the State shall guar-
4 antee, with respect to the costs to be in-
5 curred by the State in carrying out the na-
6 tionwide program, that the State will make
7 available (directly or through donations
8 from public or private entities) a particular
9 amount of non-Federal contributions, as a
10 condition of receiving the Federal match
11 under clause (ii).

12 (ii) FEDERAL MATCH.—The payment
13 amount to each State that the Secretary
14 enters into an agreement with under para-
15 graph (1)(A) shall be 3 times the amount
16 that the State guarantees to make avail-
17 able under clause (i).

18 (B) PREVIOUSLY PARTICIPATING
19 STATES.—

20 (i) IN GENERAL.—As part of the ap-
21 plication submitted by a State under para-
22 graph (1)(B)(iii), the State shall guar-
23 antee, with respect to the costs to be in-
24 curred by the State in carrying out the na-
25 tionwide program, that the State will make

1 available (directly or through donations
2 from public or private entities) a particular
3 amount of non-Federal contributions, as a
4 condition of receiving the Federal match
5 under clause (ii).

6 (ii) FEDERAL MATCH.—The payment
7 amount to each State that the Secretary
8 enters into an agreement with under para-
9 graph (1)(B) shall be 3 times the amount
10 that the State guarantees to make avail-
11 able under clause (i).

12 (6) DEFINITIONS.—Under the nationwide pro-
13 gram:

14 (A) LONG-TERM CARE FACILITY OR PRO-
15 VIDER.—The term “long-term care facility or
16 provider” means the following facilities or pro-
17 viders which receive payment for services under
18 title XVIII or XIX of the Social Security Act:

19 (i) A skilled nursing facility (as de-
20 fined in section 1819(a) of the Social Secu-
21 rity Act (42 U.S.C. 1395i–3(a))).

22 (ii) A nursing facility (as defined in
23 section 1919(a) of such Act (42 U.S.C.
24 1396r(a))).

25 (iii) A home health agency.

1 (iv) A provider of hospice care (as de-
2 fined in section 1861(dd)(1) of such Act
3 (42 U.S.C. 1395x(dd)(1))).

4 (v) A long-term care hospital (as de-
5 scribed in section 1886(d)(1)(B)(iv) of
6 such Act (42 U.S.C.
7 1395ww(d)(1)(B)(iv))).

8 (vi) A provider of personal care serv-
9 ices.

10 (vii) A provider of adult day care.

11 (viii) A residential care provider that
12 arranges for, or directly provides, long-
13 term care services, including an assisted
14 living facility that provides a nursing home
15 level of care conveyed by State licensure or
16 State definition.

17 (ix) An intermediate care facility for
18 the mentally retarded (as defined in sec-
19 tion 1905(d) of such Act (42 U.S.C.
20 1396d(d))).

21 (x) Any other facility or provider of
22 long-term care services under such titles as
23 the participating State determines appro-
24 priate.

1 (B) DIRECT PATIENT ACCESS EM-
2 PLOYEE.—The term “direct patient access em-
3 ployee” means any individual who has access to
4 a patient or resident of a long-term care facility
5 or provider through employment or through a
6 contract with such facility or provider and has
7 duties that involve (or may involve) one-on-one
8 contact with a patient or resident of the facility
9 or provider, as determined by the State for pur-
10 poses of the nationwide program. Such term
11 does not include a volunteer unless the volun-
12 teer has duties that are equivalent to the duties
13 of a direct patient access employee and those
14 duties involve (or may involve) one-on-one con-
15 tact with a patient or resident of the long-term
16 care facility or provider.

17 (7) EVALUATION AND REPORT.—

18 (A) EVALUATION.—The Inspector General
19 of the Department of Health and Human Serv-
20 ices shall conduct an evaluation of the nation-
21 wide program. Such evaluation shall include—

22 (i) a review of the various procedures
23 implemented by participating States for
24 long-term care facilities or providers, in-
25 cluding staffing agencies, to conduct back-

1 ground checks of direct patient access em-
2 ployees and identify the most efficient, ef-
3 fective, and economical procedures for con-
4 ducting such background checks;

5 (ii) an assessment of the costs of con-
6 ducting such background checks (including
7 start-up and administrative costs);

8 (iii) a determination of the extent to
9 which conducting such background checks
10 leads to any unintended consequences, in-
11 cluding a reduction in the available work-
12 force for such facilities or providers;

13 (iv) an assessment of the impact of
14 the program on reducing the number of in-
15 cidents of neglect, abuse, and misappro-
16 priation of resident property to the extent
17 practicable; and

18 (v) an evaluation of other aspects of
19 the program, as determined appropriate by
20 the Secretary.

21 (B) REPORT.—Not later than 180 days
22 after the completion of the nationwide program,
23 the Inspector General of the Department of
24 Health and Human Services shall submit a re-

1 port to Congress containing the results of the
2 evaluation conducted under subparagraph (A).

3 (b) FUNDING.—

4 (1) NOTIFICATION.—The Secretary of Health
5 and Human Services shall notify the Secretary of
6 the Treasury of the amount necessary to carry out
7 the nationwide program under this section, including
8 costs for the Department of Health and Human
9 Services to administer and evaluate the program, for
10 the period of fiscal years 2010 through 2012, except
11 that in no case shall such amount exceed
12 \$160,000,000.

13 (2) TRANSFER OF FUNDS.—Out of any funds
14 in the Treasury not otherwise appropriated, the Sec-
15 retary of the Treasury shall provide for the transfer
16 to the Secretary of Health and Human Services of
17 the amount specified as necessary to carry out the
18 nationwide program under paragraph (1). Such
19 amount shall remain available until expended.

20 **PART 2—TARGETING ENFORCEMENT**

21 **SEC. 1421. CIVIL MONEY PENALTIES.**

22 (a) SKILLED NURSING FACILITIES.—

23 (1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of
24 the Social Security Act (42 U.S.C. 1395i-
25 3(h)(2)(B)(ii)) is amended to read as follows:

1 “(ii) AUTHORITY WITH RESPECT TO
2 CIVIL MONEY PENALTIES.—

3 “(I) AMOUNT.—The Secretary
4 may impose a civil money penalty in
5 the applicable per instance or per day
6 amount (as defined in subclause (II)
7 and (III)) for each day or instance,
8 respectively, of noncompliance (as de-
9 termined appropriate by the Sec-
10 retary).

11 “(II) APPLICABLE PER INSTANCE
12 AMOUNT.—In this clause, the term
13 ‘applicable per instance amount’
14 means—

15 “(aa) in the case where the
16 deficiency is found to be a direct
17 proximate cause of death of a
18 resident of the facility, an
19 amount not to exceed \$100,000.

20 “(bb) in each case of a defi-
21 ciency where the facility is cited
22 for actual harm or immediate
23 jeopardy, an amount not less
24 than \$3,050 and not more than
25 \$25,000; and

1 “(cc) in each case of any
2 other deficiency, an amount not
3 less than \$250 and not to exceed
4 \$3050.

5 “(III) APPLICABLE PER DAY
6 AMOUNT.—In this clause, the term
7 ‘applicable per day amount’ means—

8 “(aa) in each case of a defi-
9 ciency where the facility is cited
10 for actual harm or immediate
11 jeopardy, an amount not less
12 than \$3,050 and not more than
13 \$25,000 and

14 “(bb) in each case of any
15 other deficiency, an amount not
16 less than \$250 and not to exceed
17 \$3,050.

18 “(IV) REDUCTION OF CIVIL
19 MONEY PENALTIES IN CERTAIN CIR-
20 CUMSTANCES.—Subject to subclauses
21 (V) and (VI), in the case where a fa-
22 cility self-reports and promptly cor-
23 rects a deficiency for which a penalty
24 was imposed under this clause not
25 later than 10 calendar days after the

1 date of such imposition, the Secretary
2 may reduce the amount of the penalty
3 imposed by not more than 50 percent.

4 “(V) PROHIBITION ON REDUC-
5 TION FOR CERTAIN DEFICIENCIES.—

6 “(aa) REPEAT DEFICI-
7 CIENCIES.—The Secretary may
8 not reduce under subclause (IV)
9 the amount of a penalty if the
10 deficiency is a repeat deficiency.

11 “(bb) CERTAIN OTHER DE-
12 FICIENCIES.—The Secretary may
13 not reduce under subclause (IV)
14 the amount of a penalty if the
15 penalty is imposed for a defi-
16 ciency described in subclause
17 (II)(aa) or (III)(aa) and the ac-
18 tual harm or widespread harm
19 immediately jeopardizes the
20 health or safety of a resident or
21 residents of the facility, or if the
22 penalty is imposed for a defi-
23 ciency described in subclause
24 (II)(bb).

1 “(VI) LIMITATION ON AGGREGATE
2 GATE REDUCTIONS.—The aggregate
3 reduction in a penalty under sub-
4 clause (IV) may not exceed 35 percent
5 on the basis of self-reporting, on the
6 basis of a waiver of an appeal (as pro-
7 vided for under regulations under sec-
8 tion 488.436 of title 42, Code of Fed-
9 eral Regulations), or on the basis of
10 both.

11 “(VII) COLLECTION OF CIVIL
12 MONEY PENALTIES.—In the case of a
13 civil money penalty imposed under
14 this clause, the Secretary—

15 “(aa) subject to item (cc),
16 shall, not later than 30 days
17 after the date of imposition of
18 the penalty, provide the oppor-
19 tunity for the facility to partici-
20 pate in an independent informal
21 dispute resolution process, estab-
22 lished by the State survey agen-
23 cy, which generates a written
24 record prior to the collection of
25 such penalty, but such oppor-

1 tunity shall not affect the respon-
2 sibility of the State survey agen-
3 cy for making final recommenda-
4 tions for such penalties;

5 “(bb) in the case where the
6 penalty is imposed for each day
7 of noncompliance, shall not im-
8 pose a penalty for any day during
9 the period beginning on the ini-
10 tial day of the imposition of the
11 penalty and ending on the day on
12 which the informal dispute reso-
13 lution process under item (aa) is
14 completed;

15 “(cc) may provide for the
16 collection of such civil money
17 penalty and the placement of
18 such amounts collected in an es-
19 crow account under the direction
20 of the Secretary on the earlier of
21 the date on which the informal
22 dispute resolution process under
23 item (aa) is completed or the
24 date that is 90 days after the

1 date of the imposition of the pen-
2 alty;

3 “(dd) may provide that such
4 amounts collected are kept in
5 such account pending the resolu-
6 tion of any subsequent appeals;

7 “(ee) in the case where the
8 facility successfully appeals the
9 penalty, may provide for the re-
10 turn of such amounts collected
11 (plus interest) to the facility; and

12 “(ff) in the case where all
13 such appeals are unsuccessful,
14 may provide that some portion of
15 such amounts collected may be
16 used to support activities that
17 benefit residents, including as-
18 sistance to support and protect
19 residents of a facility that closes
20 (voluntarily or involuntarily) or is
21 decertified (including offsetting
22 costs of relocating residents to
23 home and community-based set-
24 tings or another facility), projects
25 that support resident and family

1 councils and other consumer in-
2 volvement in assuring quality
3 care in facilities, and facility im-
4 provement initiatives approved by
5 the Secretary (including joint
6 training of facility staff and sur-
7 veyors, technical assistance for
8 facilities under quality assurance
9 programs, the appointment of
10 temporary management, and
11 other activities approved by the
12 Secretary).

13 “(VIII) PROCEDURE.—The pro-
14 visions of section 1128A (other than
15 subsections (a) and (b) and except to
16 the extent that such provisions require
17 a hearing prior to the imposition of a
18 civil money penalty) shall apply to a
19 civil money penalty under this clause
20 in the same manner as such provi-
21 sions apply to a penalty or proceeding
22 under section 1128A(a).”.

23 (2) CONFORMING AMENDMENT.—The second
24 sentence of section 1819(h)(5) of the Social Security

1 Act (42 U.S.C. 1395i-3(h)(5)) is amended by insert-
2 ing “(ii),” after “(i),”.

3 (b) NURSING FACILITIES.—

4 (1) PENALTIES IMPOSED BY THE STATE.—

5 (A) IN GENERAL.—Section 1919(h)(2) of
6 the Social Security Act (42 U.S.C. 1396r(h)(2))
7 is amended—

8 (i) in subparagraph (A)(ii), by strik-
9 ing the first sentence and inserting the fol-
10 lowing: “A civil money penalty in accord-
11 ance with subparagraph (G).”; and

12 (ii) by adding at the end the following
13 new subparagraph:

14 “(G) CIVIL MONEY PENALTIES.—

15 “(i) IN GENERAL.—The State may
16 impose a civil money penalty under sub-
17 paragraph (A)(ii) in the applicable per in-
18 stance or per day amount (as defined in
19 subclause (II) and (III)) for each day or
20 instance, respectively, of noncompliance (as
21 determined appropriate by the Secretary).

22 “(ii) APPLICABLE PER INSTANCE
23 AMOUNT.—In this subparagraph, the term
24 ‘applicable per instance amount’ means—

1 “(I) in the case where the defi-
2 ciency is found to be a direct proxi-
3 mate cause of death of a resident of
4 the facility, an amount not to exceed
5 \$100,000.

6 “(II) in each case of a deficiency
7 where the facility is cited for actual
8 harm or immediate jeopardy, an
9 amount not less than \$3,050 and not
10 more than \$25,000; and

11 “(III) in each case of any other
12 deficiency, an amount not less than
13 \$250 and not to exceed \$3050.

14 “(iii) APPLICABLE PER DAY
15 AMOUNT.—In this subparagraph, the term
16 ‘applicable per day amount’ means—

17 “(I) in each case of a deficiency
18 where the facility is cited for actual
19 harm or immediate jeopardy, an
20 amount not less than \$3,050 and not
21 more than \$25,000 and

22 “(II) in each case of any other
23 deficiency, an amount not less than
24 \$250 and not to exceed \$3,050.

1 “(iv) REDUCTION OF CIVIL MONEY
2 PENALTIES IN CERTAIN CIR-
3 CUMSTANCES.—Subject to clauses (v) and
4 (vi), in the case where a facility self-re-
5 ports and promptly corrects a deficiency
6 for which a penalty was imposed under
7 subparagraph (A)(ii) not later than 10 cal-
8 endar days after the date of such imposi-
9 tion, the State may reduce the amount of
10 the penalty imposed by not more than 50
11 percent.

12 “(v) PROHIBITION ON REDUCTION
13 FOR CERTAIN DEFICIENCIES.—

14 “(I) REPEAT DEFICIENCIES.—
15 The State may not reduce under
16 clause (iv) the amount of a penalty if
17 the State had reduced a penalty im-
18 posed on the facility in the preceding
19 year under such clause with respect to
20 a repeat deficiency.

21 “(II) CERTAIN OTHER DEFICI-
22 ENCIES.—The State may not reduce
23 under clause (iv) the amount of a pen-
24 alty if the penalty is imposed for a de-
25 ficiency described in clause (ii)(II) or

1 (iii)(I) and the actual harm or wide-
2 spread harm that immediately jeop-
3 ardizes the health or safety of a resi-
4 dent or residents of the facility, or if
5 the penalty is imposed for a deficiency
6 described in clause (ii)(I).

7 “(III) LIMITATION ON AGGRE-
8 GATE REDUCTIONS.—The aggregate
9 reduction in a penalty under clause
10 (iv) may not exceed 35 percent on the
11 basis of self-reporting, on the basis of
12 a waiver of an appeal (as provided for
13 under regulations under section
14 488.436 of title 42, Code of Federal
15 Regulations), or on the basis of both.

16 “(vi) COLLECTION OF CIVIL MONEY
17 PENALTIES.—In the case of a civil money
18 penalty imposed under subparagraph
19 (A)(ii), the State—

20 “(I) subject to subclause (III),
21 shall, not later than 30 days after the
22 date of imposition of the penalty, pro-
23 vide the opportunity for the facility to
24 participate in an independent informal
25 dispute resolution process, established

1 by the State survey agency, which
2 generates a written record prior to the
3 collection of such penalty, but such
4 opportunity shall not affect the re-
5 sponsibility of the State survey agency
6 for making final recommendations for
7 such penalties;

8 “(II) in the case where the pen-
9 alty is imposed for each day of non-
10 compliance, shall not impose a penalty
11 for any day during the period begin-
12 ning on the initial day of the imposi-
13 tion of the penalty and ending on the
14 day on which the informal dispute res-
15 olution process under subclause (I) is
16 completed;

17 “(III) may provide for the collec-
18 tion of such civil money penalty and
19 the placement of such amounts col-
20 lected in an escrow account under the
21 direction of the State on the earlier of
22 the date on which the informal dis-
23 pute resolution process under sub-
24 clause (I) is completed or the date

1 that is 90 days after the date of the
2 imposition of the penalty;

3 “(IV) may provide that such
4 amounts collected are kept in such ac-
5 count pending the resolution of any
6 subsequent appeals;

7 “(V) in the case where the facil-
8 ity successfully appeals the penalty,
9 may provide for the return of such
10 amounts collected (plus interest) to
11 the facility; and

12 “(VI) in the case where all such
13 appeals are unsuccessful, may provide
14 that such funds collected shall be used
15 for the purposes described in the sec-
16 ond sentence of subparagraph
17 (A)(ii).”.

18 (B) CONFORMING AMENDMENT.—The sec-
19 ond sentence of section 1919(h)(2)(A)(ii) of the
20 Social Security Act (42 U.S.C.
21 1396r(h)(2)(A)(ii)) is amended by inserting be-
22 fore the period at the end the following: “, and
23 some portion of such funds may be used to sup-
24 port activities that benefit residents, including
25 assistance to support and protect residents of a

1 facility that closes (voluntarily or involuntarily)
2 or is decertified (including offsetting costs of re-
3 locating residents to home and community-
4 based settings or another facility), projects that
5 support resident and family councils and other
6 consumer involvement in assuring quality care
7 in facilities, and facility improvement initiatives
8 approved by the Secretary (including joint
9 training of facility staff and surveyors, pro-
10 viding technical assistance to facilities under
11 quality assurance programs, the appointment of
12 temporary management, and other activities ap-
13 proved by the Secretary)”.
14

15 (2) PENALTIES IMPOSED BY THE SEC-
16 RETARY.—

17 (A) IN GENERAL.—Section
18 1919(h)(3)(C)(ii) of the Social Security Act (42
19 U.S.C. 1396r(h)(3)(C)) is amended to read as
20 follows:

21 “(ii) AUTHORITY WITH RESPECT TO
22 CIVIL MONEY PENALTIES.—

23 “(I) AMOUNT.—Subject to sub-
24 clause (II), the Secretary may impose
25 a civil money penalty in an amount
not to exceed \$10,000 for each day or

1 each instance of noncompliance (as
2 determined appropriate by the Sec-
3 retary).

4 “(II) REDUCTION OF CIVIL
5 MONEY PENALTIES IN CERTAIN CIR-
6 CUMSTANCES.—Subject to subclause
7 (III), in the case where a facility self-
8 reports and promptly corrects a defi-
9 ciency for which a penalty was im-
10 posed under this clause not later than
11 10 calendar days after the date of
12 such imposition, the Secretary may
13 reduce the amount of the penalty im-
14 posed by not more than 50 percent.

15 “(III) PROHIBITION ON REDUC-
16 TION FOR REPEAT DEFICIENCIES.—
17 The Secretary may not reduce the
18 amount of a penalty under subclause
19 (II) if the Secretary had reduced a
20 penalty imposed on the facility in the
21 preceding year under such subclause
22 with respect to a repeat deficiency.

23 “(IV) COLLECTION OF CIVIL
24 MONEY PENALTIES.—In the case of a

1 civil money penalty imposed under
2 this clause, the Secretary—

3 “(aa) subject to item (bb),
4 shall, not later than 30 days
5 after the date of imposition of
6 the penalty, provide the oppor-
7 tunity for the facility to partici-
8 pate in an independent informal
9 dispute resolution process which
10 generates a written record prior
11 to the collection of such penalty;

12 “(bb) in the case where the
13 penalty is imposed for each day
14 of noncompliance, shall not im-
15 pose a penalty for any day during
16 the period beginning on the ini-
17 tial day of the imposition of the
18 penalty and ending on the day on
19 which the informal dispute reso-
20 lution process under item (aa) is
21 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-

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

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 under quality assurance
15 programs, the appointment of
16 temporary management, and
17 other activities approved by the
18 Secretary).

19 “(V) PROCEDURE.—The provi-
20 sions of section 1128A (other than
21 subsections (a) and (b) and except to
22 the extent that such provisions require
23 a hearing prior to the imposition of a
24 civil money penalty) shall apply to a
25 civil money penalty under this clause

1 in the same manner as such provi-
2 sions apply to a penalty or proceeding
3 under section 1128A(a).”.

4 (B) CONFORMING AMENDMENT.—Section
5 1919(h)(8) of the Social Security Act (42
6 U.S.C. 1396r(h)(5)(8)) is amended by inserting
7 “and in paragraph (3)(C)(ii)” after “paragraph
8 (2)(A)”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall take effect 1 year after the date of the
11 enactment of this Act.

12 **SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PRO-**
13 **GRAM.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—The Secretary, in consulta-
16 tion with the Inspector General of the Department
17 of Health and Human Services, shall establish a
18 pilot program (in this section referred to as the
19 “pilot program”) to develop, test, and implement use
20 of an independent monitor to oversee interstate and
21 large intrastate chains of skilled nursing facilities
22 and nursing facilities.

23 (2) SELECTION.—The Secretary shall select
24 chains of skilled nursing facilities and nursing facili-
25 ties described in paragraph (1) to participate in the

1 pilot program from among those chains that submit
2 an application to the Secretary at such time, in such
3 manner, and containing such information as the Sec-
4 retary may require.

5 (3) DURATION.—The Secretary shall conduct
6 the pilot program for a two-year period.

7 (4) IMPLEMENTATION.—The Secretary shall
8 implement the pilot program not later than one year
9 after the date of the enactment of this Act.

10 (b) REQUIREMENTS.—The Secretary shall evaluate
11 chains selected to participate in the pilot program based
12 on criteria selected by the Secretary, including where evi-
13 dence suggests that one or more facilities of the chain are
14 experiencing serious safety and quality of care problems.
15 Such criteria may include the evaluation of a chain that
16 includes one or more facilities participating in the “Special
17 Focus Facility” program (or a successor program) or one
18 or more facilities with a record of repeated serious safety
19 and quality of care deficiencies.

20 (c) RESPONSIBILITIES OF THE INDEPENDENT MON-
21 ITOR.—An independent monitor that enters into a con-
22 tract with the Secretary to participate in the conduct of
23 such program shall—

24 (1) conduct periodic reviews and prepare root-
25 cause quality and deficiency analyses of a chain to

1 assess if facilities of the chain are in compliance
2 with State and Federal laws and regulations applica-
3 ble to the facilities;

4 (2) undertake sustained oversight of the chain,
5 whether publicly or privately held, to involve the
6 owners of the chain and the principal business part-
7 ners of such owners in facilitating compliance by fa-
8 cilities of the chain with State and Federal laws and
9 regulations applicable to the facilities;

10 (3) analyze the management structure, distribu-
11 tion of expenditures, and nurse staffing levels of fa-
12 cilities of the chain in relation to resident census,
13 staff turnover rates, and tenure;

14 (4) report findings and recommendations with
15 respect to such reviews, analyses, and oversight to
16 the chain and facilities of the chain, to the Secretary
17 and to relevant States; and

18 (5) publish the results of such reviews, anal-
19 yses, and oversight.

20 (d) IMPLEMENTATION OF RECOMMENDATIONS.—

21 (1) RECEIPT OF FINDING BY CHAIN.—Not later
22 than 10 days after receipt of a finding of an inde-
23 pendent monitor under subsection (c)(4), a chain
24 participating in the pilot program shall submit to
25 the independent monitor a report—

1 (A) outlining corrective actions the chain
2 will take to implement the recommendations in
3 such report; or

4 (B) indicating that the chain will not im-
5 plement such recommendations and why it will
6 not do so.

7 (2) RECEIPT OF REPORT BY INDEPENDENT
8 MONITOR.—Not later than 10 days after the date of
9 receipt of a report submitted by a chain under para-
10 graph (1), an independent monitor shall finalize its
11 recommendations and submit a report to the chain
12 and facilities of the chain, the Secretary, and the
13 State (or States) involved, as appropriate, containing
14 such final recommendations.

15 (e) COST OF APPOINTMENT.—A chain shall be re-
16 sponsible for a portion of the costs associated with the
17 appointment of independent monitors under the pilot pro-
18 gram. The chain shall pay such portion to the Secretary
19 (in an amount and in accordance with procedures estab-
20 lished by the Secretary).

21 (f) WAIVER AUTHORITY.—The Secretary may waive
22 such requirements of titles XVIII and XIX of the Social
23 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
24 may be necessary for the purpose of carrying out the pilot
25 program.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section.

4 (h) DEFINITIONS.—In this section:

5 (1) FACILITY.—The term “facility” means a
6 skilled nursing facility or a nursing facility.

7 (2) NURSING FACILITY.—The term “nursing
8 facility” has the meaning given such term in section
9 1919(a) of the Social Security Act (42 U.S.C.
10 1396r(a)).

11 (3) SECRETARY.—The term “Secretary” means
12 the Secretary of Health and Human Services, acting
13 through the Assistant Secretary for Planning and
14 Evaluation.

15 (4) SKILLED NURSING FACILITY.—The term
16 “skilled nursing facility” has the meaning given such
17 term in section 1819(a) of the Social Security Act
18 (42 U.S.C. 1395(a)).

19 (i) EVALUATION AND REPORT.—

20 (1) EVALUATION.—The Inspector General of
21 the Department of Health and Human Services shall
22 evaluate the pilot program. Such evaluation shall—

23 (A) determine whether the independent
24 monitor program should be established on a
25 permanent basis; and

1 (B) if the Inspector General determines
2 that the independent monitor program should
3 be established on a permanent basis, rec-
4 ommend appropriate procedures and mecha-
5 nisms for such establishment.

6 (2) REPORT.—Not later than 180 days after
7 the completion of the pilot program, the Inspector
8 General shall submit to Congress and the Secretary
9 a report containing the results of the evaluation con-
10 ducted under paragraph (1), together with rec-
11 ommendations for such legislation and administra-
12 tive action as the Inspector General determines ap-
13 propriate.

14 **SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.**

15 (a) SKILLED NURSING FACILITIES.—

16 (1) IN GENERAL.—Section 1819(c) of the So-
17 cial Security Act (42 U.S.C. 1395i–3(c)) is amended
18 by adding at the end the following new paragraph:

19 “(7) NOTIFICATION OF FACILITY CLOSURE.—

20 “(A) IN GENERAL.—Any individual who is
21 the administrator of a skilled nursing facility
22 must—

23 “(i) submit to the Secretary, the State
24 long-term care ombudsman, residents of
25 the facility, and the legal representatives of

1 such residents or other responsible parties,
2 written notification of an impending clo-
3 sure—

4 “(I) subject to subclause (II), not
5 later than the date that is 60 days
6 prior to the date of such closure; and

7 “(II) in the case of a facility
8 where the Secretary terminates the fa-
9 cility’s participation under this title,
10 not later than the date that the Sec-
11 retary determines appropriate;

12 “(ii) ensure that the facility does not
13 admit any new residents on or after the
14 date on which such written notification is
15 submitted; and

16 “(iii) include in the notice a plan for
17 the transfer and adequate relocation of the
18 residents of the facility by a specified date
19 prior to closure that has been approved by
20 the State, including assurances that the
21 residents will be transferred to the most
22 appropriate facility or other setting in
23 terms of quality, services, and location,
24 taking into consideration the needs and
25 best interests of each resident.

1 “(B) RELOCATION.—

2 “ (i) IN GENERAL.—The State shall
3 ensure that, before a facility closes, all
4 residents of the facility have been success-
5 fully relocated to another facility or an al-
6 ternative home and community-based set-
7 ting.

8 “ (ii) CONTINUATION OF PAYMENTS
9 UNTIL RESIDENTS RELOCATED.—The Sec-
10 retary may, as the Secretary determines
11 appropriate, continue to make payments
12 under this title with respect to residents of
13 a facility that has submitted a notification
14 under subparagraph (A) during the period
15 beginning on the date such notification is
16 submitted and ending on the date on which
17 the resident is successfully relocated.”.

18 (2) CONFORMING AMENDMENTS.—Section
19 1819(h)(4) of the Social Security Act (42 U.S.C.
20 1395i-3(h)(4)) is amended—

21 (A) in the first sentence, by striking “the
22 Secretary shall terminate” and inserting “the
23 Secretary, subject to subsection (c)(7), shall
24 terminate”; and

1 (B) in the second sentence, by striking
2 “subsection (c)(2)” and inserting “paragraphs
3 (2) and (7) of subsection (c)”.

4 (b) NURSING FACILITIES.—

5 (1) IN GENERAL.—Section 1919(c) of the So-
6 cial Security Act (42 U.S.C. 1396r(c)) is amended
7 by adding at the end the following new paragraph:

8 “(9) NOTIFICATION OF FACILITY CLOSURE.—

9 “(A) IN GENERAL.—Any individual who is
10 an administrator of a nursing facility must—

11 “(i) submit to the Secretary, the State
12 long-term care ombudsman, residents of
13 the facility, and the legal representatives of
14 such residents or other responsible parties,
15 written notification of an impending clo-
16 sure—

17 “(I) subject to subclause (II), not
18 later than the date that is 60 days
19 prior to the date of such closure; and

20 “(II) in the case of a facility
21 where the Secretary terminates the fa-
22 cility’s participation under this title,
23 not later than the date that the Sec-
24 retary determines appropriate;

1 “(ii) ensure that the facility does not
2 admit any new residents on or after the
3 date on which such written notification is
4 submitted; and

5 “(iii) include in the notice a plan for
6 the transfer and adequate relocation of the
7 residents of the facility by a specified date
8 prior to closure that has been approved by
9 the State, including assurances that the
10 residents will be transferred to the most
11 appropriate facility or other setting in
12 terms of quality, services, and location,
13 taking into consideration the needs and
14 best interests of each resident.

15 “(B) RELOCATION.—

16 “(i) IN GENERAL.—The State shall
17 ensure that, before a facility closes, all
18 residents of the facility have been success-
19 fully relocated to another facility or an al-
20 ternative home and community-based set-
21 ting.

22 “(ii) CONTINUATION OF PAYMENTS
23 UNTIL RESIDENTS RELOCATED.—The Sec-
24 retary may, as the Secretary determines
25 appropriate, continue to make payments

1 under this title with respect to residents of
2 a facility that has submitted a notification
3 under subparagraph (A) during the period
4 beginning on the date such notification is
5 submitted and ending on the date on which
6 the resident is successfully relocated.”.

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 **PART 3—IMPROVING STAFF TRAINING**

11 **SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.**

12 (a) SKILLED NURSING FACILITIES.—Section
13 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
14 1395i–3(f)(2)(A)(i)(I)) is amended by inserting “(includ-
15 ing, in the case of initial training and, if the Secretary
16 determines appropriate, in the case of ongoing training,
17 dementia management training and resident abuse preven-
18 tion training)” after “curriculum”.

19 (b) NURSING FACILITIES.—Section
20 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
21 1396r(f)(2)(A)(i)(I)) is amended by inserting “(including,
22 in the case of initial training and, if the Secretary deter-
23 mines appropriate, in the case of ongoing training, demen-
24 tia management training and resident abuse prevention
25 training)” after “curriculum”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect 1 year after the date of the
3 enactment of this Act.

4 **SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED**
5 **FOR CERTIFIED NURSE AIDES AND SUPER-**
6 **VISORY STAFF.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Secretary shall conduct
9 a study on the content of training for certified nurse
10 aides and supervisory staff of skilled nursing facili-
11 ties and nursing facilities. The study shall include an
12 analysis of the following:

13 (A) Whether the number of initial training
14 hours for certified nurse aides required under
15 sections 1819(f)(2)(A)(i)(II) and
16 1919(f)(2)(A)(i)(II) of the Social Security Act
17 (42 U.S.C. 1395i–3(f)(2)(A)(i)(II);
18 1396r(f)(2)(A)(i)(II)) should be increased from
19 75 and, if so, what the required number of ini-
20 tial training hours should be, including any rec-
21 ommendations for the content of such training
22 (including training related to dementia).

23 (B) Whether requirements for ongoing
24 training under such sections
25 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II)

1 should be increased from 12 hours per year, in-
2 cluding any recommendations for the content of
3 such training.

4 (2) CONSULTATION.—In conducting the anal-
5 ysis under paragraph (1)(A), the Secretary shall
6 consult with States that, as of the date of the enact-
7 ment of this Act, require more than 75 hours of
8 training for certified nurse aides.

9 (3) DEFINITIONS.—In this section:

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, acting through the Assistant Secretary
17 for Planning and Evaluation.

18 (C) SKILLED NURSING FACILITY.—The
19 term “skilled nursing facility” has the meaning
20 given such term in section 1819(a) of the Social
21 Security Act (42 U.S.C. 1395(a)).

22 (b) REPORT.—Not later than 2 years after the date
23 of the enactment of this Act, the Secretary shall submit
24 to Congress a report containing the results of the study
25 conducted under subsection (a), together with rec-

1 ommendations for such legislation and administrative ac-
2 tion as the Secretary determines appropriate.

3 **SEC. 1433. QUALIFICATION OF DIRECTOR OF FOOD SERV-**
4 **ICES OF A SKILLED NURSING FACILITY OR**
5 **NURSING FACILITY.**

6 (a) **MEDICARE.**—Section 1819(b)(4)(A) of the Social
7 Security Act (42 U.S.C. 1395i–3(b)(4)(A)) is amended by
8 adding at the end the following: “With respect to meeting
9 the staffing requirement imposed by the Secretary to carry
10 out clause (iv), the full-time director of food services of
11 the facility, if not a qualified dietitian (as defined in sec-
12 tion 483.35(a)(2) of title 42, Code of Federal Regulations,
13 as in effect as of the date of the enactment of this sen-
14 tence), shall be a Certified Dietary Manager meeting the
15 requirements of the Certifying Board for Dietary Man-
16 agers, or a Dietetic Technician, Registered meeting the
17 requirements of the Commission on Dietetic Registration
18 or have equivalent military, academic, or other qualifica-
19 tions (as specified by the Secretary).”.

20 (b) **MEDICAID.**—Section 1919(b)(4)(A) of the Social
21 Security Act (42 U.S.C. 1396r(b)(4)(A)) is amended by
22 adding at the end the following: “With respect to meeting
23 the staffing requirement imposed by the Secretary to carry
24 out clause (iv), the full-time director of food services of
25 the facility, if not a qualified dietitian (as defined in sec-

1 tion 483.35(a)(2) of title 42, Code of Federal Regulations,
2 as in effect as of the date of the enactment of this sen-
3 tence), shall be a Certified Dietary Manager meeting the
4 requirements of the Certifying Board for Dietary Man-
5 agers, or a Dietetic Technician, Registered meeting the
6 requirements of the Commission on Dietetic Registration
7 or have equivalent military, academic, or other qualifica-
8 tions (as specified by the Secretary).”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall take effect on the date that is 180 days
11 after the date of enactment of this Act.

12 **Subtitle C—Quality Measurements**

13 **SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR** 14 **QUALITY IMPROVEMENT.**

15 Title XI of the Social Security Act, as amended by
16 section 1401(a), is further amended by adding at the end
17 the following new part:

18 “PART E—QUALITY IMPROVEMENT

19 “ESTABLISHMENT OF NATIONAL PRIORITIES FOR 20 PERFORMANCE IMPROVEMENT

21 “SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRI-
22 ORITIES BY THE SECRETARY.—The Secretary shall estab-
23 lish and periodically update, not less frequently than tri-
24 ennially, national priorities for performance improvement.

1 “(b) RECOMMENDATIONS FOR NATIONAL PRIOR-
2 ITIES.—In establishing and updating national priorities
3 under subsection (a), the Secretary shall solicit and con-
4 sider recommendations from multiple outside stake-
5 holders.

6 “(c) CONSIDERATIONS IN SETTING NATIONAL PRI-
7 ORITIES.—With respect to such priorities, the Secretary
8 shall ensure that priority is given to areas in the delivery
9 of health care services in the United States that—

10 “(1) contribute to a large burden of disease, in-
11 cluding those that address the health care provided
12 to patients with prevalent, high-cost chronic dis-
13 eases;

14 “(2) have the greatest potential to decrease
15 morbidity and mortality in this country, including
16 those that are designed to eliminate harm to pa-
17 tients;

18 “(3) have the greatest potential for improving
19 the performance, affordability, and patient-
20 centeredness of health care, including those due to
21 variations in care;

22 “(4) address health disparities across groups
23 and areas; and

1 “(5) have the potential for rapid improvement
2 due to existing evidence, standards of care or other
3 reasons.

4 “(d) DEFINITIONS.—In this part:

5 “(1) CONSENSUS-BASED ENTITY.—The term
6 ‘consensus-based entity’ means an entity with a con-
7 tract with the Secretary under section 1890.

8 “(2) QUALITY MEASURE.—The term ‘quality
9 measure’ means a national consensus standard for
10 measuring the performance and improvement of pop-
11 ulation health, or of institutional providers of serv-
12 ices, physicians, and other health care practitioners
13 in the delivery of health care services.

14 “(e) FUNDING.—

15 “(1) IN GENERAL.—The Secretary shall provide
16 for the transfer, from the Federal Hospital Insur-
17 ance Trust Fund under section 1817 and the Fed-
18 eral Supplementary Medical Insurance Trust Fund
19 under section 1841 (in such proportion as the Sec-
20 retary determines appropriate), of \$2,000,000, for
21 the activities under this section for each of the fiscal
22 years 2010 through 2014.

23 “(2) AUTHORIZATION OF APPROPRIATIONS.—
24 For purposes of carrying out the provisions of this
25 section, in addition to funds otherwise available, out

1 of any funds in the Treasury not otherwise appro-
2 priated, there are appropriated to the Secretary of
3 Health and Human Services \$2,000,000 for each of
4 the fiscal years 2010 through 2014.”.

5 **SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES;**
6 **GAO EVALUATION OF DATA COLLECTION**
7 **PROCESS FOR QUALITY MEASUREMENT.**

8 Part E of title XI of the Social Security Act, as added
9 by section 1441, is amended by adding at the end the fol-
10 lowing new sections:

11 **“SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.**

12 **“(a) AGREEMENTS WITH QUALIFIED ENTITIES.—**

13 **“(1) IN GENERAL.—**The Secretary shall enter
14 into agreements with qualified entities to develop
15 quality measures for the delivery of health care serv-
16 ices in the United States.

17 **“(2) FORM OF AGREEMENTS.—**The Secretary
18 may carry out paragraph (1) by contract, grant, or
19 otherwise.

20 **“(3) RECOMMENDATIONS OF CONSENSUS-**
21 **BASED ENTITY.—**In carrying out this section, the
22 Secretary shall—

23 **“(A) seek public input; and**

1 “(B) take into consideration recommenda-
2 tions of the consensus-based entity with a con-
3 tract with the Secretary under section 1890(a).

4 “(b) DETERMINATION OF AREAS WHERE QUALITY
5 MEASURES ARE REQUIRED.—Consistent with the na-
6 tional priorities established under this part and with the
7 programs administered by the Centers for Medicare &
8 Medicaid Services and in consultation with other relevant
9 Federal agencies, the Secretary shall determine areas in
10 which quality measures for assessing health care services
11 in the United States are needed.

12 “(c) DEVELOPMENT OF QUALITY MEASURES.—

13 “(1) PATIENT-CENTERED AND POPULATION-
14 BASED MEASURES.—In entering into agreements
15 under subsection (a), the Secretary shall give pri-
16 ority to the development of quality measures that
17 allow the assessment of—

18 “(A) health outcomes, presence of impair-
19 ment, and functional status of patients;

20 “(B) the continuity and coordination of
21 care and care transitions for patients across
22 providers and health care settings, including
23 end of life care;

24 “(C) patient experience and patient en-
25 gagement;

1 “(D) the safety, effectiveness, and timeli-
2 ness of care;

3 “(E) health disparities including those as-
4 sociated with individual race, ethnicity, age,
5 gender, place of residence or language; and

6 “(F) the efficiency and resource use in the
7 provision of care.

8 “(2) USE OF FUNDS.—An entity that enters
9 into an agreement under subsection (a) shall develop
10 quality measures that—

11 “(A) to the extent feasible, have the ability
12 to be collected through the use of health infor-
13 mation technologies supporting better delivery
14 of health care services; and

15 “(B) are available free of charge to users
16 for the use of such measures.

17 “(3) AVAILABILITY OF MEASURES.—The Sec-
18 retary shall make quality measures developed under
19 this section available to the public.

20 “(4) TESTING OF PROPOSED MEASURES.—The
21 Secretary may use amounts made available under
22 subsection (f) to fund the testing of proposed quality
23 measures by qualified entities. Testing funded under
24 this paragraph shall include testing of the feasibility
25 and usability of proposed measures.

1 “(5) UPDATING OF ENDORSED MEASURES.—

2 The Secretary may use amounts made available
3 under subsection (f) to fund the updating (and test-
4 ing, if applicable) by consensus-based entities of
5 quality measures that have been previously endorsed
6 by such an entity as new evidence is developed, in
7 a manner consistent with section 1890(b)(3).

8 “(d) QUALIFIED ENTITIES.—Before entering into
9 agreements with a qualified entity, the Secretary shall en-
10 sure that the entity is a public, private, or academic insti-
11 tution with technical expertise in the area of health quality
12 measurement.

13 “(e) APPLICATION FOR GRANT.—A grant may be
14 made under this section only if an application for the
15 grant is submitted to the Secretary and the application
16 is in such form, is made in such manner, and contains
17 such agreements, assurances, and information as the Sec-
18 retary determines to be necessary to carry out this section.

19 “(f) FUNDING.—

20 “(1) IN GENERAL.—The Secretary shall provide
21 for the transfer, from the Federal Hospital Insur-
22 ance Trust Fund under section 1817 and the Fed-
23 eral Supplementary Medical Insurance Trust Fund
24 under section 1841 (in such proportion as the Sec-
25 retary determines appropriate), of \$25,000,000, to

1 the Secretary for purposes of carrying out this sec-
2 tion for each of the fiscal years 2010 through 2014.

3 “(2) AUTHORIZATION OF APPROPRIATIONS.—

4 For purposes of carrying out the provisions of this
5 section, in addition to funds otherwise available, out
6 of any funds in the Treasury not otherwise appro-
7 priated, there are appropriated to the Secretary of
8 Health and Human Services \$25,000,000 for each
9 of the fiscal years 2010 through 2014.

10 **“SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROC-**
11 **CESS FOR QUALITY MEASUREMENT.**

12 “(a) GAO EVALUATIONS.—The Comptroller General
13 of the United States shall conduct periodic evaluations of
14 the implementation of the data collection processes for
15 quality measures used by the Secretary.

16 “(b) CONSIDERATIONS.—In carrying out the evalua-
17 tion under subsection (a), the Comptroller General shall
18 determine—

19 “(1) whether the system for the collection of
20 data for quality measures provides for validation of
21 data as relevant and scientifically credible;

22 “(2) whether data collection efforts under the
23 system use the most efficient and cost-effective
24 means in a manner that minimizes administrative
25 burden on persons required to collect data and that

1 adequately protects the privacy of patients' personal
2 health information and provides data security;

3 “(3) whether standards under the system pro-
4 vide for an appropriate opportunity for physicians
5 and other clinicians and institutional providers of
6 services to review and correct findings; and

7 “(4) the extent to which quality measures are
8 consistent with section 1192(c)(1) or result in direct
9 or indirect costs to users of such measures.

10 “(c) REPORT.—The Comptroller General shall sub-
11 mit reports to Congress and to the Secretary containing
12 a description of the findings and conclusions of the results
13 of each such evaluation.”.

14 **SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT**
15 **INTO SELECTION OF QUALITY MEASURES.**

16 Section 1808 of the Social Security Act (42 U.S.C.
17 1395b–9) is amended by adding at the end the following
18 new subsection:

19 “(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT
20 INTO SELECTION OF QUALITY MEASURES.—

21 “(1) LIST OF MEASURES.—Not later than De-
22 cember 1 before each year (beginning with 2011),
23 the Secretary shall make public a list of measures
24 being considered for selection for quality measure-
25 ment by the Secretary in rulemaking with respect to

1 payment systems under this title beginning in the
2 payment year beginning in such year and for pay-
3 ment systems beginning in the calendar year fol-
4 lowing such year, as the case may be.

5 “(2) CONSULTATION ON SELECTION OF EN-
6 DORSED QUALITY MEASURES.—A consensus-based
7 entity that has entered into a contract under section
8 1890 shall, as part of such contract, convene multi-
9 stakeholder groups to provide recommendations on
10 the selection of individual or composite quality meas-
11 ures, for use in reporting performance information
12 to the public or for use in public health care pro-
13 grams.

14 “(3) MULTI-STAKEHOLDER INPUT.—Not later
15 than February 1 of each year (beginning with
16 2011), the consensus-based entity described in para-
17 graph (2) shall transmit to the Secretary the rec-
18 ommendations of multi-stakeholder groups provided
19 under paragraph (2). Such recommendations shall
20 be included in the transmissions the consensus-based
21 entity makes to the Secretary under the contract
22 provided for under section 1890.

23 “(4) REQUIREMENT FOR TRANSPARENCY IN
24 PROCESS.—

1 “(A) IN GENERAL.—In convening multi-
2 stakeholder groups under paragraph (2) with
3 respect to the selection of quality measures, the
4 consensus-based entity described in such para-
5 graph shall provide for an open and transparent
6 process for the activities conducted pursuant to
7 such convening.

8 “(B) SELECTION OF ORGANIZATIONS PAR-
9 TICIPATING IN MULTI-STAKEHOLDER
10 GROUPS.—The process under paragraph (2)
11 shall ensure that the selection of representatives
12 of multi-stakeholder groups includes provision
13 for public nominations for, and the opportunity
14 for public comment on, such selection.

15 “(5) USE OF INPUT.—The respective proposed
16 rule shall contain a summary of the recommenda-
17 tions made by the multi-stakeholder groups under
18 paragraph (2), as well as other comments received
19 regarding the proposed measures, and the extent to
20 which such proposed rule follows such recommenda-
21 tions and the rationale for not following such rec-
22 ommendations.

23 “(6) MULTI-STAKEHOLDER GROUPS.—For pur-
24 poses of this subsection, the term ‘multi-stakeholder
25 groups’ means, with respect to a quality measure, a

1 voluntary collaborative of organizations representing
2 persons interested in or affected by the use of such
3 quality measure, such as the following:

4 “(A) Hospitals and other institutional pro-
5 viders.

6 “(B) Physicians.

7 “(C) Health care quality alliances.

8 “(D) Nurses and other health care practi-
9 tioners.

10 “(E) Health plans.

11 “(F) Patient advocates and consumer
12 groups.

13 “(G) Employers.

14 “(H) Public and private purchasers of
15 health care items and services.

16 “(I) Labor organizations.

17 “(J) Relevant departments or agencies of
18 the United States.

19 “(K) Biopharmaceutical companies and
20 manufacturers of medical devices.

21 “(L) Licensing, credentialing, and accred-
22 iting bodies.

23 “(7) FUNDING.—

24 “(A) IN GENERAL.—The Secretary shall
25 provide for the transfer, from the Federal Hos-

1 pital Insurance Trust Fund under section 1817
2 and the Federal Supplementary Medical Insur-
3 ance Trust Fund under section 1841 (in such
4 proportion as the Secretary determines appro-
5 priate), of \$1,000,000, to the Secretary for pur-
6 poses of carrying out this subsection for each of
7 the fiscal years 2010 through 2014.

8 “(B) AUTHORIZATION OF APPROPRIA-
9 TIONS.—For purposes of carrying out the provi-
10 sions of this subsection, in addition to funds
11 otherwise available, out of any funds in the
12 Treasury not otherwise appropriated, there are
13 appropriated to the Secretary of Health and
14 Human Services \$1,000,000 for each of the fis-
15 cal years 2010 through 2014.”.

16 **SEC. 1444. APPLICATION OF QUALITY MEASURES.**

17 (a) INPATIENT HOSPITAL SERVICES.—Section
18 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B))
19 is amended by adding at the end the following new clause:

20 “(x)(I) Subject to subclause (II), for purposes of re-
21 porting data on quality measures for inpatient hospital
22 services furnished during fiscal year 2012 and each subse-
23 quent fiscal year, the quality measures specified under
24 clause (viii) shall be measures selected by the Secretary

1 from measures that have been endorsed by the entity with
2 a contract with the Secretary under section 1890(a).

3 “(II) In the case of a specified area or medical topic
4 determined appropriate by the Secretary for which a fea-
5 sible and practical quality measure has not been endorsed
6 by the entity with a contract under section 1890(a), the
7 Secretary may specify a measure that is not so endorsed
8 as long as due consideration is given to measures that
9 have been endorsed or adopted by a consensus organiza-
10 tion identified by the Secretary. The Secretary shall sub-
11 mit such a non-endorsed measure to the entity for consid-
12 eration for endorsement. If the entity considers but does
13 not endorse such a measure and if the Secretary does not
14 phase-out use of such measure, the Secretary shall include
15 the rationale for continued use of such a measure in rule-
16 making.”.

17 (b) OUTPATIENT HOSPITAL SERVICES.—Section
18 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is
19 amended by adding at the end the following new subpara-
20 graph:

21 “(F) USE OF ENDORSED QUALITY MEAS-
22 URES.—The provisions of clause (x) of section
23 1886(b)(3)(C) shall apply to quality measures
24 for covered OPD services under this paragraph
25 in the same manner as such provisions apply to

1 quality measures for inpatient hospital serv-
2 ices.”.

3 (c) PHYSICIANS’ SERVICES.—Section
4 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-
5 4(k)(2)(C)(ii)) is amended by adding at the end the fol-
6 lowing: “The Secretary shall submit such a non-endorsed
7 measure to the entity for consideration for endorsement.
8 If the entity considers but does not endorse such a meas-
9 ure and if the Secretary does not phase-out use of such
10 measure, the Secretary shall include the rationale for con-
11 tinued use of such a measure in rulemaking.”.

12 (d) RENAL DIALYSIS SERVICES.—Section
13 1881(h)(2)(B)(ii) of such Act (42 U.S.C.
14 1395rr(h)(2)(B)(ii)) is amended by adding at the end the
15 following: “The Secretary shall submit such a non-en-
16 dorsed measure to the entity for consideration for endorse-
17 ment. If the entity considers but does not endorse such
18 a measure and if the Secretary does not phase-out use
19 of such measure, the Secretary shall include the rationale
20 for continued use of such a measure in rulemaking.”.

21 (e) ENDORSEMENT OF STANDARDS.—Section
22 1890(b)(2) of the Social Security Act (42 U.S.C.
23 1395aaa(b)(2)) is amended by adding after and below sub-
24 paragraph (B) the following:

1 “If the entity does not endorse a measure, such enti-
2 ty shall explain the reasons and provide suggestions
3 about changes to such measure that might make it
4 a potentially endorsable measure.”.

5 (f) EFFECTIVE DATE.—Except as otherwise pro-
6 vided, the amendments made by this section shall apply
7 to quality measures applied for payment years beginning
8 with 2012 or fiscal year 2012, as the case may be.

9 **SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.**

10 Section 1890(d) of the Social Security Act (42 U.S.C.
11 1395aaa(d)) is amended by striking “for each of fiscal
12 years 2009 through 2012” and inserting “for fiscal year
13 2009, and \$12,000,000 for each of the fiscal years 2010
14 through 2012”

1 **Subtitle D—Physician Payments**
2 **Sunshine Provision**

3 **SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BE-**
4 **TWEEN MANUFACTURERS AND DISTRIBUTU-**
5 **TORS OF COVERED DRUGS, DEVICES,**
6 **BIOLOGICALS, OR MEDICAL SUPPLIES**
7 **UNDER MEDICARE, MEDICAID, OR CHIP AND**
8 **PHYSICIANS AND OTHER HEALTH CARE ENTI-**
9 **TIES AND BETWEEN PHYSICIANS AND OTHER**
10 **HEALTH CARE ENTITIES.**

11 (a) IN GENERAL.—Part A of title XI of the Social
12 Security Act (42 U.S.C. 1301 et seq.), as amended by sec-
13 tion 1631(a), is further amended by inserting after section
14 1128G the following new section:

15 **“SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS’ FINAN-**
16 **CIAL RELATIONSHIPS WITH MANUFACTUR-**
17 **ERS AND DISTRIBUTORS OF COVERED**
18 **DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL**
19 **SUPPLIES UNDER MEDICARE, MEDICAID, OR**
20 **CHIP AND WITH ENTITIES THAT BILL FOR**
21 **SERVICES UNDER MEDICARE.**

22 “(a) REPORTING OF PAYMENTS OR OTHER TRANS-
23 FERS OF VALUE.—

24 “(1) IN GENERAL.—Except as provided in this
25 subsection, not later than March 31, 2011, and an-

1 nually thereafter, each applicable manufacturer or
2 distributor that provides a payment or other transfer
3 of value to a covered recipient, or to an entity or in-
4 dividual at the request of or designated on behalf of
5 a covered recipient, shall submit to the Secretary, in
6 such electronic form as the Secretary shall require,
7 the following information with respect to the pre-
8 ceding calendar year:

9 “(A) With respect to the covered recipient,
10 the recipient’s name, business address, physi-
11 cian specialty, and national provider identifier.

12 “(B) With respect to the payment or other
13 transfer of value, other than a drug sample—

14 “(i) its value and date;

15 “(ii) the name of the related drug, de-
16 vice, or supply, if available, to the level of
17 specificity available; and

18 “(iii) a description of its form, indi-
19 cated (as appropriate for all that apply)
20 as—

21 “(I) cash or a cash equivalent;

22 “(II) in-kind items or services;

23 “(III) stock, a stock option, or
24 any other ownership interest, divi-

1 dend, profit, or other return on invest-
2 ment; or

3 “(IV) any other form (as defined
4 by the Secretary).

5 “(C) With respect to a drug sample, the
6 name, number, date, and dosage units of the
7 sample.

8 “(2) AGGREGATE REPORTING.—Information
9 submitted by an applicable manufacturer or dis-
10 tributor under paragraph (1) shall include the ag-
11 gregate amount of all payments or other transfers of
12 value provided by the manufacturer or distributor to
13 covered recipients (and to entities or individuals at
14 the request of or designated on behalf of a covered
15 recipient) during the year involved, including all pay-
16 ments and transfers of value regardless of whether
17 such payments or transfer of value were individually
18 disclosed.

19 “(3) SPECIAL RULE FOR CERTAIN PAYMENTS
20 OR OTHER TRANSFERS OF VALUE.—In the case
21 where an applicable manufacturer or distributor pro-
22 vides a payment or other transfer of value to an en-
23 tity or individual at the request of or designated on
24 behalf of a covered recipient, the manufacturer or
25 distributor shall disclose that payment or other

1 transfer of value under the name of the covered re-
2 cipient.

3 “(4) DELAYED REPORTING FOR PAYMENTS
4 MADE PURSUANT TO PRODUCT DEVELOPMENT
5 AGREEMENTS.—In the case of a payment or other
6 transfer of value made to a covered recipient by an
7 applicable manufacturer or distributor pursuant to a
8 product development agreement for services fur-
9 nished in connection with the development of a new
10 drug, device, biological, or medical supply, the appli-
11 cable manufacturer or distributor may report the
12 value and recipient of such payment or other trans-
13 fer of value in the first reporting period under this
14 subsection in the next reporting deadline after the
15 earlier of the following:

16 “(A) The date of the approval or clearance
17 of the covered drug, device, biological, or med-
18 ical supply by the Food and Drug Administra-
19 tion.

20 “(B) Two calendar years after the date
21 such payment or other transfer of value was
22 made.

23 “(5) DELAYED REPORTING FOR PAYMENTS
24 MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In
25 the case of a payment or other transfer of value

1 made to a covered recipient by an applicable manu-
2 facturer or distributor in connection with a clinical
3 investigation regarding a new drug, device, biologi-
4 cal, or medical supply, the applicable manufacturer
5 or distributor may report as required under this sec-
6 tion in the next reporting period under this sub-
7 section after the earlier of the following:

8 “(A) The date that the clinical investiga-
9 tion is registered on the website maintained by
10 the National Institutes of Health pursuant to
11 section 671 of the Food and Drug Administra-
12 tion Amendments Act of 2007.

13 “(B) Two calendar years after the date
14 such payment or other transfer of value was
15 made.

16 “(6) CONFIDENTIALITY.—Information de-
17 scribed in paragraph (4) or (5) shall be considered
18 confidential and shall not be subject to disclosure
19 under section 552 of title 5, United States Code, or
20 any other similar Federal, State, or local law, until
21 or after the date on which the information is made
22 available to the public under such paragraph.

23 “(7) PHYSICIANS IN SELF-INSURED HEALTH
24 PLANS.—Nothing in this subsection shall be con-
25 strued to require the disclosure of a payment or

1 other transfer of value to a physician by a self-in-
2 sured health plan.

3 “(b) REPORTING OF OWNERSHIP INTEREST BY PHY-
4 SICIANS.—

5 “(1) HOSPITALS AND OTHER ENTITIES THAT
6 BILL MEDICARE.—Not later than March 31 of each
7 year (beginning with 2011), each hospital or other
8 health care entity (not including a Medicare Advan-
9 tage organization) that bills the Secretary under
10 part A or part B of title XVIII for services shall re-
11 port on the ownership shares (other than ownership
12 shares described in section 1877(c)) of each physi-
13 cian who, directly or indirectly, owns an interest in
14 the entity.

15 “(2) ADDITIONAL PHYSICIAN OWNERSHIP.—
16 Not later than March 31 of each year (beginning
17 with 2011), in addition to the requirement under
18 subsection (a)(1), any applicable manufacturer, ap-
19 plicable group purchasing organization, or applicable
20 distributor shall submit to the Secretary, in such
21 electronic form as the Secretary shall require, the
22 following information regarding any ownership or in-
23 vestment interest (other than an ownership or in-
24 vestment interest in a publicly traded security and
25 mutual fund, as described in section 1877(c)) held

1 by a physician (or an immediate family member of
2 such physician (as defined for purposes of section
3 1877(a))) in the applicable manufacturer, applicable
4 group purchasing organization or applicable dis-
5 tributor during the preceding year:

6 “(A) The dollar amount invested by each
7 physician holding such an ownership or invest-
8 ment interest.

9 “(B) The value and terms of each such
10 ownership or investment interest.

11 “(C) Any payment or other transfer of
12 value provided to a physician holding such an
13 ownership or investment interest (or to an enti-
14 ty or individual at the request of or designated
15 on behalf of a physician holding such an owner-
16 ship or investment interest), including the infor-
17 mation described in clauses (i) through (iii) of
18 paragraph (a)(1)(B), and information described
19 in subsection (f)(8)(A) and (f)(8)(B).

20 “(D) Any other information regarding the
21 ownership or investment interest the Secretary
22 determines appropriate.

23 “(3) DEFINITIONS.—In this subsection:

1 “(A) PHYSICIAN.—The term ‘physician’ in-
2 cludes a physician’s immediate family members
3 (as defined for purposes of section 1877(a)).

4 “(B) APPLICABLE GROUP PURCHASING OR-
5 GANIZATION.—The term ‘applicable group pur-
6 chasing organization’ means any organization
7 or other entity (as defined by the Secretary)
8 that purchases, arranges for, or negotiates the
9 purchase of a covered drug, device, biological,
10 or medical supply.

11 “(4) STUDY OF PRACTICE PATTERNS IN AD-
12 VANCED DIAGNOSTIC IMAGING AND RADIATION ON-
13 COLOGY SERVICES.—The Comptroller General of the
14 United States shall conduct a study to evaluate the
15 extent of use of physician self-referral arrangements
16 and the effects of such arrangements on the cost of
17 providing advanced diagnostic imaging and radiation
18 oncology services to Medicare beneficiaries under
19 title XVIII. The study shall be completed and sub-
20 mitted to Congress not later than July 1, 2011.

21 “(c) PUBLIC AVAILABILITY.—

22 “(1) IN GENERAL.—The Secretary shall estab-
23 lish procedures to ensure that, not later than Sep-
24 tember 30, 2011, and on June 30 of each year be-
25 ginning thereafter, the information submitted under

1 subsections (a) and (b), other than information re-
2 gard drug samples, with respect to the preceding
3 calendar year is made available through an Internet
4 website that—

5 “(A) is searchable and is in a format that
6 is clear and understandable;

7 “(B) contains information that is pre-
8 sented by the name of the applicable manufac-
9 turer or distributor, the name of the covered re-
10 cipient, the business address of the covered re-
11 cipient, the specialty (if applicable) of the cov-
12 ered recipient, the value of the payment or
13 other transfer of value, the date on which the
14 payment or other transfer of value was provided
15 to the covered recipient, the form of the pay-
16 ment or other transfer of value, indicated (as
17 appropriate) under subsection (a)(1)(B)(ii), the
18 nature of the payment or other transfer of
19 value, indicated (as appropriate) under sub-
20 section (a)(1)(B)(iii), and the name of the cov-
21 ered drug, device, biological, or medical supply,
22 as applicable;

23 “(C) contains information that is able to
24 be easily aggregated and downloaded;

1 “(D) contains a description of any enforce-
2 ment actions taken to carry out this section, in-
3 cluding any penalties imposed under subsection
4 (d), during the preceding year;

5 “(E) contains background information on
6 industry-physician relationships;

7 “(F) in the case of information submitted
8 with respect to a payment or other transfer of
9 value described in subsection (a)(5), lists such
10 information separately from the other informa-
11 tion submitted under subsection (a) and des-
12 ignates such separately listed information as
13 funding for clinical research;

14 “(G) contains any other information the
15 Secretary determines would be helpful to the
16 average consumer; and

17 “(H) provides the covered recipient an op-
18 portunity to submit corrections to the informa-
19 tion made available to the public with respect to
20 the covered recipient.

21 “(2) ACCURACY OF REPORTING.—The accuracy
22 of the information that is submitted under sub-
23 sections (a) and (b) and made available under para-
24 graph (1) shall be the responsibility of the reporting
25 entity reporting under subsection (a) or (b), as ap-

1 plicable. The Secretary shall establish procedures to
2 ensure that the covered recipient is provided with an
3 opportunity to submit corrections to the applicable
4 reporting entity with regard to information made
5 public with respect to the covered recipient and,
6 under such procedures, the corrections shall be
7 transmitted to the Secretary.

8 “(3) SPECIAL RULE FOR DRUG SAMPLES.—In-
9 formation relating to drug samples provided under
10 subsection (a) shall not be made available to the
11 public by the Secretary but may be made available
12 outside the Department of Health and Human Serv-
13 ices by the Secretary for research or legitimate busi-
14 ness purposes pursuant to data use agreements.

15 “(4) SPECIAL RULE FOR NATIONAL PROVIDER
16 IDENTIFIERS.—Information relating to national pro-
17 vider identifiers provided under subsection (a) shall
18 not be made available to the public by the Secretary
19 but may be made available outside the Department
20 of Health and Human Services by the Secretary for
21 research or legitimate business purposes pursuant to
22 data use agreements.

23 “(d) PENALTIES FOR NONCOMPLIANCE.—

24 “(1) FAILURE TO REPORT.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), except as provided in paragraph (2),
3 any reporting entity that fails to submit infor-
4 mation required under subsection (a) or (b), as
5 applicable, in a timely manner in accordance
6 with regulations promulgated to carry out such
7 applicable subsection shall be subject to a civil
8 money penalty of not less than \$1,000, but not
9 more than \$10,000, for each payment or other
10 transfer of value or ownership or investment in-
11 terest not reported as required under such sub-
12 section. Such penalty shall be imposed and col-
13 lected in the same manner as civil money pen-
14 alties under subsection (a) of section 1128A are
15 imposed and collected under that section.

16 “(B) LIMITATION.—The total amount of
17 civil money penalties imposed under subpara-
18 graph (A), with respect to each annual submis-
19 sion of information under subsection (a) by a
20 reporting entity, shall not exceed \$150,000.

21 “(2) KNOWING FAILURE TO REPORT.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), any reporting entity that knowingly
24 fails to submit information required under sub-
25 section (a) or (b), as applicable, in a timely

1 manner in accordance with regulations promul-
2 gated to carry out such applicable subsection,
3 shall be subject to a civil money penalty of not
4 less than \$10,000, but not more than
5 \$100,000, for each payment or other transfer of
6 value or ownership or investment interest not
7 reported as required under such subsection.
8 Such penalty shall be imposed and collected in
9 the same manner as civil money penalties under
10 subsection (a) of section 1128A are imposed
11 and collected under that section.

12 “(B) LIMITATION.—The total amount of
13 civil money penalties imposed under subpara-
14 graph (A) with respect to each annual submis-
15 sion of information under subsection (a) or (b)
16 by an applicable reporting entity shall not ex-
17 ceed \$1,000,000, or, if greater, 0.1 percentage
18 of the total annual revenues of the reporting en-
19 tity.

20 “(3) USE OF FUNDS.—Funds collected by the
21 Secretary as a result of the imposition of a civil
22 money penalty under this subsection shall be used to
23 carry out this section.

24 “(4) ENFORCEMENT THROUGH STATE ATTOR-
25 NEYS GENERAL.—The attorney general of a State,

1 after providing notice to the Secretary of an intent
2 to proceed under this paragraph in a specific case
3 and providing the Secretary with an opportunity to
4 bring an action under this subsection and the Sec-
5 retary declining such opportunity, may proceed
6 under this subsection against an applicable manufac-
7 turer or distributor in the State.

8 “(e) ANNUAL REPORT TO CONGRESS.—Not later
9 than April 1 of each year beginning with 2011, the Sec-
10 retary shall submit to Congress a report that includes the
11 following:

12 “(1) The information submitted under this sec-
13 tion during the preceding year, aggregated for each
14 applicable reporting entity that submitted such in-
15 formation during such year.

16 “(2) A description of any enforcement actions
17 taken to carry out this section, including any pen-
18 alties imposed under subsection (d), during the pre-
19 ceding year.

20 “(f) DEFINITIONS.—In this section:

21 “(1) APPLICABLE DISTRIBUTOR.—The term
22 ‘applicable distributor’ means—

23 “(A) any entity, other than an applicable
24 group purchasing organization, that buys and
25 resells, or receives a commission or other simi-

1 lar form of payment, from another seller, for
2 selling or arranging for the sale of a covered
3 drug, device, biological, or medical supply; or

4 “(B) any entity under common ownership
5 with such an entity described in subparagraph
6 (A) and which provides assistance or support to
7 such entity so described with respect to the pro-
8 duction, preparation, propagation,
9 compounding, conversion, processing, mar-
10 keting, or distribution of a covered drug, device,
11 biological, or medical supply.

12 Such term does not include a wholesale pharma-
13 ceutical distributor.

14 “(2) APPLICABLE MANUFACTURER.—The term
15 ‘applicable manufacturer’ means any entity which is
16 engaged in the production, preparation, propagation,
17 compounding, conversion, processing, marketing, or
18 manufacturer-direct distribution of a covered drug,
19 device, biological, or medical supply (or any entity
20 under common ownership with such entity and which
21 provides assistance or support to such entity with re-
22 spect to the production, preparation, propagation,
23 compounding, conversion, processing, marketing, or
24 distribution or a covered drug, device, biological, or
25 medical supply). For purposes of this section only,

1 such term does not include a retail pharmacy li-
2 censed under State law.

3 “(3) CLINICAL INVESTIGATION.—The term
4 ‘clinical investigation’ means any experiment involv-
5 ing one or more human subjects, or materials de-
6 rived from human subjects, in which a drug or de-
7 vice is administered, dispensed, or used.

8 “(4) COVERED DRUG, DEVICE, BIOLOGICAL, OR
9 MEDICAL SUPPLY.—The term ‘covered’ means, with
10 respect to a drug, device, biological, or medical sup-
11 ply, such a drug, device, biological, or medical supply
12 for which payment is available under title XVIII or
13 a State plan under title XIX or XXI (or a waiver
14 of such a plan).

15 “(5) COVERED RECIPIENT.—The term ‘covered
16 recipient’ means the following:

17 “(A) A physician.

18 “(B) A physician group practice.

19 “(C) Any other prescriber of a covered
20 drug, device, biological, or medical supply.

21 “(D) A pharmacy or pharmacist.

22 “(E) A health insurance issuer, group
23 health plan, or other entity offering a health
24 benefits plan, including any employee of such
25 an issuer, plan, or entity.

1 “(F) A pharmacy benefit manager, includ-
2 ing any employee of such a manager.

3 “(G) A hospital.

4 “(H) A medical school.

5 “(I) A sponsor of a continuing medical
6 education program.

7 “(J) A patient advocacy or disease specific
8 group.

9 “(K) A organization of health care profes-
10 sionals.

11 “(L) A biomedical researcher.

12 “(M) A group purchasing organization.

13 “(6) EMPLOYEE.—The term ‘employee’ has the
14 meaning given such term in section 1877(h)(2).

15 “(7) KNOWINGLY.—The term ‘knowingly’ has
16 the meaning given such term in section 3729(b) of
17 title 31, United States Code.

18 “(8) PAYMENT OR OTHER TRANSFER OF
19 VALUE.—

20 “(A) IN GENERAL.—The term ‘payment or
21 other transfer of value’ means a transfer of
22 anything of value for or of any of the following:

23 “(i) Gift, food, or entertainment.

24 “(ii) Travel or trip.

25 “(iii) Honoraria.

1 “(iv) Research funding or grant.

2 “(v) Education or conference funding.

3 “(vi) Consulting fees.

4 “(vii) Ownership or investment inter-
5 est and royalties or license fee.

6 “(B) INCLUSIONS.—Subject to subpara-
7 graph (C), the term ‘payment or other transfer
8 of value’ includes any compensation, gift, hono-
9 rarium, speaking fee, consulting fee, travel,
10 services, dividend, profit distribution, stock or
11 stock option grant, or any ownership or invest-
12 ment interest held by a physician in a manufac-
13 turer (excluding a dividend or other profit dis-
14 tribution from, or ownership or investment in-
15 terest in, a publicly traded security or mutual
16 fund (as described in section 1877(c))).

17 “(C) EXCLUSIONS.—The term ‘payment or
18 other transfer of value’ does not include the fol-
19 lowing:

20 “(i) Any payment or other transfer of
21 value provided by an applicable manufac-
22 turer or distributor to a covered recipient
23 where the amount transferred to, requested
24 by, or designated on behalf of the covered
25 recipient does not exceed \$5.

1 “(ii) The loan of a covered device for
2 a short-term trial period, not to exceed 90
3 days, to permit evaluation of the covered
4 device by the covered recipient.

5 “(iii) Items or services provided under
6 a contractual warranty, including the re-
7 placement of a covered device, where the
8 terms of the warranty are set forth in the
9 purchase or lease agreement for the cov-
10 ered device.

11 “(iv) A transfer of anything of value
12 to a covered recipient when the covered re-
13 cipient is a patient and not acting in the
14 professional capacity of a covered recipient.

15 “(v) In-kind items used for the provi-
16 sion of charity care.

17 “(vi) A dividend or other profit dis-
18 tribution from, or ownership or investment
19 interest in, a publicly traded security and
20 mutual fund (as described in section
21 1877(c)).

22 “(vii) Compensation paid by an appli-
23 cable manufacturer or distributor to a cov-
24 ered recipient who is directly employed by

1 and works solely for such manufacturer or
2 distributor.

3 “(viii) Payments made to a covered
4 recipient by an applicable manufacturer or
5 by a health plan affiliated with an applica-
6 ble manufacturer for medical care provided
7 to employees of such manufacturer or their
8 dependents.

9 “(ix) Any discount (including a re-
10 bate).

11 “(x) Any payment or other transfer of
12 value that is made to a covered recipient
13 indirectly through an entity other than the
14 applicable manufacturer in connection with
15 an activity or service—

16 “(I) in which the applicable man-
17 ufacturer is unaware of the identity of
18 the covered recipient and is not using
19 such activity or service to market its
20 product to the covered recipient; and

21 “(II) that is not designed to mar-
22 ket or promote the product to the cov-
23 ered recipient.

24 “(xi) In the case of an applicable
25 manufacturer who offers a self-insured

1 plan, payments for the provision of health
2 care to employees under the plan.

3 “(9) PHYSICIAN.—The term ‘physician’ has the
4 meaning given that term in section 1861(r). For
5 purposes of this section, such term does not include
6 a physician who is an employee of the applicable
7 manufacturer that is required to submit information
8 under subsection (a).

9 “(10) REPORTING ENTITY.—The term ‘report-
10 ing entity’ means—

11 “(A) with respect to the reporting require-
12 ment under subsection (a), an applicable manu-
13 facturer or distributor of a covered drug, device,
14 biological, or medical supply required to report
15 under such subsection; and

16 “(B) with respect to the reporting require-
17 ment under subsection (b), a hospital, other
18 health care entity, applicable manufacturer, ap-
19 plicable distributor, or applicable group pur-
20 chasing organization required to report physi-
21 cian ownership under such subsection.

22 “(g) ANNUAL REPORTS TO STATES.—Not later than
23 April 1 of each year beginning with 2011, the Secretary
24 shall submit to States a report that includes a summary
25 of the information submitted under subsections (a), (b),

1 and (e) during the preceding year with respect to covered
2 recipients or other hospitals and entities in the State.

3 “(h) RELATION TO STATE LAWS.—

4 “(1) IN GENERAL.—Effective on January 1,
5 2011, subject to paragraph (2), the provisions of
6 this section shall preempt any law or regulation of
7 a State or of a political subdivision of a State that
8 requires an applicable manufacturer and applicable
9 distributor (as such terms are defined in subsection
10 (f)) to disclose or report, in any format, the type of
11 information (described in subsection (a)) regarding a
12 payment or other transfer of value provided by the
13 manufacturer to a covered recipient (as so defined).

14 “(2) NO PREEMPTION OF ADDITIONAL RE-
15 QUIREMENTS.—Paragraph (1) shall not preempt any
16 statute or regulation of a State or political subdivi-
17 sion of a State that requires any of the following:

18 “(A) The disclosure or reporting of infor-
19 mation not of the type required to be disclosed
20 or reported under this section.

21 “(B) The disclosure or reporting, in any
22 format, of information described in subsection
23 (f)(8)(C), except in the case of information de-
24 scribed in clause (i) of subsection (f)(8)(C).

1 “(C) The disclosure or reporting, in any
2 format, of the type of information by any per-
3 son or entity other than an applicable manufac-
4 turer (as so defined) or a covered recipient (as
5 defined in subsection (f)).

6 “(D) The disclosure or reporting, in any
7 format, of the type of information required to
8 be disclosed or reported under this section to a
9 Federal, State, or local governmental agency for
10 public health surveillance, investigation, or
11 other public health purposes or health oversight
12 purposes.

13 Nothing in paragraph (1) shall be construed to limit
14 the discovery or admissibility of information de-
15 scribed in this paragraph in a criminal, civil, or ad-
16 ministrative proceeding.”.

17 (b) AVAILABILITY OF INFORMATION FROM THE DIS-
18 CLOSURE OF FINANCIAL RELATIONSHIP REPORT
19 (DFRR).—The Secretary of Health and Human Services
20 shall submit to Congress a report on the full results of
21 the Disclosure of Physician Financial Relationships sur-
22 veys required pursuant to section 5006 of the Deficit Re-
23 duction Act of 2005. Such report shall be submitted to
24 Congress not later than the date that is 6 months after
25 the date such surveys are collected and shall be made pub-

1 lically available on an Internet website of the Department
2 of Health and Human Services.

3 (c) GAO REPORT.—Not later than December 31,
4 2012, the Comptroller General of the United States shall
5 submit to Congress a report on section 1128H of the So-
6 cial Security Act, as added by subsection (a). Such report
7 shall address the extent to which important transfers of
8 value are being adequately reported under such section
9 (including unreported transfers required by such section
10 as well as transfers not required to be reported by such
11 section), the impact on States of the federal preemption
12 provision under subsection (h) of such section, whether
13 changes have occurred in the pattern of payments as a
14 result of efforts to evade reporting requirements, a de-
15 scription of the financial relationships subject to delayed
16 reporting under subsection (a) of such section, and any
17 recommended improvements to the collection or the anal-
18 ysis of data reported under such section.

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

3 **SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY**
4 **HOSPITALS AND AMBULATORY SURGICAL**
5 **CENTERS ON HEALTH CARE-ASSOCIATED IN-**
6 **FECTIONS.**

7 (a) IN GENERAL.—Title XI of the Social Security Act
8 is amended by inserting after section 1138 the following
9 section:

10 **“SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY**
11 **HOSPITALS AND AMBULATORY SURGICAL**
12 **CENTERS ON HEALTH CARE-ASSOCIATED IN-**
13 **FECTIONS.**

14 “(a) REPORTING REQUIREMENT.—

15 “(1) IN GENERAL.—The Secretary shall provide
16 that a hospital (as defined in subsection (g)) or am-
17 bulatory surgical center meeting the requirements of
18 titles XVIII or XIX may participate in the programs
19 established under such titles only if, in accordance
20 with this section, the hospital or center reports such
21 information on health care-associated infections that
22 develop in the hospital or center (and such demo-
23 graphic information associated with such infections)
24 as the Secretary specifies.

1 “(2) REPORTING PROTOCOLS.— Such informa-
2 tion shall be reported in accordance with reporting
3 protocols established by the Secretary through the
4 Director of the Centers for Disease Control and Pre-
5 vention (in this section referred to as the ‘CDC’)
6 and to the National Healthcare Safety Network of
7 the CDC or under such another reporting system of
8 such Centers as determined appropriate by the Sec-
9 retary in consultation with such Director.

10 “(3) COORDINATION WITH HIT.—The Sec-
11 retary, through the Director of the CDC and the Of-
12 fice of the National Coordinator for Health Informa-
13 tion Technology, shall ensure that the transmission
14 of information under this subsection is coordinated
15 with systems established under the HITECH Act,
16 where appropriate.

17 “(4) PROCEDURES TO ENSURE THE VALIDITY
18 OF INFORMATION.—The Secretary shall establish
19 procedures regarding the validity of the information
20 submitted under this subsection in order to ensure
21 that such information is appropriately compared
22 across hospitals and centers. Such procedures shall
23 address failures to report as well as errors in report-
24 ing.

1 “(5) IMPLEMENTATION.—Not later than 1 year
2 after the date of enactment of this section, the Sec-
3 retary, through the Director of CDC, shall promul-
4 gate regulations to carry out this section.

5 “(b) PUBLIC POSTING OF INFORMATION.—The Sec-
6 retary shall promptly post, on the official public Internet
7 site of the Department of Health and Human Services,
8 the information reported under subsection (a). Such infor-
9 mation shall be set forth in a manner that allows for the
10 comparison of information on health care-associated infec-
11 tions—

12 “(1) among hospitals and ambulatory surgical
13 centers; and

14 “(2) by demographic information.

15 “(c) ANNUAL REPORT TO CONGRESS.—On an annual
16 basis the Secretary shall submit to the Congress a report
17 that summarizes each of the following:

18 “(1) The number and types of health care-asso-
19 ciated infections reported under subsection (a) in
20 hospitals and ambulatory surgical centers during
21 such year.

22 “(2) Factors that contribute to the occurrence
23 of such infections, including health care worker im-
24 munization rates.

1 “(3) Based on the most recent information
2 available to the Secretary on the composition of the
3 professional staff of hospitals and ambulatory sur-
4 gical centers, the number of certified infection con-
5 trol professionals on the staff of hospitals and ambu-
6 latory surgical centers.

7 “(4) The total increases or decreases in health
8 care costs that resulted from increases or decreases
9 in the rates of occurrence of each such type of infec-
10 tion during such year.

11 “(5) Recommendations, in coordination with the
12 Center for Quality Improvement established under
13 section 931 of the Public Health Service Act, for
14 best practices to eliminate the rates of occurrence of
15 each such type of infection in hospitals and ambula-
16 tory surgical centers.

17 “(d) NON-PREEMPTION OF STATE LAWS.—Nothing
18 in this section shall be construed as preempting or other-
19 wise affecting any provision of State law relating to the
20 disclosure of information on health care-associated infec-
21 tions or patient safety procedures for a hospital or ambu-
22 latory surgical center.

23 “(e) HEALTH CARE-ASSOCIATED INFECTION.—For
24 purposes of this section:

1 “(1) IN GENERAL.—The term ‘health care-asso-
2 ciated infection’ means an infection that develops in
3 a patient who has received care in any institutional
4 setting where health care is delivered and is related
5 to receiving health care.

6 “(2) RELATED TO RECEIVING HEALTH CARE.—
7 The term ‘related to receiving health care’, with re-
8 spect to an infection, means that the infection was
9 not incubating or present at the time health care
10 was provided.

11 “(f) APPLICATION TO CRITICAL ACCESS HOS-
12 PITALS.—For purposes of this section, the term ‘hospital’
13 includes a critical access hospital, as defined in section
14 1861(mm)(1).”.

15 (b) EFFECTIVE DATE.—With respect to section
16 1138A of the Social Security Act (as inserted by sub-
17 section (a) of this section), the requirement under such
18 section that hospitals and ambulatory surgical centers
19 submit reports takes effect on such date (not later than
20 2 years after the date of the enactment of this Act) as
21 the Secretary of Health and Human Services shall specify.
22 In order to meet such deadline, the Secretary may imple-
23 ment such section through guidance or other instructions.

24 (c) GAO REPORT.—Not later than 18 months after
25 the date of the enactment of this Act, the Comptroller

1 General of the United States shall submit to Congress a
2 report on the program established under section 1138A
3 of the Social Security Act, as inserted by subsection (a).
4 Such report shall include an analysis of the appropriate-
5 ness of the types of information required for submission,
6 compliance with reporting requirements, the success of the
7 validity procedures established, and any conflict or overlap
8 between the reporting required under such section and any
9 other reporting systems mandated by either the States or
10 the Federal Government.

11 (d) REPORT ON ADDITIONAL DATA.—Not later than
12 18 months after the date of the enactment of this Act,
13 the Secretary of Health and Human Services shall submit
14 to the Congress a report on the appropriateness of expand-
15 ing the requirements under such section to include addi-
16 tional information (such as health care worker immuniza-
17 tion rates), in order to improve health care quality and
18 patient safety.

19 **TITLE V—MEDICARE GRADUATE**
20 **MEDICAL EDUCATION**

21 **SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSI-**
22 **TIONS.**

23 (a) IN GENERAL.—Section 1886(h) of the Social Se-
24 curity Act (42 U.S.C. 1395ww(h)) is amended—

1 (1) in paragraph (4)(F)(i), by striking “para-
2 graph (7)” and inserting “paragraphs (7) and (8)”;

3 (2) in paragraph (4)(H)(i), by striking “para-
4 graph (7)” and inserting “paragraphs (7) and (8)”;

5 (3) in paragraph (7)(E), by inserting “and
6 paragraph (8)” after “this paragraph”; and

7 (4) by adding at the end the following new
8 paragraph:

9 “(8) ADDITIONAL REDISTRIBUTION OF UNUSED
10 RESIDENCY POSITIONS.—

11 “(A) REDUCTIONS IN LIMIT BASED ON UN-
12 USED POSITIONS.—

13 “(i) PROGRAMS SUBJECT TO REDUC-
14 TION.—If a hospital’s reference resident
15 level (specified in clause (ii)) is less than
16 the otherwise applicable resident limit (as
17 defined in subparagraph (C)(ii)), effective
18 for portions of cost reporting periods oc-
19 curring on or after July 1, 2011, the oth-
20 erwise applicable resident limit shall be re-
21 duced by 90 percent of the difference be-
22 tween such otherwise applicable resident
23 limit and such reference resident level.

24 “(ii) REFERENCE RESIDENT LEVEL.—

1 “(I) IN GENERAL.—Except as
2 otherwise provided in a subsequent
3 subclause, the reference resident level
4 specified in this clause for a hospital
5 is the highest resident level for any of
6 the 3 most recent cost reporting peri-
7 ods (ending before the date of the en-
8 actment of this paragraph) of the hos-
9 pital for which a cost report has been
10 settled (or, if not, submitted (subject
11 to audit)), as determined by the Sec-
12 retary.

13 “(II) USE OF MOST RECENT AC-
14 COUNTING PERIOD TO RECOGNIZE EX-
15 PANSION OF EXISTING PROGRAMS.—If
16 a hospital submits a timely request to
17 increase its resident level due to an
18 expansion, or planned expansion, of
19 an existing residency training pro-
20 gram that is not reflected on the most
21 recent settled or submitted cost re-
22 port, after audit and subject to the
23 discretion of the Secretary, subject to
24 subclause (IV), the reference resident
25 level for such hospital is the resident

1 level that includes the additional resi-
2 dents attributable to such expansion
3 or establishment, as determined by
4 the Secretary. The Secretary is au-
5 thORIZED to determine an alternative
6 reference resident level for a hospital
7 that submitted to the Secretary a
8 timely request, before the start of the
9 2009–2010 academic year, for an in-
10 crease in its reference resident level
11 due to a planned expansion.

12 “(III) SPECIAL PROVIDER
13 AGREEMENT.—In the case of a hos-
14 pital described in paragraph
15 (4)(H)(v), the reference resident level
16 specified in this clause is the limita-
17 tion applicable under subclause (I) of
18 such paragraph.

19 “(IV) PREVIOUS REDISTRIBU-
20 TION.—The reference resident level
21 specified in this clause for a hospital
22 shall be increased to the extent re-
23 quired to take into account an in-
24 crease in resident positions made
25 available to the hospital under para-

1 graph (7)(B) that are not otherwise
2 taken into account under a previous
3 subclause.

4 “(iii) AFFILIATION.—The provisions
5 of clause (i) shall be applied to hospitals
6 which are members of the same affiliated
7 group (as defined by the Secretary under
8 paragraph (4)(H)(ii)) and to the extent the
9 hospitals can demonstrate that they are
10 filling any additional resident slots allo-
11 cated to other hospitals through an affili-
12 ation agreement, the Secretary shall adjust
13 the determination of available slots accord-
14 ingly, or which the Secretary otherwise has
15 permitted the resident positions (under
16 section 402 of the Social Security Amend-
17 ments of 1967) to be aggregated for pur-
18 poses of applying the resident position lim-
19 itations under this subsection.

20 “(B) REDISTRIBUTION.—

21 “(i) IN GENERAL.—The Secretary
22 shall increase the otherwise applicable resi-
23 dent limit for each qualifying hospital that
24 submits an application under this subpara-
25 graph by such number as the Secretary

1 may approve for portions of cost reporting
2 periods occurring on or after July 1, 2011.
3 The estimated aggregate number of in-
4 creases in the otherwise applicable resident
5 limit under this subparagraph may not ex-
6 ceed the Secretary's estimate of the aggre-
7 gate reduction in such limits attributable
8 to subparagraph (A).

9 “(ii) REQUIREMENTS FOR QUALI-
10 FYING HOSPITALS.—A hospital is not a
11 qualifying hospital for purposes of this
12 paragraph unless the following require-
13 ments are met:

14 “(I) MAINTENANCE OF PRIMARY
15 CARE RESIDENT LEVEL.—The hos-
16 pital maintains the number of primary
17 care residents at a level that is not
18 less than the base level of primary
19 care residents increased by the num-
20 ber of additional primary care resi-
21 dent positions provided to the hospital
22 under this subparagraph. For pur-
23 poses of this subparagraph, the ‘base
24 level of primary care residents’ for a
25 hospital is the level of such residents

1 as of a base period (specified by the
2 Secretary), determined without regard
3 to whether such positions were in ex-
4 cess of the otherwise applicable resi-
5 dent limit for such period but taking
6 into account the application of sub-
7 clauses (II) and (III) of subparagraph
8 (A)(ii).

9 “(II) DEDICATED ASSIGNMENT
10 OF ADDITIONAL RESIDENT POSITIONS
11 TO PRIMARY CARE.—The hospital as-
12 signs all such additional resident posi-
13 tions for primary care residents.

14 “(III) ACCREDITATION.—The
15 hospital’s residency programs in pri-
16 mary care are fully accredited or, in
17 the case of a residency training pro-
18 gram not in operation as of the base
19 year, the hospital is actively applying
20 for such accreditation for the program
21 for such additional resident positions
22 (as determined by the Secretary).

23 “(iii) CONSIDERATIONS IN REDIS-
24 TRIBUTION.—In determining for which
25 qualifying hospitals the increase in the oth-

1 otherwise applicable resident limit is provided
2 under this subparagraph, the Secretary
3 shall take into account the demonstrated
4 likelihood of the hospital filling the posi-
5 tions within the first 3 cost reporting peri-
6 ods beginning on or after July 1, 2011,
7 made available under this subparagraph,
8 as determined by the Secretary.

9 “(iv) PRIORITY FOR CERTAIN HOS-
10 PITALS.—In determining for which quali-
11 fying hospitals the increase in the other-
12 wise applicable resident limit is provided
13 under this subparagraph, the Secretary
14 shall distribute the increase to qualifying
15 hospitals based on the following criteria:

16 “(I) The Secretary shall give
17 preference to hospitals that had a re-
18 duction in resident training positions
19 under subparagraph (A).

20 “(II) The Secretary shall give
21 preference to hospitals with 3-year
22 primary care residency training pro-
23 grams, such as family practice and
24 general internal medicine.

1 “(III) The Secretary shall give
2 preference to hospitals insofar as they
3 have in effect formal arrangements
4 (as determined by the Secretary) that
5 place greater emphasis upon training
6 in Federally qualified health centers,
7 rural health clinics, and other nonpro-
8 vider settings, and to hospitals that
9 receive additional payments under
10 subsection (d)(5)(F) and emphasize
11 training in an outpatient department.

12 “(IV) The Secretary shall give
13 preference to hospitals with a number
14 of positions (as of July 1, 2009) in
15 excess of the otherwise applicable resi-
16 dent limit for such period.

17 “(V) The Secretary shall give
18 preference to hospitals that place
19 greater emphasis upon training in a
20 health professional shortage area (des-
21 ignated under section 332 of the Pub-
22 lic Health Service Act) or a health
23 professional needs area (designated
24 under section 2211 of such Act).

1 “(VI) The Secretary shall give
2 preference to hospitals in States that
3 have low resident-to-population ratios
4 (including a greater preference for
5 those States with lower resident-to-
6 population ratios).

7 “(v) LIMITATION.—In no case shall
8 more than 20 full-time equivalent addi-
9 tional residency positions be made available
10 under this subparagraph with respect to
11 any hospital.

12 “(vi) APPLICATION OF PER RESIDENT
13 AMOUNTS FOR PRIMARY CARE.—With re-
14 spect to additional residency positions in a
15 hospital attributable to the increase pro-
16 vided under this subparagraph, the ap-
17 proved FTE resident amounts are deemed
18 to be equal to the hospital per resident
19 amounts for primary care and nonprimary
20 care computed under paragraph (2)(D) for
21 that hospital.

22 “(vii) DISTRIBUTION.—The Secretary
23 shall distribute the increase in resident
24 training positions to qualifying hospitals

1 under this subparagraph not later than
2 July 1, 2011.

3 “(C) RESIDENT LEVEL AND LIMIT DE-
4 FINED.—In this paragraph:

5 “(i) The term ‘resident level’ has the
6 meaning given such term in paragraph
7 (7)(C)(i).

8 “(ii) The term ‘otherwise applicable
9 resident limit’ means, with respect to a
10 hospital, the limit otherwise applicable
11 under subparagraphs (F)(i) and (H) of
12 paragraph (4) on the resident level for the
13 hospital determined without regard to this
14 paragraph but taking into account para-
15 graph (7)(A).

16 “(D) MAINTENANCE OF PRIMARY CARE
17 RESIDENT LEVEL.—In carrying out this para-
18 graph, the Secretary shall require hospitals that
19 receive additional resident positions under sub-
20 paragraph (B)—

21 “(i) to maintain records, and periodi-
22 cally report to the Secretary, on the num-
23 ber of primary care residents in its resi-
24 dency training programs; and

1 “(ii) as a condition of payment for a
2 cost reporting period under this subsection
3 for such positions, to maintain the level of
4 such positions at not less than the sum
5 of—

6 “(I) the base level of primary
7 care resident positions (as determined
8 under subparagraph (B)(ii)(I)) before
9 receiving such additional positions;
10 and

11 “(II) the number of such addi-
12 tional positions.”.

13 (b) IME.—

14 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
15 the Social Security Act (42 U.S.C.
16 1395ww(d)(5)(B)(v)), in the third sentence, is
17 amended—

18 (A) by striking “subsection (h)(7)” and in-
19 serting “subsections (h)(7) and (h)(8)”; and

20 (B) by striking “it applies” and inserting
21 “they apply”.

22 (2) CONFORMING PROVISION.—Section
23 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
24 1395ww(d)(5)(B)) is amended by adding at the end
25 the following clause:

1 “(x) For discharges occurring on or after July 1,
2 2011, insofar as an additional payment amount under this
3 subparagraph is attributable to resident positions distrib-
4 uted to a hospital under subsection (h)(8)(B), the indirect
5 teaching adjustment factor shall be computed in the same
6 manner as provided under clause (ii) with respect to such
7 resident positions.”.

8 (c) CONFORMING AMENDMENT.—Section 422(b)(2)
9 of the Medicare Prescription Drug, Improvement, and
10 Modernization Act of 2003 (Public Law 108–173) is
11 amended by striking “section 1886(h)(7)” and all that fol-
12 lows and inserting “paragraphs (7) and (8) of subsection
13 (h) of section 1886 of the Social Security Act.”.

14 **SEC. 1502. INCREASING TRAINING IN NONPROVIDER SET-**
15 **TINGS.**

16 (a) DIRECT GME.—Section 1886(h)(4)(E) of the So-
17 cial Security Act (42 U.S.C. 1395ww(h)) is amended—

18 (1) by designating the first sentence as a clause
19 (i) with the heading “IN GENERAL.—” and appro-
20 priate indentation;

21 (2) by striking “shall be counted and that all
22 the time” and inserting “shall be counted and
23 that—

1 “(I) effective for cost reporting
2 periods beginning before July 1, 2009,
3 all the time”;

4 (3) in subclause (I), as inserted by paragraph
5 (1), by striking the period at the end and inserting
6 “; and”; and

7 (A) by inserting after subclause (I), as so
8 inserted, the following:

9 “(II) effective for cost reporting
10 periods beginning on or after July 1,
11 2009, all the time so spent by a resi-
12 dent shall be counted towards the de-
13 termination of full-time equivalency,
14 without regard to the setting in which
15 the activities are performed, if the
16 hospital incurs the costs of the sti-
17 pends and fringe benefits of the resi-
18 dent during the time the resident
19 spends in that setting.

20 Any hospital claiming under this subpara-
21 graph for time spent in a nonprovider set-
22 ting shall maintain and make available to
23 the Secretary records regarding the
24 amount of such time and such amount in
25 comparison with amounts of such time in

1 such base year as the Secretary shall speci-
2 fy.”.

3 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
4 Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amend-
5 ed—

6 (1) by striking “(iv) Effective for discharges oc-
7 ccurring on or after October 1, 1997” and inserting
8 “(iv)(I) Effective for discharges occurring on or
9 after October 1, 1997, and before July 1, 2009”;
10 and

11 (2) by inserting after subclause (I), as inserted
12 by paragraph (1), the following new subclause:

13 “(II) Effective for discharges occurring on or
14 after July 1, 2009, all the time spent by an intern
15 or resident in patient care activities at an entity in
16 a nonprovider setting shall be counted towards the
17 determination of full-time equivalency if the hospital
18 incurs the costs of the stipends and fringe benefits
19 of the intern or resident during the time the intern
20 or resident spends in that setting.”.

21 (c) OIG STUDY ON IMPACT ON TRAINING.—The In-
22 spector General of the Department of Health and Human
23 Services shall analyze the data collected by the Secretary
24 of Health and Human Services from the records made
25 available to the Secretary under section 1886(h)(4)(E) of

1 the Social Security Act, as amended by subsection (a), in
2 order to assess the extent to which there is an increase
3 in time spent by medical residents in training in nonpro-
4 vider settings as a result of the amendments made by this
5 section. Not later than 4 years after the date of the enact-
6 ment of this Act, the Inspector General shall submit a re-
7 port to Congress on such analysis and assessment.

8 (d) DEMONSTRATION PROJECT FOR APPROVED
9 TEACHING HEALTH CENTERS.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services shall conduct a demonstration
12 project under which an approved teaching health
13 center (as defined in paragraph (3)) would be eligi-
14 ble for payment under subsections (h) and (k) of
15 section 1886 of the Social Security Act (42 U.S.C.
16 1395ww) of amounts for its own direct costs of
17 graduate medical education activities for primary
18 care residents, as well as for the direct costs of grad-
19 uate medical education activities of its contracting
20 hospital for such residents, in a manner similar to
21 the manner in which such payments would be made
22 to a hospital if the hospital were to operate such a
23 program.

24 (2) CONDITIONS.—Under the demonstration
25 project—

1 (A) an approved teaching health center
2 shall contract with an accredited teaching hos-
3 pital to carry out the inpatient responsibilities
4 of the primary care residency program of the
5 hospital involved and is responsible for payment
6 to the hospital for the hospital's costs of the
7 salary and fringe benefits for residents in the
8 program;

9 (B) the number of primary care residents
10 of the center shall not count against the con-
11 tracting hospital's resident limit; and

12 (C) the contracting hospital shall agree not
13 to diminish the number of residents in its pri-
14 mary care residency training program.

15 (3) APPROVED TEACHING HEALTH CENTER DE-
16 FINED.—In this subsection, the term “approved
17 teaching health center” means a nonprovider setting,
18 such as a Federally qualified health center or rural
19 health clinic (as defined in section 1861(aa) of the
20 Social Security Act), that develops and operates an
21 accredited primary care residency program for which
22 funding would be available if it were operated by a
23 hospital.

1 **SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DI-**
2 **DACTIC AND SCHOLARLY ACTIVITIES AND**
3 **OTHER ACTIVITIES.**

4 (a) DIRECT GME.—Section 1886(h) of the Social Se-
5 curity Act (42 U.S.C. 1395ww(h)) is amended—

6 (1) in paragraph (4)(E), as amended by section
7 1502(a)—

8 (A) in clause (i), by striking “Such rules”
9 and inserting “Subject to clause (ii), such
10 rules”; and

11 (B) by adding at the end the following new
12 clause:

13 “(ii) TREATMENT OF CERTAIN NON-
14 PROVIDER AND DIDACTIC ACTIVITIES.—
15 Such rules shall provide that all time spent
16 by an intern or resident in an approved
17 medical residency training program in a
18 nonprovider setting that is primarily en-
19 gaged in furnishing patient care (as de-
20 fined in paragraph (5)(K)) in nonpatient
21 care activities, such as didactic conferences
22 and seminars, but not including research
23 not associated with the treatment or diag-
24 nosis of a particular patient, as such time
25 and activities are defined by the Secretary,

1 shall be counted toward the determination
2 of full-time equivalency.”;

3 (2) in paragraph (4), by adding at the end the
4 following new subparagraph:

5 “(I) TREATMENT OF CERTAIN TIME IN AP-
6 PROVED MEDICAL RESIDENCY TRAINING PRO-
7 GRAMING.—In determining the hospital’s num-
8 ber of full-time equivalent residents for pur-
9 poses of this subsection, all the time that is
10 spent by an intern or resident in an approved
11 medical residency training program on vacation,
12 sick leave, or other approved leave, as such time
13 is defined by the Secretary, and that does not
14 prolong the total time the resident is partici-
15 pating in the approved program beyond the nor-
16 mal duration of the program shall be counted
17 toward the determination of full-time equiva-
18 lency.”; and

19 (3) in paragraph (5), by adding at the end the
20 following new subparagraph:

21 “(K) NONPROVIDER SETTING THAT IS PRI-
22 MARILY ENGAGED IN FURNISHING PATIENT
23 CARE.—The term ‘nonprovider setting that is
24 primarily engaged in furnishing patient care’
25 means a nonprovider setting in which the pri-

1 mary activity is the care and treatment of pa-
2 tients, as defined by the Secretary.”.

3 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
4 of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by
5 section 1501(b), is amended by adding at the end the fol-
6 lowing new clause:

7 “(xi)(I) The provisions of subparagraph (I) of sub-
8 section (h)(4) shall apply under this subparagraph in the
9 same manner as they apply under such subsection.

10 “(II) In determining the hospital’s number of full-
11 time equivalent residents for purposes of this subpara-
12 graph, all the time spent by an intern or resident in an
13 approved medical residency training program in non-
14 patient care activities, such as didactic conferences and
15 seminars, as such time and activities are defined by the
16 Secretary, that occurs in the hospital shall be counted to-
17 ward the determination of full-time equivalency if the hos-
18 pital—

19 “(aa) is recognized as a subsection (d) hospital;

20 “(bb) is recognized as a subsection (d) Puerto
21 Rico hospital;

22 “(cc) is reimbursed under a reimbursement sys-
23 tem authorized under section 1814(b)(3); or

24 “(dd) is a provider-based hospital outpatient de-
25 partment.

1 “(III) In determining the hospital’s number of full-
2 time equivalent residents for purposes of this subpara-
3 graph, all the time spent by an intern or resident in an
4 approved medical residency training program in research
5 activities that are not associated with the treatment or di-
6 agnosis of a particular patient, as such time and activities
7 are defined by the Secretary, shall not be counted toward
8 the determination of full-time equivalency.”.

9 (c) EFFECTIVE DATES; APPLICATION.—

10 (1) IN GENERAL.—Except as otherwise pro-
11 vided, the Secretary of Health and Human Services
12 shall implement the amendments made by this sec-
13 tion in a manner so as to apply to cost reporting pe-
14 riods beginning on or after January 1, 1983.

15 (2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of
16 the Social Security Act, as added by subsection
17 (a)(1)(B), shall apply to cost reporting periods be-
18 ginning on or after July 1, 2008.

19 (3) IME.—Section 1886(d)(5)(B)(x)(III) of the
20 Social Security Act, as added by subsection (b), shall
21 apply to cost reporting periods beginning on or after
22 October 1, 2001. Such section, as so added, shall
23 not give rise to any inference on how the law in ef-
24 fect prior to such date should be interpreted.

1 (4) APPLICATION.—The amendments made by
2 this section shall not be applied in a manner that re-
3 quires reopening of any settled hospital cost reports
4 as to which there is not a jurisdictionally proper ap-
5 peal pending as of the date of the enactment of this
6 Act on the issue of payment for indirect costs of
7 medical education under section 1886(d)(5)(B) of
8 the Social Security Act or for direct graduate med-
9 ical education costs under section 1886(h) of such
10 Act.

11 **SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS**
12 **FROM CLOSED HOSPITALS.**

13 (a) DIRECT GME.—Section 1886(h)(4)(H) of the So-
14 cial Security Act (42 U.S.C. Section 1395ww(h)(4)(H))
15 is amended by adding at the end the following new clause:

16 “(vi) REDISTRIBUTION OF RESIDENCY
17 SLOTS AFTER A HOSPITAL CLOSES.—

18 “(I) IN GENERAL.—The Sec-
19 retary shall, by regulation, establish a
20 process consistent with subclauses (II)
21 and (III) under which, in the case
22 where a hospital (other than a hos-
23 pital described in clause (v)) with an
24 approved medical residency program
25 in a State closes on or after the date

1 that is 2 years before the date of the
2 enactment of this clause, the Sec-
3 retary shall increase the otherwise ap-
4 plicable resident limit under this para-
5 graph for other hospitals in the State
6 in accordance with this clause.

7 “(II) PROCESS FOR HOSPITALS
8 IN CERTAIN AREAS.—In determining
9 for which hospitals the increase in the
10 otherwise applicable resident limit de-
11 scribed in subclause (I) is provided,
12 the Secretary shall establish a process
13 to provide for such increase to one or
14 more hospitals located in the State.
15 Such process shall take into consider-
16 ation the recommendations submitted
17 to the Secretary by the senior health
18 official (as designated by the chief ex-
19 ecutive officer of such State) if such
20 recommendations are submitted not
21 later than 180 days after the date of
22 the hospital closure involved (or, in
23 the case of a hospital that closed after
24 the date that is 2 years before the
25 date of the enactment of this clause,

1 180 days after such date of enact-
2 ment).

3 “(III) LIMITATION.—The esti-
4 mated aggregate number of increases
5 in the otherwise applicable resident
6 limits for hospitals under this clause
7 shall be equal to the estimated num-
8 ber of resident positions in the ap-
9 proved medical residency programs
10 that closed on or after the date de-
11 scribed in subclause (I).”.

12 (b) NO EFFECT ON TEMPORARY FTE CAP ADJUST-
13 MENTS.—The amendments made by this section shall not
14 effect any temporary adjustment to a hospital’s FTE cap
15 under section 413.79(h) of title 42, Code of Federal Regu-
16 lations (as in effect on the date of enactment of this Act)
17 and shall not affect the application of section
18 1886(h)(4)(H)(v) of the Social Security Act.

19 (c) CONFORMING AMENDMENTS.—

20 (1) Section 422(b)(2) of the Medicare Prescrip-
21 tion Drug, Improvement, and Modernization Act of
22 2003 (Public Law 108–173), as amended by section
23 1501(e), is amended by striking “(7) and” and in-
24 serting “(4)(H)(vi), (7), and”.

1 (2) Section 1886(h)(7)(E) of the Social Secu-
2 rity Act (42 U.S.C. 1395ww(h)(7)(E)) is amended
3 by inserting “or under paragraph (4)(H)(vi)” after
4 “under this paragraph”.

5 **SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED**
6 **MEDICAL RESIDENCY TRAINING.**

7 (a) SPECIFICATION OF GOALS FOR APPROVED MED-
8 ICAL RESIDENCY TRAINING PROGRAMS.—Section
9 1886(h)(1) of the Social Security Act (42 U.S.C.
10 1395ww(h)(1)) is amended—

11 (1) by designating the matter beginning with
12 “Notwithstanding” as a subparagraph (A) with the
13 heading “IN GENERAL.—” and with appropriate in-
14 dentation; and

15 (2) by adding at the end the following new sub-
16 paragraph:

17 “(B) GOALS AND ACCOUNTABILITY FOR
18 APPROVED MEDICAL RESIDENCY TRAINING PRO-
19 GRAMS.—The goals of medical residency train-
20 ing programs are to foster a physician work-
21 force so that physicians are trained to be able
22 to do the following:

23 “(i) Work effectively in various health
24 care delivery settings, such as nonprovider
25 settings.

1 “(ii) Coordinate patient care within
2 and across settings relevant to their spe-
3 cialties.

4 “(iii) Understand the relevant cost
5 and value of various diagnostic and treat-
6 ment options.

7 “(iv) Work in inter-professional teams
8 and multi-disciplinary team-based models
9 in provider and nonprovider settings to en-
10 hance safety and improve quality of patient
11 care.

12 “(v) Be knowledgeable in methods of
13 identifying systematic errors in health care
14 delivery and in implementing systematic
15 solutions in case of such errors, including
16 experience and participation in continuous
17 quality improvement projects to improve
18 health outcomes of the population the phy-
19 sicians serve.

20 “(vi) Be meaningful EHR users (as
21 determined under section 1848(o)(2)) in
22 the delivery of care and in improving the
23 quality of the health of the community and
24 the individuals that the hospital serves.”

1 (b) GAO STUDY ON EVALUATION OF TRAINING PRO-
2 GRAMS.—

3 (1) IN GENERAL.—The Comptroller General of
4 the United States shall conduct a study to evaluate
5 the extent to which medical residency training pro-
6 grams—

7 (A) are meeting the goals described in sec-
8 tion 1886(h)(1)(B) of the Social Security Act,
9 as added by subsection (a), in a range of resi-
10 dency programs, including primary care and
11 other specialties; and

12 (B) have the appropriate faculty expertise
13 to teach the topics required to achieve such
14 goals.

15 (2) REPORT.—Not later than 18 months after
16 the date of the enactment of this Act, the Comp-
17 troller General shall submit to Congress a report on
18 such study and shall include in such report rec-
19 ommendations as to how medical residency training
20 programs could be further encouraged to meet such
21 goals through means such as—

22 (A) development of curriculum require-
23 ments; and

24 (B) assessment of the accreditation proc-
25 esses of the Accreditation Council for Graduate

1 Medical Education and the American Osteo-
2 pathic Association and effectiveness of those
3 processes in accrediting medical residency pro-
4 grams that meet the goals referred to in para-
5 graph (1)(A).

6 **TITLE VI—PROGRAM INTEGRITY**
7 **Subtitle A—Increased Funding to**
8 **Fight Waste, Fraud, and Abuse**

9 **SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO**
10 **FIGHT FRAUD AND ABUSE.**

11 (a) IN GENERAL.—Section 1817(k) of the Social Se-
12 curity Act (42 U.S.C. 1395i(k)) is amended—

13 (1) by adding at the end the following new
14 paragraph:

15 “(7) ADDITIONAL FUNDING.—In addition to the
16 funds otherwise appropriated to the Account from
17 the Trust Fund under paragraphs (3) and (4) and
18 for purposes described in paragraphs (3)(C) and
19 (4)(A), there are hereby appropriated an additional
20 \$100,000,000 to such Account from such Trust
21 Fund for each fiscal year beginning with 2011. The
22 funds appropriated under this paragraph shall be al-
23 located in the same proportion as the total funding
24 appropriated with respect to paragraphs (3)(A) and
25 (4)(A) was allocated with respect to fiscal year

1 2010, and shall be available without further appro-
2 priation until expended.”.

3 (2) in paragraph (4)(A)—

4 (A) by inserting “for activities described in
5 paragraph (3)(C) and” after “necessary”; and

6 (B) by inserting “until expended” after
7 “appropriation”.

8 (b) FLEXIBILITY IN PURSUING FRAUD AND
9 ABUSE.—Section 1893(a) of the Social Security Act (42
10 U.S.C. 1395ddd(a)) is amended by inserting “, or other-
11 wise,” after “entities”.

12 **Subtitle B—Enhanced Penalties for** 13 **Fraud and Abuse**

14 **SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS** 15 **ON PROVIDER OR SUPPLIER ENROLLMENT** 16 **APPLICATIONS.**

17 (a) IN GENERAL.—Section 1128A(a) of the Social
18 Security Act (42 U.S.C. 1320a–7a(a)) is amended—

19 (1) in paragraph (1)(D), by striking all that fol-
20 lows “in which the person was excluded” and insert-
21 ing “under Federal law from the Federal health care
22 program under which the claim was made, or”;

23 (2) by striking “or” at the end of paragraph
24 (6);

1 (3) in paragraph (7), by inserting at the end
2 “or”;

3 (4) by inserting after paragraph (7) the fol-
4 lowing new paragraph:

5 “(8) knowingly makes or causes to be made any
6 false statement, omission, or misrepresentation of a
7 material fact in any application, agreement, bid, or
8 contract to participate or enroll as a provider of
9 services or supplier under a Federal health care pro-
10 gram, including managed care organizations under
11 title XIX, Medicare Advantage organizations under
12 part C of title XVIII, prescription drug plan spon-
13 sors under part D of title XVIII, and entities that
14 apply to participate as providers of services or sup-
15 pliers in such managed care organizations and such
16 plans;”;

17 (5) in the matter following paragraph (8), as
18 inserted by paragraph (4), by striking “or in cases
19 under paragraph (7), \$50,000 for each such act)”
20 and inserting “in cases under paragraph (7),
21 \$50,000 for each such act, or in cases under para-
22 graph (8), \$50,000 for each false statement, omis-
23 sion, or misrepresentation of a material fact)”;

24 (6) in the second sentence, by striking “for a
25 lawful purpose)” and inserting “for a lawful pur-

1 pose, or in cases under paragraph (8), an assess-
2 ment of not more than 3 times the amount claimed
3 as the result of the false statement, omission, or
4 misrepresentation of material fact claimed by a pro-
5 vider of services or supplier whose application to
6 participate contained such false statement, omission,
7 or misrepresentation)”.
8

9 (b) **EFFECTIVE DATE.**—The amendments made by
10 subsection (a) shall apply to acts committed on or after
11 January 1, 2010.

12 **SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF**
13 **FALSE STATEMENTS MATERIAL TO A FALSE**
14 **CLAIM.**

15 (a) **IN GENERAL.**—Section 1128A(a) of the Social
16 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
17 tion 1611, is further amended—

18 (1) in paragraph (7), by striking “or” at the
19 end;

20 (2) in paragraph (8), by inserting “or” at the
21 end; and

22 (3) by inserting after paragraph (8), the fol-
23 lowing new paragraph:

24 “(9) knowingly makes, uses, or causes to be
25 made or used, a false record or statement material
26 to a false or fraudulent claim for payment for items

1 and services furnished under a Federal health care
2 program;” and

3 (4) in the matter following paragraph (9), as
4 inserted by paragraph (3)—

5 (A) by striking “or in cases under para-
6 graph (8)” and inserting “in cases under para-
7 graph (8)”; and

8 (B) by striking “a material fact)” and in-
9 serting “a material fact, in cases under para-
10 graph (9), \$50,000 for each false record or
11 statement)”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to acts committed on or after
14 January 1, 2010.

15 **SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPEC-**
16 **TIONS.**

17 (a) IN GENERAL.—Section 1128A(a) of the Social
18 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
19 tions 1611 and 1612, is further amended—

20 (1) in paragraph (8), by striking “or” at the
21 end;

22 (2) in paragraph (9), by inserting “or” at the
23 end;

24 (3) by inserting after paragraph (9) the fol-
25 lowing new paragraph:

1 “(10) fails to grant timely access, upon reason-
2 able request (as defined by the Secretary in regula-
3 tions), to the Inspector General of the Department
4 of Health and Human Services, for the purpose of
5 audits, investigations, evaluations, or other statutory
6 functions of the Inspector General of the Depart-
7 ment of Health and Human Services;” and

8 (4) in the matter following paragraph (10), as
9 inserted by paragraph (3), by inserting “, or in cases
10 under paragraph (10), \$15,000 for each day of the
11 failure described in such paragraph” after “false
12 record or statement”.

13 (b) ENSURING TIMELY INSPECTIONS RELATING TO
14 CONTRACTS WITH MA ORGANIZATIONS.—Section
15 1857(d)(2) of such Act (42 U.S.C. 1395w-27(d)(2)) is
16 amended—

17 (1) in subparagraph (A), by inserting “timely”
18 before “inspect”; and

19 (2) in subparagraph (B), by inserting “timely”
20 before “audit and inspect”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 subsection (a) shall apply to violations committed on or
23 after January 1, 2010.

1 **SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.**

2 (a) MEDICARE.—Part A of title XVIII of the Social
3 Security Act is amended by inserting after section 1819
4 the following new section:

5 **“SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE**
6 **CARE.**

7 “(a) IN GENERAL.—If the Secretary determines on
8 the basis of a survey or otherwise, that a hospice program
9 that is certified for participation under this title has dem-
10 onstrated a substandard quality of care and failed to meet
11 such other requirements as the Secretary may find nec-
12 essary in the interest of the health and safety of the indi-
13 viduals who are provided care and services by the agency
14 or organization involved and determines—

15 “(1) that the deficiencies involved immediately
16 jeopardize the health and safety of the individuals to
17 whom the program furnishes items and services, the
18 Secretary shall take immediate action to remove the
19 jeopardy and correct the deficiencies through the
20 remedy specified in subsection (b)(2)(A)(iii) or ter-
21minate the certification of the program, and may
22 provide, in addition, for 1 or more of the other rem-
23 edies described in subsection (b)(2)(A); or

24 “(2) that the deficiencies involved do not imme-
25 diately jeopardize the health and safety of the indi-

1 viduals to whom the program furnishes items and
2 services, the Secretary may—

3 “(A) impose intermediate sanctions devel-
4 oped pursuant to subsection (b), in lieu of ter-
5 minating the certification of the program; and

6 “(B) if, after such a period of intermediate
7 sanctions, the program is still not in compliance
8 with such requirements, the Secretary shall ter-
9 minate the certification of the program.

10 If the Secretary determines that a hospice program
11 that is certified for participation under this title is
12 in compliance with such requirements but, as of a
13 previous period, was not in compliance with such re-
14 quirements, the Secretary may provide for a civil
15 money penalty under subsection (b)(2)(A)(i) for the
16 days in which it finds that the program was not in
17 compliance with such requirements.

18 “(b) INTERMEDIATE SANCTIONS.—

19 “(1) DEVELOPMENT AND IMPLEMENTATION.—
20 The Secretary shall develop and implement, by not
21 later than July 1, 2012—

22 “(A) a range of intermediate sanctions to
23 apply to hospice programs under the conditions
24 described in subsection (a), and

1 “(B) appropriate procedures for appealing
2 determinations relating to the imposition of
3 such sanctions.

4 “(2) SPECIFIED SANCTIONS.—

5 “(A) IN GENERAL.—The intermediate
6 sanctions developed under paragraph (1) may
7 include—

8 “(i) civil money penalties in an
9 amount not to exceed \$10,000 for each day
10 of noncompliance or, in the case of a per
11 instance penalty applied by the Secretary,
12 not to exceed \$25,000,

13 “(ii) denial of all or part of the pay-
14 ments to which a hospice program would
15 otherwise be entitled under this title with
16 respect to items and services furnished by
17 a hospice program on or after the date on
18 which the Secretary determines that inter-
19 mediate sanctions should be imposed pur-
20 suant to subsection (a)(2),

21 “(iii) the appointment of temporary
22 management to oversee the operation of
23 the hospice program and to protect and as-
24 sure the health and safety of the individ-

1 uals under the care of the program while
2 improvements are made,

3 “ (iv) corrective action plans, and

4 “ (v) in-service training for staff.

5 The provisions of section 1128A (other than
6 subsections (a) and (b)) shall apply to a civil
7 money penalty under clause (i) in the same
8 manner as such provisions apply to a penalty or
9 proceeding under section 1128A(a). The tem-
10 porary management under clause (iii) shall not
11 be terminated until the Secretary has deter-
12 mined that the program has the management
13 capability to ensure continued compliance with
14 all requirements referred to in that clause.

15 “(B) CLARIFICATION.—The sanctions
16 specified in subparagraph (A) are in addition to
17 sanctions otherwise available under State or
18 Federal law and shall not be construed as lim-
19 iting other remedies, including any remedy
20 available to an individual at common law.

21 “(C) COMMENCEMENT OF PAYMENT.—A
22 denial of payment under subparagraph (A)(ii)
23 shall terminate when the Secretary determines
24 that the hospice program no longer dem-
25 onstrates a substandard quality of care and

1 meets such other requirements as the Secretary
2 may find necessary in the interest of the health
3 and safety of the individuals who are provided
4 care and services by the agency or organization
5 involved.

6 “(3) SECRETARIAL AUTHORITY.—The Secretary
7 shall develop and implement, by not later than July
8 1, 2011, specific procedures with respect to the con-
9 ditions under which each of the intermediate sanc-
10 tions developed under paragraph (1) is to be applied,
11 including the amount of any fines and the severity
12 of each of these sanctions. Such procedures shall be
13 designed so as to minimize the time between identi-
14 fication of deficiencies and imposition of these sanc-
15 tions and shall provide for the imposition of incre-
16 mentally more severe fines for repeated or uncor-
17 rected deficiencies.”.

18 (b) APPLICATION TO MEDICAID.—Section 1905(o) of
19 the Social Security Act (42 U.S.C. 1396d(o)) is amended
20 by adding at the end the following new paragraph:

21 “(4) The provisions of section 1819A shall apply to
22 a hospice program providing hospice care under this title
23 in the same manner as such provisions apply to a hospice
24 program providing hospice care under title XVIII.”.

1 (c) APPLICATION TO CHIP.—Title XXI of the Social
2 Security Act is amended by adding at the end the fol-
3 lowing new section:

4 **“SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.**

5 “The provisions of section 1819A shall apply to a
6 hospice program providing hospice care under this title in
7 the same manner such provisions apply to a hospice pro-
8 gram providing hospice care under title XVIII.”.

9 **SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EX-**
10 **CLUDED FROM PROGRAM PARTICIPATION.**

11 (a) IN GENERAL.—Section 1128A(a) of the Social
12 Security Act (42 U.S.C. 1320a–7a(a)), as amended by the
13 previous sections, is further amended—

14 (1) by striking “or” at the end of paragraph
15 (9);

16 (2) by inserting “or” at the end of paragraph
17 (10);

18 (3) by inserting after paragraph (10) the fol-
19 lowing new paragraph:

20 “(11) orders or prescribes an item or service,
21 including without limitation home health care, diag-
22 nostic and clinical lab tests, prescription drugs, du-
23 rable medical equipment, ambulance services, phys-
24 ical or occupational therapy, or any other item or
25 service, during a period when the person has been

1 excluded from participation in a Federal health care
2 program, and the person knows or should know that
3 a claim for such item or service will be presented to
4 such a program;” and

5 (4) in the matter following paragraph (11), as
6 inserted by paragraph (2), by striking “\$15,000 for
7 each day of the failure described in such paragraph”
8 and inserting “\$15,000 for each day of the failure
9 described in such paragraph, or in cases under para-
10 graph (11), \$50,000 for each order or prescription
11 for an item or service by an excluded individual”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to violations committed on or
14 after January 1, 2010.

15 **SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF**
16 **FALSE INFORMATION BY MEDICARE ADVAN-**
17 **TAGE AND PART D PLANS.**

18 (a) IN GENERAL.—Section 1857(g)(2)(A) of the So-
19 cial Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is
20 amended by inserting “except with respect to a determina-
21 tion under subparagraph (E), an assessment of not more
22 than 3 times the amount claimed by such plan or plan
23 sponsor based upon the misrepresentation or falsified in-
24 formation involved,” after “for each such determination,”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to violations committed on or
3 after January 1, 2010.

4 **SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVAN-**
5 **TAGE AND PART D MARKETING VIOLATIONS.**

6 (a) IN GENERAL.—Section 1857(g)(1) of the Social
7 Security Act (42 U.S.C. 1395w—27(g)(1)), as amended
8 by section 1221(b), is amended—

9 (1) in subparagraph (G), by striking “or” at
10 the end;

11 (2) by inserting after subparagraph (H) the fol-
12 lowing new subparagraphs:

13 “(I) except as provided under subpara-
14 graph (C) or (D) of section 1860D–1(b)(1), en-
15 rolls an individual in any plan under this part
16 without the prior consent of the individual or
17 the designee of the individual;

18 “(J) transfers an individual enrolled under
19 this part from one plan to another without the
20 prior consent of the individual or the designee
21 of the individual or solely for the purpose of
22 earning a commission;

23 “(K) fails to comply with marketing re-
24 strictions described in subsections (h) and (j) of

1 section 1851 or applicable implementing regula-
2 tions or guidance; or

3 “(L) employs or contracts with any indi-
4 vidual or entity who engages in the conduct de-
5 scribed in subparagraphs (A) through (K) of
6 this paragraph;” and

7 (3) by adding at the end the following new sen-
8 tence: “The Secretary may provide, in addition to
9 any other remedies authorized by law, for any of the
10 remedies described in paragraph (2), if the Secretary
11 determines that any employee or agent of such orga-
12 nization, or any provider or supplier who contracts
13 with such organization, has engaged in any conduct
14 described in subparagraphs (A) through (L) of this
15 paragraph.”

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall apply to violations committed on or
18 after January 1, 2010.

19 **SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF**
20 **PROGRAM AUDITS.**

21 (a) IN GENERAL.—Section 1128(b)(2) of the Social
22 Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

23 (1) in the heading, by inserting “OR AUDIT”
24 after “INVESTIGATION”; and

1 (2) by striking “investigation into” and all that
2 follows through the period and inserting “investiga-
3 tion or audit related to—”

4 “(i) any offense described in para-
5 graph (1) or in subsection (a); or

6 “(ii) the use of funds received, directly
7 or indirectly, from any Federal health care
8 program (as defined in section
9 1128B(f)).”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall apply to violations committed on or
12 after January 1, 2010.

13 **SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND EN-**
14 **TITIES FROM PARTICIPATION IN MEDICARE**
15 **AND STATE HEALTH CARE PROGRAMS.**

16 (a) IN GENERAL.—Section 1128(c) of the Social Se-
17 curity Act, as previously amended by this division, is fur-
18 ther amended—

19 (1) in the heading, by striking “AND PERIOD”
20 and inserting “PERIOD, AND EFFECT”; and

21 (2) by adding at the end the following new
22 paragraph:

23 “(4)(A) For purposes of this Act, subject to subpara-
24 graph (C), the effect of exclusion is that no payment may
25 be made by any Federal health care program (as defined

1 in section 1128B(f)) with respect to any item or service
2 furnished—

3 “(i) by an excluded individual or entity; or

4 “(ii) at the medical direction or on the prescrip-
5 tion of a physician or other authorized individual
6 when the person submitting a claim for such item or
7 service knew or had reason to know of the exclusion
8 of such individual.

9 “(B) For purposes of this section and sections 1128A
10 and 1128B, subject to subparagraph (C), an item or serv-
11 ice has been furnished by an individual or entity if the
12 individual or entity directly or indirectly provided, ordered,
13 manufactured, distributed, prescribed, or otherwise sup-
14 plied the item or service regardless of how the item or
15 service was paid for by a Federal health care program or
16 to whom such payment was made.

17 “(C)(i) Payment may be made under a Federal
18 health care program for emergency items or services (not
19 including items or services furnished in an emergency
20 room of a hospital) furnished by an excluded individual
21 or entity, or at the medical direction or on the prescription
22 of an excluded physician or other authorized individual
23 during the period of such individual’s exclusion.

24 “(ii) In the case that an individual eligible for bene-
25 fits under title XVIII or XIX submits a claim for payment

1 for items or services furnished by an excluded individual
2 or entity, and such individual eligible for such benefits did
3 not know or have reason to know that such excluded indi-
4 vidual or entity was so excluded, then, notwithstanding
5 such exclusion, payment shall be made for such items or
6 services. In such case the Secretary shall notify such indi-
7 vidual eligible for such benefits of the exclusion of the indi-
8 vidual or entity furnishing the items or services. Payment
9 shall not be made for items or services furnished by an
10 excluded individual or entity to an individual eligible for
11 such benefits after a reasonable time (as determined by
12 the Secretary in regulations) after the Secretary has noti-
13 fied the individual eligible for such benefits of the exclu-
14 sion of the individual or entity furnishing the items or
15 services.

16 “(iii) In the case that a claim for payment for items
17 or services furnished by an excluded individual or entity
18 is submitted by an individual or entity other than an indi-
19 vidual eligible for benefits under title XVIII or XIX or
20 the excluded individual or entity, and the Secretary deter-
21 mines that the individual or entity that submitted the
22 claim took reasonable steps to learn of the exclusion and
23 reasonably relied upon inaccurate or misleading informa-
24 tion from the relevant Federal health care program or its
25 contractor, the Secretary may waive repayment of the

1 amount paid in violation of the exclusion to the individual
2 or entity that submitted the claim for the items or services
3 furnished by the excluded individual or entity. If a Federal
4 health care program contractor provided inaccurate or
5 misleading information that resulted in the waiver of an
6 overpayment under this clause, the Secretary shall take
7 appropriate action to recover the improperly paid amount
8 from the contractor.”.

9 **SEC. 1620. OIG AUTHORITY TO EXCLUDE FROM FEDERAL**
10 **HEALTH CARE PROGRAMS OFFICERS AND**
11 **OWNERS OF ENTITIES CONVICTED OF FRAUD.**

12 Section 1128(b)(15)(A) of the Social Security Act
13 (42 U.S.C. 1320a-7(b)(15)(A)) is amended—

14 (1) in clause (i)—

15 (A) by striking “has” and inserting “had”;

16 and

17 (B) by striking “sanctioned entity and who

18 knows or should know (as defined in section

19 1128A(i)(6)) of” and inserting “sanctioned en-

20 tity at the time of, and who knew or should

21 have known (as defined in section 1128A(i)(6))

22 of,” ; and

23 (2) in clause (ii)—

24 (A) by striking “is an officer” and insert-

25 ing “was an officer”; and

1 (B) by inserting before the period the fol-
2 lowing: “at the time of the action constituting
3 the basis for the conviction or exclusion de-
4 scribed in subparagraph (B)”.

5 **SEC. 1621. SELF-REFERRAL DISCLOSURE PROTOCOL.**

6 (a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE
7 PROTOCOL.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services, in cooperation with the Inspector
10 General of the Department of Health and Human
11 Services, shall establish, not later than 6 months
12 after the date of the enactment of this Act, a pro-
13 tocol to enable health care providers of services and
14 suppliers to disclose an actual or potential violation
15 of section 1877 of the Social Security Act (42
16 U.S.C. 1395nn) pursuant to a self-referral disclosure
17 protocol (in this section referred to as an “SRDP”).
18 The SRDP shall include direction to health care pro-
19 viders of services and suppliers on—

20 (A) a specific person, official, or office to
21 whom such disclosures shall be made; and

22 (B) instruction on the implication of the
23 SRDP on corporate integrity agreements and
24 corporate compliance agreements.

1 (2) PUBLICATION ON INTERNET WEBSITE OF
2 SRDP INFORMATION.—The Secretary shall post in-
3 formation on the public Internet website of the Cen-
4 ters for Medicare & Medicaid Services to inform rel-
5 evant stakeholders of how to disclose actual or po-
6 tential violations pursuant to an SRDP.

7 (3) RELATION TO ADVISORY OPINIONS.—The
8 SRDP shall be separate from the advisory opinion
9 process set forth in regulations implementing section
10 1877(g) of the Social Security Act.

11 (b) REDUCTION IN AMOUNTS OWED.—The Secretary
12 is authorized to reduce the amount due and owing for all
13 violations under section 1877 of the Social Security Act
14 to an amount less than that specified in subsection (g)
15 of such section. In establishing such amount for a viola-
16 tion, the Secretary may consider the following factors:

17 (1) The nature and extent of the improper or
18 illegal practice.

19 (2) The timeliness of such self-disclosure.

20 (3) The cooperation in providing additional in-
21 formation related to the disclosure.

22 (4) Such other factors as the Secretary con-
23 siders appropriate.

24 (c) REPORT.—Not later than 18 months after the
25 date on which the SRDP protocol is established under sub-

1 section (a)(1), the Secretary shall submit to Congress a
2 report on the implementation of this section. Such report
3 shall include—

4 (1) the number of health care providers of serv-
5 ices and suppliers making disclosures pursuant to an
6 SRDP;

7 (2) the amounts collected pursuant to the
8 SRDP;

9 (3) the types of violations reported under the
10 SRDP; and

11 (4) such other information as may be necessary
12 to evaluate the impact of this section.

13 (d) RELATION TO OTHER LAW AND REGULATION.—

14 Nothing in this section shall affect the application of sec-
15 tion 1128G(c) of the Social Security Act, as added by sec-
16 tion 1641, except, in the case of a health care provider
17 of services or supplier who is a person (as defined in para-
18 graph (4) of such section 1128G(c)) who discloses an over-
19 payment (as defined in such paragraph) to the Secretary
20 of Health and Human Services pursuant to a SRDP es-
21 tablished under this section, the 60-day period described
22 in paragraph (2) of such section 1128G(c) shall be ex-
23 tended with respect to the return of an overpayment to
24 the extent necessary for the Secretary to determine pursu-
25 ant to the SRDP the amount due and owing.

1 **Subtitle C—Enhanced Program**
2 **and Provider Protections**

3 **SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AU-**
4 **THORITY.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 (42 U.S.C. 1301 et seq.) is amended by inserting after
7 section 1128F the following new section:

8 **“SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PRO-**
9 **TECTIONS IN THE MEDICARE, MEDICAID, AND**
10 **CHIP PROGRAMS.**

11 “(a) CERTAIN AUTHORIZED SCREENING, ENHANCED
12 OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

13 “(1) IN GENERAL.—For periods beginning after
14 January 1, 2011, in the case that the Secretary de-
15 termines there is a significant risk of fraudulent ac-
16 tivity (as determined by the Secretary based on rel-
17 evant complaints, reports, referrals by law enforce-
18 ment or other sources, data analysis, trending infor-
19 mation, or claims submissions by providers of serv-
20 ices and suppliers) with respect to a category of pro-
21 vider of services or supplier of items or services, in-
22 cluding a category within a geographic area, under
23 title XVIII, XIX, or XXI, the Secretary may impose
24 any of the following requirements with respect to a
25 provider of services or a supplier (whether such pro-

1 vider or supplier is initially enrolling in the program
2 or is renewing such enrollment):

3 “(A) Screening under paragraph (2).

4 “(B) Enhanced oversight periods under
5 paragraph (3).

6 “(C) Enrollment moratoria under para-
7 graph (4).

8 In applying this subsection for purposes of title XIX
9 and XXI the Secretary may require a State to carry
10 out the provisions of this subsection as a require-
11 ment of the State plan under title XIX or the child
12 health plan under title XXI. Actions taken and de-
13 terminations made under this subsection shall not be
14 subject to review by a judicial tribunal.

15 “(2) SCREENING.—For purposes of paragraph
16 (1), the Secretary shall establish procedures under
17 which screening is conducted with respect to pro-
18 viders of services and suppliers described in such
19 paragraph. Such screening may include—

20 “(A) licensing board checks;

21 “(B) screening against the list of individ-
22 uals and entities excluded from the program
23 under title XVIII, XIX, or XXI;

24 “(C) the excluded provider list system;

25 “(D) background checks; and

1 “(E) unannounced pre-enrollment or other
2 site visits.

3 “(3) ENHANCED OVERSIGHT PERIOD.—For
4 purposes of paragraph (1), the Secretary shall estab-
5 lish procedures to provide for a period of not less
6 than 30 days and not more than 365 days during
7 which providers of services and suppliers described
8 in such paragraph, as the Secretary determines ap-
9 propriate, would be subject to enhanced oversight,
10 such as required or unannounced (or required and
11 unannounced) site visits or inspections, prepayment
12 review, enhanced review of claims, and such other
13 actions as specified by the Secretary, under the pro-
14 grams under titles XVIII, XIX, and XXI. Under
15 such procedures, the Secretary may extend such pe-
16 riod for more than 365 days if the Secretary deter-
17 mines that after the initial period such additional
18 period of oversight is necessary.

19 “(4) MORATORIUM ON ENROLLMENT OF PRO-
20 VIDERS AND SUPPLIERS.—For purposes of para-
21 graph (1), the Secretary, based upon a finding of a
22 risk of serious ongoing fraud within a program
23 under title XVIII, XIX, or XXI, may impose a mor-
24 atorium on the enrollment of providers of services
25 and suppliers within a category of providers of serv-

1 ices and suppliers (including a category within a spe-
2 cific geographic area) under such title. Such a mora-
3 torium may only be imposed if the Secretary makes
4 a determination that the moratorium would not ad-
5 versely impact access of individuals to care under
6 such program.

7 “(5) CLARIFICATION.—Nothing in this sub-
8 section shall be interpreted to preclude or limit the
9 ability of a State to engage in provider screening or
10 enhanced provider oversight activities beyond those
11 required by the Secretary.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) MEDICAID.—Section 1902(a) of the Social
14 Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is
15 amended—

16 (A) in paragraph (23), by inserting before
17 the semicolon at the end the following: “or by
18 a person to whom or entity to which a morato-
19 rium under section 1128G(a)(4) is applied dur-
20 ing the period of such moratorium”;

21 (B) in paragraph (72); by striking at the
22 end “and”;

23 (C) in paragraph (73), by striking the pe-
24 riod at the end and inserting “; and”; and

1 (D) by adding after paragraph (73) the
2 following new paragraph:

3 “(74) provide that the State will enforce any
4 determination made by the Secretary under sub-
5 section (a) of section 1128G (relating to a signifi-
6 cant risk of fraudulent activity with respect to a cat-
7 egory of provider or supplier described in such sub-
8 section (a) through use of the appropriate proce-
9 dures described in such subsection (a)), and that the
10 State will carry out any activities as required by the
11 Secretary for purposes of such subsection (a).”.

12 (2) CHIP.—Section 2102 of such Act (42
13 U.S.C. 1397bb) is amended by adding at the end the
14 following new subsection:

15 “(d) PROGRAM INTEGRITY.—A State child health
16 plan shall include a description of the procedures to be
17 used by the State—

18 “(1) to enforce any determination made by the
19 Secretary under subsection (a) of section 1128G (re-
20 lating to a significant risk of fraudulent activity with
21 respect to a category of provider or supplier de-
22 scribed in such subsection through use of the appro-
23 priate procedures described in such subsection); and

24 “(2) to carry out any activities as required by
25 the Secretary for purposes of such subsection.”.

1 (3) MEDICARE.—Section 1866(j) of such Act
2 (42 U.S.C. 1395cc(j)) is amended by adding at the
3 end the following new paragraph:

4 “(3) PROGRAM INTEGRITY.—The provisions of
5 section 1128G(a) apply to enrollments and renewals
6 of enrollments of providers of services and suppliers
7 under this title.”.

8 **SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP**
9 **PROGRAM DISCLOSURE REQUIREMENTS RE-**
10 **LATING TO PREVIOUS AFFILIATIONS.**

11 (a) IN GENERAL.—Section 1128G of the Social Secu-
12 rity Act, as inserted by section 1631, is amended by add-
13 ing at the end the following new subsection:

14 “(b) ENHANCED PROGRAM DISCLOSURE REQUIRE-
15 MENTS.—

16 “(1) DISCLOSURE.—A provider of services or
17 supplier who submits on or after July 1, 2011, an
18 application for enrollment and renewing enrollment
19 in a program under title XVIII, XIX, or XXI shall
20 disclose (in a form and manner determined by the
21 Secretary) any current affiliation or affiliation with-
22 in the previous 10-year period with a provider of
23 services or supplier that has uncollected debt or with
24 a person or entity that has been suspended or ex-

1 cluded under such program, subject to a payment
2 suspension, or has had its billing privileges revoked.

3 “(2) ENHANCED SAFEGUARDS.—If the Sec-
4 retary determines that such previous affiliation of
5 such provider or supplier poses a risk of fraud,
6 waste, or abuse, the Secretary may apply such en-
7 hanced safeguards as the Secretary determines nec-
8 essary to reduce such risk associated with such pro-
9 vider or supplier enrolling or participating in the
10 program under title XVIII, XIX, or XXI. Such safe-
11 guards may include enhanced oversight, such as en-
12 hanced screening of claims, required or unannounced
13 (or required and unannounced) site visits or inspec-
14 tions, additional information reporting requirements,
15 and conditioning such enrollment on the provision of
16 a surety bond.

17 “(3) AUTHORITY TO DENY PARTICIPATION.—If
18 the Secretary determines that there has been at
19 least one such affiliation and that such affiliation or
20 affiliations, as applicable, of such provider or sup-
21 plier poses a serious risk of fraud, waste, or abuse,
22 the Secretary may deny the application of such pro-
23 vider or supplier.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) MEDICAID.—Paragraph (74) of section
2 1902(a) of such Act (42 U.S.C. 1396a(a)), as added
3 by section 1631(b)(1), is amended—

4 (A) by inserting “or subsection (b) of such
5 section (relating to disclosure requirements)”
6 before “, and that the State”; and

7 (B) by inserting before the period the fol-
8 lowing: “and apply any enhanced safeguards,
9 with respect to a provider or supplier described
10 in such subsection (b), as the Secretary deter-
11 mines necessary under such subsection (b)”.

12 (2) CHIP.—Subsection (d) of section 2102 of
13 such Act (42 U.S.C. 1397bb), as added by section
14 1631(b)(2), is amended—

15 (A) in paragraph (1), by striking at the
16 end “and”;

17 (B) in paragraph (2) by striking the period
18 at the end and inserting “; and’ ” and

19 (C) by adding at the end the following new
20 paragraph:

21 “(3) to enforce any determination made by the
22 Secretary under subsection (b) of section 1128G (re-
23 lating to disclosure requirements) and to apply any
24 enhanced safeguards, with respect to a provider or

1 supplier described in such subsection, as the Sec-
2 retary determines necessary under such subsection.”.

3 **SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER**
4 **FOR CERTAIN EVALUATION AND MANAGE-**
5 **MENT SERVICES.**

6 Section 1848 of the Social Security Act (42 U.S.C.
7 1395w-4), as amended by section 4101 of the HITECH
8 Act (Public Law 111-5), is amended by adding at the end
9 the following new subsection:

10 “(p) PAYMENT MODIFIER FOR CERTAIN EVALUA-
11 TION AND MANAGEMENT SERVICES.—The Secretary shall
12 establish a payment modifier under the fee schedule under
13 this section for evaluation and management services (as
14 specified in section 1842(b)(16)(B)(ii)) that result in the
15 ordering of additional services (such as lab tests), the pre-
16 scription of drugs, the furnishing or ordering of durable
17 medical equipment in order to enable better monitoring
18 of claims for payment for such additional services under
19 this title, or the ordering, furnishing, or prescribing of
20 other items and services determined by the Secretary to
21 pose a high risk of waste, fraud, and abuse. The Secretary
22 may require providers of services or suppliers to report
23 such modifier in claims submitted for payment.”.

1 **SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER**
2 **MEDICARE INTEGRITY PROGRAM.**

3 (a) IN GENERAL.—Section 1893(c) of the Social Se-
4 curity Act (42 U.S.C. 1395ddd(e)) is amended—

5 (1) in paragraph (3), by striking at the end
6 “and”;

7 (2) by redesignating paragraph (4) as para-
8 graph (5); and

9 (3) by inserting after paragraph (3) the fol-
10 lowing new paragraph:

11 “(4) for the contract year beginning in 2011
12 and each subsequent contract year, the entity pro-
13 vides assurances to the satisfaction of the Secretary
14 that the entity will conduct periodic evaluations of
15 the effectiveness of the activities carried out by such
16 entity under the Program and will submit to the
17 Secretary an annual report on such activities; and”.

18 (b) REFERENCE TO MEDICAID INTEGRITY PRO-
19 GRAM.—For a similar provision with respect to the Med-
20 icaid Integrity Program, see section 1752.

21 **SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO**
22 **ADOPT PROGRAMS TO REDUCE WASTE,**
23 **FRAUD, AND ABUSE.**

24 (a) IN GENERAL.—Section 1866(j) of the Social Se-
25 curity Act (42 U.S.C. 42 U.S.C. 1395cc(j)), as amended

1 by section 1631(d)(3), is further amended by adding at
2 the end the following new paragraph:

3 “(4) COMPLIANCE PROGRAMS FOR PROVIDERS
4 OF SERVICES AND SUPPLIERS.—

5 “(A) IN GENERAL.—The Secretary may
6 not enroll (or renew the enrollment of) a pro-
7 vider of services or a supplier (other than a
8 physician or a skilled nursing facility) under
9 this title if such provider of services or supplier
10 fails to, subject to subparagraph (E), establish
11 a compliance program that contains the core
12 elements established under subparagraph (B)
13 and certify in a manner determined by the Sec-
14 retary, that the provider or supplier has estab-
15 lished such a program.

16 “(B) ESTABLISHMENT OF CORE ELE-
17 MENTS.—The Secretary, in consultation with
18 the Inspector General of the Department of
19 Health and Human Services, shall establish
20 core elements for a compliance program under
21 subparagraph (A). Such elements may include
22 written policies, procedures, and standards of
23 conduct, a designated compliance officer and a
24 compliance committee; effective training and
25 education pertaining to fraud, waste, and abuse

1 for the organization’s employees, and contrac-
2 tors; a confidential or anonymous mechanism,
3 such as a hotline, to receive compliance ques-
4 tions and reports of fraud, waste, or abuse; dis-
5 ciplinary guidelines for enforcement of stand-
6 ards; internal monitoring and auditing proce-
7 dures, including monitoring and auditing of
8 contractors; procedures for ensuring prompt re-
9 sponses to detected offenses and development of
10 corrective action initiatives, including responses
11 to potential offenses; and procedures to return
12 all identified overpayments to the programs
13 under this title, title XIX, and title XXI.

14 “(C) TIMELINE FOR IMPLEMENTATION.—
15 The Secretary shall determine a timeline for the
16 establishment of the core elements under sub-
17 paragraph (B) and the date on which a pro-
18 vider of services and suppliers (other than phy-
19 sicians and skilled nursing facilities) shall be re-
20 quired to have established such a program for
21 purposes of this subsection.

22 “(D) PILOT PROGRAM.—The Secretary
23 may conduct a pilot program on the application
24 of this subsection with respect to a category of
25 providers of services or suppliers (other than

1 physicians and skilled nursing facilities) that
2 the Secretary determines to be a category which
3 is at high risk for waste, fraud, and abuse be-
4 fore implementing the requirements of this sub-
5 section to all providers of services and suppliers
6 described in subparagraph (C).

7 “(E) TREATMENT OF SKILLED NURSING
8 FACILITIES.—For the requirement for skilled
9 nursing facilities to establish compliance and
10 ethics programs see section 1819(d)(1)(C).

11 “(F) CONSTRUCTION.—Nothing in this
12 subsection exempts a physician from partici-
13 pating in a compliance program established by
14 a health care provider or other entity with
15 which the physician is employed, under con-
16 tract, or affiliated if such compliance is re-
17 quired by such provider or entity.”.

18 (b) REFERENCE TO SIMILAR MEDICAID PROVI-
19 SION.—For a similar provision with respect to the Med-
20 icaid program under title XIX of the Social Security Act,
21 see section 1753.

1 **SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-**
2 **CARE CLAIMS REDUCED TO NOT MORE THAN**
3 **12 MONTHS.**

4 (a) PURPOSE.—In general, the 36-month period cur-
5 rently allowed for claims filing under parts A, B, C, and,
6 D of title XVIII of the Social Security Act presents oppor-
7 tunities for fraud schemes in which processing patterns
8 of the Centers for Medicare & Medicaid Services can be
9 observed and exploited. Narrowing the window for claims
10 processing will not overburden providers and will reduce
11 fraud and abuse.

12 (b) REDUCING MAXIMUM PERIOD FOR SUBMIS-
13 SION.—

14 (1) PART A.—Section 1814(a) of the Social Se-
15 curity Act (42 U.S.C. 1395f(a)) is amended—

16 (A) in paragraph (1), by striking “period
17 of 3 calendar years” and all that follows and in-
18 serting “period of 1 calendar year from which
19 such services are furnished; and”; and

20 (B) by adding at the end the following new
21 sentence: “In applying paragraph (1), the Sec-
22 retary may specify exceptions to the 1 calendar
23 year period specified in such paragraph.”.

24 (2) PART B.—Section 1835(a) of such Act (42
25 U.S.C. 1395n(a)) is amended—

1 (A) in paragraph (1), by striking “period
2 of 3 calendar years” and all that follows and in-
3 serting “period of 1 calendar year from which
4 such services are furnished; and”;

5 (B) by adding at the end the following new
6 sentence: “In applying paragraph (1), the Sec-
7 retary may specify exceptions to the 1 calendar
8 year period specified in such paragraph.”.

9 (3) PARTS C AND D.—Section 1857(d) of such
10 Act is amended by adding at the end the following
11 new paragraph:

12 “(7) PERIOD FOR SUBMISSION OF CLAIMS.—
13 The contract shall require an MA organization or
14 PDP sponsor to require any provider of services
15 under contract with, in partnership with, or affili-
16 ated with such organization or sponsor to ensure
17 that, with respect to items and services furnished by
18 such provider to an enrollee of such organization,
19 written request, signed by such enrollee, except in
20 cases in which the Secretary finds it impracticable
21 for the enrollee to do so, is filed for payment for
22 such items and services in such form, in such man-
23 ner, and by such person or persons as the Secretary
24 may by regulation prescribe, no later than the close
25 of the 1 calendar year period after such items and

1 services are furnished. In applying the previous sen-
2 tence, the Secretary may specify exceptions to the 1
3 calendar year period specified.”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 subsection (b) shall be effective for items and services fur-
6 nished on or after January 1, 2011.

7 **SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL**
8 **EQUIPMENT OR HOME HEALTH SERVICES RE-**
9 **QUIRED TO BE MEDICARE ENROLLED PHYSI-**
10 **CIA NS OR ELIGIBLE PROFESSIONALS.**

11 (a) DME.—Section 1834(a)(11)(B) of the Social Se-
12 curity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
13 striking “physician” and inserting “physician enrolled
14 under section 1866(j) or other professional, as determined
15 by the Secretary”.

16 (b) HOME HEALTH SERVICES.—

17 (1) PART A.—Section 1814(a)(2) of such Act
18 (42 U.S.C. 1395(a)(2)) is amended in the matter
19 preceding subparagraph (A) by inserting “in the
20 case of services described in subparagraph (C), a
21 physician enrolled under section 1866(j) or other
22 professional, as determined by the Secretary,” before
23 “or, in the case of services”.

24 (2) PART B.—Section 1835(a)(2) of such Act
25 (42 U.S.C. 1395n(a)(2)) is amended in the matter

1 preceding subparagraph (A) by inserting “, or in the
2 case of services described in subparagraph (A), a
3 physician enrolled under section 1866(j) or other
4 professional, as determined by the Secretary,” after
5 “a physician”.

6 (c) DISCRETION TO EXPAND APPLICATION.—The
7 Secretary may extend the requirement applied by the
8 amendments made by subsections (a) and (b) to durable
9 medical equipment and home health services (relating to
10 requiring certifications and written orders to be made by
11 enrolled physicians and health professions) to other cat-
12 egories of items or services under this title, including cov-
13 ered part D drugs as defined in section 1860D–2(e), if
14 the Secretary determines that such application would help
15 to reduce the risk of waste, fraud, and abuse with respect
16 to such other categories under title XVIII of the Social
17 Security Act.

18 (d) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to written orders and certifications
20 made on or after July 1, 2010.

1 **SEC. 1638. 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 is further amended by
6 adding at the end the following new paragraph

7 “(9) The Secretary may disenroll, for a period of not
8 more than one year for each act, a physician or supplier
9 under section 1866(j) if such physician or supplier fails
10 to maintain and, upon request of the Secretary, provide
11 access to documentation relating to written orders or re-
12 quests for payment for durable medical equipment, certifi-
13 cations for home health services, or referrals for other
14 items or services written or ordered by such physician or
15 supplier under this title, as specified by the Secretary.”.

16 (b) PROVIDERS OF SERVICES.—Section 1866(a)(1)
17 of such Act (42 U.S.C. 1395cc), is amended—

18 (1) in subparagraph (U), by striking at the end
19 “and”;

20 (2) in subparagraph (V), by striking the period
21 at the end and adding “; and”; and

22 (3) by adding at the end the following new sub-
23 paragraph:

24 “(W) maintain and, upon request of the
25 Secretary, provide access to documentation re-
26 lating to written orders or requests for payment

1 tification or recertification made by a physician
2 after January 1, 2010, prior to making such
3 certification the physician must document that
4 the physician has had a face-to-face encounter
5 (including through use of telehealth and other
6 than with respect to encounters that are inci-
7 dent to services involved) with the individual
8 during the 6-month period preceding such cer-
9 tification, or other reasonable timeframe as de-
10 termined by the Secretary”.

11 (2) PART B.—Section 1835(a)(2)(A) of the So-
12 cial Security Act is amended—

13 (A) by striking “and” before “(iii)”; and

14 (B) by inserting after “care of a physi-
15 cian” the following: “, and (iv) in the case of
16 a certification or recertification after January
17 1, 2010, prior to making such certification the
18 physician must document that the physician has
19 had a face-to-face encounter (including through
20 use of telehealth and other than with respect to
21 encounters that are incident to services in-
22 volved) with the individual during the 6-month
23 period preceding such certification or recertifi-
24 cation, or other reasonable timeframe as deter-
25 mined by the Secretary”.

1 (b) CONDITION OF PAYMENT FOR DURABLE MED-
2 ICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social
3 Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
4 adding before the period at the end the following: “and
5 shall require that any written order required for payment
6 under this subsection be written only pursuant to the eligi-
7 ble health care professional authorized to make such writ-
8 ten order documenting that such professional has had a
9 face-to-face encounter (including through use of telehealth
10 and other than with respect to encounters that are inci-
11 dent to services involved) with the individual involved dur-
12 ing the 6-month period preceding such written order, or
13 other reasonable timeframe as determined by the Sec-
14 retary”.

15 (c) APPLICATION TO OTHER AREAS UNDER MEDI-
16 CARE.—The Secretary may apply a face-to-face encounter
17 requirement similar to the requirement described in the
18 amendments made by subsections (a) and (b) to other
19 items and services for which payment is provided under
20 title XVIII of the Social Security Act based upon a finding
21 that such a decision would reduce the risk of waste, fraud,
22 or abuse.

23 (d) APPLICATION TO MEDICAID AND CHIP.—The
24 face-to-face encounter requirements described in the
25 amendments made by subsections (a) and (b) and any ex-

1 panded application of similar requirements pursuant to
2 subsection (c) shall apply with respect to a certification
3 or recertification for home health services under title XIX
4 or XXI of the Social Security Act, a written order for du-
5 rable medical equipment under such title, and any other
6 applicable item or service identified pursuant to subsection
7 (c) for which payment is made under such title, respec-
8 tively, in the same manner and to the same extent as such
9 requirements apply in the case of such a certification or
10 recertification, written order, or other applicable item or
11 service so identified, respectively, under title XVIII of such
12 Act.

13 **SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AU-**
14 **THORITY TO PROGRAM EXCLUSION INVES-**
15 **TIGATIONS.**

16 (a) IN GENERAL.—Section 1128(f) of the Social Se-
17 curity Act (42 U.S.C. 1320a-7(f)) is amended by adding
18 at the end the following new paragraph:

19 “(4) The provisions of subsections (d) and (e) of sec-
20 tion 205 shall apply with respect to this section to the
21 same extent as they are applicable with respect to title
22 II. The Secretary may delegate the authority granted by
23 section 205(d) (as made applicable to this section) to the
24 Inspector General of the Department of Health and
25 Human Services or the Administrator of the Centers for

1 Medicare & Medicaid Services for purposes of any inves-
2 tigation under this section.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 subsection (a) shall apply to investigations beginning on
5 or after January 1, 2010.

6 **SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND**
7 **MEDICAID OVERPAYMENTS.**

8 Section 1128G of the Social Security Act, as inserted
9 by section 1631 and amended by section 1632, is further
10 amended by adding at the end the following new sub-
11 section:

12 “(c) **REPORTS ON AND REPAYMENT OF OVERPAY-**
13 **MENTS IDENTIFIED THROUGH INTERNAL AUDITS AND**
14 **REVIEWS.**—

15 “(1) **REPORTING AND RETURNING OVERPAY-**
16 **MENTS.**—If a person knows of an overpayment, the
17 person must—

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, the State, inter-
23 mediary, carrier, or contractor to whom the
24 overpayment was returned in writing of the rea-
25 son for the overpayment.

1 “(2) TIMING.—Subject to section 1620(d) of
2 the Affordable Health Care for America Act, an
3 overpayment must be reported and returned under
4 paragraph (1)(A) by not later than the date that is
5 60 days after the date the person knows of the over-
6 payment.

7 Any known overpayment retained later than the ap-
8 plicable date specified in this paragraph creates an
9 obligation as defined in section 3729(b)(3) of title
10 31 of the United States Code.

11 “(3) CLARIFICATION.—Repayment of any over-
12 payments (or refunding by withholding of future
13 payments) by a provider of services or supplier does
14 not otherwise limit the provider or supplier’s poten-
15 tial liability for administrative obligations such as
16 applicable interests, fines, and penalties or civil or
17 criminal sanctions involving the same claim if it is
18 determined later that the reason for the overpay-
19 ment was related to fraud or other intentional con-
20 duct by the provider or supplier or the employees or
21 agents of such provider or supplier.

22 “(4) DEFINITIONS.—In this subsection:

23 “(A) KNOWS.—The term ‘knows’ has the
24 meaning given the terms ‘knowing’ and ‘know-

1 ingly’ in section 3729(b) of title 31 of the
2 United States Code.

3 “(B) OVERPAYMENT.—The term “overpay-
4 ment” means any funds that a person receives
5 or retains under title XVIII, XIX, or XXI to
6 which the person, after applicable reconciliation
7 (pursuant to the applicable existing process
8 under the respective title), is not entitled under
9 such title.

10 “(C) PERSON.—The term ‘person’ means a
11 provider of services, supplier, Medicaid man-
12 aged care organization (as defined in section
13 1903(m)(1)(A)), Medicare Advantage organiza-
14 tion (as defined in section 1859(a)(1)), or PDP
15 sponsor (as defined in section 1860D-
16 41(a)(13)), but excluding a beneficiary.”.

17 **SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIV-**
18 **ERS FOR OIG EXCLUSIONS TO BENE-**
19 **FICIARIES OF ANY FEDERAL HEALTH CARE**
20 **PROGRAM.**

21 Section 1128(c)(3)(B) of the Social Security Act (42
22 U.S.C. 1320a-7(c)(3)(B)) is amended by striking “indi-
23 viduals entitled to benefits under part A of title XVIII
24 or enrolled under part B of such title, or both” and insert-

1 ing “beneficiaries (as defined in section 1128A(i)(5)) of
2 that program”.

3 **SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL**
4 **DIALYSIS FACILITIES.**

5 Section 1881(b) of the Social Security Act (42 U.S.C.
6 1395rr(b)) is amended by adding at the end the following
7 new paragraph:

8 “(15) For purposes of evaluating or auditing pay-
9 ments made to renal dialysis facilities for items and serv-
10 ices under this section under paragraph (1), each such
11 renal dialysis facility, upon the request of the Secretary,
12 shall provide to the Secretary access to information relat-
13 ing to any ownership or compensation arrangement be-
14 tween such facility and the medical director of such facility
15 or between such facility and any physician.”.

16 **SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**
17 **ALTERNATE PAYEES REQUIRED TO REG-**
18 **ISTER UNDER MEDICARE.**

19 (a) MEDICARE.—Section 1866(j)(1) of the Social Se-
20 curity Act (42 U.S.C. 1395cc(j)(1)) is amended by adding
21 at the end the following new subparagraph:

22 “(D) BILLING AGENTS AND CLEARING-
23 HOUSES REQUIRED TO BE REGISTERED UNDER
24 MEDICARE.—Any agent, clearinghouse, or other
25 alternate payee that submits claims on behalf of

1 a health care provider must be registered with
2 the Secretary in a form and manner specified
3 by the Secretary.”.

4 (b) **MEDICAID.**—For a similar provision with respect
5 to the Medicaid program under title XIX of the Social Se-
6 curity Act, see section 1759.

7 (c) **EFFECTIVE DATE.**—The amendment made by
8 subsection (a) shall apply to claims submitted on or after
9 January 1, 2012.

10 **SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO**
11 **FALSE CLAIMS ACT AMENDMENTS.**

12 Section 1128A of the Social Security Act, as amended
13 by sections 1611, 1612, 1613, and 1615, is further
14 amended—

15 (1) in subsection (a)—

16 (A) in paragraph (1), by striking “to an
17 officer, employee, or agent of the United States,
18 or of any department or agency thereof, or of
19 any State agency (as defined in subsection
20 (i)(1))”;

21 (B) in paragraph (4)—

22 (i) in the matter preceding subpara-
23 graph (A), by striking “participating in a
24 program under title XVIII or a State
25 health care program” and inserting “par-

1 participating in a Federal health care program
2 (as defined in section 1128B(f))”; and

3 (ii) in subparagraph (A), by striking
4 “title XVIII or a State health care pro-
5 gram” and inserting “a Federal health
6 care program (as defined in section
7 1128B(f))”;

8 (C) by striking “or” at the end of para-
9 graph (10);

10 (D) by inserting after paragraph (11) the
11 following new paragraphs:

12 “(12) conspires to commit a violation of this
13 section; or

14 “(13) knowingly makes, uses, or causes to be
15 made or used, a false record or statement material
16 to an obligation to pay or transmit money or prop-
17 erty to a Federal health care program, or knowingly
18 conceals or knowingly and improperly avoids or de-
19 creases an obligation to pay or transmit money or
20 property to a Federal health care program;”; and

21 (E) in the matter following paragraph
22 (13), as inserted by subparagraph (D)—

23 (i) by striking “or” before “in cases
24 under paragraph (11)”; and

1 (ii) by inserting “, in cases under
2 paragraph (12), \$50,000 for any violation
3 described in this section committed in fur-
4 therance of the conspiracy involved; or in
5 cases under paragraph (13), \$50,000 for
6 each false record or statement, or conceal-
7 ment, avoidance, or decrease” after “by an
8 excluded individual”; and

9 (F) in the second sentence, by striking
10 “such false statement, omission, or misrepre-
11 sentation)” and inserting “such false statement
12 or misrepresentation, in cases under paragraph
13 (12), an assessment of not more than 3 times
14 the total amount that would otherwise apply for
15 any violation described in this section com-
16 mitted in furtherance of the conspiracy in-
17 volved, or in cases under paragraph (13), an as-
18 sessment of not more than 3 times the total
19 amount of the obligation to which the false
20 record or statement was material or that was
21 avoided or decreased)”.

22 (2) in subsection (c)(1), by striking “six years”
23 and inserting “10 years”; and

24 (3) in subsection (i)—

1 (A) by amending paragraph (2) to read as
2 follows:

3 “(2) The term ‘claim’ means any application,
4 request, or demand, whether under contract, or oth-
5 erwise, for money or property for items and services
6 under a Federal health care program (as defined in
7 section 1128B(f)), whether or not the United States
8 or a State agency has title to the money or property,
9 that—

10 “(A) is presented or caused to be pre-
11 sented to an officer, employee, or agent of the
12 United States, or of any department or agency
13 thereof, or of any State agency (as defined in
14 subsection (i)(1)); or

15 “(B) is made to a contractor, grantee, or
16 other recipient if the money or property is to be
17 spent or used on the Federal health care pro-
18 gram’s behalf or to advance a Federal health
19 care program interest, and if the Federal health
20 care program—

21 “(i) provides or has provided any por-
22 tion of the money or property requested or
23 demanded; or

24 “(ii) will reimburse such contractor,
25 grantee, or other recipient for any portion

1 of the money or property which is re-
2 quested or demanded.”;

3 (B) by amending paragraph (3) to read as
4 follows:

5 “(3) The term ‘item or service’ means, without
6 limitation, any medical, social, management, admin-
7 istrative, or other item or service used in connection
8 with or directly or indirectly related to a Federal
9 health care program.”;

10 (C) in paragraph (6)—

11 (i) in subparagraph (C), by striking at
12 the end “or”;

13 (ii) in the first subparagraph (D), by
14 striking at the end the period and inserting
15 “; or”; and

16 (iii) by redesignating the second sub-
17 paragraph (D) as a subparagraph (E);

18 (D) by amending paragraph (7) to read as
19 follows:

20 “(7) The terms ‘knowing’, ‘knowingly’, and
21 ‘should know’ mean that a person, with respect to
22 information—

23 “(A) has actual knowledge of the informa-
24 tion;

1 “(B) acts in deliberate ignorance of the
2 truth or falsity of the information; or

3 “(C) acts in reckless disregard of the truth
4 or falsity of the information;
5 and require no proof of specific intent to defraud.”;

6 and

7 (E) by adding at the end the following new
8 paragraphs:

9 “(8) The term ‘obligation’ means an established
10 duty, whether or not fixed, arising from an express
11 or implied contractual, grantor-grantee, or licensor-
12 licensee relationship, from a fee-based or similar re-
13 lationship, from statute or regulation, or from the
14 retention of any overpayment.

15 “(9) The term ‘material’ means having a nat-
16 ural tendency to influence, or be capable of influ-
17 encing, the payment or receipt of money or prop-
18 erty.”.

1 **SEC. 1646. REQUIRING PROVIDER AND SUPPLIER PAY-**
2 **MENTS UNDER MEDICARE TO BE MADE**
3 **THROUGH DIRECT DEPOSIT OR ELECTRONIC**
4 **FUNDS TRANSFER (EFT) AT INSURED DEPOSI-**
5 **TORY INSTITUTIONS.**

6 (a) **MEDICARE.**—Section 1874 of the Social Security
7 Act (42 U.S.C. 1395kk) is amended by adding at the end
8 the following new subsection:

9 “(e) **LIMITATION ON PAYMENT TO PROVIDERS OF**
10 **SERVICES AND SUPPLIERS.**—No payment shall be made
11 under this title for items and services furnished by a pro-
12 vider of services or supplier unless each payment to the
13 provider of services or supplier is in the form of direct
14 deposit or electronic funds transfer to the provider of serv-
15 ices’ or supplier’s account, as applicable, at a depository
16 institution (as defined in section 19(b)(1)(A) of the Fed-
17 eral Reserve Act.”.

18 (b) **EFFECTIVE DATE.**—The amendments made by
19 this section shall apply to each payment made to a pro-
20 vider of services, provider, or supplier on or after such
21 date (not later than July 1, 2012) as the Secretary of
22 Health and Human Services shall specify, regardless of
23 when the items and services for which such payment is
24 made were furnished.

1 **SEC. 1647. INSPECTOR GENERAL FOR THE HEALTH**
2 **CHOICES ADMINISTRATION.**

3 (a) ESTABLISHMENT; APPOINTMENT.—There is
4 hereby established an Office of Inspector General for the
5 Health Choices Administration, to be headed by the In-
6 spector General for the Health Choices Administration to
7 be appointed by the President, by and with the advice and
8 consent of the Senate.

9 (b) AMENDMENTS TO THE INSPECTOR GENERAL ACT
10 OF 1978.—

11 (1) APPLICATION TO HEALTH CHOICES ADMIN-
12 STRATION.—Section 12 of the Inspector General
13 Act of 1978 (5 U.S.C. App.) is amended—

14 (A) in paragraph (1), by striking “or the
15 Federal Cochairpersons of the Commissions es-
16 tablished under section 15301 of title 40,
17 United States Code” and inserting “the Federal
18 Cochairpersons of the Commissions established
19 under section 15301 of title 40, United States
20 Code; or the Commissioner of the Health
21 Choices Administration established under sec-
22 tion 241 of the Affordable Health Care for
23 America Act”; and

24 (B) in paragraph (2), by striking “or the
25 Commissions established under section 15301
26 of title 40, United States Code” and inserting

1 “the Commissions established under section
2 15301 of title 40, United States Code, or the
3 Health Choices Administration established
4 under section 241 of the Affordable Health
5 Care for America Act”.

6 (2) SPECIAL PROVISIONS RELATING TO HEALTH
7 CHOICES ADMINISTRATION AND HHS.—The Inspec-
8 tor General Act of 1978 (5 U.S.C. App.) is further
9 amended by inserting after section 8L the following
10 new section:

11 **“SEC. 8M SPECIAL PROVISIONS RELATING TO THE HEALTH**
12 **CHOICES ADMINISTRATION AND THE DE-**
13 **PARTMENT OF HEALTH AND HUMAN SERV-**
14 **ICES.**

15 “(a) The Inspector General of the Health Choices Ad-
16 ministration shall—

17 “(1) have the authority to conduct, supervise,
18 and coordinate audits, evaluations, and investiga-
19 tions of the programs and operations of the Health
20 Choices Administration established under section
21 241 of the Affordable Health Care for America Act,
22 including matters relating to fraud, abuse, and mis-
23 conduct in connection with the admission and con-
24 tinued participation of any health benefits plan par-

1 participating in the Health Insurance Exchange estab-
2 lished under section 301 of such Act;

3 “(2) have the authority to conduct audits, eval-
4 uations, and investigations relating to any private
5 Exchange-participating health benefits plan, as de-
6 fined in section 201(c) of such Act;

7 “(3) have the authority, in consultation with
8 the Office of Inspector General for the Department
9 of Health and Human Services and subject to sub-
10 section (b), to conduct audits, evaluations, and in-
11 vestigations relating to the public health insurance
12 option established under section 321 of such Act;
13 and

14 “(4) have access to all relevant records nec-
15 essary to carry out this section, including records re-
16 lating to claims paid by Exchange-participating
17 health benefits plans.

18 “(b) Authority granted to the Health Choices Admin-
19 istration and the Inspector General of the Health Choices
20 Administration by the Affordable Health Care for America
21 Act does not limit the duties, authorities, and responsibil-
22 ities of the Office of Inspector General for the Department
23 of Health and Human Services, as in existence as of the
24 date of the enactment of the Affordable Health Care for
25 America Act , to oversee programs and operations of such

1 department. The Office of Inspector General for the De-
2 partment of Health and Human Services retains primary
3 jurisdiction over fraud and abuse in connection with pay-
4 ments made under the public health insurance option es-
5 tablished under section 321 of such Act and administered
6 by the Department of Health and Human Services.”.

7 (3) APPLICATION OF RULE OF CONSTRUC-
8 TION.—Section 8J of the Inspector General Act of
9 1978 (5 U.S.C. App.) is amended by striking “or
10 8H” and inserting “, 8H, or 8M”.

11 (c) EFFECTIVE DATE.—The provisions of and
12 amendments made by this section shall take effect on the
13 date of the enactment of this Act.

14 **Subtitle D—Access to Information**
15 **Needed to Prevent Fraud,**
16 **Waste, and Abuse**

17 **SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDEN-**
18 **TIFY FRAUD, WASTE, AND ABUSE.**

19 (a) GAO ACCESS.—Subchapter II of chapter 7 of
20 title 31, United States Code, is amended by adding at the
21 end the following:

22 **“§ 721. Access to certain information**

23 “No provision of the Social Security Act shall be con-
24 strued to limit, amend, or supersede the authority of the
25 Comptroller General to obtain any information, to inspect

1 any record, or to interview any officer or employee under
2 section 716 of this title, including with respect to any in-
3 formation disclosed to or obtained by the Secretary of
4 Health and Human Services under part C or D of title
5 XVIII of the Social Security Act.”.

6 (b) ACCESS TO MEDICARE PART D DATA PROGRAM
7 INTEGRITY PURPOSES.—

8 (1) PROVISION OF INFORMATION AS CONDITION
9 OF PAYMENT.—Section 1860D–15(d)(2)(B) of the
10 Social Security Act (42 U.S.C. 1395w–
11 115(d)(2)(B)) is amended—

12 (A) by striking “may be used by officers”
13 and all that follows through the period and in-
14 serting “may be used by—”; and

15 (B) by adding at the end the following
16 clauses:

17 “(i) officers, employees, and contrac-
18 tors of the Department of Health and
19 Human Services only for the purposes of,
20 and to the extent necessary in, carrying
21 out this section; and

22 “(ii) the Inspector General of the De-
23 partment of Health and Human Services,
24 the Administrator of the Centers for Medi-
25 care & Medicaid Services, and the Attorney

1 General only for the purposes of protecting
2 the integrity of the programs under this
3 title and title XIX; conducting the activi-
4 ties described in section 1893 and subpara-
5 graphs (A) through (E) of section
6 1128C(a)(1); and for investigation, audit,
7 evaluation, oversight, and law enforce-
8 ment purposes to the extent consistent
9 with applicable law.”.

10 (2) GENERAL DISCLOSURE OF INFORMATION.—

11 Section 1860D–15(f)(2) of the Social Security Act
12 (42 U.S.C. 1395w–115(f)(2)) is amended—

13 (A) by striking “may be used by officers”
14 and all that follows through the period and in-
15 serting “may be used by—”; and

16 (B) by adding at the end the following sub-
17 paragraphs:

18 “(A) officers, employees, and contractors
19 of the Department of Health and Human Serv-
20 ices only for the purposes of, and to the extent
21 necessary in, carrying out this section; and

22 “(B) the Inspector General of the Depart-
23 ment of Health and Human Services, the Ad-
24 ministrator of the Centers for Medicare & Med-
25 icaid Services, and the Attorney General only

1 for the purposes of protecting the integrity of
2 the programs under this title and title XIX;
3 conducting the activities described in section
4 1893 and subparagraphs (A) through (E) of
5 section 1128C(a)(1); and for investigation,
6 audit, evaluation, oversight, and law enforce-
7 ment purposes to the extent consistent with ap-
8 plicable law.”.

9 **SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE**
10 **HEALTHCARE INTEGRITY AND PROTECTION**
11 **DATA BANK AND THE NATIONAL PRACTI-**
12 **TIONER DATA BANK.**

13 (a) IN GENERAL.—To eliminate duplication between
14 the Healthcare Integrity and Protection Data Bank
15 (HIPDB) established under section 1128E of the Social
16 Security Act and the National Practitioner Data Bank
17 (NPBD) established under the Health Care Quality Im-
18 provement Act of 1986, section 1128E of the Social Secu-
19 rity Act (42 U.S.C. 1320a-7e) is amended—

20 (1) in subsection (a), by striking “Not later
21 than” and inserting “Subject to subsection (h), not
22 later than”;

23 (2) in the first sentence of subsection (d)(2), by
24 striking “(other than with respect to requests by
25 Federal agencies)”; and

1 (3) by adding at the end the following new sub-
2 section:

3 “(h) SUNSET OF THE HEALTHCARE INTEGRITY AND
4 PROTECTION DATA BANK; TRANSITION PROCESS.—Ef-
5 fective upon the enactment of this subsection, the Sec-
6 retary shall implement a process to eliminate duplication
7 between the Healthcare Integrity and Protection Data
8 Bank (in this subsection referred to as the ‘HIPDB’ es-
9 tablished pursuant to subsection (a) and the National
10 Practitioner Data Bank (in this subsection referred to as
11 the ‘NPDB’) as implemented under the Health Care Qual-
12 ity Improvement Act of 1986 and section 1921 of this Act,
13 including systems testing necessary to ensure that infor-
14 mation formerly collected in the HIPDB will be accessible
15 through the NPDB, and other activities necessary to
16 eliminate duplication between the two data banks. Upon
17 the completion of such process, notwithstanding any other
18 provision of law, the Secretary shall cease the operation
19 of the HIPDB and shall collect information required to
20 be reported under the preceding provisions of this section
21 in the NPDB. Except as otherwise provided in this sub-
22 section, the provisions of subsections (a) through (g) shall
23 continue to apply with respect to the reporting of (or fail-
24 ure to report), access to, and other treatment of the infor-
25 mation specified in this section.”.

1 (b) ELIMINATION OF THE RESPONSIBILITY OF THE
2 HHS OFFICE OF THE INSPECTOR GENERAL.—Section
3 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-
4 7c(a)(1)) is amended—

5 (1) in subparagraph (C), by adding at the end
6 “and”;

7 (2) in subparagraph (D), by striking at the end
8 “, and” and inserting a period; and

9 (3) by striking subparagraph (E).

10 (c) SPECIAL PROVISION FOR ACCESS TO THE NA-
11 TIONAL PRACTITIONER DATA BANK BY THE DEPART-
12 MENT OF VETERANS AFFAIRS.—

13 (1) IN GENERAL.—Notwithstanding any other
14 provision of law, during the one year period that be-
15 gins on the effective date specified in subsection
16 (e)(1), the information described in paragraph (2)
17 shall be available from the National Practitioner
18 Data Bank (described in section 1921 of the Social
19 Security Act) to the Secretary of Veterans Affairs
20 without charge.

21 (2) INFORMATION DESCRIBED.—For purposes
22 of paragraph (1), the information described in this
23 paragraph is the information that would, but for the
24 amendments made by this section, have been avail-

1 able to the Secretary of Veterans Affairs from the
2 Healthcare Integrity and Protection Data Bank.

3 (d) FUNDING.—Notwithstanding any provisions of
4 this Act, sections 1128E(d)(2) and 1817(k)(3) of the So-
5 cial Security Act, or any other provision of law, there shall
6 be available for carrying out the transition process under
7 section 1128E(h) of the Social Security Act over the pe-
8 riod required to complete such process, and for operation
9 of the National Practitioner Data Bank until such process
10 is completed, without fiscal year limitation—

11 (1) any fees collected pursuant to section
12 1128E(d)(2) of such Act; and

13 (2) such additional amounts as necessary, from
14 appropriations available to the Secretary and to the
15 Office of the Inspector General of the Department of
16 Health and Human Services under clauses (i) and
17 (ii), respectively, of section 1817(k)(3)(A) of such
18 Act, for costs of such activities during the first 12
19 months following the date of the enactment of this
20 Act.

21 (e) EFFECTIVE DATE.—The amendments made—

22 (1) by subsection (a)(2) shall take effect on the
23 first day after the Secretary of Health and Human
24 Services certifies that the process implemented pur-

1 suant to section 1128E(h) of the Social Security Act
2 (as added by subsection (a)(3)) is complete; and
3 (2) by subsection (b) shall take effect on the
4 earlier of the date specified in paragraph (1) or the
5 first day of the second succeeding fiscal year after
6 the fiscal year during which this Act is enacted.

7 **SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECUR-**
8 **RITY STANDARDS.**

9 The provisions of sections 262(a) and 264 of the
10 Health Insurance Portability and Accountability Act of
11 1996 (and standards promulgated pursuant to such sec-
12 tions) and the Privacy Act of 1974 shall apply with respect
13 to the provisions of this subtitle and amendments made
14 by this subtitle.

15 **TITLE VII—MEDICAID AND CHIP**

16 **SEC. 1. TABLE OF CONTENTS [TEMPORARY].**

Sec. 1. Table of contents [*Temporary*].

Subtitle A—Medicaid and Health Reform

Sec. 1701. Eligibility for individuals with income below 150 percent of the Federal poverty level.

Sec. 1702. Requirements and special rules for certain Medicaid eligible individuals.

Sec. 1703. CHIP and Medicaid maintenance of eligibility.

Sec. 1704. Reduction in Medicaid DSH.

Sec. 1705. Expanded outstationing.

Subtitle B—Prevention

Sec. 1711. Required coverage of preventive services.

Sec. 1712. Tobacco cessation.

Sec. 1713. Optional coverage of nurse home visitation services.

Sec. 1714. State eligibility option for family planning services.

Subtitle C—Access

- Sec. 1721. Payments to primary care practitioners.
- Sec. 1722. Medical home pilot program.
- Sec. 1723. Translation or interpretation services.
- Sec. 1724. Optional coverage for freestanding birth center services.
- Sec. 1725. Inclusion of public health clinics under the vaccines for children program.
- Sec. 1726. Requiring coverage of services of podiatrists.
- Sec. 1726A. Requiring coverage of services of optometrists.
- Sec. 1727. Therapeutic foster care.
- Sec. 1728. Assuring adequate payment levels for services.
- Sec. 1729. Preserving Medicaid coverage for youths upon release from public institutions.
- Sec. 1730. Quality measures for maternity and adult health services under Medicaid and CHIP.
- Sec. 1730A. Accountable care organization pilot program.
- Sec. 1730B. FQHC coverage.

Subtitle D—Coverage

- Sec. 1731. Optional Medicaid coverage of low-income HIV-infected individuals.
- Sec. 1732. Extending transitional Medicaid Assistance (TMA).
- Sec. 1733. Requirement of 12-month continuous coverage under certain CHIP programs.
- Sec. 1734. Preventing the application under CHIP of coverage waiting periods for certain children.
- Sec. 1735. Adult day health care services.
- Sec. 1736. Medicaid coverage for citizens of Freely Associated States.
- Sec. 1737. Continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services.
- Sec. 1738. State option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high prescription costs.
- Sec. 1739. Provisions relating to community living assistance services and supports (CLASS).

Subtitle E—Financing

- Sec. 1741. Payments to pharmacists.
- Sec. 1742. Prescription drug rebates.
- Sec. 1743. Extension of prescription drug discounts to enrollees of Medicaid managed care organizations.
- Sec. 1744. Payments for graduate medical education.
- Sec. 1745. Nursing Facility Supplemental Payment Program.
- Sec. 1746. Report on Medicaid payments.
- Sec. 1747. Reviews of Medicaid.
- Sec. 1748. Extension of delay in managed care organization provider tax elimination.
- Sec. 1749. Extension of ARRA increase in FMAP.

Subtitle F—Waste, Fraud, and Abuse

- Sec. 1751. Health care acquired conditions.
- Sec. 1752. Evaluations and reports required under Medicaid Integrity Program.
- Sec. 1753. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.
- Sec. 1754. Overpayments.

- Sec. 1755. Managed care organizations.
- Sec. 1756. Termination of provider participation under Medicaid and CHIP if terminated under Medicare or other State plan or child health plan.
- Sec. 1757. Medicaid and CHIP exclusion from participation relating to certain ownership, control, and management affiliations.
- Sec. 1758. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.
- Sec. 1759. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.
- Sec. 1760. Denial of payments for litigation-related misconduct.
- Sec. 1761. Mandatory State use of national correct coding initiative.

Subtitle G—Payments to the Territories

- Sec. 1771. Payment to territories.

Subtitle H—Miscellaneous

- Sec. 1781. Technical corrections.
- Sec. 1782. Extension of QI program.
- Sec. 1783. Assuring transparency of information.
- Sec. 1784. Medicaid and CHIP Payment and Access Commission.
- Sec. 1785. Outreach and enrollment of Medicaid and CHIP eligible individuals.
- Sec. 1786. Prohibitions on Federal Medicaid and CHIP payment for undocumented aliens.
- Sec. 1787. Demonstration project for stabilization of emergency medical conditions by institutions for mental diseases.
- Sec. 1788. Application of Medicaid Improvement Fund.
- Sec. 1789. Treatment of certain Medicaid brokers.
- Sec. 1790. Rule for changes requiring State legislation.

1 **Subtitle A—Medicaid and Health**
 2 **Reform**

3 **SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME**
 4 **BELOW 150 PERCENT OF THE FEDERAL POV-**
 5 **ERTY LEVEL.**

6 (a) ELIGIBILITY FOR NON-TRADITIONAL INDIVID-
 7 UALS WITH INCOME BELOW 150 PERCENT OF THE FED-
 8 ERAL POVERTY LEVEL.—

9 (1) FULL MEDICAID BENEFITS FOR NON-MEDI-
 10 CARE ELIGIBLE INDIVIDUALS.—Section

1 1902(a)(10)(A)(i) of the Social Security Act (42
2 U.S.C. 1396b(a)(10)(A)(i)) is amended—

3 (A) by striking “or” at the end of sub-
4 clause (VI);

5 (B) by adding “or” at the end of subclause
6 (VII); and

7 (C) by adding at the end the following new
8 subclause:

9 “(VIII) who are under 65 years
10 of age, who are not described in a pre-
11 vious subclause of this clause, who are
12 not entitled to hospital insurance ben-
13 efits under part A of title XVIII, and
14 whose family income (determined
15 using methodologies and procedures
16 specified by the Secretary in consulta-
17 tion with the Health Choices Commis-
18 sioner) does not exceed 150 percent of
19 the income official poverty line (as de-
20 fined by the Office of Management
21 and Budget, and revised annually in
22 accordance with section 673(2) of the
23 Omnibus Budget Reconciliation Act of
24 1981) applicable to a family of the
25 size involved;”.

1 (2) MEDICARE COST SHARING ASSISTANCE FOR
2 MEDICARE-ELIGIBLE INDIVIDUALS.—Section
3 1902(a)(10)(E) of such Act (42 U.S.C.
4 1396b(a)(10)(E)) is amended—

5 (A) in clause (iii), by striking “and” at the
6 end;

7 (B) in clause (iv), by adding “and” at the
8 end; and

9 (C) by adding at the end the following new
10 clause:

11 “(v) for making medical assistance avail-
12 able for medicare cost-sharing described in sub-
13 paragraphs (B) and (C) of section 1905(p)(3),
14 for individuals under 65 years of age who would
15 be qualified medicare beneficiaries described in
16 section 1905(p)(1) but for the fact that their
17 income exceeds the income level established by
18 the State under section 1905(p)(2) but is less
19 than 150 percent of the official poverty line (re-
20 ferred to in such section) for a family of the
21 size involved; and”.

22 (3) INCREASED FMAP FOR NON-TRADITIONAL
23 FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section
24 1905 of such Act (42 U.S.C. 1396d) is amended—

1 (A) in the first sentence of subsection (b),
2 by striking “and” before “(4)” and by inserting
3 before the period at the end the following: “,
4 and (5) 100 percent (for periods before 2015
5 and 91 percent for periods beginning with
6 2015) with respect to amounts described in
7 subsection (y)”;

8 (B) by adding at the end the following new
9 subsection:

10 “(y) ADDITIONAL EXPENDITURES SUBJECT TO IN-
11 CREASED FMAP.—For purposes of section 1905(b)(5),
12 the amounts described in this subsection are the following:

13 “(1) Amounts expended for medical assistance
14 for individuals described in subclause (VIII) of sec-
15 tion 1902(a)(10)(A)(i).”.

16 (4) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as not providing for cov-
18 erage under subparagraph (A)(i)(VIII) or (E)(v) of
19 section 1902(a)(10) of the Social Security Act, as
20 added by paragraphs (1) and (2), or an increased
21 FMAP under the amendments made by paragraph
22 (3), for an individual who has been provided medical
23 assistance under title XIX of the Act under a dem-
24 onstration waiver approved under section 1115 of
25 such Act or with State funds.

1 (5) CONFORMING AMENDMENTS.—

2 (A) Section 1903(f)(4) of the Social Secu-
3 rity Act (42 U.S.C. 1396b(f)(4)) is amended—

4 (i) by inserting
5 “1902(a)(10)(A)(i)(VIII),” after
6 “1902(a)(10)(A)(i)(VII),”; and

7 (ii) by inserting “1902(a)(10)(E)(v),”
8 before “1905(p)(1)”.

9 (B) Section 1905(a) of such Act (42
10 U.S.C. 1396d(a)), as amended by sections
11 1714(a)(4) and 1731(c), is further amended, in
12 the matter preceding paragraph (1)—

13 (i) by striking “or” at the end of
14 clause (xiv);

15 (ii) by adding “or” at the end of
16 clause (xv); and

17 (iii) by inserting after clause (xv) the
18 following:

19 “(xvi) individuals described in section
20 1902(a)(10)(A)(i)(VIII),”.

21 (b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELI-
22 GIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150
23 PERCENT OF THE FEDERAL POVERTY LEVEL .—

24 (1) IN GENERAL.—Section 1902(a)(10)(A)(i) of
25 the Social Security Act (42 U.S.C.

1 1396b(a)(10)(A)(i)), as amended by subsection (a),
2 is amended—

3 (A) by striking “or” at the end of sub-
4 clause (VII); and

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

7 “(IX) who are over 18, and
8 under 65 years of age, who would be
9 eligible for medical assistance under
10 the State plan under subclause (I) or
11 section 1931 (based on the income
12 standards, methodologies, and proce-
13 dures in effect as of June 16, 2009)
14 but for income, who are in families
15 whose income does not exceed 150
16 percent of the income official poverty
17 line (as defined by the Office of Man-
18 agement and Budget, and revised an-
19 nually in accordance with section
20 673(2) of the Omnibus Budget Rec-
21 onciliation Act of 1981) applicable to
22 a family of the size involved; or

23 “(X) beginning with 2014, who
24 are over 5, and under 19, years of
25 age, who would be eligible for medical

1 assistance under the State plan under
2 subclause (I) or (VII) (based on the
3 income standards, methodologies, and
4 procedures in effect as of June 16,
5 2009) but for income, who are in fam-
6 ilies whose income does not exceed
7 150 percent of the income official pov-
8 erty line (as defined by the Office of
9 Management and Budget, and revised
10 annually in accordance with section
11 673(2) of the Omnibus Budget Rec-
12 onciliation Act of 1981) applicable to
13 a family of the size involved; or

14 “(XI) beginning with 2014, who
15 are under 19 years of age, who are
16 not described in subclause (X), and
17 who would be eligible for child health
18 assistance under a State child health
19 plan insofar as such plan provides
20 benefits under this title (as described
21 in section 2101(a)(2)) based on such
22 plan as in effect as of June 16, 2009;
23 or”.

24 (2) INCREASED FMAP FOR CERTAIN TRADI-
25 TIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

1 (A) INCREASED FMAP FOR ADULTS.—Sec-
2 tion 1905(y) of such Act (42 U.S.C. 1396d(y)),
3 as added by subsection (a)(2)(B), is amended
4 by inserting “or (IX)” after “(VIII)”.

5 (B) ENHANCED FMAP FOR CHILDREN.—
6 Section 1905(b)(4) of such Act is amended by
7 inserting “1902(a)(10)(A)(i)(X),
8 1902(a)(10)(A)(i)(XI), or” after “on the basis
9 of section”.

10 (3) CONSTRUCTION.—Nothing in this sub-
11 section shall be construed as not providing for cov-
12 erage under subelause (IX), (X), or (XI) of section
13 1902(a)(10)(A)(i) of the Social Security Act, as
14 added by paragraph (1), or an increased or en-
15 hanced FMAP under the amendments made by
16 paragraph (2), for an individual who has been pro-
17 vided medical assistance under title XIX of the Act
18 under a demonstration waiver approved under sec-
19 tion 1115 of such Act or with State funds.

20 (4) CONFORMING AMENDMENT.—Section
21 1903(f)(4) of the Social Security Act (42 U.S.C.
22 1396b(f)(4)), as amended by subsection (a)(4), is
23 amended by inserting “1902(a)(10)(A)(i)(IX),
24 1902(a)(10)(A)(i)(X), 1902(a)(10)(A)(i)(XI),” after
25 “1902(a)(10)(A)(i)(VIII),”.

1 (c) INCREASED MATCHING RATE FOR TEMPORARY
2 COVERAGE OF CERTAIN NEWBORNS.—Section 1905(y) of
3 such Act, as added by subsection (a)(3)(B), is amended
4 by adding at the end the following:

5 “(2) Amounts expended for medical assistance
6 for children described in section 305(d)(1) of the Af-
7 fordable Health Care for America Act during the
8 time period specified in such section.”.

9 (d) NETWORK ADEQUACY.—Section 1932(a)(2) of
10 the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is
11 amended by adding at the end the following new subpara-
12 graph:

13 “(D) ENROLLMENT OF NON-TRADITIONAL
14 MEDICAID ELIGIBLES.—A State may not re-
15 quire under paragraph (1) the enrollment in a
16 managed care entity of an individual described
17 in section 1902(a)(10)(A)(i)(VIII) unless the
18 State demonstrates, to the satisfaction of the
19 Secretary, that the entity, through its provider
20 network and other arrangements, has the ca-
21 pacity to meet the health, mental health, and
22 substance abuse needs of such individuals.”.

23 (e) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect on the first day of Y1, and

1 shall apply with respect to items and services furnished
2 on or after such date.

3 **SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CER-**
4 **TAIN MEDICAID ELIGIBLE INDIVIDUALS.**

5 (a) IN GENERAL.—Title XIX of the Social Security
6 Act is amended by adding at the end the following new
7 section:

8 “ REQUIREMENTS AND SPECIAL RULES FOR CERTAIN
9 MEDICAID ELIGIBLE INDIVIDUALS

10 “SEC. 1943. (a) COORDINATION WITH NHI EX-
11 CHANGE THROUGH MEMORANDUM OF UNDER-
12 STANDING.—

13 “(1) IN GENERAL.—The State shall enter into
14 a Medicaid memorandum of understanding described
15 in section 305(e)(2) of the Affordable Health Care
16 for America Act with the Health Choices Commis-
17 sioner, acting in consultation with the Secretary,
18 with respect to coordinating the implementation of
19 the provisions of division A of such Act with the
20 State plan under this title in order to ensure the en-
21 rollment of Medicaid eligible individuals in accept-
22 able coverage. Nothing in this section shall be con-
23 strued as permitting such memorandum to modify or
24 vitiate any requirement of a State plan under this
25 title.

1 “(2) ENROLLMENT OF EXCHANGE-REFERRED
2 INDIVIDUALS.—

3 “(A) NON-TRADITIONAL INDIVIDUALS.—

4 Pursuant to such memorandum the State shall
5 accept without further determination the enroll-
6 ment under this title of an individual deter-
7 mined by the Commissioner to be a non-tradi-
8 tional Medicaid eligible individual. The State
9 shall not do any redeterminations of eligibility
10 for such individuals unless the periodicity of
11 such redeterminations is consistent with the pe-
12 riodicity for redeterminations by the Commis-
13 sioner of eligibility for affordability credits
14 under subtitle C of title II of division A of the
15 Affordable Health Care for America Act, as
16 specified under such memorandum.

17 “(B) TRADITIONAL INDIVIDUALS.—Pursu-
18 ant to such memorandum, the State shall ac-
19 cept without further determination the enroll-
20 ment under this title of an individual deter-
21 mined by the Commissioner to be a traditional
22 Medicaid eligible individual. The State may do
23 redeterminations of eligibility of such individual
24 consistent with such section and the memo-
25 randum.

1 “(3) DETERMINATIONS OF ELIGIBILITY FOR
2 AFFORDABILITY CREDITS.—If the Commissioner de-
3 termines that a State Medicaid agency has the ca-
4 pacity to make determinations of eligibility for af-
5 fordability credits under subtitle C of title II of divi-
6 sion A of the Affordable Health Care for America
7 Act, under such memorandum—

8 “(A) the State Medicaid agency shall con-
9 duct such determinations for any Exchange-eli-
10 gible individual who requests such a determina-
11 tion;

12 “(B) in the case that a State Medicaid
13 agency determines that an Exchange-eligible in-
14 dividual is not eligible for affordability credits,
15 the agency shall forward the information on the
16 basis of which such determination was made to
17 the Commissioner; and

18 “(C) the Commissioner shall reimburse the
19 State Medicaid agency for the costs of con-
20 ducting such determinations.

21 “(4) REFERRALS UNDER MEMORANDUM.—Pur-
22 suant to such memorandum, if an individual applies
23 to the State for assistance in obtaining health cov-
24 erage and the State determines that the individual
25 is not eligible for medical assistance under this title

1 and is not authorized under such memorandum to
2 make an determination with respect to eligibility for
3 coverage and affordability credits through the
4 Health Insurance Exchange, the State shall refer
5 the individual to the Commissioner for a determina-
6 tion of such eligibility and, with the individual's au-
7 thorization, provide to the Commissioner information
8 obtained by the State as part of the application
9 process.

10 “(5) ADDITIONAL TERMS.—Such memorandum
11 shall include such additional provisions as are nec-
12 essary to implement efficiently the provisions of this
13 section and title II of division A of the Affordable
14 Health Care for America Act.

15 “(b) TREATMENT OF CERTAIN NEWBORNS.—

16 “(1) IN GENERAL.—In the case of a child who
17 is deemed under section 305(d) of the Affordable
18 Health Care for America Act to be a Medicaid eligi-
19 ble individual and enrolled under this title pursuant
20 to such section, the State shall provide for a deter-
21 mination, by not later than the end of the period re-
22 ferred to in paragraph (2) of such section, of the
23 child's eligibility for medical assistance under this
24 title.

1 “(2) EXTENDED TREATMENT AS TRADITIONAL
2 MEDICAID ELIGIBLE INDIVIDUAL.—In accordance
3 with paragraph (2) of section 305(d) of the Afford-
4 able Health Care for America Act, in the case of a
5 child described in paragraph (1) of such section who
6 at the end of the period referred to in such para-
7 graph is not otherwise covered under acceptable cov-
8 erage, the child shall be deemed (until such time as
9 the child obtains such coverage or the State other-
10 wise makes a determination of the child’s eligibility
11 for medical assistance under its plan under this title
12 pursuant to paragraph (1)) to be a Medicaid eligible
13 individual described in section 1902(l)(1)(B).

14 “(c) DEFINITIONS.—In this section:

15 “(1) MEDICAID ELIGIBLE INDIVIDUAL.—The
16 term ‘Medicaid eligible individual’ means an indi-
17 vidual who is eligible for medical assistance under
18 Medicaid.

19 “(2) TRADITIONAL MEDICAID ELIGIBLE INDI-
20 VIDUAL.—The term ‘traditional Medicaid eligible in-
21 dividual’ means a Medicaid eligible individual other
22 than an individual who is—

23 “(A) a Medicaid eligible individual by rea-
24 son of the application of subclause (VIII) of

1 section 1902(a)(10)(A)(i) of the Social Security
2 Act; or

3 “(B) a childless adult not described in sec-
4 tion 1902(a)(10)(A) or (C) of such Act (as in
5 effect as of the day before the date of the en-
6 actment of this Act).

7 “(3) NON-TRADITIONAL MEDICAID ELIGIBLE
8 INDIVIDUAL.—The term ‘non-traditional Medicaid
9 eligible individual’ means a Medicaid eligible indi-
10 vidual who is not a traditional Medicaid eligible indi-
11 vidual.

12 “(4) MEMORANDUM.—The term ‘memorandum’
13 means a Medicaid memorandum of understanding
14 under section 305(e)(2) of the Affordable Health
15 Care for America Act.

16 “(5) Y1.—The term ‘Y1’ has the meaning given
17 such term in section 100(c) of the Affordable Health
18 Care for America Act.”.

19 (b) CONFORMING AMENDMENTS TO ERROR RATE.—

20 (1) Section 1903(u)(1)(D) of the Social Secu-
21 rity Act (42 U.S.C. 1396b(u)(1)(D)) is amended by
22 adding at the end the following new clause:

23 “(vi) In determining the amount of erroneous excess
24 payments, there shall not be included any erroneous pay-
25 ments made that are attributable to an error in an eligi-

1 bility determination under subtitle C of title II of division
2 A of the Affordable Health Care for America Act.”.

3 (2) Section 2105(e)(11) of such Act (42 U.S.C.
4 1397ee(e)(11)) is amended by adding at the end the
5 following new sentence: “Clause (vi) of section
6 1903(u)(1)(D) shall apply with respect to the appli-
7 cation of such requirements under this title and title
8 XIX.”.

9 **SEC. 1703. CHIP AND MEDICAID MAINTENANCE OF ELIGI-**
10 **BILITY.**

11 (a) CHIP MAINTENANCE OF ELIGIBILITY.—Section
12 1902 of the Social Security Act (42 U.S.C. 1396a) is
13 amended—

14 (1) in subsection (a), as amended by section
15 1631(b)(1)(D)—

16 (A) by striking “and” at the end of para-
17 graph (73);

18 (B) by striking the period at the end of
19 paragraph (74) and inserting “; and”; and

20 (C) by inserting after paragraph (74) the
21 following new paragraph:

22 “(75) provide for maintenance of effort under
23 the State child health plan under title XXI in ac-
24 cordance with subsection (gg).”; and

1 (2) by adding at the end the following new sub-
2 section:

3 “(gg) CHIP MAINTENANCE OF ELIGIBILITY RE-
4 QUIREMENT.—

5 “(1) IN GENERAL.—Subject to paragraph (2),
6 as a condition of its State plan under this title under
7 subsection (a)(75) and receipt of any Federal finan-
8 cial assistance under section 1903(a) for calendar
9 quarters beginning after the date of the enactment
10 of this subsection and before CHIP MOE termi-
11 nation date specified in paragraph (3), a State shall
12 not have in effect eligibility standards, methodolo-
13 gies, or procedures under its State child health plan
14 under title XXI (including any waiver under such
15 title or demonstration project under section 1115)
16 that are more restrictive than the eligibility stand-
17 ards, methodologies, or procedures, respectively,
18 under such plan (or waiver) as in effect on June 16,
19 2009.

20 “(2) LIMITATION.—Paragraph (1) shall not be
21 construed as preventing a State from imposing a
22 limitation described in section 2110(b)(5)(C)(i)(II)
23 for a fiscal year in order to limit expenditures under
24 its State child health plan under title XXI to those

1 for which Federal financial participation is available
2 under section 2105 for the fiscal year.

3 “(3) CHIP MOE TERMINATION DATE.—In para-
4 graph (1), the ‘CHIP MOE termination date’ for a
5 State is the date that is the last day of Y1 (as de-
6 fined in section 100(c) of the Affordable Health
7 Care for America Act).

8 “(4) CHIP TRANSITION REPORT.—Not later
9 than December 31, 2011, the Secretary shall submit
10 to Congress a report—

11 “(A) that compares the benefits packages
12 offered under an average State child health
13 plan under title XXI in 2011 and to the benefit
14 standards initially adopted under section 224(b)
15 of the Affordable Health Care for America Act
16 and for affordability credits under subtitle C of
17 title II of division C of such Act; and

18 “(B) that includes such recommendations
19 as may be necessary to ensure that—

20 “(i) such coverage is at least com-
21 parable to the coverage provided to chil-
22 dren under such an average State child
23 health plan; and

24 “(ii) there are procedures in effect for
25 the enrollment of CHIP enrollees (includ-

1 ing CHIP-eligible pregnant women) at the
2 end of Y1 under this title, into a qualified
3 health benefits plan offered through the
4 Health Insurance Exchange, or into other
5 acceptable coverage (as defined for pur-
6 poses of such Act) without interruption of
7 coverage or a written plan of treatment.”.

8 (b) MEDICAID MAINTENANCE OF EFFORT; SIMPLI-
9 FYING AND COORDINATING ELIGIBILITY RULES BE-
10 TWEEN EXCHANGE AND MEDICAID.—

11 (1) IN GENERAL.—Section 1903 of such Act
12 (42 U.S.C. 1396b) is amended by adding at the end
13 the following new subsection:

14 “(aa) MAINTENANCE OF MEDICAID EFFORT; SIMPLI-
15 FYING AND COORDINATING ELIGIBILITY RULES BE-
16 TWEEN HEALTH INSURANCE EXCHANGE AND MED-
17 ICAID.—

18 “(1) MAINTENANCE OF EFFORT.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (B), a State is not eligible for payment
21 under subsection (a) for a calendar quarter be-
22 ginning after the date of the enactment of this
23 subsection if eligibility standards, methodolo-
24 gies, or procedures under its plan under this
25 title (including any waiver under this title or

1 demonstration project under section 1115) that
2 are more restrictive than the eligibility stand-
3 ards, methodologies, or procedures, respectively,
4 under such plan (or waiver) as in effect on
5 June 16, 2009. The Secretary shall extend such
6 a waiver (including the availability of Federal
7 financial participation under such waiver) for
8 such period as may be required for a State to
9 meet the requirement of the previous sentence.

10 “(B) EXCEPTION FOR CERTAIN DEM-
11 ONSTRATION PROJECTS.—In the case of a State
12 demonstration project under section 1115 in ef-
13 fect on June 16, 2009, that permits individuals
14 to be eligible solely to receive a premium or
15 cost-sharing subsidy for individual or group
16 health insurance coverage, effective for coverage
17 provided in Y1—

18 “(i) the Secretary shall permit the
19 State to amend such waiver to apply more
20 restrictive eligibility standards, methodolo-
21 gies, or procedures with respect to such in-
22 dividuals under such waiver; and

23 “(ii) the application of such more re-
24 strictive, standards, methodologies, or pro-
25 cedures under such an amendment shall

1 not be considered in violation of the re-
2 quirement of subparagraph (A).

3 “(2) REMOVAL OF ASSET TEST FOR CERTAIN
4 ELIGIBILITY CATEGORIES.—

5 “(A) IN GENERAL.—A State is not eligible
6 for payment under subsection (a) for a calendar
7 quarter beginning on or after the first day of
8 Y1 (as defined in section 100(c) of the Afford-
9 able Health Care for America Act), if the State
10 applies any asset or resource test in deter-
11 mining (or redetermining) eligibility of any indi-
12 vidual on or after such first day under any of
13 the following:

14 “(i) Subclause (I), (III), (IV), (VI),
15 (VIII), (IX), (X), or (XI) of section
16 1902(a)(10)(A)(i).

17 “(ii) Subclause (II), (IX), (XIV) or
18 (XVII) of section 1902(a)(10)(A)(ii).

19 “(iii) Section 1931(b).

20 “(B) OVERRIDING CONTRARY PROVISIONS;
21 REFERENCES.—The provisions of this title that
22 prevent the waiver of an asset or resource test
23 described in subparagraph (A) are hereby
24 waived.

1 “(C) REFERENCES.—Any reference to a
2 provision described in a provision in subpara-
3 graph (A) shall be deemed to be a reference to
4 such provision as modified through the applica-
5 tion of subparagraphs (A) and (B).”.

6 (2) CONFORMING AMENDMENTS.—(A) Section
7 1902(a)(10)(A) of such Act (42 U.S.C.
8 1396a(a)(10)(A)) is amended, in the matter before
9 clause (i), by inserting “subject to section
10 1903(aa)(2),” after “(A)”.

11 (B) Section 1931(b)(1) of such Act (42 U.S.C.
12 1396u–1(b)(1)) is amended by inserting “and sec-
13 tion 1903(aa)(2)” after “and (3)”.

14 (c) STANDARDS FOR BENCHMARK PACKAGES.—Sec-
15 tion 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is
16 amended—

17 (1) in each of paragraphs (1) and (2), by in-
18 serting “subject to paragraph (5),” after “subsection
19 (a)(1),”; and

20 (2) by adding at the end the following new
21 paragraph:

22 “(5) MINIMUM STANDARDS.—Effective January
23 1, 2013, any benchmark benefit package (or bench-
24 mark equivalent coverage under paragraph (2))
25 must meet the minimum benefits and cost-sharing

1 standards of a basic plan offered through the Health
2 Insurance Exchange.”.

3 (d) REPEAL OF CHIP.—Section 2104(a) of the So-
4 cial Security Act is amended by inserting at the end the
5 following:

6 “No funds shall be appropriated or authorized to be
7 appropriated under this section for fiscal year 2014
8 and subsequent years.”.

9 **SEC. 1704. REDUCTION IN MEDICAID DSH.**

10 (a) REPORT.—

11 (1) IN GENERAL.—Not later than January 1,
12 2016, the Secretary of Health and Human Services
13 (in this title referred to as the “Secretary”) shall
14 submit to Congress a report concerning the extent to
15 which, based upon the impact of the health care re-
16 forms carried out under division A in reducing the
17 number of uninsured individuals, there is a contin-
18 ued role for Medicaid DSH. In preparing the report,
19 the Secretary shall consult with community-based
20 health care networks serving low-income bene-
21 ficiaries.

22 (2) MATTERS TO BE INCLUDED.—The report
23 shall include the following:

24 (A) RECOMMENDATIONS.—Recommendations
25 regarding—

1 (i) the appropriate targeting of Med-
2 icaid DSH within States; and

3 (ii) the distribution of Medicaid DSH
4 among the States, taking into account the
5 ratio of the amount of DSH funds allo-
6 cated to a State to the number of unin-
7 sured individuals in such State.

8 (B) SPECIFICATION OF DSH HEALTH RE-
9 FORM METHODOLOGY.—The DSH Health Re-
10 form methodology described in paragraph (2) of
11 subsection (b) for purposes of implementing the
12 requirements of such subsection.

13 (3) COORDINATION WITH MEDICARE DSH RE-
14 PORT.—The Secretary shall coordinate the report
15 under this subsection with the report on Medicare
16 DSH under section 1112.

17 (4) MEDICAID DSH.—In this section, the term
18 “Medicaid DSH” means adjustments in payments
19 under section 1923 of the Social Security Act for in-
20 patient hospital services furnished by dispropor-
21 tionate share hospitals.

22 (b) MEDICAID DSH REDUCTIONS.—

23 (1) REDUCTIONS.—

1 (A) IN GENERAL.—For each of fiscal years
2 2017 through 2019 the Secretary shall effect
3 the following reductions:

4 (i) REDUCTION DSH ALLOTMENTS.—
5 The Secretary shall reduce DSH allot-
6 ments to States in the amount specified
7 under the DSH health reform methodology
8 under paragraph (2) for the State for the
9 fiscal year.

10 (ii) REDUCTIONS IN PAYMENTS.—The
11 Secretary shall reduce payments to States
12 under section 1903(a) of the Social Secu-
13 rity Act (42 U.S.C. 1396b(a)) for each cal-
14 endar quarter in the fiscal year, in the
15 manner specified in subparagraph (C), in
16 an amount equal to $\frac{1}{4}$ of the DSH allot-
17 ment reduction under clause (i) for the
18 State for the fiscal year.

19 (B) AGGREGATE REDUCTIONS.—The ag-
20 gregate reductions in DSH allotments for all
21 States under subparagraph (A)(i) shall be equal
22 to—

23 (i) \$1,500,000,000 for fiscal year
24 2017;

- 1 (ii) \$2,500,000,000 for fiscal year
2 2018; and
3 (iii) \$6,000,000,000 for fiscal year
4 2019.

5 The Secretary shall distribute such aggregate
6 reduction among States in accordance with
7 paragraph (2).

8 (C) MANNER OF PAYMENT REDUCTION.—

9 The amount of the payment reduction under
10 subparagraph (A)(ii) for a State for a quarter
11 shall be deemed an overpayment to the State
12 under title XIX of the Social Security Act to be
13 disallowed against the State's regular quarterly
14 draw for all Medicaid spending under section
15 1903(d)(2) of such Act (42 U.S.C.
16 1396b(d)(2)). Such a disallowance is not sub-
17 ject to a reconsideration under 1116(d) of such
18 Act (42 U.S.C. 1316(d)).

19 (D) DEFINITIONS.—In this section:

20 (i) STATE.—The term “State” means
21 the 50 States and the District of Colum-
22 bia.

23 (ii) DSH ALLOTMENT.—The term
24 “DSH allotment” means, with respect to a
25 State for a fiscal year, the allotment made

1 under section 1923(f) of the Social Secu-
2 rity Act (42 U.S.C. 1396r-4(f)) to the
3 State for the fiscal year.

4 (2) DSH HEALTH REFORM METHODOLOGY.—
5 The Secretary shall carry out paragraph (1) through
6 use of a DSH Health Reform methodology issued by
7 the Secretary that imposes the largest percentage re-
8 ductions on the States that—

9 (A) have the lowest percentages of unin-
10 sured individuals (determined on the basis of
11 audited hospital cost reports) during the most
12 recent year for which such data are available;
13 or

14 (B) do not target their DSH payments
15 on—

16 (i) hospitals with high volumes of
17 Medicaid inpatients (as defined in section
18 1923(b)(1)(A) of the Social Security Act
19 (42 U.S.C. 1396r-4(b)(1)(A)); and

20 (ii) hospitals that have high levels of
21 uncompensated care (excluding bad debt).

22 (3) DSH ALLOTMENT PUBLICATIONS.—

23 (A) IN GENERAL.—Not later than the pub-
24 lication deadline specified in subparagraph (B),
25 the Secretary shall publish in the Federal Reg-

1 ister a notice specifying the DSH allotment to
2 each State under 1923(f) of the Social Security
3 Act for the respective fiscal year specified in
4 such subparagraph, consistent with the applica-
5 tion of the DSH Health Reform methodology
6 described in paragraph (2).

7 (B) PUBLICATION DEADLINE.—The publi-
8 cation deadline specified in this subparagraph
9 is—

10 (i) January 1, 2016, with respect to
11 DSH allotments described in subparagraph
12 (A) for fiscal year 2017;

13 (ii) January 1, 2017, with respect to
14 DSH allotments described in subparagraph
15 (A) for fiscal year 2018; and

16 (iii) January 1, 2018, with respect to
17 DSH allotments described in subparagraph
18 (A) for fiscal year 2019.

19 (c) CONFORMING AMENDMENTS.—

20 (1) Section 1923(f) of the Social Security Act
21 (42 U.S.C. 1396r-4(f)) is amended—

22 (A) by redesignating paragraph (7) as
23 paragraph (8); and

24 (B) by inserting after paragraph (6) the
25 following new paragraph:

1 “(7) SPECIAL RULE FOR FISCAL YEARS 2017,
2 2018, AND 2019.—For each of fiscal years 2017,
3 2018, and 2018, the DSH allotments under this
4 subsection are subject to reduction under section
5 1704(b) of the Affordable Health Care for America
6 Act.”.

7 (2) The second sentence of section 1923(b)(4)
8 of such Act (42 U.S.C. 1396r-4(b)(4)) is amended
9 by inserting before the period the following: “or to
10 affect the authority of the Secretary to issue and im-
11 plement the DSH Health Reform methodology under
12 section 1704(b)(2) of the Affordable Health Care for
13 America Act”.

14 (d) DISPROPORTIONATE SHARE HOSPITALS (DSH)
15 AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DIS-
16 CRIMINATION.—

17 (1) IN GENERAL.—Section 1923(d) of the So-
18 cial Security Act (42 U.S.C. 1396r-4) is amended by
19 adding at the end the following new paragraph:

20 “(4) No hospital may be defined or deemed as
21 a disproportionate share hospital, or as an essential
22 access hospital (for purposes of subsection
23 (f)(6)(A)(iv)), under a State plan under this title or
24 subsection (b) of this section (including any dem-

1 onstration project under section 1115) unless the
2 hospital—

3 “(A) provides services to beneficiaries
4 under this title without discrimination on the
5 ground of race, color, national origin, creed,
6 source of payment, status as a beneficiary
7 under this title, or any other ground unrelated
8 to such beneficiary’s need for the services or the
9 availability of the needed services in the hos-
10 pital; and

11 “(B) makes arrangements for, and accepts,
12 reimbursement under this title for services pro-
13 vided to eligible beneficiaries under this title.”.

14 (2) EFFECTIVE DATE.—The amendment made
15 by paragraph (1) shall apply to expenditures made
16 on or after July 1, 2010.

17 **SEC. 1705. EXPANDED OUTSTATIONING.**

18 (a) IN GENERAL.—Section 1902(a)(55) of the Social
19 Security Act (42 U.S.C. 1396a(a)(55)) is amended by
20 striking “under subsection (a)(10)(A)(i)(IV),
21 (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or
22 (a)(10)(A)(ii)(IX)” and inserting “(including receipt and
23 processing of applications of individuals for affordability
24 credits under subtitle C of title II of division A of the Af-
25 fordable Health Care for America Act pursuant to a Med-

1 icaid memorandum of understanding under section
2 1943(a)(1))”.

3 (b) EFFECTIVE DATE.—Except as provided in sec-
4 tion 1790, the amendment made by subsection (a) shall
5 apply to services furnished on or after July 1, 2010, with-
6 out regard to whether or not final regulations to carry out
7 such amendment have been promulgated by such date.

8 **Subtitle B—Prevention**

9 **SEC. 1711. REQUIRED COVERAGE OF PREVENTIVE SERV-** 10 **ICES.**

11 (a) COVERAGE.—Section 1905 of the Social Security
12 Act (42 U.S.C. 1396d), as amended by section
13 1701(a)(3)(B), is amended—

14 (1) in subsection (a)(4)—

15 (A) by striking “and” before “(C)”; and

16 (B) by inserting before the semicolon at
17 the end the following: “; and (D) preventive
18 services described in subsection (z)”; and

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

21 “(z) PREVENTIVE SERVICES.—The preventive serv-
22 ices described in this subsection are services not otherwise
23 described in subsection (a) or (r) that the Secretary deter-
24 mines are—

1 “(1)(A) recommended with a grade of A or B
2 by the Task Force for Clinical Preventive Services;
3 or

4 “(B) vaccines recommended for use as appro-
5 priate by the Director of the Centers for Disease
6 Control and Prevention; and

7 “(2) appropriate for individuals entitled to med-
8 ical assistance under this title.”.

9 (b) ELIMINATION OF COST-SHARING.—

10 (1) Subsections (a)(2)(D) and (b)(2)(D) of sec-
11 tion 1916 of such Act (42 U.S.C. 1396o) are each
12 amended by inserting “preventive services described
13 in section 1905(z),” after “emergency services (as
14 defined by the Secretary),”.

15 (2) Section 1916A(a)(1) of such Act (42 U.S.C.
16 1396o–1 (a)(1)) is amended by inserting “, preven-
17 tive services described in section 1905(z),” after
18 “subsection (c)”.

19 (c) CONFORMING AMENDMENT.—Section 1928 of
20 such Act (42 U.S.C. 1396s) is amended—

21 (1) in subsection (c)(2)(B)(i), by striking “the
22 advisory committee referred to in subsection (e)”
23 and inserting “the Director of the Centers for Dis-
24 ease Control and Prevention”;

1 (2) in subsection (e), by striking “Advisory
2 Committee” and all that follows and inserting “Di-
3 rector of the Centers for Disease Control and Pre-
4 vention.”; and

5 (3) by striking subsection (g).

6 (d) EFFECTIVE DATE.—Except as provided in sec-
7 tion 1790, the amendments made by this section shall
8 apply to services furnished on or after July 1, 2010, with-
9 out regard to whether or not final regulations to carry out
10 such amendments have been promulgated by such date.

11 **SEC. 1712. TOBACCO CESSATION.**

12 (a) DROPPING TOBACCO CESSATION EXCLUSION
13 FROM COVERED OUTPATIENT DRUGS.—Section
14 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r-
15 8(d)(2)) is amended—

16 (1) by striking subparagraph (E);

17 (2) in subparagraph (G), by inserting before the
18 period at the end the following: “, except agents ap-
19 proved by the Food and Drug Administration for
20 purposes of promoting, and when used to promote,
21 tobacco cessation”; and

22 (3) by redesignating subparagraphs (F)
23 through (K) as subparagraphs (E) through (J), re-
24 spectively.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to drugs and services furnished
3 on or after January 1, 2010.

4 **SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITA-**
5 **TION SERVICES.**

6 (a) IN GENERAL.—Section 1905 of the Social Secu-
7 rity Act (42 U.S.C. 1396d), as amended by sections
8 1701(a)(3)(B) and 1711(a), is amended—

9 (1) in subsection (a)—

10 (A) in paragraph (27), by striking “and”
11 at the end;

12 (B) by redesignating paragraph (28) as
13 paragraph (29); and

14 (C) by inserting after paragraph (27) the
15 following new paragraph:

16 “(28) nurse home visitation services (as defined
17 in subsection (aa)); and”;

18 (2) by adding at the end the following new sub-
19 section:

20 “(aa) The term ‘nurse home visitation services’
21 means home visits by trained nurses to families with a
22 first-time pregnant woman, or a child (under 2 years of
23 age), who is eligible for medical assistance under this title,
24 but only, to the extent determined by the Secretary based

1 upon evidence, that such services are effective in one or
2 more of the following:

3 “(1) Improving maternal or child health and
4 pregnancy outcomes or increasing birth intervals be-
5 tween pregnancies.

6 “(2) Reducing the incidence of child abuse, ne-
7 glect, and injury, improving family stability (includ-
8 ing reduction in the incidence of intimate partner vi-
9 olence), or reducing maternal and child involvement
10 in the criminal justice system.

11 “(3) Increasing economic self-sufficiency, em-
12 ployment advancement, school-readiness, and edu-
13 cational achievement, or reducing dependence on
14 public assistance.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to services furnished on or after
17 January 1, 2010.

18 (c) CONSTRUCTION.—Nothing in the amendments
19 made by this section shall be construed as affecting the
20 ability of a State under title XIX or XXI of the Social
21 Security Act to provide nurse home visitation services as
22 part of another class of items and services falling within
23 the definition of medical assistance or child health assist-
24 ance under the respective title, or as an administrative ex-
25 penditure for which payment is made under section

1 1903(a) or 2105(a) of such Act, respectively, on or after
2 the date of the enactment of this Act.

3 **SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLAN-**
4 **NING SERVICES.**

5 (a) COVERAGE AS OPTIONAL CATEGORICALLY
6 NEEDY GROUP.—

7 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
8 of the Social Security Act (42 U.S.C.
9 1396a(a)(10)(A)(ii)) is amended—

10 (A) in subclause (XVIII), by striking “or”
11 at the end;

12 (B) in subclause (XIX), by adding “or” at
13 the end; and

14 (C) by adding at the end the following new
15 subclause:

16 “(XX) who are described in sub-
17 section (hh) (relating to individuals
18 who meet certain income standards);”.

19 (2) GROUP DESCRIBED.—Section 1902 of such
20 Act (42 U.S.C. 1396a), as amended by section 1703,
21 is amended by adding at the end the following new
22 subsection:

23 “(hh)(1) Individuals described in this subsection are
24 individuals—

1 “(A) whose income does not exceed an in-
2 come eligibility level established by the State
3 that does not exceed the highest income eligi-
4 bility level established under the State plan
5 under this title (or under its State child health
6 plan under title XXI) for pregnant women; and

7 “(B) who are not pregnant.

8 “(2) At the option of a State, individuals described
9 in this subsection may include individuals who, had indi-
10 viduals applied on or before January 1, 2007, would have
11 been made eligible pursuant to the standards and proc-
12 esses imposed by that State for benefits described in
13 clause (XV) of the matter following subparagraph (G) of
14 section subsection (a)(10) pursuant to a demonstration
15 project waiver granted under section 1115.

16 “(3) At the option of a State, for purposes of sub-
17 section (a)(17)(B), in determining eligibility for services
18 under this subsection, the State may consider only the in-
19 come of the applicant or recipient.”.

20 (3) LIMITATION ON BENEFITS.—Section
21 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10))
22 is amended in the matter following subparagraph
23 (G)—

24 (A) by striking “and (XIV)” and inserting
25 “(XIV)”; and

1 (B) by inserting “, and (XV) the medical
2 assistance made available to an individual de-
3 scribed in subsection (hh) shall be limited to
4 family planning services and supplies described
5 in section 1905(a)(4)(C) including medical di-
6 agnosis and treatment services that are pro-
7 vided pursuant to a family planning service in
8 a family planning setting” after “cervical can-
9 cer”.

10 (4) CONFORMING AMENDMENTS.—Section
11 1905(a) of such Act (42 U.S.C. 1396d(a)), as
12 amended by section 1731(c), is amended in the mat-
13 ter preceding paragraph (1)—

14 (A) in clause (xiii), by striking “or” at the
15 end;

16 (B) in clause (xiv), by adding “or” at the
17 end; and

18 (C) by inserting after clause (xiv) the fol-
19 lowing:

20 “(xv) individuals described in section
21 1902(hh),”.

22 (b) PRESUMPTIVE ELIGIBILITY.—

23 (1) IN GENERAL.—Title XIX of the Social Se-
24 curity Act (42 U.S.C. 1396 et seq.) is amended by
25 inserting after section 1920B the following:

1 “(i) the day on which a determination
2 is made with respect to the eligibility of
3 such individual for services under the State
4 plan; or

5 “(ii) in the case of such an individual
6 who does not file an application by the last
7 day of the month following the month dur-
8 ing which the entity makes the determina-
9 tion referred to in subparagraph (A), such
10 last day.

11 “(2) QUALIFIED ENTITY.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), the term ‘qualified entity’ means
14 any entity that—

15 “(i) is eligible for payments under a
16 State plan approved under this title; and

17 “(ii) is determined by the State agen-
18 cy to be capable of making determinations
19 of the type described in paragraph (1)(A).

20 “(B) RULE OF CONSTRUCTION.—Nothing
21 in this paragraph shall be construed as pre-
22 venting a State from limiting the classes of en-
23 tities that may become qualified entities in
24 order to prevent fraud and abuse.

25 “(c) ADMINISTRATION.—

1 “(1) IN GENERAL.—The State agency shall pro-
2 vide qualified entities with—

3 “(A) such forms as are necessary for an
4 application to be made by an individual de-
5 scribed in subsection (a) for medical assistance
6 under the State plan; and

7 “(B) information on how to assist such in-
8 dividuals in completing and filing such forms.

9 “(2) NOTIFICATION REQUIREMENTS.—A quali-
10 fied entity that determines under subsection
11 (b)(1)(A) that an individual described in subsection
12 (a) is presumptively eligible for medical assistance
13 under a State plan shall—

14 “(A) notify the State agency of the deter-
15 mination within 5 working days after the date
16 on which determination is made; and

17 “(B) inform such individual at the time
18 the determination is made that an application
19 for medical assistance is required to be made by
20 not later than the last day of the month fol-
21 lowing the month during which the determina-
22 tion is made.

23 “(3) APPLICATION FOR MEDICAL ASSIST-
24 ANCE.—In the case of an individual described in
25 subsection (a) who is determined by a qualified enti-

1 ty to be presumptively eligible for medical assistance
2 under a State plan, the individual shall apply for
3 medical assistance by not later than the last day of
4 the month following the month during which the de-
5 termination is made.

6 “(d) PAYMENT.—Notwithstanding any other provi-
7 sion of law, medical assistance that—

8 “(1) is furnished to an individual described in
9 subsection (a)—

10 “(A) during a presumptive eligibility pe-
11 riod;

12 “(B) by a entity that is eligible for pay-
13 ments under the State plan; and

14 “(2) is included in the care and services covered
15 by the State plan,

16 shall be treated as medical assistance provided by such
17 plan for purposes of clause (4) of the first sentence of
18 section 1905(b).”.

19 (2) CONFORMING AMENDMENTS.—

20 (A) Section 1902(a)(47) of the Social Se-
21 curity Act (42 U.S.C. 1396a(a)(47)) is amend-
22 ed by inserting before the semicolon at the end
23 the following: “and provide for making medical
24 assistance available to individuals described in
25 subsection (a) of section 1920C during a pre-

1 sumptive eligibility period in accordance with
2 such section”.

3 (B) Section 1903(u)(1)(D)(v) of such Act
4 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

5 (i) by striking “or for” and inserting
6 “for”; and

7 (ii) by inserting before the period the
8 following: “, or for medical assistance pro-
9 vided to an individual described in sub-
10 section (a) of section 1920C during a pre-
11 sumptive eligibility period under such sec-
12 tion”.

13 (c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
14 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
15 Social Security Act (42 U.S.C. 1396u–7(b)), as amended
16 by section 1703(c)(2), is amended by adding at the end
17 the following:

18 “(6) COVERAGE OF FAMILY PLANNING SERV-
19 ICES AND SUPPLIES.—Notwithstanding the previous
20 provisions of this section, a State may not provide
21 for medical assistance through enrollment of an indi-
22 vidual with benchmark coverage or benchmark-equiv-
23 alent coverage under this section unless such cov-
24 erage includes for any individual described in section
25 1905(a)(4)(C), medical assistance for family plan-

1 a physician) at a rate not less than 80 percent
2 of the payment rate that would be applicable if
3 the adjustment described in subsection (kk)(2)
4 were to apply to such services and physicians or
5 professionals (as the case may be) under part
6 B of title XVIII for services furnished in 2010,
7 90 percent of such adjusted payment rate for
8 services and physicians (or professionals) fur-
9 nished in 2011, or 100 percent of such adjusted
10 payment rate for services and physicians (or
11 professionals) furnished in 2012 and each sub-
12 sequent year;” and

13 (B) by adding at the end the following new
14 subsection:

15 “(kk) INCREASED PAYMENT FOR PRIMARY CARE
16 SERVICES.—For purposes of subsection (a)(13)(C):

17 “(1) PRIMARY CARE SERVICES DEFINED.—The
18 term ‘primary care services’ means evaluation and
19 management services, without regard to the specialty
20 of the physician furnishing the services, that are
21 procedure codes (for services covered under title
22 XVIII) for services in the category designated Eval-
23 uation and Management in the Health Care Com-
24 mon Procedure Coding System (established by the
25 Secretary under section 1848(c)(5) as of December

1 31, 2009, and as subsequently modified by the Sec-
2 retary).

3 “(2) ADJUSTMENT.—The adjustment described
4 in this paragraph is the substitution of 1.25 percent
5 for the update otherwise provided under section
6 1848(d)(4) for each year beginning with 2010.”.

7 (2) UNDER MEDICAID MANAGED CARE
8 PLANS.—Section 1932(f) of such Act (42 U.S.C.
9 1396u–2(f)) is amended—

10 (A) in the heading, by adding at the end
11 the following: “; ADEQUACY OF PAYMENT FOR
12 PRIMARY CARE SERVICES”; and

13 (B) by inserting before the period at the
14 end the following: “and, in the case of primary
15 care services described in section
16 1902(a)(13)(C), consistent with the minimum
17 payment rates specified in such section (regard-
18 less of the manner in which such payments are
19 made, including in the form of capitation or
20 partial capitation)”.

21 (b) INCREASE IN PAYMENT USING INCREASED
22 FMAP.—Section 1905(y) of the Social Security Act, as
23 added by section 1701(a)(3)(B) and as amended by sec-
24 tion 1701(c)(2), is amended by adding at the end the fol-
25 lowing:

1 “(3)(A) The portion of the amounts expended
2 for medical assistance for services described in sec-
3 tion 1902(a)(13)(C) furnished on or after January
4 1, 2010, that is attributable to the amount by which
5 the minimum payment rate required under such sec-
6 tion (or, by application, section 1932(f)) exceeds the
7 payment rate applicable to such services under the
8 State plan as of June 16, 2009.

9 “(B) Subparagraph (A) shall not be construed
10 as preventing the payment of Federal financial par-
11 ticipation based on the Federal medical assistance
12 percentage for amounts in excess of those specified
13 under such subparagraph.”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished on or after
16 January 1, 2010.

17 **SEC. 1722. MEDICAL HOME PILOT PROGRAM.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services shall establish under this section a med-
20 ical home pilot program under which a State may apply
21 to the Secretary for approval of a medical home pilot
22 project described in subsection (b) (in this section referred
23 to as a “pilot project”) for the application of the medical
24 home concept under title XIX of the Social Security Act.

1 The pilot program shall operate for a period of up to 5
2 years.

3 (b) PILOT PROJECT DESCRIBED.—

4 (1) IN GENERAL.—A pilot project is a project
5 that applies one or more of the medical home models
6 described in section 1866F(a)(3) of the Social Secu-
7 rity Act (as inserted by section 1302(a)) or such
8 other model as the Secretary may approve, to indi-
9 viduals (including medically fragile children and
10 high-risk pregnant women) who are eligible for med-
11 ical assistance under title XIX of the Social Security
12 Act. The Secretary shall provide for appropriate co-
13 ordination of the pilot program under this section
14 with the medical home pilot program under section
15 1866F of such Act.

16 (2) LIMITATION.—A pilot project shall be for a
17 duration of not more than 5 years.

18 (3) CONSIDERATION FOR CERTAIN TECH-
19 NOLOGIES.—In considering applications for pilots
20 projects under this section, the Secretary may ap-
21 prove a project which tests the effectiveness of appli-
22 cations and devices, such as wireless patient man-
23 agement technologies, that are approved by the Food
24 and Drug Administration and enable providers and

1 practitioners to communicate directly with their pa-
2 tients in managing chronic illness.

3 (c) **ADDITIONAL INCENTIVES.**—In the case of a pilot
4 project, the Secretary may—

5 (1) waive the requirements of section
6 1902(a)(1) of the Social Security Act (relating to
7 statewideness) and section 1902(a)(10)(B) of such
8 Act (relating to comparability); and

9 (2) increase to up to 90 percent (for the first
10 2 years of the pilot program) or 75 percent (for the
11 next 3 years) the matching percentage for adminis-
12 trative expenditures (such as those for community
13 care workers).

14 (d) **MEDICALLY FRAGILE CHILDREN.**—In the case of
15 a model involving medically fragile children, the model
16 shall ensure that the patient-centered medical home serv-
17 ices received by each child, in addition to fulfilling the re-
18 quirements under 1866F(b)(1) of the Social Security Act,
19 provide for continuous involvement and education of the
20 parent or caregiver and for assistance to the child in ob-
21 taining necessary transitional care if a child's enrollment
22 ceases for any reason.

23 (e) **EVALUATION; REPORT.**—

24 (1) **EVALUATION.**—The Secretary, using the
25 criteria described in section 1866F(e)(1) of the So-

1 cial Security Act (as inserted by section 1123), shall
2 conduct an evaluation of the pilot program under
3 this section.

4 (2) REPORT.—Not later than 60 days after the
5 date of completion of the evaluation under para-
6 graph (1), the Secretary shall submit to Congress
7 and make available to the public a report on the
8 findings of the evaluation under such paragraph.

9 (f) FUNDING.—The additional Federal financial par-
10 ticipation resulting from the implementation of the pilot
11 program under this section may not exceed in the aggre-
12 gate \$1,235,000,000 over the 5-year period of the pro-
13 gram.

14 **SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.**

15 (a) IN GENERAL.—Section 1903(a)(2)(E) of the So-
16 cial Security Act (42 U.S.C. 1396b(a)(2)), as added by
17 section 201(b)(2)(A) of the Children’s Health Insurance
18 Program Reauthorization Act of 2009 (Public Law 111–
19 3), is amended by inserting “and other individuals” after
20 “children of families”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to payment for translation or
23 interpretation services furnished on or after January 1,
24 2010.

1 **SEC. 1724. OPTIONAL COVERAGE FOR FREESTANDING**
2 **BIRTH CENTER SERVICES.**

3 (a) IN GENERAL.—Section 1905 of the Social Secu-
4 rity Act (42 U.S.C. 1396d), as amended by section
5 1713(a), is amended—

6 (1) in subsection (a)—

7 (A) by redesignating paragraph (29) as
8 paragraph (30);

9 (B) in paragraph (28), by striking at the
10 end “and”; and

11 (C) by inserting after paragraph (28) the
12 following new paragraph:

13 “(29) freestanding birth center services (as de-
14 fined in subsection (1)(3)(A)) and other ambulatory
15 services that are offered by a freestanding birth cen-
16 ter (as defined in subsection (1)(3)(B)) and that are
17 otherwise included in the plan; and”;

18 (2) in subsection (1), by adding at the end the
19 following new paragraph:

20 “(3)(A) The term ‘freestanding birth center services’
21 means services furnished to an individual at a freestanding
22 birth center (as defined in subparagraph (B)), including
23 by a licensed birth attendant (as defined in subparagraph
24 (C)) at such center.

25 “(B) The term ‘freestanding birth center’ means a
26 health facility—

1 **SEC. 1726. REQUIRING COVERAGE OF SERVICES OF PODIA-**
2 **TRISTS.**

3 (a) IN GENERAL.—Section 1905(a)(5)(A) of the So-
4 cial Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended
5 by striking “section 1861(r)(1)” and inserting “para-
6 graphs (1) and (3) of section 1861(r)”.

7 (b) EFFECTIVE DATE.—Except as provided in sec-
8 tion 1790, the amendment made by subsection (a) shall
9 apply to services furnished on or after January 1, 2010.

10 **SEC. 1726A. REQUIRING COVERAGE OF SERVICES OF OP-**
11 **TOMETRISTS.**

12 (a) IN GENERAL.—Section 1905(a)(5) of the Social
13 Security Act (42 U.S.C. 1396d(a)(5)) is amended—

14 (1) by striking “and” before “(B)”; and

15 (2) by inserting before the semicolon at the end
16 the following: “, and (C) medical and other health
17 services (as defined in section 1861(s)) as authorized
18 by State law, furnished by an optometrist (described
19 in section 1861(r)(4)) to the extent such services
20 may be performed under State law”.

21 (b) EFFECTIVE DATE.—Except as provided in sec-
22 tion 1790, the amendments made by subsection (a) shall
23 take effect 90 days after the date of the enactment of this
24 Act and shall apply to services furnished or other actions
25 required on or after such date.

1 **SEC. 1727. THERAPEUTIC FOSTER CARE.**

2 (a) RULE OF CONSTRUCTION.—Nothing in this title
3 shall prevent or limit a State from covering therapeutic
4 foster care for eligible children in out-of-home placements
5 under section 1905(a) of the Social Security Act (42
6 U.S.C. 1396d(a)).

7 (b) THERAPEUTIC FOSTER CARE DEFINED.—For
8 purposes of this section, the term “therapeutic foster
9 care” means a foster care program that provides—

10 (1) to the child—

11 (A) structured daily activities that develop,
12 improve, monitor, and reinforce age-appropriate
13 social, communications, and behavioral skills;

14 (B) crisis intervention and crisis support
15 services;

16 (C) medication monitoring;

17 (D) counseling; and

18 (E) case management services; and

19 (2) specialized training for the foster parent
20 and consultation with the foster parent on the man-
21 agement of children with mental illnesses and re-
22 lated health and developmental conditions.

1 **SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR**
2 **SERVICES.**

3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act is amended by inserting after section 1925 the fol-
5 lowing new section:

6 “ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

7 “SEC. 1926. (a) IN GENERAL.—A State plan under
8 this title shall not be considered to meet the requirement
9 of section 1902(a)(30)(A) for a year (beginning with
10 2011) unless, by not later than April 1 before the begin-
11 ning of such year, the State submits to the Secretary an
12 amendment to the plan that specifies the payment rates
13 to be used for such services under the plan in such year
14 and includes in such submission such additional data as
15 will assist the Secretary in evaluating the State’s compli-
16 ance with such requirement, including data relating to how
17 rates established for payments to medicaid managed care
18 organizations under sections 1903(m) and 1932 take into
19 account such payment rates.

20 “(b) SECRETARIAL REVIEW.—The Secretary, by not
21 later than 90 days after the date of submission of a plan
22 amendment under subsection (a), shall—

23 “(1) review each such amendment for compli-
24 ance with the requirement of section
25 1902(a)(30)(A); and

1 “(2) approve or disapprove each such amend-
2 ment.

3 If the Secretary disapproves such an amendment, the
4 State shall immediately submit a revised amendment that
5 meets such requirement.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall take effect on the date of the enact-
8 ment of this Act.

9 **SEC. 1729. PRESERVING MEDICAID COVERAGE FOR**
10 **YOUTHS UPON RELEASE FROM PUBLIC INSTI-**
11 **TUTIONS.**

12 Section 1902(a) of the Social Security Act (42 U.S.C.
13 1396a), as amended by section 1631(b) and 1703(a), is
14 amended—

15 (1) by striking “and” at the end of paragraph
16 (74);

17 (2) by striking the period at the end of para-
18 graph (75) and inserting “; and”; and

19 (3) by inserting after paragraph (75) the fol-
20 lowing new paragraph:

21 “(76) provide that in the case of any youth who
22 is 18 years of age or younger, was enrolled for med-
23 ical assistance under the State plan immediately be-
24 fore becoming an inmate of a public institution, is
25 18 years of age or younger upon release from such

1 institution, and is eligible for such medical assist-
2 ance under the State plan at the time of release
3 from such institution—

4 “(A) during the period such youth is incar-
5 cerated in a public institution, the State shall
6 not terminate eligibility for medical assistance
7 under the State plan for such youth;

8 “(B) during the period such youth is incar-
9 cerated in a public institution, the State shall
10 establish a process that ensures—

11 “(i) that the State does not claim fed-
12 eral financial participation for services that
13 are provided to such youth and that are
14 excluded under subsection 1905(a)(28)(A);
15 and

16 “(ii) that the youth receives medical
17 assistance for which federal participation is
18 available under this title;

19 “(C) on or before the date such youth is
20 released from such institution, the State shall
21 ensure that such youth is enrolled for medical
22 assistance under this title, unless and until
23 there is a determination that the individual is
24 no longer eligible to be so enrolled; and

1 “(D) the State shall ensure that enroll-
2 ment under subparagraph (C) will be completed
3 before such date so that the youth can access
4 medical assistance under this title immediately
5 upon leaving the institution.”

6 **SEC. 1730. QUALITY MEASURES FOR MATERNITY AND**
7 **ADULT HEALTH SERVICES UNDER MEDICAID**
8 **AND CHIP.**

9 Title XI of the Social Security Act (42 U.S.C. 1301
10 et seq.) is amended by inserting after section 1139A the
11 following new section:

12 **“SEC. 1139B. QUALITY MEASURES FOR MATERNITY AND**
13 **ADULT HEALTH SERVICES UNDER MEDICAID**
14 **AND CHIP.**

15 “(a) MATERNITY CARE QUALITY MEASURES UNDER
16 MEDICAID AND CHIP.—

17 “(1) DEVELOPMENT OF MEASURES.—No later
18 than January 1, 2011, the Secretary shall develop
19 and publish for comment a proposed set of measures
20 that accurately describe the quality of maternity
21 care provided under State plans under titles XIX
22 and XXI. The Secretary shall publish a final rec-
23 ommended set of such measures no later than July
24 1, 2011.

1 “(2) STANDARDIZED REPORTING FORMAT.—No
2 later than January 1, 2012, the Secretary shall de-
3 velop and publish a standardized reporting format
4 for maternity care quality measures for use by State
5 programs under titles XIX and XXI to collect data
6 from managed care entities and providers and prac-
7 titioners that participate in such programs and to
8 report maternity care quality measures to the Sec-
9 retary.

10 “(b) OTHER ADULT HEALTH QUALITY MEASURES
11 UNDER MEDICAID.—

12 “(1) DEVELOPMENT OF MEASURES.—The Sec-
13 retary shall develop quality measures that are not
14 otherwise developed under section 1192 for services
15 received under State plans under title XIX by indi-
16 viduals who are 21 years of age or older but have
17 not attained age 65. The Secretary shall publish
18 such quality measures through notice and comment
19 rulemaking.

20 “(2) STANDARDIZED REPORTING FORMAT.—
21 The Secretary shall develop and publish a standard-
22 ized reporting format for quality measures developed
23 under paragraph (1) and section 1192 for services
24 furnished under State plans under title XIX to indi-
25 viduals who are 21 years of age or older but have

1 not attained age 65 for use under such plans and
2 State plans under title XXI. The format shall enable
3 State agencies administering such plans to collect
4 data from managed care entities and providers and
5 practitioners that participate in such plans and to
6 report quality measures to the Secretary.

7 “(c) DEVELOPMENT PROCESS.—With respect to the
8 development of quality measures under subsections (a)
9 and (b)—

10 “(1) USE OF QUALIFIED ENTITIES.—The Sec-
11 retary may enter into agreements with public, non-
12 profit, or academic institutions with technical exper-
13 tise in the area of health quality measurement to as-
14 sist in such development. The Secretary may carry
15 out these agreements by contract, grant, or other-
16 wise.

17 “(2) MULTI-STAKEHOLDER PRE-RULEMAKING
18 INPUT.—The Secretary shall obtain the input of
19 stakeholders with respect to such quality measures
20 using a process similar to that described in section
21 1808(d).

22 “(3) COORDINATION.—The Secretary shall co-
23 ordinate the development of such measures under
24 such subsections and with the development of child
25 health quality measures under section 1139A.

1 “(d) ANNUAL REPORT TO CONGRESS.—No later than
2 January 1, 2013, and annually thereafter, the Secretary
3 shall report to the Committee on Energy and Commerce
4 of the House of Representatives the Committee on Fi-
5 nance of the Senate regarding—

6 “(1) the availability of reliable data relating to
7 the quality of maternity care furnished under State
8 plans under titles XIX and XXI;

9 “(2) the availability of reliable data relating to
10 the quality of services furnished under State plans
11 under title XIX to adults who are 21 years of age
12 or older but have not attained age 65; and

13 “(3) recommendations for improving the quality
14 of such care and services furnished under such State
15 plans.

16 “(e) RULE OF CONSTRUCTION.—Notwithstanding
17 any other provision in this section, no quality measure de-
18 veloped, published, or used as a basis of measurement or
19 reporting under this section may be used to establish an
20 irrebuttable presumption regarding either the medical ne-
21 cessity of care or the maximum permissible coverage for
22 any individual who receives medical assistance under title
23 XIX or child health assistance under title XXI.

24 “(f) APPROPRIATION.—For purposes of carrying out
25 this section, in addition to funds otherwise available, out

1 of any funds in the Treasury not otherwise appropriated,
2 there are appropriated \$40,000,000 for the 5-fiscal-year
3 period beginning with fiscal year 2010. Funds appro-
4 priated under this subsection shall remain available until
5 expended.”.

6 **SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT**
7 **PROGRAM.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall establish under this section an ac-
10 countable care program under which a State may apply
11 to the Secretary for approval of an accountable care orga-
12 nization pilot program described in subsection (b) (in this
13 section referred to as a “pilot program”) for the applica-
14 tion of the accountable care organization concept under
15 title XIX of the Social Security Act.

16 (b) PILOT PROGRAM DESCRIBED.—

17 (1) IN GENERAL.—The pilot program described
18 in this subsection is a program that applies one or
19 more of the accountable care organization models
20 described in section 1866E of the Social Security
21 Act, as added by section 1301 of this Act.

22 (2) LIMITATION.—The pilot program shall op-
23 erate for a period of not more than 5 years.

24 (c) ADDITIONAL INCENTIVES.—In the case of the
25 pilot program under this section, the Secretary may—

1 (1) waive the requirements of—

2 (A) section 1902(a)(1) of the Social Secu-
3 rity Act (relating to statewideness);

4 (B) section 1902(a)(10)(B) of such Act
5 (relating to comparability); and

6 (2) increase the matching percentage for ad-
7 ministrative expenditures up to—

8 (A) 90 percent (for the first 2 years of the
9 pilot program); and

10 (B) 75 percent (for the next 3 years).

11 (d) EVALUATION; REPORT.—

12 (1) EVALUATION.—The Secretary shall conduct
13 an evaluation of the pilot program under this sec-
14 tion. In conducting such evaluation, the Secretary
15 shall use the criteria used under subsection (g)(1) of
16 section 1866E of the Social Security Act (as in-
17 serted by section 1301 of this Act) to evaluate pilot
18 programs under such section.

19 (2) REPORT.—Not later than 60 days after the
20 date of completion of the evaluation under para-
21 graph (1), the Secretary shall submit to Congress
22 and make available to the public a report on the
23 findings of the evaluation under such paragraph.

1 **SEC. 1730B. FQHC COVERAGE.**

2 Section 1905(l)(2)(B) of the Social Security Act (42
3 U.S.C. 1396d(l)(2)(B)) is amended—

4 (1) by striking “or” at the end of clause (iii);

5 (2) by striking the semicolon at the end of
6 clause (iv) and inserting “, and”; and

7 (3) by inserting after clause (iv) the following
8 new clause:

9 “(v) is receiving a grant under section 399Z–1
10 of the Public Health Service Act;”.

11 **Subtitle D—Coverage**

12 **SEC. 1731. OPTIONAL MEDICAID COVERAGE OF LOW-IN-**
13 **COME HIV-INFECTED INDIVIDUALS.**

14 (a) IN GENERAL.— Section 1902 of the Social Secu-
15 rity Act (42 U.S.C. 1396a), as amended by section
16 1714(a)(1), is amended—

17 (1) in subsection (a)(10)(A)(ii)—

18 (A) by striking “or” at the end of sub-
19 clause (XIX);

20 (B) by adding “or” at the end of subclause
21 (XX); and

22 (C) by adding at the end the following:

23 “(XXI) who are described in sub-
24 section (ii) (relating to HIV-infected
25 individuals);”; and

1 (2) by adding at the end, as amended by sec-
2 tions 1703 and 1714(a), the following:

3 “(ii) Individuals described in this subsection are indi-
4 viduals not described in subsection (a)(10)(A)(i)—

5 “(1) who have HIV infection;

6 “(2) whose income (as determined under the
7 State plan under this title with respect to disabled
8 individuals) does not exceed the maximum amount
9 of income a disabled individual described in sub-
10 section (a)(10)(A)(i) may have and obtain medical
11 assistance under the plan; and

12 “(3) whose resources (as determined under the
13 State plan under this title with respect to disabled
14 individuals) do not exceed the maximum amount of
15 resources a disabled individual described in sub-
16 section (a)(10)(A)(i) may have and obtain medical
17 assistance under the plan.”.

18 (b) ENHANCED MATCH.—The first sentence of sec-
19 tion 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended
20 by striking “section 1902(a)(10)(A)(ii)(XVIII)” and in-
21 serting “subclause (XVIII) or (XXI) of section
22 1902(a)(10)(A)(ii)”.

23 (c) CONFORMING AMENDMENTS.—Section 1905(a) of
24 such Act (42 U.S.C. 1396d(a)) is amended, in the matter
25 preceding paragraph (1)—

1 (1) by striking “or” at the end of clause (xii);

2 (2) by adding “or” at the end of clause (xiii);

3 and

4 (3) by inserting after clause (xiii) the following:

5 “(xiv) individuals described in section
6 1902(ii),”.

7 (d) EXEMPTION FROM FUNDING LIMITATION FOR
8 TERRITORIES.—Section 1108(g) of the Social Security
9 Act (42 U.S.C. 1308(g)) is amended by adding at the end
10 the following:

11 “(5) DISREGARDING MEDICAL ASSISTANCE FOR
12 OPTIONAL LOW-INCOME HIV-INFECTED INDIVID-
13 UALS.—The limitations under subsection (f) and the
14 previous provisions of this subsection shall not apply
15 to amounts expended for medical assistance for indi-
16 viduals described in section 1902(ii) who are only el-
17 igible for such assistance on the basis of section
18 1902(a)(10)(A)(ii)(XXI).”.

19 (e) EFFECTIVE DATE; SUNSET.—The amendments
20 made by this section shall apply to expenditures for cal-
21 endar quarters beginning on or after the date of the enact-
22 ment of this Act, and before January 1, 2013, without
23 regard to whether or not final regulations to carry out
24 such amendments have been promulgated by such date.

1 **SEC. 1732. EXTENDING TRANSITIONAL MEDICAID ASSIST-**
2 **ANCE (TMA).**

3 Sections 1902(e)(1)(B) and 1925(f) of the Social Se-
4 curity Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)), as
5 amended by section 5004(a)(1) of the American Recovery
6 and Reinvestment Act of 2009 (Public Law 111-5), are
7 each amended by striking “December 31, 2010” and in-
8 serting “December 31, 2012”.

9 **SEC. 1733. REQUIREMENT OF 12-MONTH CONTINUOUS COV-**
10 **ERAGE UNDER CERTAIN CHIP PROGRAMS.**

11 (a) IN GENERAL.—Section 2102(b) of the Social Se-
12 curity Act (42 U.S.C. 1397bb(b)) is amended by adding
13 at the end the following new paragraph:

14 “(6) REQUIREMENT FOR 12-MONTH CONTIN-
15 UOUS ELIGIBILITY.—In the case of a State child
16 health plan that provides child health assistance
17 under this title through a means other than de-
18 scribed in section 2101(a)(2), the plan shall provide
19 for implementation under this title of the 12-month
20 continuous eligibility option described in section
21 1902(e)(12) for targeted low-income children whose
22 family income is below 200 percent of the poverty
23 line.”.

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply to determinations (and redeter-
26 minations) of eligibility made on or after January 1, 2010.

1 **SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF**
2 **COVERAGE WAITING PERIODS FOR CERTAIN**
3 **CHILDREN.**

4 (a) IN GENERAL.—Section 2102(b)(1) of the Social
5 Security Act (42 U.S.C. 1397bb(b)(1)) is amended—

6 (1) in subparagraph (B)—

7 (A) in clause (iii), by striking “and” at the
8 end;

9 (B) in clause (iv), by striking the period at
10 the end and inserting “; and”; and

11 (C) by adding at the end the following new
12 clause:

13 “(v) may not apply a waiting period
14 (including a waiting period to carry out
15 paragraph (3)(C)) in the case of a child
16 described in subparagraph (C).”; and

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(C) DESCRIPTION OF CHILDREN NOT
20 SUBJECT TO WAITING PERIOD.—For purposes
21 of this paragraph, a child described in this sub-
22 paragraph is a child who, on the date an appli-
23 cation is submitted for such child for child
24 health assistance under this title, meets any of
25 the following requirements:

1 “(i) INFANTS AND TODDLERS.—The
2 child is under two years of age.

3 “(ii) LOSS OF GROUP HEALTH PLAN
4 COVERAGE.—The child previously had pri-
5 vate health insurance coverage through a
6 group health plan or health insurance cov-
7 erage offered through an employer and lost
8 such coverage due to—

9 “(I) termination of an individ-
10 ual’s employment;

11 “(II) a reduction in hours that
12 an individual works for an employer;

13 “(III) elimination of an individ-
14 ual’s retiree health benefits; or

15 “(IV) termination of an individ-
16 ual’s group health plan or health in-
17 surance coverage offered through an
18 employer.

19 “(iii) UNAFFORDABLE PRIVATE COV-
20 ERAGE.—

21 “(I) IN GENERAL.—The family of
22 the child demonstrates that the cost
23 of health insurance coverage (includ-
24 ing the cost of premiums, co-pay-
25 ments, deductibles, and other cost

1 sharing) for such family exceeds 10
2 percent of the income of such family.

3 “(II) DETERMINATION OF FAM-
4 ILY INCOME.—For purposes of sub-
5 clause (I), family income shall be de-
6 termined in the same manner speci-
7 fied by the State for purposes of de-
8 termining a child’s eligibility for child
9 health assistance under this title.”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect as of the date that is 90 days
12 after the date of the enactment of this Act.

13 **SEC. 1735. ADULT DAY HEALTH CARE SERVICES.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall not—

16 (1) withhold, suspend, disallow, or otherwise
17 deny Federal financial participation under section
18 1903(a) of the Social Security Act (42 U.S.C.
19 1396b(a)) for the provision of adult day health care
20 services, day activity and health services, or adult
21 medical day care services, as defined under a State
22 Medicaid plan approved during or before 1994, dur-
23 ing such period if such services are provided con-
24 sistent with such definition and the requirements of
25 such plan; or

1 (b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—
2 Section 403(d) of such Act (8 U.S.C. 1613(d)) is amend-
3 ed—

4 (1) in paragraph (1), by striking “or” at the
5 end;

6 (2) in paragraph (2), by striking the period at
7 the end and inserting “; or”; and

8 (3) by adding at the end the following:

9 “(3) an individual described in section
10 402(b)(2)(G), but only with respect to the des-
11 ignated Federal program defined in section
12 402(b)(3)(C).”.

13 (c) DEFINITION OF QUALIFIED ALIEN.—Section
14 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

15 (1) in paragraph (6), by striking “; or” at the
16 end and inserting a comma;

17 (2) in paragraph (7), by striking the period at
18 the end and inserting “, or”; and

19 (3) by adding at the end the following:

20 “(8) an individual who lawfully resides in the
21 United States in accordance with a Compact of Free
22 Association referred to in section 402(b)(2)(G), but
23 only with respect to the designated Federal program
24 defined in section 402(b)(3)(C) (relating to the Med-
25 icaid program).”.

1 **SEC. 1737. CONTINUING REQUIREMENT OF MEDICAID COV-**
2 **ERAGE OF NONEMERGENCY TRANSPOR-**
3 **TATION TO MEDICALLY NECESSARY SERV-**
4 **ICES.**

5 (a) REQUIREMENT.—Section 1902(a)(10) of the So-
6 cial Security Act (42 U.S.C. 1396a(a)(10)) is amended—

7 (1) in subparagraph (A), in the matter pre-
8 ceding clause (i), by striking “and (21)” and insert-
9 ing “, (21), and (30)”; and

10 (2) in subparagraph (C)(iv), by striking “and
11 (17)” and inserting “, (17), and (30)”.

12 (b) DESCRIPTION OF SERVICES.—Section 1905(a) of
13 such Act (42 U.S.C. 1395d(a)), as amended by sections
14 1713(a)(1) and 1724(a)(1), is amended—

15 (1) in paragraph (29), by striking “and” at the
16 end;

17 (2) by redesignating paragraph (30) as para-
18 graph (31) and by striking the comma at the end
19 and inserting a semicolon; and

20 (3) by inserting after paragraph (29) the fol-
21 lowing new paragraph:

22 “(30) nonemergency transportation to medically
23 necessary services, consistent with the requirement
24 of section 431.53 of title 42, Code of Federal Regu-
25 lations, as in effect as of June 1, 2008; and”.

1 (c) **EFFECTIVE DATE.**—The amendments made by
2 this section shall take effect on the date of the enactment
3 of this Act and shall apply to transportation on or after
4 such date.

5 **SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME**
6 **IN PROVIDING CONTINUED MEDICAID COV-**
7 **ERAGE FOR CERTAIN INDIVIDUALS WITH EX-**
8 **TREMELY HIGH PRESCRIPTION COSTS.**

9 Section 1902(e) of the Social Security Act (42 U.S.C.
10 1396b(e)), as amended by section 203(a) of the Children’s
11 Health Insurance Program Reauthorization Act of 2009
12 (Public Law 111–3), is amended by adding at the end the
13 following new paragraph:

14 “(14)(A) At the option of the State, in the case of
15 an individual with extremely high prescription drug costs
16 described in subparagraph (B) who has been determined
17 (without the application of this paragraph) to be eligible
18 for medical assistance under this title, the State may, in
19 redetermining the individual’s eligibility for medical assist-
20 ance under this title, disregard any family income of the
21 individual to the extent such income is less than an
22 amount that is specified by the State and does not exceed
23 the amount specified in subparagraph (C), or, if greater,
24 income equal to the cost of the orphan drugs described
25 in subparagraph (B)(iii).

1 “(B) An individual with extremely high prescription
2 drug costs described in this subparagraph for a 12-month
3 period is an individual—

4 “(i) who is covered under health insurance or a
5 health benefits plan that has a maximum lifetime
6 limit of not less than \$1,000,000 which includes all
7 prescription drug coverage;

8 “(ii) who has exhausted all available prescrip-
9 tion drug coverage under the plan as of the begin-
10 ning of such period;

11 “(iii) who incurs (or is reasonably expected to
12 incur) on an annual basis during the period costs for
13 orphan drugs in excess of the amount specified in
14 subparagraph (C) for the period; and

15 “(iv) whose annual family income (determined
16 without regard to this paragraph) as of the begin-
17 ning of the period does not exceed 75 percent of the
18 amount incurred for such drugs (as described in
19 clause (iii)).

20 “(C) The amount specified in this subparagraph for
21 a 12-month period beginning in—

22 “(i) 2009 or 2010, is \$200,000; or

23 “(ii) a subsequent year, is the amount specified
24 in clause (i) (or this subparagraph) for the previous
25 year increased by the annual rate of increase in the

1 medical care component of the consumer price index
2 (U.S. city average) for the 12-month period ending
3 in August of the previous year.

4 Any amount computed under clause (ii) that is not a mul-
5 tiple of \$1,000 shall be rounded to the nearest multiple
6 of \$1,000.

7 “(D) In applying this paragraph, amounts incurred
8 for prescription drugs for cosmetic purposes shall not be
9 taken into account.

10 “(E) With respect to an individual described in sub-
11 paragraph (A), notwithstanding section 1916, the State
12 plan—

13 “(i) shall provide for the application of cost-
14 sharing that is at least nominal as determined under
15 section 1916; and

16 “(ii) may provide, consistent with section
17 1916A, for such additional cost-sharing as does not
18 exceed a maximum level of cost-sharing that is speci-
19 fied by the Secretary and is adjusted by the Sec-
20 retary on an annual basis.

21 “(F) A State electing the option under this para-
22 graph shall provide for a determination on an individual’s
23 application for continued medical assistance under this
24 title within 30 days of the date the application is filed with
25 the State.

1 “(G) In this paragraph:

2 “(i) The term ‘orphan drugs’ means prescrip-
3 tion drugs designated under section 526 of the Fed-
4 eral Food, Drug, and Cosmetic Act (21 U.S.C.
5 360bb) as a drug for a rare disease or condition.

6 “(ii) The term ‘health benefits plan’ includes
7 coverage under a plan offered under a State high
8 risk pool.”.

9 **SEC. 1739. PROVISIONS RELATING TO COMMUNITY LIVING**
10 **ASSISTANCE SERVICES AND SUPPORTS**
11 **(CLASS).**

12 (a) COORDINATION WITH CLASS PROVISIONS.—
13 Section 1902(a) of the Social Security Act (42 U.S.C.
14 1396a(a)), as amended by sections 1631(b), 1703(a),
15 1729, 1753, 1757(a), 1759(a), 1783(a), and 1907(b), is
16 amended—

17 (1) in paragraph (80), by striking “and” at the
18 end;

19 (2) in paragraph (81), by striking the period
20 and inserting “; and”; and

21 (3) by inserting after paragraph (81) the fol-
22 lowing:

23 “(82) provide that the State will comply with
24 such regulations regarding the application of pri-
25 mary and secondary payor rules with respect to indi-

1 viduals who are eligible for medical assistance under
2 this title and are eligible beneficiaries under the
3 CLASS program established under title XXXII of
4 the Public Health Service Act as the Secretary shall
5 establish.”.

6 (b) ASSURANCE OF ADEQUATE INFRASTRUCTURE
7 FOR THE PROVISION OF PERSONAL CARE ATTENDANT
8 WORKERS.—Section 1902(a) of such Act (42 U.S.C.
9 1396a(a)), as amended by subsection (a), is amended—

10 (1) in paragraph (81), by striking “and” at the
11 end;

12 (2) in paragraph (82), by striking the period at
13 the end and inserting “; and”; and

14 (3) by inserting after paragraph (82), the fol-
15 lowing:

16 “(83) provide that, not later than 2 years after
17 the date of enactment of this paragraph, each State
18 shall—

19 “(A) assess the extent to which entities
20 such as providers of home care, home health
21 services, home and community service providers,
22 public authorities created to provide personal
23 care services to individuals eligible for medical
24 assistance under the State plan, and nonprofit
25 organizations, are serving or have the capacity

1 to serve as fiscal agents for, employers of, and
2 providers of employment-related benefits for,
3 personal care attendant workers who provide
4 personal care services to individuals receiving
5 benefits under the CLASS program established
6 under title XXXII of the Public Health Service
7 Act, including in rural and underserved areas;

8 “(B) designate or create such entities to
9 serve as fiscal agents for, employers of, and
10 providers of employment-related benefits for,
11 such workers to ensure an adequate supply of
12 the workers for individuals receiving benefits
13 under the CLASS program, including in rural
14 and underserved areas; and

15 “(C) ensure that the designation or cre-
16 ation of such entities will not negatively alter or
17 impede existing programs, models, methods, or
18 administration of service delivery that provide
19 for consumer controlled or self-directed home
20 and community services and further ensure that
21 such entities will not impede the ability of indi-
22 viduals to direct and control their home and
23 community services, including the ability to se-
24 lect, manage, dismiss, co-employ, or employ
25 such workers or inhibit such individuals from

1 relying on family members for the provision of
2 personal care services.”.

3 (c) INCLUSION OF INFORMATION ON SUPPLEMENTAL
4 COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR
5 LONG-TERM CARE INFORMATION; EXTENSION OF FUND-
6 ING.—Section 6021(d) of the Deficit Reduction Act of
7 2005 (42 U.S.C. 1396p note) is amended—

8 (1) in paragraph (2)(A)—

9 (A) in clause (ii), by striking “and” at the
10 end;

11 (B) in clause (iii), by striking the period at
12 the end and inserting “; and”; and

13 (C) by adding at the end the following:

14 “(iv) include information regarding
15 the CLASS program established under
16 title XXXII of the Public Health Service
17 Act.”; and

18 (2) in paragraph (3)—

19 (A) by striking “2010” and inserting
20 “2015”; and

21 (B) by adding at the end the following: “In
22 addition to the amount appropriated under the
23 previous sentence, there are authorized to be
24 appropriated to carry out this subsection,

1 \$7,000,000 for each of fiscal years 2011, 2012,
2 and 2013.”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section take effect on January 1, 2011.

5 **Subtitle E—Financing**

6 **SEC. 1741. PAYMENTS TO PHARMACISTS.**

7 (a) PHARMACY REIMBURSEMENT LIMITS.—

8 (1) IN GENERAL.—Section 1927(e) of the So-
9 cial Security Act (42 U.S.C. 1396r–8(e)) is amend-
10 ed—

11 (A) by striking paragraph (5) and insert-
12 ing the following:

13 “(5) USE OF AMP IN UPPER PAYMENT LIM-
14 ITS.—The Secretary shall calculate the Federal
15 upper reimbursement limit established under para-
16 graph (4) as 130 percent of the weighted average
17 (determined on the basis of manufacturer utiliza-
18 tion) of monthly average manufacturer prices. Noth-
19 ing in the previous sentence shall be construed as
20 preventing the Secretary from performing such cal-
21 culation using a smoothing process in order to re-
22 duce significant variations from month to month as
23 a result of rebates, discounts, and other pricing
24 practices, such as in the manner such a process is
25 used by the Secretary in determining the average

1 sales price of a drug or biological under section
2 1847A.”

3 (2) DEFINITION OF AMP.—Section
4 1927(k)(1)(B) of such Act (42 U.S.C. 1396r–
5 8(k)(1)(B)) is amended—

6 (B) in the heading, by striking “EX-
7 TENDED TO WHOLESALERS” and inserting
8 “AND OTHER PAYMENTS”; and

9 (C) by striking “regard to” and all that
10 follows through the period and inserting the fol-
11 lowing: “regard to—

12 “(i) customary prompt pay discounts
13 extended to wholesalers;

14 “(ii) bona fide service fees paid by
15 manufacturers;

16 “(iii) reimbursement by manufactur-
17 ers for recalled, damaged, expired, or oth-
18 erwise unsalable returned goods, including
19 reimbursement for the cost of the goods
20 and any reimbursement of costs associated
21 with return goods handling and processing,
22 reverse logistics, and drug destruction;

23 “(iv) sales directly to, or rebates, dis-
24 counts, or other price concessions provided
25 to, pharmacy benefit managers, managed

1 care organizations, health maintenance or-
2 ganizations, insurers, mail order phar-
3 macies that are not open to all members of
4 the public, or long term care providers,
5 provided that these rebates, discounts, or
6 price concessions are not passed through to
7 retail pharmacies;

8 “(v) sales directly to, or rebates, dis-
9 counts, or other price concessions provided
10 to, hospitals, clinics, and physicians, unless
11 the drug is an inhalation, infusion, or
12 injectable drug, or unless the Secretary de-
13 termines, as allowed for in Agency admin-
14 istrative procedures, that it is necessary to
15 include such sales, rebates, discounts, and
16 price concessions in order to obtain an ac-
17 curate AMP for the drug. Such a deter-
18 mination shall not be subject to judicial re-
19 view; or

20 “(vi) rebates, discounts, and other
21 price concessions required to be provided
22 under agreements under subsections (f)
23 and (g) of section 1860D–2(f).”.

1 (3) MANUFACTURER REPORTING REQUIRE-
2 MENTS.—Section 1927(b)(3)(A) of such Act (42
3 U.S.C. 1396r–8(b)(3)(A)) is amended—

4 (A) in clause (ii), by striking “and” at the
5 end;

6 (B) by striking the period at the end of
7 clause (iii) and inserting “; and”; and

8 (C) by inserting after clause (iii) the fol-
9 lowing new clause:

10 “(iv) not later than 30 days after the
11 last day of each month of a rebate period
12 under the agreement, on the manufactur-
13 er’s total number of units that are used to
14 calculate the monthly average manufac-
15 turer price for each covered outpatient
16 drug.”.

17 (4) AUTHORITY TO PROMULGATE REGULA-
18 TION.—The Secretary of Health and Human Serv-
19 ices may promulgate regulations to clarify the re-
20 quirements for upper payment limits and for the de-
21 termination of the average manufacturer price in an
22 expedited manner. Such regulations may become ef-
23 fective on an interim final basis, pending oppor-
24 tunity for public comment.

1 (5) PHARMACY REIMBURSEMENTS THROUGH
2 DECEMBER 31, 2010.—The specific upper limit under
3 section 447.332 of title 42, Code of Federal Regula-
4 tions (as in effect on December 31, 2006) applicable
5 to payments made by a State for multiple source
6 drugs under a State Medicaid plan shall continue to
7 apply through December 31, 2010, for purposes of
8 the availability of Federal financial participation for
9 such payments.

10 (b) DISCLOSURE OF PRICE INFORMATION TO THE
11 PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C.
12 1396r-8(b)(3)) is amended—

13 (1) in subparagraph (A)—

14 (A) in clause (i), in the matter preceding
15 subclause (I), by inserting “month of a” after
16 “each”; and

17 (B) in the last sentence, by striking “and
18 shall,” and all that follows up to the period;
19 and

20 (2) in subparagraph (D)(v), by inserting
21 “weighted” before “average manufacturer prices”.

22 **SEC. 1742. PRESCRIPTION DRUG REBATES.**

23 (a) ADDITIONAL REBATE FOR NEW FORMULATIONS
24 OF EXISTING DRUGS.—

1 (1) IN GENERAL.—Section 1927(c)(2) of the
2 Social Security Act (42 U.S.C. 1396r–8(c)(2)) is
3 amended by adding at the end the following new
4 subparagraph:

5 “(C) TREATMENT OF NEW FORMULA-
6 TIONS.—In the case of a drug that is a line ex-
7 tension of a single source drug or an innovator
8 multiple source drug that is an oral solid dos-
9 age form, the rebate obligation with respect to
10 such drug under this section shall be the
11 amount computed under this section for such
12 new drug or, if greater, the product of—

13 “(i) the average manufacturer price of
14 the line extension of a single source drug
15 or an innovator multiple source drug that
16 is an oral solid dosage form;

17 “(ii) the highest additional rebate
18 (calculated as a percentage of average
19 manufacturer price) under this section for
20 any strength of the original single source
21 drug or innovator multiple source drug;
22 and

23 “(iii) the total number of units of
24 each dosage form and strength of the line
25 extension product paid for under the State

1 plan in the rebate period (as reported by
2 the State).

3 In this subparagraph, the term ‘line extension’
4 means, with respect to a drug, a new formula-
5 tion of the drug, such as an extended release
6 formulation.”.

7 (2) EFFECTIVE DATE.—The amendment made
8 by paragraph (1) shall apply to drugs dispensed
9 after December 31, 2009.

10 (b) INCREASE MINIMUM REBATE PERCENTAGE FOR
11 SINGLE SOURCE DRUGS.—

12 (1) IN GENERAL.—Section 1927(c)(1)(B)(i) of
13 the Social Security Act (42 U.S.C. 1396r-
14 8(c)(1)(B)(i)) is amended—

15 (A) in subclause (IV), by striking “and” at
16 the end;

17 (B) in subclause (V)—

18 (i) by inserting “and before January
19 1, 2010” after “December 31, 1995,”; and

20 (ii) by striking the period at the end
21 and inserting “; and”; and

22 (C) by adding at the end the following new
23 subclause:

24 “(VI) after December 31, 2009,
25 is 23.1 percent.”.

1 (2) RECAPTURE OF TOTAL SAVINGS DUE TO IN-
2 CREASE.—Section 1927(b)(1) of such Act is amend-
3 ed by adding at the end the following new subpara-
4 graph:

5 “(C) SPECIAL RULE FOR INCREASED MIN-
6 IMUM REBATE PERCENTAGE.—

7 “(i) IN GENERAL.—In addition to the
8 amounts applied as a reduction under sub-
9 paragraph (B), for rebate periods begin-
10 ning on or after January 1, 2010, during
11 a fiscal year, the Secretary shall reduce
12 payments to a State under section 1903(a)
13 in the manner specified in clause (ii), in an
14 amount equal to the product of—

15 “(I) 100 percent minus the Fed-
16 eral medical assistance percentage ap-
17 plicable to the rebate period for the
18 State; and

19 “(II) the amounts received by the
20 State under such subparagraph that
21 are attributable (as estimated by the
22 Secretary based on utilization and
23 other data) to the increase in the min-
24 imum rebate percentage effected by
25 the amendments made by section

1 1742(b)(1) of the Affordable Health
2 Care for America Act, taking into ac-
3 count the additional drugs included
4 under the amendments made by sec-
5 tion 1743 of such Act.

6 The Secretary shall adjust such payment
7 reduction for a calendar quarter to the ex-
8 tent the Secretary determines, based upon
9 subsequent utilization and other data, that
10 the reduction for such quarter was greater
11 or less than the amount of payment reduc-
12 tion that should have been made.

13 “(ii) MANNER OF PAYMENT REDUC-
14 TION.—The amount of the payment reduc-
15 tion under clause (i) for a State for a
16 quarter shall be deemed an overpayment to
17 the State under this title to be disallowed
18 against the State’s regular quarterly draw
19 for all Medicaid spending under section
20 1903(d)(2). Such a disallowance is not
21 subject to a reconsideration under
22 1116(d).”.

1 **SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DIS-**
2 **COUNTS TO ENROLLEES OF MEDICAID MAN-**
3 **AGED CARE ORGANIZATIONS.**

4 (a) IN GENERAL.—Section 1903(m)(2)(A) of the So-
5 cial Security Act (42 U.S.C. 1396b(m)(2)(A)) is amend-
6 ed—

7 (1) in clause (xi), by striking “and” at the end;

8 (2) in clause (xii), by striking the period at the
9 end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(xiii) such contract provides that the entity
12 shall report to the State such information, on such
13 timely and periodic basis as specified by the Sec-
14 retary, as the State may require in order to include,
15 in the information submitted by the State to a man-
16 ufacturer under section 1927(b)(2)(A) and to the
17 Secretary under section 1927(b)(2)(C), information
18 on covered outpatient drugs dispensed to individuals
19 eligible for medical assistance who are enrolled with
20 the entity and for which the entity is responsible for
21 coverage of such drugs under this subsection.”.

22 (b) CONFORMING AMENDMENTS.—Section 1927 of
23 such Act (42 U.S.C. 1396r-8) is amended—

24 (1) in the first sentence of subsection (b)(1)(A),
25 by inserting before the period at the end the fol-
26 lowing: “, including such drugs dispensed to individ-

1 uals enrolled with a medicaid managed care organi-
2 zation if the organization is responsible for coverage
3 of such drugs”;

4 (2) in subsection (b)(2), by adding at the end
5 the following new subparagraph:

6 “(C) REPORTING ON MMCO DRUGS.—On a
7 quarterly basis, each State shall report to the
8 Secretary the total amount of rebates in dollars
9 received from pharmacy manufacturers for
10 drugs provided to individuals enrolled with
11 Medicaid managed care organizations that con-
12 tract under section 1903(m) and such other in-
13 formation as the Secretary may require to carry
14 out paragraph (1)(C) with respect to such re-
15 bates.”; and

16 (3) in subsection (j)—

17 (A) in the heading by striking “EXEMP-
18 TION” and inserting “SPECIAL RULES”; and

19 (B) in paragraph (1), by striking “are not
20 subject to the requirements of this section” and
21 inserting “are subject to the requirements of
22 this section unless such drugs are subject to
23 discounts under section 340B of the Public
24 Health Service Act”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section take effect on January 1, 2010, and shall
3 apply to drugs dispensed on or after such date, without
4 regard to whether or not final regulations to carry out
5 such amendments have been promulgated by such date.

6 **SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDU-**
7 **CATION.**

8 (a) IN GENERAL.—Section 1905 of the Social Secu-
9 rity Act (42 U.S.C. 1396d), as amended by sections
10 1701(a)(3)(B), 1711(a), and 1713(a), is amended by add-
11 ing at the end the following new subsection:

12 “(bb) PAYMENT FOR GRADUATE MEDICAL EDU-
13 CATION.—

14 “(1) IN GENERAL.—The term ‘medical assist-
15 ance’ includes payment for costs of graduate medical
16 education consistent with this subsection, whether
17 provided in or outside of a hospital.

18 “(2) SUBMISSION OF INFORMATION.—For pur-
19 poses of paragraph (1) and section
20 1902(a)(13)(A)(v), payment for such costs is not
21 consistent with this subsection unless—

22 “(A) the State submits to the Secretary, in
23 a timely manner and on an annual basis speci-
24 fied by the Secretary, information on total pay-
25 ments for graduate medical education and how

1 such payments are being used for graduate
2 medical education, including—

3 “(i) the institutions and programs eli-
4 gible for receiving the funding;

5 “(ii) the manner in which such pay-
6 ments are calculated;

7 “(iii) the types and fields of education
8 being supported;

9 “(iv) the workforce or other goals to
10 which the funding is being applied;

11 “(v) State progress in meeting such
12 goals; and

13 “(vi) such other information as the
14 Secretary determines will assist in carrying
15 out paragraphs (3) and (4); and

16 “(B) such expenditures are made con-
17 sistent with such goals and requirements as are
18 established under paragraph (4).

19 “(3) REVIEW OF INFORMATION.—The Secretary
20 shall make the information submitted under para-
21 graph (2) available to the Advisory Committee on
22 Health Workforce Evaluation and Assessment (es-
23 tablished under section 2261 of the Public Health
24 Service Act). The Secretary and the Advisory Com-
25 mittee shall independently review the information

1 submitted under paragraph (2), taking into account
2 State and local workforce needs.

3 “(4) SPECIFICATION OF GOALS AND REQUIRE-
4 MENTS.—The Secretary shall specify by rule, ini-
5 tially published by not later than December 31,
6 2011—

7 “(A) program goals for the use of funds
8 described in paragraph (1), taking into account
9 recommendations of the such Advisory Com-
10 mittee and the goals for approved medical resi-
11 dency training programs described in section
12 1886(h)(1)(B); and

13 “(B) requirements for use of such funds
14 consistent with such goals.

15 Such rule may be effective on an interim basis pend-
16 ing revision after an opportunity for public com-
17 ment.”.

18 (b) CONFORMING AMENDMENT.—Section
19 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)),
20 as amended by section 1721(a)(1)(A), is amended—

21 (1) by striking “and” at the end of clause (iii);

22 (2) by striking the semicolon in clause (iv) and
23 inserting “, and”; and

24 (3) by adding at the end the following new
25 clause:

1 “(v) in the case of hospitals and at
2 the option of a State, such rates may in-
3 clude, to the extent consistent with section
4 1905(bb), payment for graduate medical
5 education; and”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall take effect on the date of the enactment
8 of this Act. Nothing in this section shall be construed as
9 affecting payments made before such date under a State
10 plan under title XIX of the Social Security Act for grad-
11 uate medical education.

12 **SEC. 1745. NURSING FACILITY SUPPLEMENTAL PAYMENT**
13 **PROGRAM.**

14 (a) TOTAL AMOUNT AVAILABLE FOR PAYMENTS.—

15 (1) IN GENERAL.—Out of any funds in the
16 Treasury not otherwise appropriated, there are ap-
17 propriated to the Secretary of Health and Human
18 Services (in this section referred to as the “Sec-
19 retary”) to carry out this section \$6,000,000,000, of
20 which the following amounts shall be available for
21 obligation in the following years:

22 (A) \$1,500,000,000 shall be available be-
23 ginning in 2010.

24 (B) \$1,500,000,000 shall be available be-
25 ginning in 2011.

1 (C) \$1,500,000,000 shall be available be-
2 ginning in 2012.

3 (D) \$1,500,000,000 shall be available be-
4 ginning in 2013.

5 (2) AVAILABILITY.—Funds appropriated under
6 paragraph (1) shall remain available until all eligible
7 dually-certified facilities (as defined in subsection
8 (b)(3)) have been reimbursed for underpayments
9 under this section during cost reporting periods end-
10 ing during calendar years 2010 through 2013.

11 (3) LIMITATION OF AUTHORITY.—The Sec-
12 retary may not may payments under this section
13 that exceed the funds appropriated under paragraph
14 (1).

15 (4) DISPOSITION OF REMAINING FUNDS INTO
16 MIF.—Any funds appropriated under paragraph (1)
17 which remain available after the application of para-
18 graph (2) shall be deposited into the Medicaid Im-
19 provement Fund under section 1941 of the Social
20 Security Act.

21 (b) USE OF FUNDS.—

22 (1) AUTHORITY TO MAKE PAYMENTS.—From
23 the amounts available for obligation in a year under
24 subsection (a), the Secretary, acting through the Ad-
25 ministrator of the Centers for Medicare & Medicaid

1 Services, shall pay the amount determined under
2 paragraph (2) directly to an eligible dually-certified
3 facility for the purpose of providing funding to reim-
4 burse such facility for furnishing quality care to
5 Medicaid-eligible individuals.

6 (2) DETERMINATION OF PAYMENT AMOUNTS.—

7 (A) IN GENERAL.—Subject to subpara-
8 graphs (B) and (C), the payment amount deter-
9 mined under this paragraph for a year for an
10 eligible dually-certified facility shall be an
11 amount determined by the Secretary as re-
12 ported on the facility's latest available Medicare
13 cost report.

14 (B) LIMITATION ON PAYMENT AMOUNT.—

15 In no case shall the payment amount for an eli-
16 gible dually-certified facility for a year under
17 subparagraph (A) be more than the payment
18 deficit described in paragraph (3)(D) for such
19 facility as reported on the facility's latest avail-
20 able Medicare cost report.

21 (C) PRO-RATA REDUCTION.—If the
22 amount available for obligation under sub-
23 section (a) for a year (as reduced by allowable
24 administrative costs under this section) is insuf-
25 ficient to ensure that each eligible dually-cer-

1 tified facility receives the amount of payment
2 calculated under subparagraph (A), the Sec-
3 retary shall reduce that amount of payment
4 with respect to each such facility in a pro-rata
5 manner to ensure that the entire amount avail-
6 able for such payments for the year be paid.

7 (D) NO REQUIRED MATCH.—The Secretary
8 may not require that a State provide matching
9 funds for any payment made under this sub-
10 section.

11 (3) ELIGIBLE DUALY-CERTIFIED FACILITY DE-
12 FINED.—For purposes of this section, the term “eli-
13 gible dually-certified facility” means, for a cost re-
14 porting period ending during a year (beginning no
15 earlier than 2010) that is covered by the latest avail-
16 able Medicare cost report, a nursing facility that
17 meets all of the following requirements:

18 (A) The facility is participating as a nurs-
19 ing facility under title XIX of the Social Secu-
20 rity Act and as a skilled nursing facility under
21 title XVIII of such Act during the entire year.

22 (B) The base Medicaid payment rate (ex-
23 cluding any supplemental payments) to the fa-
24 cility is not less than the base Medicaid pay-

1 ment rate (excluding any supplemental pay-
2 ments) to such facility as of June 16, 2009.

3 (C) As reported on the facility's latest
4 Medicare cost report—

5 (i) the Medicaid share of patient days
6 for such facility is not less than 60 percent
7 of the combined Medicare and Medicaid
8 share of resident days for such facility; and

9 (ii) the combined Medicare and Med-
10 icaid share of resident days for such facil-
11 ity, as reported on the facility's latest
12 available Medicare cost report, is not less
13 than 75 percent of the total resident days
14 for such facility.

15 (D) The facility has received Medicaid re-
16 imbursement (including any supplemental pay-
17 ments) for the provision of covered services to
18 Medicaid eligible individuals, as reported on the
19 facility's latest available Medicare cost report,
20 that is significantly less (as determined by the
21 Secretary) than the allowable costs (as deter-
22 mined by the Secretary) incurred by the facility
23 in providing such services.

24 (E) The facility is not in the highest quar-
25 tile of costs costs per day, as determined by the

1 Secretary and as adjusted for case mix, wages,
2 and type of facility.

3 (F) The facility provides quality care, as
4 determined by the Secretary, to—

5 (i) Medicaid eligible individuals; and

6 (ii) individuals who are entitled to
7 items and services under part A of title
8 XVIII of the Social Security Act.

9 (G) In the most recent standard survey
10 available, the facility was not cited for any im-
11 mediate jeopardy deficiencies as defined by the
12 Secretary.

13 (H) In the most recent standard survey
14 available, the facility maintains an appropriate
15 staffing level to attain or maintain the highest
16 practicable well-being of each resident as de-
17 fined by the Secretary

18 (I) The facility complies with all the re-
19 quirements, as determined by the Secretary,
20 contained in sections 1411 through 1416 and
21 the amendments made by such sections.

22 (J) The facility was not listed as a Centers
23 for Medicare & Medicaid Services Special Focus
24 Facility (SFF) nor as a SFF on a State-based
25 list.

1 (4) FREQUENCY OF PAYMENT.—Payment of an
2 amount under this subsection to an eligible dually-
3 certified facility shall be made for a year in a lump
4 sum or in such periodic payments in such frequency
5 as the Secretary determines appropriate.

6 (5) DIRECT PAYMENTS.—Such payment—

7 (A) shall be made directly by the Secretary
8 to an eligible dually-certified facility or a con-
9 tractor designated by such facility; and

10 (B) shall not be made through a State.

11 (c) ADMINISTRATION.—

12 (1) ANNUAL APPLICATIONS; DEADLINES.—The
13 Secretary shall establish a process, including dead-
14 lines, under which facilities may apply on an annual
15 basis to qualify as eligible dually-certified facilities
16 for payment under subsection (b).

17 (2) CONTRACTING AUTHORITY.—The Secretary
18 may enter into one or more contracts with entities
19 for the purpose of implementation of this section.

20 (3) LIMITATION.—The Secretary may not
21 spend more than 0.75 percent of the amount made
22 available under subsection (a) in any year on the
23 costs of administering the program of payments
24 under this section for the year.

1 (4) IMPLEMENTATION.—Notwithstanding any
2 other provision of law, the Secretary may implement,
3 by program instruction or otherwise, the provisions
4 of this section.

5 (5) LIMITATIONS ON REVIEW.—There shall be
6 no administrative or judicial review of—

7 (A) the determination of the eligibility of a
8 facility for payments under subsection (b); or

9 (B) the determination of the amount of
10 any payment made to a facility under such sub-
11 section.

12 (d) ANNUAL REPORTS.—The Secretary shall submit
13 an annual report to the committees with jurisdiction in
14 the Congress on payments made under subsection (b).
15 Each such report shall include information on—

16 (1) the facilities receiving such payments;

17 (2) the amount of such payments to such facili-
18 ties; and

19 (3) the basis for selecting such facilities and the
20 amount of such payments.

21 (e) REFERENCE TO REPORT.—For report by the
22 Medicaid and CHIP Payment and Access Commission on
23 the adequacy of payments to nursing facilities under the
24 Medicaid program, see section 1900(b)(2)(B) of the Social
25 Security Act, as amended by section 1784.

1 (f) DEFINITIONS.—For purposes of this section:

2 (1) DUALY-CERTIFIED FACILITY.—The term
3 “dually-certified facility” means a facility that is
4 participating as a nursing facility under title XIX of
5 the Social Security Act and as a skilled nursing fa-
6 cility under title XVIII of such Act.

7 (2) MEDICAID ELIGIBLE INDIVIDUAL.—The
8 term “Medicaid eligible individual” means an indi-
9 vidual who is eligible for medical assistance, with re-
10 spect to nursing facility services (as defined in sec-
11 tion 1905(f) of the Social Security Act), under title
12 XIX of the such Act.

13 (3) STATE.—The term “State” means the 50
14 States and the District of Columbia.

15 **SEC. 1746. REPORT ON MEDICAID PAYMENTS.**

16 Section 1902 of the Social Security Act (42 U.S.C.
17 1396), as amended by sections 1703(a), 1714(a), and
18 1731(a), is amended by adding at the end the following
19 new subsection:

20 “(jj) REPORT ON MEDICAID PAYMENTS.—Each year,
21 on or before a date determined by the Secretary, a State
22 participating in the Medicaid program under this title
23 shall submit to the Administrator of the Centers for Medi-
24 care & Medicaid Services—

1 “(1) information on the determination of rates
2 of payment to providers for covered services under
3 the State plan, including—

4 “(A) the final rates;

5 “(B) the methodologies used to determine
6 such rates; and

7 “(C) justifications for the rates; and

8 “(2) an explanation of the process used by the
9 State to allow providers, beneficiaries and their rep-
10 resentatives, and other concerned State residents a
11 reasonable opportunity to review and comment on
12 such rates, methodologies, and justifications before
13 the State made such rates final.”.

14 **SEC. 1747. REVIEWS OF MEDICAID.**

15 (a) GAO STUDY ON FMAP.—

16 (1) STUDY.—The Comptroller General of the
17 United States shall conduct a study regarding fed-
18 eral payments made to the State Medicaid programs
19 under title XIX of the Social Security Act for the
20 purposes of making recommendations to Congress.

21 (2) REPORT.—Not later than February 15,
22 2011, the Comptroller General shall submit to the
23 appropriate committees of Congress a report on the
24 study conducted under paragraph (1) and the effect

1 on the federal government, States, providers, and
2 beneficiaries of—

3 (A) removing the 50 percent floor, or 83
4 percent ceiling, or both, in the Federal medical
5 assistance percentage under section 1905(b)(1)
6 of the Social Security Act; and

7 (B) revising the current formula for such
8 Federal medical assistance percentage to better
9 reflect State fiscal capacity and State effort to
10 pay for health and long-term care services and
11 to better adjust for national or regional eco-
12 nomic downturns.

13 (b) GAO STUDY ON MEDICAID ADMINISTRATIVE
14 COSTS.—

15 (1) STUDY.—The Comptroller General of the
16 United States shall conduct a study of the adminis-
17 tration of the Medicaid program by the Department
18 of Health and Human Services, State Medicaid
19 agencies, and local government agencies. The report
20 shall address the following issues:

21 (A) The extent to which federal funds for
22 each administrative function, such as survey
23 and certification and claims processing, are
24 being used effectively and efficiently.

1 (B) The administrative functions on which
2 federal Medicaid funds are expended and the
3 amounts of such expenditures (whether spent
4 directly or by contract).

5 (2) REPORT.—Not later than February 15,
6 2011, the Comptroller General shall submit to the
7 appropriate committees of Congress a report on the
8 study conducted under paragraph (1).

9 **SEC. 1748. EXTENSION OF DELAY IN MANAGED CARE ORGA-**
10 **NIZATION PROVIDER TAX ELIMINATION.**

11 Effective as if included in the enactment of section
12 6051 of the Deficit Reduction Act of 2005 (Public Law
13 109–171), subsection (b)(2)(A) of such section is amended
14 by striking “October 1, 2009” and inserting “October 1,
15 2010”.

16 **SEC. 1749. EXTENSION OF ARRA INCREASE IN FMAP.**

17 Section 5001 of the American Recovery and Reinvest-
18 ment Act of 2009 (Public Law 111–5) is amended—

19 (1) in subsection (a)(3), by striking “first cal-
20 endar quarter” and inserting “first 3 calendar quar-
21 ters”;

22 (2) in subsection (b)(2), by inserting before the
23 period at the end the following: “and such para-
24 graph shall not apply to calendar quarters beginning
25 on or after October 1, 2010”;

1 (3) in subsection (c)(4)(C)(ii), by striking “De-
2 cember 2009” and “January 2010” and inserting
3 “June 2010” and “July 2010”, respectively;

4 (4) in subsection (d), by inserting “ending be-
5 fore October 1, 2010” after “entire fiscal years” and
6 after “with respect to fiscal years”;

7 (5) in subsection (g)(1), by striking “September
8 30, 2011” and inserting “December 31, 2011”; and

9 (6) in subsection (h)(3), by striking “December
10 31, 2010” and inserting “June 30, 2011”.

11 **Subtitle F—Waste, Fraud, and** 12 **Abuse**

13 **SEC. 1751. HEALTH CARE ACQUIRED CONDITIONS.**

14 (a) MEDICAID NON-PAYMENT FOR CERTAIN HEALTH
15 CARE-ACQUIRED CONDITIONS.—Section 1903(i) of the
16 Social Security Act (42 U.S.C. 1396b(i)) is amended—

17 (1) by striking “or” at the end of paragraph
18 (23);

19 (2) by striking the period at the end of para-
20 graph (24) and inserting “; or”; and

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

23 “(25) with respect to amounts expended for
24 services related to the presence of a condition that
25 could be identified by a secondary diagnostic code

1 described in section 1886(d)(4)(D)(iv) and for any
2 health care acquired condition determined as a non-
3 covered service under title XVIII.”.

4 (b) APPLICATION TO CHIP.—Section 2107(e)(1)(G)
5 of such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by
6 striking “and (17)” and inserting “(17), and (25)”.

7 (c) PERMISSION TO INCLUDE ADDITIONAL HEALTH
8 CARE-ACQUIRED CONDITIONS.—Nothing in this section
9 shall prevent a State from including additional health
10 care-acquired conditions for non-payment in its Medicaid
11 program under title XIX of the Social Security Act.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to discharges occurring on or after
14 January 1, 2010.

15 **SEC. 1752. EVALUATIONS AND REPORTS REQUIRED UNDER**
16 **MEDICAID INTEGRITY PROGRAM.**

17 Section 1936(c)(2)) of the Social Security Act (42
18 U.S.C. 1396u–7(c)(2)) is amended—

19 (1) by redesignating subparagraph (D) as sub-
20 paragraph (E); and

21 (2) by inserting after subparagraph (C) the fol-
22 lowing new subparagraph:

23 “(D) For the contract year beginning in
24 2011 and each subsequent contract year, the
25 entity provides assurances to the satisfaction of

1 the Secretary that the entity will conduct peri-
2 odic evaluations of the effectiveness of the ac-
3 tivities carried out by such entity under the
4 Program and will submit to the Secretary an
5 annual report on such activities.”.

6 **SEC. 1753. REQUIRE PROVIDERS AND SUPPLIERS TO**
7 **ADOPT PROGRAMS TO REDUCE WASTE,**
8 **FRAUD, AND ABUSE.**

9 Section 1902(a) of such Act (42 U.S.C. 42 U.S.C.
10 1396a(a)), as amended by sections 1631(b)(1), 1703, and
11 1729, is further amended—

12 (1) in paragraph (75), by striking at the end
13 “and”;

14 (2) in paragraph (76), by striking at the end
15 the period and inserting “; and”; and

16 (3) by inserting after paragraph (76) the fol-
17 lowing new paragraph:

18 “(77) provide that any provider or supplier
19 (other than a physician or nursing facility) providing
20 services under such plan shall, subject to paragraph
21 (5) of section 1874(d), establish a compliance pro-
22 gram described in paragraph (1) of such section in
23 accordance with such section.”.

1 **SEC. 1754. OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1903(d)(2)(C) of the So-
3 cial Security Act (42 U.S.C. 1396b(d)(2)(C)) is amend-
4 ed—

5 (1) in the first sentence, by inserting “(or of 1
6 year in the case of overpayments due to fraud)”
7 after “60 days”; and

8 (2) in the second sentence, by striking “the 60
9 days” and inserting “such period”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall apply in the case of overpayments dis-
12 covered on or after the date of the enactment of this Act.

13 **SEC. 1755. MANAGED CARE ORGANIZATIONS.**

14 (a) MINIMUM MEDICAL LOSS RATIO.—

15 (1) MEDICAID.—Section 1903(m)(2)(A) of the
16 Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as
17 amended by section 1743(a)(3), is amended—

18 (A) by striking “and” at the end of clause
19 (xii);

20 (B) by striking the period at the end of
21 clause (xiii) and inserting “; and”; and

22 (C) by adding at the end the following new
23 clause:

24 “(xiv) such contract has a medical loss ratio, as
25 determined in accordance with a methodology speci-

1 fied by the Secretary that is a percentage (not less
2 than 85 percent) as specified by the Secretary.”.

3 (2) CHIP.—Section 2107(e)(1) of such Act (42
4 U.S.C. 1397gg(e)(1)) is amended—

5 (A) by redesignating subparagraphs (H)
6 through (L) as subparagraphs (I) through (M);
7 and

8 (B) by inserting after subparagraph (G)
9 the following new subparagraph:

10 “(H) Section 1903(m)(2)(A)(xiv) (relating
11 to application of minimum loss ratios), with re-
12 spect to comparable contracts under this title.”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to contracts entered
15 into or renewed on or after July 1, 2010.

16 (b) PATIENT ENCOUNTER DATA.—

17 (1) IN GENERAL.—Section 1903(m)(2)(A)(xi)
18 of the Social Security Act (42 U.S.C.
19 1396b(m)(2)(A)(xi)) is amended by inserting “and
20 for the provision of such data to the State at a fre-
21 quency and level of detail to be specified by the Sec-
22 retary” after “patients”.

23 (2) EFFECTIVE DATE.—The amendment made
24 by paragraph (1) shall apply with respect to contract
25 years beginning on or after January 1, 2010.

1 **SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION**
2 **UNDER MEDICAID AND CHIP IF TERMINATED**
3 **UNDER MEDICARE OR OTHER STATE PLAN**
4 **OR CHILD HEALTH PLAN.**

5 (a) STATE PLAN REQUIREMENT.—Section
6 1902(a)(39) of the Social Security Act (42 U.S.C. 42
7 U.S.C. 1396a(a)) is amended by inserting after “1128A,”
8 the following: “terminate the participation of any indi-
9 vidual or entity in such program if (subject to such excep-
10 tions are permitted with respect to exclusion under sec-
11 tions 1128(b)(3)(C) and 1128(d)(3)(B)) participation of
12 such individual or entity is terminated under title XVIII,
13 any other State plan under this title, or any child health
14 plan under title XXI,”.

15 (b) APPLICATION TO CHIP.—Section 2107(e)(1)(A)
16 of such Act (42 U.S.C. 1397gg(e)(1)(A)) is amended by
17 inserting before the period at the end the following: “and
18 section 1902(a)(39) (relating to exclusion and termination
19 of participation)”.

20 (c) EFFECTIVE DATE.—Except as provided in section
21 1790, the amendments made by this section shall apply
22 to services furnished on or after January 1, 2011, without
23 regard to whether or not final regulations to carry out
24 such amendments have been promulgated by such date.

1 **SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICI-**
2 **PATION RELATING TO CERTAIN OWNERSHIP,**
3 **CONTROL, AND MANAGEMENT AFFILIATIONS.**

4 (a) STATE PLAN REQUIREMENT.—Section 1902(a)
5 of the Social Security Act (42 U.S.C. 1396a(a)), as
6 amended by sections 1631(b)(1), 1703(a), 1729, and
7 1753, is further amended—

8 (1) in paragraph (76), by striking at the end
9 “and”;

10 (2) in paragraph (77), by striking at the end
11 the period and inserting “; and”; and

12 (3) by inserting after paragraph (77) the fol-
13 lowing new paragraph:

14 “(78) provide that the State agency described
15 in paragraph (9) exclude, with respect to a period,
16 any individual or entity from participation in the
17 program under the State plan if such individual or
18 entity owns, controls, or manages an entity that (or
19 if such entity is owned, controlled, or managed by an
20 individual or entity that)—

21 “(A) has unpaid overpayments under this
22 title during such period determined by the Sec-
23 retary or the State agency to be delinquent;

24 “(B) is suspended or excluded from par-
25 ticipation under or whose participation is termi-
26 nated under this title during such period; or

1 “(C) is affiliated with an individual or enti-
2 ty that has been suspended or excluded from
3 participation under this title or whose participa-
4 tion is terminated under this title during such
5 period.”.

6 (b) CHILD HEALTH PLAN REQUIREMENT.—Section
7 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)),
8 as amended by section 1756(b), is amended by striking
9 “section 1902(a)(39)” and inserting “sections
10 1902(a)(39) and 1902(a)(78)”.

11 (c) EFFECTIVE DATE.—Except as provided in section
12 1790, the amendments made by this section shall apply
13 to services furnished on or after January 1, 2011, without
14 regard to whether or not final regulations to carry out
15 such amendments have been promulgated by such date.

16 **SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF**
17 **DATA ELEMENTS UNDER MMIS TO DETECT**
18 **FRAUD AND ABUSE.**

19 Section 1903(r)(1)(F) of the Social Security Act (42
20 U.S.C. 1396b(r)(1)(F)) is amended by inserting after
21 “necessary” the following: “and including, for data sub-
22 mitted to the Secretary on or after July 1, 2010, data
23 elements from the automated data system that the Sec-
24 retary determines to be necessary for detection of waste,
25 fraud, and abuse”.

1 **SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**
2 **ALTERNATE PAYEES REQUIRED TO REG-**
3 **ISTER UNDER MEDICAID.**

4 (a) IN GENERAL.—Section 1902(a) of the Social Se-
5 curity Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended
6 by sections 1631(b), 1703(a), 1729, 1753, and 1757(a),
7 is further amended—

8 (1) in paragraph (77); by striking at the end
9 “and”;

10 (2) in paragraph (78), by striking the period at
11 the end and inserting “and”; and

12 (3) by inserting after paragraph (78) the fol-
13 lowing new paragraph:

14 “(79) provide that any agent, clearinghouse, or
15 other alternate payee that submits claims on behalf
16 of a health care provider must register with the
17 State and the Secretary in a form and manner speci-
18 fied by the Secretary under section 1866(j)(1)(D).”.

19 (b) DENIAL OF PAYMENT.—Section 1903(i) of such
20 Act (42 U.S.C. 1396b(i)), as amended by section 1751,
21 is amended—

22 (1) by striking “or” at the end of paragraph
23 (24);

24 (2) by striking the period at the end of para-
25 graph (25) and inserting “; or”; and

1 “(A) on litigation in which a court imposes
2 sanctions on the State, its employees, or its
3 counsel for litigation-related misconduct; or

4 “(B) to reimburse (or otherwise com-
5 pensate) a managed care entity for payment of
6 legal expenses associated with any action in
7 which a court imposes sanctions on the man-
8 aged care entity for litigation-related mis-
9 conduct.”.

10 (b) **EFFECTIVE DATE.**—The amendments made by
11 subsection (a) shall apply to amounts expended on or after
12 January 1, 2010.

13 **SEC. 1761. 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” at the
21 end; 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-

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) Not later than September 1, 2010, the Secretary
14 shall do the following:

15 “(A) Identify those methodologies of the Na-
16 tional Correct Coding Initiative administered by the
17 Secretary (or any successor initiative to promote cor-
18 rect coding and to control improper coding leading
19 to inappropriate payment) which are compatible to
20 claims filed under this title.

21 “(B) Identify those methodologies of such Ini-
22 tiative (or such other national correct coding meth-
23 odologies) that should be incorporated into claims
24 filed under this title with respect to items or services
25 for which States provide medical assistance under

1 this title and no national correct coding methodolo-
2 gies have been established under such Initiative with
3 respect to title XVIII.

4 “(C) Notify States of—

5 “(i) the methodologies identified under
6 subparagraphs (A) and (B) (and of any other
7 national correct coding methodologies identified
8 under subparagraph (B)); and

9 “(ii) how States are to incorporate such
10 methodologies into claims filed under this title.

11 “(D) Submit a report to Congress that includes
12 the notice to States under subparagraph (C) and an
13 analysis supporting the identification of the meth-
14 odologies made under subparagraphs (A) and (B).”.

15 **Subtitle G—Payments to the**
16 **Territories**

17 **SEC. 1771. PAYMENT TO TERRITORIES.**

18 (a) INCREASE IN CAP.—Section 1108 of the Social
19 Security Act (42 U.S.C. 1308) is amended—

20 (1) in subsection (f), by striking “subsection
21 (g)” and inserting “subsections (g) and (h)”;

22 (2) in subsection (g)(1), by striking “With re-
23 spect to” and inserting “Subject to subsection (h),
24 with respect to”; and

1 (3) by adding at the end the following new sub-
2 section:

3 “(h) ADDITIONAL INCREASE FOR FISCAL YEARS
4 2011 THROUGH 2019.—Subject to section 347(b)(1) of
5 the Affordable Health Care for America Act, with respect
6 to fiscal years 2011 through 2019, the amounts otherwise
7 determined under subsections (f) and (g) for Puerto Rico,
8 the Virgin Islands, Guam, the Northern Mariana Islands
9 and American Samoa shall be increased by the following
10 amounts:

11 “(1) For Puerto Rico, for fiscal year 2011,
12 \$727,600,000; for fiscal year 2012, \$775,000,000;
13 for fiscal year 2013, \$850,000,000; for fiscal year
14 2014, \$925,000,000; for fiscal year 2015,
15 \$1,000,000,000; for fiscal year 2016,
16 \$1,075,000,000; for fiscal year 2017,
17 \$1,150,000,000; for fiscal year 2018,
18 \$1,225,000,000; and for fiscal year 2019,
19 \$1,396,400,000.

20 “(2) For the Virgin Islands, for fiscal year
21 2011, \$34,000,000; for fiscal year 2012,
22 \$37,000,000; for fiscal year 2013, \$40,000,000; for
23 fiscal year 2014, \$43,000,000; for fiscal year 2015,
24 \$46,000,000; for fiscal year 2016, \$49,000,000; for

1 fiscal year 2017, \$52,000,000; for fiscal year 2018,
2 \$55,000,000; and for fiscal year 2019, \$58,000,000.

3 “(3) For Guam, for fiscal year 2011,
4 \$34,000,000; for fiscal year 2012, \$37,000,000; for
5 fiscal year 2013, \$40,000,000; for fiscal year 2014,
6 \$43,000,000; for fiscal year 2015, \$46,000,000; for
7 fiscal year 2016, \$49,000,000; for fiscal year 2017,
8 \$52,000,000; for fiscal year 2018, \$55,000,000; and
9 for fiscal year 2019, \$58,000,000.

10 “(4) For the Northern Mariana Islands, for fis-
11 cal year 2011, \$13,500,000; fiscal year 2012,
12 \$14,500,000; for fiscal year 2013, \$15,500,000; for
13 fiscal year 2014, \$16,500,000; for fiscal year 2015,
14 \$17,500,000; for fiscal year 2016, \$18,500,000; for
15 fiscal year 2017, \$19,500,000; for fiscal year 2018,
16 \$21,000,000; and for fiscal year 2019, \$22,000,000.

17 “(5) For American Samoa, fiscal year 2011,
18 \$22,000,000; fiscal year 2012, \$23,687,500; for fis-
19 cal year 2013, \$24,687,500; for fiscal year 2014,
20 \$25,687,500; for fiscal year 2015, \$26,687,500; for
21 fiscal year 2016, \$27,687,500; for fiscal year 2017,
22 \$28,687,500; for fiscal year 2018, \$29,687,500; and
23 for fiscal year 2019, \$30,687,500.”

24 (b) REPORT ON ACHIEVING MEDICAID PARITY PAY-
25 MENTS BEGINNING WITH FISCAL YEAR 2020.—

1 (1) IN GENERAL.—Not later than October 1,
2 2013, the Secretary of Health and Human Services
3 shall submit to Congress a report that details a plan
4 for the transition of each territory to full parity in
5 Medicaid with the 50 States and the District of Co-
6 lumbia in fiscal year 2020 by modifying their exist-
7 ing Medicaid programs and outlining actions the
8 Secretary and the governments of each territory
9 must take by fiscal year 2020 to ensure parity in fi-
10 nancing. Such report shall include what the Federal
11 medical assistance percentages would be for each
12 territory if the formula applicable to the 50 States
13 were applied. Such report shall also include any rec-
14 ommendations that the Secretary may have as to
15 whether the mandatory ceiling amounts for each ter-
16 ritory provided for in section 1108 of the Social Se-
17 curity Act (42 U.S.C. 1308) should be increased any
18 time before fiscal year 2020 due to any factors that
19 the Secretary deems relevant.

20 (2) PER CAPITA DATA.—As part of such report
21 the Secretary shall include information about per
22 capita income data that could be used to calculate
23 Federal medical assistance percentages under section
24 1905(b) of the Social Security Act, under section
25 1108(a)(8)(B) of such Act, for each territory on how

1 such data differ from the per capita income data
2 used to promulgate Federal medical assistance per-
3 centages for the 50 States. The report under this
4 subsection shall include recommendations on how
5 the Federal medical assistance percentages can be
6 calculated for the territories beginning in fiscal year
7 2020 to ensure parity with the 50 States.

8 (3) SUBSEQUENT REPORTS.—The Secretary
9 shall submit subsequent reports to Congress in
10 2015, 2017, and 2019 detailing the progress that
11 the Secretary and the governments of each territory
12 have made in fulfilling the actions outlined in the
13 plan submitted under paragraph (1).

14 (c) APPLICATION OF FMAP FOR ADDITIONAL
15 FUNDS.—Section 1905(b) of such Act (42 U.S.C.
16 1396d(b)) is amended by adding at the end the following
17 sentence: “Notwithstanding the first sentence of this sub-
18 section and any other provision of law, for fiscal years
19 2011 through 2019, the Federal medical assistance per-
20 centage for Puerto Rico, the Virgin Islands, Guam, the
21 Northern Mariana Islands, and American Samoa shall be
22 the highest Federal medical assistance percentage applica-
23 ble to any of the 50 States or the District of Columbia
24 for the fiscal year involved, taking into account the appli-
25 cation of subsections (a) and (b)(1) of section 5001 of di-

1 vision B of the American Recovery and Reinvestment Act
2 of 2009 (Public Law 111–5) to such States and the Dis-
3 trict for calendar quarters during such fiscal years for
4 which such subsections apply.”.

5 (d) WAIVERS.—

6 (1) IN GENERAL.—Section 1902(j) of the Social
7 Security Act (42 U.S.C. 1396a(j)) is amended—

8 (A) by striking “American Samoa and the
9 Northern Mariana Islands” and inserting
10 “Puerto Rico, the Virgin Islands, Guam, the
11 Northern Mariana Islands, and American
12 Samoa”; and

13 (B) by striking “American Samoa or the
14 Northern Mariana Islands” and inserting
15 “Puerto Rico, the Virgin Islands, Guam, the
16 Northern Mariana Islands, or American
17 Samoa”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply beginning with fiscal
20 year 2011.

21 (e) TECHNICAL ASSISTANCE.—The Secretary shall
22 provide nonmonetary technical assistance to the govern-
23 ments of Puerto Rico, the Virgin Islands, Guam, the
24 Northern Mariana Islands, and American Samoa in up-
25 grading their existing computer systems in order to antici-

1 pate meeting reporting requirements necessary to imple-
2 ment the plan contained in the report under subsection
3 (b)(1).

4 **Subtitle H—Miscellaneous**

5 **SEC. 1781. TECHNICAL CORRECTIONS.**

6 (a) TECHNICAL CORRECTION TO SECTION 1144 OF
7 THE SOCIAL SECURITY ACT.—The first sentence of sec-
8 tion 1144(c)(3) of the Social Security Act (42 U.S.C.
9 1320b—14(c)(3)) is amended—

10 (1) by striking “transmittal”; and

11 (2) by inserting before the period the following:
12 “as specified in section 1935(a)(4)”.

13 (b) CLARIFYING AMENDMENT TO SECTION 1935 OF
14 THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the
15 Social Security Act (42 U.S.C. 1396u—5(a)(4)), as
16 amended by section 113(b) of Public Law 110–275, is
17 amended—

18 (1) by striking the second sentence;

19 (2) by redesignating the first sentence as a sub-
20 paragraph (A) with appropriate indentation and
21 with the following heading: “IN GENERAL.—”;

22 (3) by adding at the end the following subpara-
23 graphs:

24 “(B) FURNISHING MEDICAL ASSISTANCE
25 WITH REASONABLE PROMPTNESS.—For the

1 purpose of a State’s obligation under section
2 1902(a)(8) to furnish medical assistance with
3 reasonable promptness, the date of the elec-
4 tronic transmission of low-income subsidy pro-
5 gram data, as described in section 1144(c),
6 from the Commissioner of Social Security to the
7 State Medicaid Agency, shall constitute the date
8 of filing of such application for benefits under
9 the Medicare Savings Program.

10 “(C) DETERMINING AVAILABILITY OF
11 MEDICAL ASSISTANCE.—For the purpose of de-
12 termining when medical assistance will be made
13 available, the State shall consider the date of
14 the individual’s application for the low income
15 subsidy program to constitute the date of filing
16 for benefits under the Medicare Savings Pro-
17 gram.”.

18 (c) EFFECTIVE DATE RELATING TO MEDICAID
19 AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY AP-
20 PPLICATION AND DATA TRANSMITTAL.—The amendments
21 made by subsections (a) and (b) shall be effective as if
22 included in the enactment of section 113(b) of Public Law
23 110–275.

24 (d) TECHNICAL CORRECTION TO SECTION 605 OF
25 CHIPRA.—Section 605 of the Children’s Health Insur-

1 ance Program Reauthorization Act of 2009 (Public Law
2 111–3) is amended by striking “legal residents” and in-
3 serting “lawfully residing in the United States”.

4 (e) TECHNICAL CORRECTION TO SECTION 1905 OF
5 THE SOCIAL SECURITY ACT.—Section 1905(a) of the So-
6 cial Security Act (42 U.S.C. 1396d(a)) is amended by in-
7 serting “or the care and services themselves, or both” be-
8 fore “(if provided in or after”.

9 (f) CLARIFYING AMENDMENT TO SECTION 1115 OF
10 THE SOCIAL SECURITY ACT.—Section 1115(a) of the So-
11 cial Security Act (42 U.S.C. 1315(a)) is amended by add-
12 ing at the end the following: “If an experimental, pilot,
13 or demonstration project that relates to title XIX is ap-
14 proved pursuant to any part of this subsection, such
15 project shall be treated as part of the State plan, all med-
16 ical assistance provided on behalf of any individuals af-
17 fected by such project shall be medical assistance provided
18 under the State plan, and all provisions of this Act not
19 explicitly waived in approving such project shall remain
20 fully applicable to all individuals receiving benefits under
21 the State plan.”.

22 **SEC. 1782. EXTENSION OF QI PROGRAM.**

23 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the
24 Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is
25 amended—

1 (1) by striking “sections 1933 and” and by in-
2 serting “section”; and

3 (2) by striking “December 2010” and inserting
4 “December 2012”.

5 (b) ELIMINATION OF FUNDING LIMITATION.—

6 (1) IN GENERAL.—Section 1933 of such Act
7 (42 U.S.C. 1396u–3) is amended—

8 (A) in subsection (a), by striking “who are
9 selected to receive such assistance under sub-
10 section (b)”;

11 (B) by striking subsections (b), (c), (e),
12 and (g);

13 (C) in subsection (d), by striking “fur-
14 nished in a State” and all that follows and in-
15 serting “the Federal medical assistance percent-
16 age shall be equal to 100 percent.”; and

17 (D) by redesignating subsections (d) and
18 (f) as subsections (b) and (e), respectively.

19 (2) CONFORMING AMENDMENT.—Section
20 1905(b) of such Act (42 U.S.C. 1396d(b)) is amend-
21 ed by striking “1933(d)” and inserting “1933(b)”.

22 (3) EFFECTIVE DATE.—The amendments made
23 by paragraph (1) shall take effect on January 1,
24 2011.

1 **SEC. 1783. ASSURING TRANSPARENCY OF INFORMATION.**

2 (a) IN GENERAL.—Section 1902(a) of the Social Se-
3 curity Act (42 U.S.C. 1396a(a)), as amended by sections
4 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), and
5 1907(b), is amended—

6 (1) by striking “and” at the end of paragraph
7 (79);

8 (2) by striking the period at the end of para-
9 graph (80) and inserting “; and”; and

10 (3) by inserting after paragraph (80) the fol-
11 lowing new paragraph:

12 “(81) provide that the State will establish and
13 maintain laws, in accordance with the requirements
14 of section 1921A, to require disclosure of informa-
15 tion on hospital charges and quality and to make
16 such information available to the public and the Sec-
17 retary.”; and

18 (4) by inserting after section 1921 the following
19 new section:

20 “HOSPITAL PRICE TRANSPARENCY

21 “SEC. 1921A. (a) IN GENERAL.—The requirements
22 referred to in section 1902(a)(81) are that the laws of a
23 State must—

24 “(1) require reporting to the State (or its
25 agent) by each hospital located therein, of informa-
26 tion on,—

1 “(A) the charges for the most common in-
2 patient and outpatient hospital services;

3 “(B) the Medicare and Medicaid reim-
4 bursement amount for such services; and

5 “(C) if the hospitals allows for or provides
6 reduced charges for individuals based on finan-
7 cial need, the factors considered in making de-
8 terminations for reductions in charges, includ-
9 ing any formula for such determination and the
10 contact information for the specific department
11 of a hospital that responds to such inquiries;

12 “(2) provide for notice to individuals seeking or
13 requiring such services of the availability of informa-
14 tion on charges described in paragraph (1);

15 “(3) provide for timely access to such informa-
16 tion, including at least through an Internet website,
17 by individuals seeking or requiring such services;
18 and

19 “(4) provide for timely access to information re-
20 garding the quality of care at each hospital made
21 publicly available in accordance with section 501 of
22 the Medicare Prescription Drug, Improvement, and
23 Modernization Act of 2003 (Public Law 108–173),
24 section 1139A, or section 1139B.

1 The Secretary shall consult with stakeholders (including
2 those entities in section 1808(d)(6) and the National Gov-
3 ernors Association) through a formal process to obtain
4 guidance prior to issuing implementing policies under this
5 section.

6 “(b) HOSPITAL DEFINED.—For purposes of this sec-
7 tion, the term ‘hospital’ means an institution that meets
8 the requirements of paragraphs (1) and (7) of section
9 1861(e) and includes those to which section 1820(c) ap-
10 plies.”.

11 (b) EFFECTIVE DATE; ADMINISTRATION.—

12 (1) IN GENERAL.—Except as provided in para-
13 graphs (2)(B) and section 1790, the amendments
14 made by subsection (a) shall take effect on October
15 1, 2010.

16 (2) EXISTING PROGRAMS.—

17 (A) IN GENERAL.—The Secretary of
18 Health and Human Services shall establish a
19 process by which a State with an existing pro-
20 gram may certify to the Secretary that its pro-
21 gram satisfies the requirements of section
22 1921A of the Social Security Act, as inserted
23 by subsection (a).

24 (B) 2-YEAR PERIOD TO BECOME IN COM-
25 PLIANCE.—States that, as of the date of the en-

1 actment of this Act, administer hospital price
2 transparency policies that do not meet such re-
3 quirements shall have 2 years from such date to
4 make necessary modifications to come into com-
5 pliance and shall not be regarded as failing to
6 comply with such requirements during such 2-
7 year period.

8 **SEC. 1784. MEDICAID AND CHIP PAYMENT AND ACCESS**
9 **COMMISSION.**

10 (a) REPORT ON NURSING FACILITY PAYMENT POLI-
11 CIES.—Section 1900(b) of the Social Security Act (42
12 U.S.C. 1396(b)) is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(10) REPORTS ON SPECIAL TOPICS ON PAY-
15 MENT POLICIES.—

16 “(A) NURSING FACILITY PAYMENT POLI-
17 CIES.—Not later than January 1, 2012, the
18 Commission shall submit to Congress a report
19 on nursing facility payment policies under Med-
20 icaid that includes—

21 “(i) information on the difference be-
22 tween the amount paid by each State to
23 nursing facilities in such State under the
24 Medicaid program under this title and the
25 cost to such facilities of providing efficient

1 quality care to Medicaid eligible individ-
2 uals;

3 “(ii) an evaluation of patient out-
4 comes and quality as a result of the sup-
5 plemental payments under section 1745(b)
6 of the Affordable Health Care for America
7 Act; and

8 “(iii) whether adjustments should be
9 made under the Medicaid program to the
10 rates that States pay skilled nursing facili-
11 ties to ensure that such rates are sufficient
12 to provide efficient quality care to Med-
13 icaid eligible individuals.”.

14 (b) PEDIATRIC SUBSPECIALIST PAYMENT POLI-
15 CIES.—Section 1900(b)(10) of the Social Security Act, as
16 added by subsection (a) is amended by adding at the end
17 the following new subparagraph:

18 “(B) PEDIATRIC SUBSPECIALIST PAYMENT
19 POLICIES.—Not later than January 1, 2011,
20 the Commission shall submit to Congress a re-
21 port on payment policies for pediatric sub-
22 specialist services under Medicaid that in-
23 cludes—

24 “(i) a comprehensive review of each
25 State’s Medicaid payment rates for inpa-

1 tient and outpatient pediatric speciality
2 services;

3 “(ii) a comparison, on a State-by-
4 State basis, of the rates under clause (i) to
5 Medicare payments for similar services;

6 “(iii) information on any limitations
7 in patient access to pediatric speciality
8 care, such as delays in receiving care or
9 wait times for receiving care;

10 “(iv) an analysis of the extent to
11 which low Medicaid payment rates in any
12 State contributes to limits in access to pe-
13 diatric subspecialty services in such State;
14 and

15 “(v) recommendations to ameliorate
16 any problems found with such payment
17 rates or with access to such services.”.

18 (c) ADDITIONAL AMENDMENTS.—

19 (1) COMMISSION STATUS.—Section 1900(a) of
20 the Social Security Act is amended by inserting “as
21 an agency of Congress” after “established”.

22 (2) EXPANSION OF SCOPE.—Section
23 1900(b)(1)(A) of the Social Security Act is amended
24 by striking “children’s access” and inserting “access

1 by low-income children and other eligible individ-
2 uals”.

3 (3) CHANGE IN REPORT DEADLINES.—Subpara-
4 graphs (C) and (D) of section 1900(b)(1) of such
5 Act are amended by striking “2010” and inserting
6 “2011” each place it appears.

7 (4) REPORT IN HEALTH REFORM.—Section
8 1900(b)(2) of such Act is amended—

9 (A) in subparagraph (A)(i), by striking
10 “skilled”;

11 (B) by striking subparagraph (B);

12 (C) by redesignating subparagraph (C) as
13 subparagraph (B); and

14 (D) by adding at the end the following new
15 subparagraph:

16 “(C) IMPLEMENTATION OF HEALTH RE-
17 FORM.—The implementation of the provisions
18 of the Affordable Health Care for America Act
19 that relate to Medicaid or CHIP by the Sec-
20 retary, the Health Choices Commissioner, and
21 the States, including the effect of such imple-
22 mentation on the access to needed health care
23 items and services by low-income individuals
24 and families.”.

1 (5) CLARIFICATION OF MEMBERSHIP.—Section
2 1900(e)(2)(B) of such Act is amended by striking
3 “consumers” and inserting “individuals”.

4 (6) AUTHORIZATION OF APPROPRIATIONS.—

5 (A) CURRENT AUTHORIZATION.—Section
6 1900(f)(2) of such Act is amended—

7 (i) in the heading, by inserting “OF
8 APPROPRIATIONS PRIOR TO 2010” after
9 “AUTHORIZATION”; and

10 (ii) by striking “There are” and in-
11 serting “Prior to January 1, 2010, there
12 are”

13 (B) FUTURE AUTHORIZATION.—Section
14 1900(f) of such Act is further amended by add-
15 ing at the end the following new paragraph:
16 after the period the following:

17 “(3) AUTHORIZATION OF APPROPRIATIONS FOR
18 2010.—Beginning on January 1, 2010, there is au-
19 thorized to be appropriated \$11,800,000 to carry
20 out the provisions of this section. Such funds shall
21 remain available until expended.”.

22 **SEC. 1785. OUTREACH AND ENROLLMENT OF MEDICAID**
23 **AND CHIP ELIGIBLE INDIVIDUALS.**

24 (a) IN GENERAL.—Not later than 12 months after
25 date of enactment of this Act, the Secretary of Health and

1 Human Services shall issue guidance regarding standards
2 and best practices for conducting outreach to inform eligi-
3 ble individuals about healthcare coverage under Medicaid
4 under title XIX of the Social Security Act or for child
5 health assistance under CHIP under title XXI of such
6 Act, providing assistance to such individuals for enroll-
7 ment in applicable programs, and establishing methods or
8 procedures for eliminating application and enrollment bar-
9 riers. Such guidance shall include provisions to ensure
10 that outreach, enrollment assistance, and administrative
11 simplification efforts are targeted specifically to vulnerable
12 populations such as children, unaccompanied homeless
13 youth, victims of abuse or trauma, individuals with mental
14 health or substance related disorders, and individuals with
15 HIV/AIDS. Guidance issued pursuant to this section re-
16 lating to methods to increase outreach and enrollment pro-
17 vided for under titles XIX and XXI of the Social Security
18 Act shall specifically target such vulnerable and under-
19 served populations and shall include, but not be limited
20 to, guidance on outstationing of eligibility workers, express
21 lane eligibility, residence requirements, documentation of
22 income and assets, presumptive eligibility, continuous eli-
23 gibility, and automatic renewal.

24 (b) IMPLEMENTATION.—In implementing the re-
25 quirements under subsection (a), the Secretary may use

1 such authorities as are available under law and may work
2 with such entities as the Secretary deems appropriate to
3 facilitate effective implementation of such programs. Not
4 later than 2 years after the enactment of this Act and
5 annually thereafter, the Secretary shall review and report
6 to Congress on progress in implementing targeted out-
7 reach, application and enrollment assistance, and adminis-
8 trative simplification methods for such vulnerable and un-
9 derserved populations as are specified in subsection (a).

10 **SEC. 1786. PROHIBITIONS ON FEDERAL MEDICAID AND**
11 **CHIP PAYMENT FOR UNDOCUMENTED**
12 **ALIENS.**

13 Nothing in this title shall change current prohibitions
14 against Federal Medicaid and CHIP payments under titles
15 XIX and XXI of the Social Security Act on behalf of indi-
16 viduals who are not lawfully present in the United States.

17 **SEC. 1787. DEMONSTRATION PROJECT FOR STABILIZATION**
18 **OF EMERGENCY MEDICAL CONDITIONS BY**
19 **INSTITUTIONS FOR MENTAL DISEASES.**

20 (a) **AUTHORITY TO CONDUCT DEMONSTRATION**
21 **PROJECT.**—The Secretary of Health and Human Services
22 (in this section referred to as the “Secretary”) shall estab-
23 lish a demonstration project under which an eligible State
24 (as described in subsection (c)) shall provide reimburse-
25 ment under the State Medicaid plan under title XIX of

1 the Social Security Act to an institution for mental dis-
2 eases that is subject to the requirements of section 1867
3 of the Social Security Act (42 U.S.C. 1395dd) for the pro-
4 vision of medical assistance available under such plan to
5 an individual who—

6 (1) has attained age 21, but has not attained
7 age 65;

8 (2) is eligible for medical assistance under such
9 plan; and

10 (3) requires such medical assistance to stabilize
11 an emergency medical condition.

12 (b) IN-STAY REVIEW.—The Secretary shall establish
13 a mechanism for in-stay review to determine whether or
14 not the patient has been stabilized (as defined in sub-
15 section (h)(5)). This mechanism shall commence before
16 the third day of the inpatient stay. States participating
17 in the demonstration project may manage the provision
18 of these benefits under the project through utilization re-
19 view, authorization, or management practices, or the ap-
20 plication of medical necessity and appropriateness criteria
21 applicable to behavioral health.

22 (c) ELIGIBLE STATE DEFINED.—

23 (1) APPLICATION.—Upon approval of an appli-
24 cation submitted by a State described in paragraph

25 (2), the State shall be an eligible State for purposes

1 of conducting a demonstration project under this
2 section.

3 (2) STATE DESCRIBED.—States shall be se-
4 lected by the Secretary in a manner so as to provide
5 geographic diversity on the basis of the application
6 to conduct a demonstration project under this sec-
7 tion submitted by such States.

8 (d) LENGTH OF DEMONSTRATION PROJECT.—The
9 demonstration project established under this section shall
10 be conducted for a period of 3 consecutive years.

11 (e) LIMITATIONS ON FEDERAL FUNDING.—

12 (1) APPROPRIATION.—

13 (A) IN GENERAL.—Out of any funds in the
14 Treasury not otherwise appropriated, there is
15 appropriated to carry out this section,
16 \$75,000,000 for fiscal year 2010.

17 (B) BUDGET AUTHORITY.—Subparagraph
18 (A) constitutes budget authority in advance of
19 appropriations Act and represents the obliga-
20 tion of the Federal Government to provide for
21 the payment of the amounts appropriated under
22 that subparagraph.

23 (2) 3-YEAR AVAILABILITY.—Funds appro-
24 priated under paragraph (1) shall remain available
25 for obligation through December 31, 2012.

1 (3) LIMITATION ON PAYMENTS.—In no case
2 may—

3 (A) the aggregate amount of payments
4 made by the Secretary to eligible States under
5 this section exceed \$75,000,000; or

6 (B) payments be provided by the Secretary
7 under this section after December 31, 2012.

8 (4) FUNDS ALLOCATED TO STATES.—The Sec-
9 retary shall allocate funds to eligible States based on
10 their applications and the availability of funds.

11 (5) PAYMENTS TO STATES.—The Secretary
12 shall pay to each eligible State, from its allocation
13 under paragraph (4), an amount each quarter equal
14 to the Federal medical assistance percentage of ex-
15 penditures in the quarter for medical assistance de-
16 scribed in subsection (a).

17 (f) REPORTS.—

18 (1) ANNUAL PROGRESS REPORTS.—The Sec-
19 retary shall submit annual reports to Congress on
20 the progress of the demonstration project conducted
21 under this section.

22 (2) FINAL REPORT AND RECOMMENDATION.—
23 An evaluation shall be conducted of the demonstra-
24 tion project's impact on the functioning of the health
25 and mental health service system and on individuals

1 enrolled in the Medicaid program. This evaluation
2 shall include collection of baseline data for one-year
3 prior to the initiation of the demonstration project
4 as well as collection of data from matched compari-
5 son states not participating in the demonstration.
6 The evaluation measures shall include the following:

7 (A) A determination, by State, as to
8 whether the demonstration project resulted in
9 increased access to inpatient mental health
10 services under the Medicaid program and
11 whether average length of stays were longer (or
12 shorter) for individuals admitted under the
13 demonstration project compared with individ-
14 uals otherwise admitted in comparison sites.

15 (B) An analysis, by State, regarding
16 whether the demonstration project produced a
17 significant reduction in emergency room visits
18 for individuals eligible for assistance under the
19 Medicaid program or in the duration of emer-
20 gency room lengths of stay.

21 (C) An assessment of discharge planning
22 by participating hospitals that ensures access to
23 further (non-emergency) inpatient or residential
24 care as well as continuity of care for those dis-
25 charged to outpatient care.

1 (D) An assessment of the impact of the
2 demonstration project on the costs of the full
3 range of mental health services (including inpa-
4 tient, emergency and ambulatory care) under
5 the plan as contrasted with the comparison
6 areas.

7 (E) Data on the percentage of consumers
8 with Medicaid coverage who are admitted to in-
9 patient facilities as a result of the demonstra-
10 tion project as compared to those admitted to
11 these same facilities through other means.

12 (F) A recommendation regarding whether
13 the demonstration project should be continued
14 after December 31, 2012, and expanded on a
15 national basis.

16 (g) WAIVER AUTHORITY.—

17 (1) IN GENERAL.—The Secretary shall waive
18 the limitation of subdivision (B) following paragraph
19 (28) of section 1905(a) of the Social Security Act
20 (42 U.S.C. 1396d(a)) (relating to limitations on pay-
21 ments for care or services for individuals under 65
22 years of age who are patients in an institution for
23 mental diseases) for purposes of carrying out the
24 demonstration project under this section.

1 (2) LIMITED OTHER WAIVER AUTHORITY.—The
2 Secretary may waive other requirements of title XIX
3 of the Social Security Act (including the require-
4 ments of sections 1902(a)(1) (relating to
5 statewideness) and 1902(1)(10)(B) (relating to com-
6 parability)) only to extent necessary to carry out the
7 demonstration project under this section.

8 (h) DEFINITIONS.—In this section:

9 (1) EMERGENCY MEDICAL CONDITION.—The
10 term “emergency medical condition” means, with re-
11 spect to an individual, an individual who expresses
12 suicidal or homicidal thoughts or gestures, if deter-
13 mined dangerous to self or others.

14 (2) FEDERAL MEDICAL ASSISTANCE PERCENT-
15 AGE.—The term “Federal medical assistance per-
16 centage” has the meaning given that term with re-
17 spect to a State under section 1905(b) of the Social
18 Security Act (42 U.S.C. 1396d(b)).

19 (3) INSTITUTION FOR MENTAL DISEASES.—The
20 term “institution for mental diseases” has the mean-
21 ing given to that term in section 1905(i) of the So-
22 cial Security Act (42 U.S.C. 1396d(i)).

23 (4) MEDICAL ASSISTANCE.—The term “medical
24 assistance” has the meaning given to that term in

1 section 1905(a) of the Social Security Act (42
2 U.S.C. 1396d(a)).

3 (5) STABILIZED.—The term “stabilized”
4 means, with respect to an individual, that the emer-
5 gency medical condition no longer exists with respect
6 to the individual and the individual is no longer dan-
7 gerous to self or others.

8 (6) STATE.—The term “State” has the mean-
9 ing given that term for purposes of title XIX of the
10 Social Security Act (42 U.S.C. 1396 et seq.).

11 **SEC. 1788. APPLICATION OF MEDICAID IMPROVEMENT**
12 **FUND.**

13 Section 1941(b)(1) of the Social Security Act (42
14 U.S.C. 1396w–1(b)(1)) is amended by striking “from the
15 Fund” and all that follows and inserting “from the Fund,
16 only such amounts as may be appropriated or otherwise
17 made available by law.”.

18 **SEC. 1789. TREATMENT OF CERTAIN MEDICAID BROKERS.**

19 Section 1903(b)(4) of the Social Security Act (42
20 U.S.C. 1396b(b)(4)) is amended—

21 (1) in the matter before subparagraph (A), by
22 inserting after “respect to the broker” the following:
23 “(or, in the case of subparagraph (A) and subpara-
24 graph (B)(i), if the Inspector General of Department
25 of Health and Human Services finds that the broker

1 has established and maintains procedures to ensure
2 the independence of its enrollment activities from
3 the interests of any managed care entity or pro-
4 vider)”; and

5 (2) in subparagraph (B)—

6 (A) by inserting “(i)” after “either”; and

7 (B) by inserting “(ii)” after “health care
8 provider or”.

9 **SEC. 1790. RULE FOR CHANGES REQUIRING STATE LEGIS-**
10 **LATION.**

11 In the case of a State plan for medical assistance
12 under title XIX of the Social Security Act which the Sec-
13 retary of Health and Human Services determines requires
14 State legislation (other than legislation appropriating
15 funds) in order for the plan to meet an additional require-
16 ment imposed by an amendment made by this title, the
17 State plan shall not be regarded as failing to comply with
18 the requirements of such title XIX solely on the basis of
19 its failure to meet this additional requirement before the
20 first day of the first calendar quarter beginning after the
21 close of the first regular session of the State legislature
22 that begins after the date of the enactment of this Act.
23 For purposes of the previous sentence, in the case of a
24 State that has a 2-year legislative session, each year of

1 such session shall be deemed to be a separate regular ses-
2 sion of the State legislature.

3 **TITLE VIII—REVENUE-RELATED**
4 **PROVISIONS**

5 **SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION**
6 **OF INDIVIDUALS LIKELY TO BE INELIGIBLE**
7 **FOR THE LOW-INCOME ASSISTANCE UNDER**
8 **THE MEDICARE PRESCRIPTION DRUG PRO-**
9 **GRAM TO ASSIST SOCIAL SECURITY ADMINIS-**
10 **TRATION'S OUTREACH TO ELIGIBLE INDIVID-**
11 **UALS.**

12 (a) IN GENERAL.—Paragraph (19) of section 6103(l)
13 of the Internal Revenue Code of 1986 is amended to read
14 as follows:

15 “(19) DISCLOSURES TO FACILITATE IDENTI-
16 FICATION OF INDIVIDUALS LIKELY TO BE INELI-
17 GIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDI-
18 CARE PRESCRIPTION DRUG PROGRAM TO ASSIST SO-
19 CIAL SECURITY ADMINISTRATION'S OUTREACH TO
20 ELIGIBLE INDIVIDUALS.—

21 “(A) IN GENERAL.—Upon written request
22 from the Commissioner of Social Security, the
23 following return information (including such in-
24 formation disclosed to the Social Security Ad-
25 ministration under paragraph (1) or (5)) shall

1 be disclosed to officers and employees of the So-
2 cial Security Administration, with respect to
3 any taxpayer identified by the Commissioner of
4 Social Security—

5 “(i) return information for the appli-
6 cable year from returns with respect to
7 wages (as defined in section 3121(a) or
8 3401(a)) and payments of retirement in-
9 come (as described in paragraph (1) of this
10 subsection),

11 “(ii) unearned income information
12 and income information of the taxpayer
13 from partnerships, trusts, estates, and sub-
14 chapter S corporations for the applicable
15 year,

16 “(iii) if the individual filed an income
17 tax return for the applicable year, the fil-
18 ing status, number of dependents, income
19 from farming, and income from self-em-
20 ployment, on such return,

21 “(iv) if the individual is a married in-
22 dividual filing a separate return for the ap-
23 plicable year, the social security number (if
24 reasonably available) of the spouse on such
25 return,

1 “(v) if the individual files a joint re-
2 turn for the applicable year, the social se-
3 curity number, unearned income informa-
4 tion, and income information from partner-
5 ships, trusts, estates, and subchapter S
6 corporations of the individual’s spouse on
7 such return, and

8 “(vi) such other return information
9 relating to the individual (or the individ-
10 ual’s spouse in the case of a joint return)
11 as is prescribed by the Secretary by regula-
12 tion as might indicate that the individual
13 is likely to be ineligible for a low-income
14 prescription drug subsidy under section
15 1860D–14 of the Social Security Act.

16 “(B) APPLICABLE YEAR.—For the pur-
17 poses of this paragraph, the term ‘applicable
18 year’ means the most recent taxable year for
19 which information is available in the Internal
20 Revenue Service’s taxpayer information records.

21 “(C) RESTRICTION ON INDIVIDUALS FOR
22 WHOM DISCLOSURE MAY BE REQUESTED.—The
23 Commissioner of Social Security shall request
24 information under this paragraph only with re-
25 spect to—

1 “(i) individuals the Social Security
2 Administration has identified, using all
3 other reasonably available information, as
4 likely to be eligible for a low-income pre-
5 scription drug subsidy under section
6 1860D–14 of the Social Security Act and
7 who have not applied for such subsidy, and

8 “(ii) any individual the Social Security
9 Administration has identified as a spouse
10 of an individual described in clause (i).

11 “(D) RESTRICTION ON USE OF DISCLOSED
12 INFORMATION.—Return information disclosed
13 under this paragraph may be used only by offi-
14 cers and employees of the Social Security Ad-
15 ministration solely for purposes of identifying
16 individuals likely to be ineligible for a low-in-
17 come prescription drug subsidy under section
18 1860D–14 of the Social Security Act for use in
19 outreach efforts under section 1144 of the So-
20 cial Security Act.”.

21 (b) SAFEGUARDS.—Paragraph (4) of section 6103(p)
22 of such Code is amended—

23 (1) by striking “(19),” each place it appears,
24 and

1 (2) by striking “or (17)” each place it appears
2 and inserting “(17), or (19)”.

3 (c) CONFORMING AMENDMENT.—Paragraph (3) of
4 section 6103(a) of such Code is amended by striking
5 “(19),”.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to disclosures made after the date
8 which is 12 months after the date of the enactment of
9 this Act.

10 **SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH**
11 **TRUST FUND; FINANCING FOR TRUST FUND.**

12 (a) ESTABLISHMENT OF TRUST FUND.—

13 (1) IN GENERAL.—Subchapter A of chapter 98
14 of the Internal Revenue Code of 1986 (relating to
15 trust fund code) is amended by adding at the end
16 the following new section:

17 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**
18 **RESEARCH TRUST FUND.**

19 “(a) CREATION OF TRUST FUND.—There is estab-
20 lished in the Treasury of the United States a trust fund
21 to be known as the ‘Health Care Comparative Effective-
22 ness Research Trust Fund’ (hereinafter in this section re-
23 ferred to as the ‘CERTF’), consisting of such amounts
24 as may be appropriated or credited to such Trust Fund
25 as provided in this section and section 9602(b).

1 “(b) TRANSFERS TO FUND.—

2 “(1) IN GENERAL.—There are hereby appro-
3 priated to the Trust Fund the following:

4 “(A) For fiscal year 2010, \$90,000,000.

5 “(B) For fiscal year 2011, \$100,000,000.

6 “(C) For fiscal year 2012, \$110,000,000.

7 “(D) For each fiscal year beginning with
8 fiscal year 2013—

9 “(i) an amount equivalent to the net
10 revenues received in the Treasury from the
11 fees imposed under subchapter B of chap-
12 ter 34 (relating to fees on health insurance
13 and self-insured plans) for such fiscal year;
14 and

15 “(ii) subject to subsection (c)(2),
16 amounts determined by the Secretary of
17 Health and Human Services to be equiva-
18 lent to the fair share per capita amount
19 computed under subsection (c)(1) for the
20 fiscal year multiplied by the average num-
21 ber of individuals entitled to benefits under
22 part A, or enrolled under part B, of title
23 XVIII of the Social Security Act during
24 such fiscal year.

25 “(2) ADMINISTRATIVE PROVISIONS.—

1 “(A) TRANSFERS FROM OTHER TRUST
2 FUNDS.—The amounts appropriated by sub-
3 paragraphs (A), (B), (C), and (D)(ii) of para-
4 graph (1) shall be transferred from the Federal
5 Hospital Insurance Trust Fund and from the
6 Federal Supplementary Medical Insurance
7 Trust Fund (established under section 1841 of
8 such Act), and from the Medicare Prescription
9 Drug Account within such Trust Fund, in pro-
10 portion (as estimated by the Secretary) to the
11 total expenditures during such fiscal year that
12 are made under title XVIII of such Act from
13 the respective trust fund or account.

14 “(B) APPROPRIATIONS NOT SUBJECT TO
15 FISCAL YEAR LIMITATION.—The amounts ap-
16 propriated by paragraph (1) shall not be sub-
17 ject to any fiscal year limitation.

18 “(C) PERIODIC TRANSFERS, ESTIMATES,
19 AND ADJUSTMENTS.—Except as provided in
20 subparagraph (A), the provisions of section
21 9601 shall apply to the amounts appropriated
22 by paragraph (1).

23 “(c) FAIR SHARE PER CAPITA AMOUNT.—

24 “(1) COMPUTATION.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the fair share per capita amount
3 under this paragraph for a fiscal year (begin-
4 ning with fiscal year 2013) is an amount com-
5 puted by the Secretary of Health and Human
6 Services for such fiscal year that, when applied
7 under this section and subchapter B of chapter
8 34 of the Internal Revenue Code of 1986, will
9 result in revenues to the CERTF of
10 \$375,000,000 for the fiscal year.

11 “(B) ALTERNATIVE COMPUTATION.—

12 “(i) IN GENERAL.—If the Secretary is
13 unable to compute the fair share per capita
14 amount under subparagraph (A) for a fis-
15 cal year, the fair share per capita amount
16 under this paragraph for the fiscal year
17 shall be the default amount determined
18 under clause (ii) for the fiscal year.

19 “(ii) DEFAULT AMOUNT.—The default
20 amount under this clause for—

21 “(I) fiscal year 2013 is equal to
22 \$2; or

23 “(II) a subsequent year is equal
24 to the default amount under this
25 clause for the preceding fiscal year in-

1 creased by the annual percentage in-
2 crease in the medical care component
3 of the consumer price index (United
4 States city average) for the 12-month
5 period ending with April of the pre-
6 ceding fiscal year.

7 Any amount determined under subclause
8 (II) shall be rounded to the nearest penny.

9 “(2) LIMITATION ON MEDICARE FUNDING.—In
10 no case shall the amount transferred under sub-
11 section (b)(4)(B) for any fiscal year exceed
12 \$90,000,000.

13 “(d) EXPENDITURES FROM FUND.—

14 “(1) IN GENERAL.—Subject to paragraph (2),
15 amounts in the CERTF are available, without the
16 need for further appropriations and without fiscal
17 year limitation, to the Secretary of Health and
18 Human Services to carry out section 1181 of the So-
19 cial Security Act.

20 “(2) ALLOCATION FOR COMMISSION.—The fol-
21 lowing amounts in the CERTF shall be available,
22 without the need for further appropriations and
23 without fiscal year limitation, to the Commission to
24 carry out the activities of the Comparative Effective-

1 ness Research Commission established under section
2 1181(b) of the Social Security Act:

3 “(A) For fiscal year 2010, \$7,000,000.

4 “(B) For fiscal year 2011, \$9,000,000.

5 “(C) For each fiscal year beginning with
6 2012, 2.6 percent of the total amount appro-
7 priated to the CERTF under subsection (b) for
8 the fiscal year.

9 “(e) NET REVENUES.—For purposes of this section,
10 the term ‘net revenues’ means the amount estimated by
11 the Secretary based on the excess of—

12 “(1) the fees received in the Treasury under
13 subchapter B of chapter 34, over

14 “(2) the decrease in the tax imposed by chapter
15 1 resulting from the fees imposed by such sub-
16 chapter.”.

17 (2) CLERICAL AMENDMENT.—The table of sec-
18 tions for such subchapter A is amended by adding
19 at the end thereof the following new item:

 “Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.”.

20 (b) FINANCING FOR FUND FROM FEES ON INSURED
21 AND SELF-INSURED HEALTH PLANS.—

22 (1) GENERAL RULE.—Chapter 34 of the Inter-
23 nal Revenue Code of 1986 is amended by adding at
24 the end the following new subchapter:

1 “(A) IN GENERAL.—In the case of any ar-
2 rangement described in subparagraph (B)—

3 “(i) such arrangement shall be treated
4 as a specified health insurance policy, and

5 “(ii) the person referred to in such
6 subparagraph shall be treated as the
7 issuer.

8 “(B) DESCRIPTION OF ARRANGEMENTS.—

9 An arrangement is described in this subpara-
10 graph if under such arrangement fixed pay-
11 ments or premiums are received as consider-
12 ation for any person’s agreement to provide or
13 arrange for the provision of accident or health
14 coverage to residents of the United States, re-
15 gardless of how such coverage is provided or ar-
16 ranged to be provided.

17 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

18 “(a) IMPOSITION OF FEE.—In the case of any appli-
19 cable self-insured health plan for each plan year, there is
20 hereby imposed a fee equal to the fair share per capita
21 amount determined under section 9511(c)(1) multiplied by
22 the average number of lives covered under the plan.

23 “(b) LIABILITY FOR FEE.—

24 “(1) IN GENERAL.—The fee imposed by sub-
25 section (a) shall be paid by the plan sponsor.

1 “(2) PLAN SPONSOR.—For purposes of para-
2 graph (1) the term ‘plan sponsor’ means—

3 “(A) the employer in the case of a plan es-
4 tablished or maintained by a single employer,

5 “(B) the employee organization in the case
6 of a plan established or maintained by an em-
7 ployee organization,

8 “(C) in the case of—

9 “(i) a plan established or maintained
10 by 2 or more employers or jointly by 1 or
11 more employers and 1 or more employee
12 organizations,

13 “(ii) a multiple employer welfare ar-
14 rangement, or

15 “(iii) a voluntary employees’ bene-
16 ficiary association described in section
17 501(c)(9),

18 the association, committee, joint board of trust-
19 ees, or other similar group of representatives of
20 the parties who establish or maintain the plan,
21 or

22 “(D) the cooperative or association de-
23 scribed in subsection (c)(2)(F) in the case of a
24 plan established or maintained by such a coop-
25 erative or association.

1 “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—

2 For purposes of this section, the term ‘applicable self-in-

3 sured health plan’ means any plan for providing accident

4 or health coverage if—

5 “(1) any portion of such coverage is provided

6 other than through an insurance policy, and

7 “(2) such plan is established or maintained—

8 “(A) by one or more employers for the

9 benefit of their employees or former employees,

10 “(B) by one or more employee organiza-

11 tions for the benefit of their members or former

12 members,

13 “(C) jointly by 1 or more employers and 1

14 or more employee organizations for the benefit

15 of employees or former employees,

16 “(D) by a voluntary employees’ beneficiary

17 association described in section 501(c)(9),

18 “(E) by any organization described in sec-

19 tion 501(c)(6), or

20 “(F) in the case of a plan not described in

21 the preceding subparagraphs, by a multiple em-

22 ployer welfare arrangement (as defined in sec-

23 tion 3(40) of Employee Retirement Income Se-

24 curity Act of 1974), a rural electric cooperative

25 (as defined in section 3(40)(B)(iv) of such Act),

1 or a rural telephone cooperative association (as
2 defined in section 3(40)(B)(v) of such Act).

3 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

4 “(a) DEFINITIONS.—For purposes of this sub-
5 chapter—

6 “(1) ACCIDENT AND HEALTH COVERAGE.—The
7 term ‘accident and health coverage’ means any cov-
8 erage which, if provided by an insurance policy,
9 would cause such policy to be a specified health in-
10 surance policy (as defined in section 4375(c)).

11 “(2) INSURANCE POLICY.—The term ‘insurance
12 policy’ means any policy or other instrument where-
13 by a contract of insurance is issued, renewed, or ex-
14 tended.

15 “(3) UNITED STATES.—The term ‘United
16 States’ includes any possession of the United States.

17 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

18 “(1) IN GENERAL.—For purposes of this sub-
19 chapter—

20 “(A) the term ‘person’ includes any gov-
21 ernmental entity, and

22 “(B) notwithstanding any other law or rule
23 of law, governmental entities shall not be ex-
24 empt from the fees imposed by this subchapter
25 except as provided in paragraph (2).

1 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
2 PROGRAMS.—In the case of an exempt governmental
3 program, no fee shall be imposed under section 4375
4 or section 4376 on any covered life under such pro-
5 gram.

6 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
7 FINED.—For purposes of this subchapter, the term
8 ‘exempt governmental program’ means—

9 “(A) any insurance program established
10 under title XVIII of the Social Security Act,

11 “(B) the medical assistance program es-
12 tablished by title XIX or XXI of the Social Se-
13 curity Act,

14 “(C) any program established by Federal
15 law for providing medical care (other than
16 through insurance policies) to individuals (or
17 the spouses and dependents thereof) by reason
18 of such individuals being—

19 “(i) members of the Armed Forces of
20 the United States, or

21 “(ii) veterans, and

22 “(D) any program established by Federal
23 law for providing medical care (other than
24 through insurance policies) to members of In-

1 dian tribes (as defined in section 4(d) of the In-
2 dian Health Care Improvement Act).

3 “(c) TREATMENT AS TAX.—For purposes of subtitle
4 F, the fees imposed by this subchapter shall be treated
5 as if they were taxes.

6 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
7 standing any other provision of law, no amount collected
8 under this subchapter shall be covered over to any posses-
9 sion of the United States.”.

10 (2) CLERICAL AMENDMENTS.—

11 (A) Chapter 34 of such Code is amended
12 by striking the chapter heading and inserting
13 the following:

14 **“CHAPTER 34—TAXES ON CERTAIN**
15 **INSURANCE POLICIES**

 “SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

 “SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

16 **“Subchapter A—Policies Issued By Foreign**
17 **Insurers”.**

18 (B) The table of chapters for subtitle D of
19 such Code is amended by striking the item re-
20 lating to chapter 34 and inserting the following
21 new item:

 “CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

22 (3) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply with respect to policies

1 and plans for portions of policy or plan years begin-
2 ning on or after October 1, 2012.

3 **TITLE IX—MISCELLANEOUS**
4 **PROVISIONS**

5 **SEC. 1901. REPEAL OF TRIGGER PROVISION.**

6 Subtitle A of title VIII of the Medicare Prescription
7 Drug, Improvement, and Modernization Act of 2003 (Pub-
8 lic Law 108–173) is repealed and the provisions of law
9 amended by such subtitle are restored as if such subtitle
10 had never been enacted.

11 **SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT**
12 **(CCA) PROGRAM.**

13 Section 1860C–1 of the Social Security Act (42
14 U.S.C. 1395w–29), as added by section 241(a) of the
15 Medicare Prescription Drug, Improvement, and Mod-
16 ernization Act of 2003 (Public Law 108–173), is repealed.

17 **SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.**

18 (a) IN GENERAL.—Subsection (d)(3) of section 5007
19 of the Deficit Reduction Act of 2005 (Public Law 109–
20 171) is amended by inserting “(or September 30, 2011,
21 in the case of a demonstration project in operation as of
22 October 1, 2008)” after “December 31, 2009”.

23 (b) FUNDING.—

1 (1) IN GENERAL.—Subsection (f)(1) of such
2 section is amended by inserting “and for fiscal year
3 2010, \$1,600,000,” after “\$6,000,000,”.

4 (2) AVAILABILITY.—Subsection (f)(2) of such
5 section is amended by striking “2010” and inserting
6 “2014 or until expended”.

7 (c) REPORTS.—

8 (1) QUALITY IMPROVEMENT AND SAVINGS.—
9 Subsection (e)(3) of such section is amended by
10 striking “December 1, 2008” and inserting “March
11 31, 2011”.

12 (2) FINAL REPORT.—Subsection (e)(4) of such
13 section is amended by striking “May 1, 2010” and
14 inserting “March 31, 2013”.

15 **SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITA-**
16 **TION PROGRAMS FOR FAMILIES WITH YOUNG**
17 **CHILDREN AND FAMILIES EXPECTING CHIL-**
18 **DREN.**

19 Part B of title IV of the Social Security Act (42
20 U.S.C. 621–629i) is amended by adding at the end the
21 following:

1 **“Subpart 3—Support for Quality Home Visitation**
2 **Programs**

3 **“SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES**
4 **WITH YOUNG CHILDREN AND FAMILIES EX-**
5 **PECTING CHILDREN.**

6 “(a) PURPOSE.—The purpose of this section is to im-
7 prove the well-being, health, and development of children
8 by enabling the establishment and expansion of high qual-
9 ity programs providing voluntary home visitation for fami-
10 lies with young children and families expecting children.

11 “(b) GRANT APPLICATION.—A State that desires to
12 receive a grant under this section shall submit to the Sec-
13 retary for approval, at such time and in such manner as
14 the Secretary may require, an application for the grant
15 that includes the following:

16 “(1) DESCRIPTION OF HOME VISITATION PRO-
17 GRAMS.—A description of the high quality programs
18 of home visitation for families with young children
19 and families expecting children that will be sup-
20 ported by a grant made to the State under this sec-
21 tion, the outcomes the programs are intended to
22 achieve, and the evidence supporting the effective-
23 ness of the programs.

24 “(2) RESULTS OF NEEDS ASSESSMENT.—The
25 results of a statewide needs assessment that de-
26 scribes—

1 “(A) the number, quality, and capacity of
2 home visitation programs for families with
3 young children and families expecting children
4 in the State;

5 “(B) the number and types of families who
6 are receiving services under the programs;

7 “(C) the sources and amount of funding
8 provided to the programs;

9 “(D) the gaps in home visitation in the
10 State, including identification of communities
11 that are in high need of the services; and

12 “(E) training and technical assistance ac-
13 tivities designed to achieve or support the goals
14 of the programs.

15 “(3) ASSURANCES.—Assurances from the State
16 that—

17 “(A) in supporting home visitation pro-
18 grams using funds provided under this section,
19 the State shall identify and prioritize serving
20 communities that are in high need of such serv-
21 ices, especially communities with a high propor-
22 tion of low-income families or a high incidence
23 of child maltreatment;

24 “(B) the State will reserve 5 percent of the
25 grant funds for training and technical assist-

1 ance to the home visitation programs using
2 such funds;

3 “(C) in supporting home visitation pro-
4 grams using funds provided under this section,
5 the State will promote coordination and collabo-
6 ration with other home visitation programs (in-
7 cluding programs funded under title XIX) and
8 with other child and family services, health
9 services, income supports, and other related as-
10 sistance;

11 “(D) home visitation programs supported
12 using such funds will, when appropriate, pro-
13 vide referrals to other programs serving chil-
14 dren and families; and

15 “(E) the State will comply with subsection
16 (i), and cooperate with any evaluation con-
17 ducted under subsection (j).

18 “(4) OTHER INFORMATION.—Such other infor-
19 mation as the Secretary may require.

20 “(c) ALLOTMENTS.—

21 “(1) INDIAN TRIBES.—From the amount re-
22 served under subsection (l)(2) for a fiscal year, the
23 Secretary shall allot to each Indian tribe that meets
24 the requirement of subsection (d), if applicable, for
25 the fiscal year the amount that bears the same ratio

1 to the amount so reserved as the number of children
2 in the Indian tribe whose families have income that
3 does not exceed 200 percent of the poverty line bears
4 to the total number of children in such Indian tribes
5 whose families have income that does not exceed 200
6 percent of the poverty line.

7 “(2) STATES AND TERRITORIES.—From the
8 amount appropriated under subsection (m) for a fis-
9 cal year that remains after making the reservations
10 required by subsection (l), the Secretary shall allot
11 to each State that is not an Indian tribe and that
12 meets the requirement of subsection (d), if applica-
13 ble, for the fiscal year the amount that bears the
14 same ratio to the remainder of the amount so appro-
15 priated as the number of children in the State whose
16 families have income that does not exceed 200 per-
17 cent of the poverty line bears to the total number of
18 children in such States whose families have income
19 that does not exceed 200 percent of the poverty line.

20 “(3) REALLOTMENTS.—The amount of any al-
21 lotment to a State under a paragraph of this sub-
22 section for any fiscal year that the State certifies to
23 the Secretary will not be expended by the State pur-
24 suant to this section shall be available for reallocot-
25 ment using the allotment methodology specified in

1 that paragraph. Any amount so reallocated to a State
2 is deemed part of the allotment of the State under
3 this subsection.

4 “(d) MAINTENANCE OF EFFORT.—Beginning with
5 fiscal year 2011, a State meets the requirement of this
6 subsection for a fiscal year if the Secretary finds that the
7 aggregate expenditures by the State from State and local
8 sources for programs of home visitation for families with
9 young children and families expecting children for the then
10 preceding fiscal year was not less than 100 percent of such
11 aggregate expenditures for the then 2nd preceding fiscal
12 year.

13 “(e) PAYMENT OF GRANT.—

14 “(1) IN GENERAL.—The Secretary shall make a
15 grant to each State that meets the requirements of
16 subsections (b) and (d), if applicable, for a fiscal
17 year for which funds are appropriated under sub-
18 section (m), in an amount equal to the reimbursable
19 percentage of the eligible expenditures of the State
20 for the fiscal year, but not more than the amount
21 allotted to the State under subsection (c) for the fis-
22 cal year.

23 “(2) REIMBURSABLE PERCENTAGE DEFINED.—
24 In paragraph (1), the term ‘reimbursable percent-
25 age’ means, with respect to a fiscal year—

1 “(A) 85 percent, in the case of fiscal year
2 2010;

3 “(B) 80 percent, in the case of fiscal year
4 2011; or

5 “(C) 75 percent, in the case of fiscal year
6 2012 and any succeeding fiscal year.

7 “(f) ELIGIBLE EXPENDITURES.—

8 “(1) IN GENERAL.—In this section, the term
9 ‘eligible expenditures’—

10 “(A) means expenditures to provide vol-
11 untary home visitation for as many families
12 with young children (under the age of school
13 entry) and families expecting children as prac-
14 ticable, through the implementation or expan-
15 sion of high quality home visitation programs
16 that—

17 “(i) adhere to clear evidence-based
18 models of home visitation that have dem-
19 onstrated positive effects on important pro-
20 gram-determined child and parenting out-
21 comes, such as reducing abuse and neglect
22 and improving child health and develop-
23 ment;

24 “(ii) employ well-trained and com-
25 petent staff, maintain high quality super-

1 vision, provide for ongoing training and
2 professional development, and show strong
3 organizational capacity to implement such
4 a program;

5 “(iii) establish appropriate linkages
6 and referrals to other community resources
7 and supports;

8 “(iv) monitor fidelity of program im-
9 plementation to ensure that services are
10 delivered according to the specified model;
11 and

12 “(v) provide parents with—

13 “(I) knowledge of age-appro-
14 priate child development in cognitive,
15 language, social, emotional, and motor
16 domains (including knowledge of sec-
17 ond language acquisition, in the case
18 of English language learners);

19 “(II) knowledge of realistic ex-
20 pectations of age-appropriate child be-
21 haviors;

22 “(III) knowledge of health and
23 wellness issues for children and par-
24 ents;

1 “(IV) modeling, consulting, and
2 coaching on parenting practices;

3 “(V) skills to interact with their
4 child to enhance age-appropriate de-
5 velopment;

6 “(VI) skills to recognize and seek
7 help for issues related to health, devel-
8 opmental delays, and social, emo-
9 tional, and behavioral skills; and

10 “(VII) activities designed to help
11 parents become full partners in the
12 education of their children;

13 “(B) includes expenditures for training,
14 technical assistance, and evaluations related to
15 the programs; and

16 “(C) does not include any expenditure with
17 respect to which a State has submitted a claim
18 for payment under any other provision of Fed-
19 eral law.

20 “(2) PRIORITY FUNDING FOR PROGRAMS WITH
21 STRONGEST EVIDENCE.—

22 “(A) IN GENERAL.—The expenditures, de-
23 scribed in paragraph (1), of a State for a fiscal
24 year that are attributable to the cost of pro-
25 grams that do not adhere to a model of home

1 visitation with the strongest evidence of effec-
2 tiveness shall not be considered eligible expendi-
3 tures for the fiscal year to the extent that the
4 total of the expenditures exceeds the applicable
5 percentage for the fiscal year of the allotment
6 of the State under subsection (c) for the fiscal
7 year.

8 “(B) APPLICABLE PERCENTAGE DE-
9 FINED.—In subparagraph (A), the term ‘appli-
10 cable percentage’ means, with respect to a fiscal
11 year—

12 “(i) 60 percent for fiscal year 2010;

13 “(ii) 55 percent for fiscal year 2011;

14 “(iii) 50 percent for fiscal year 2012;

15 “(iv) 45 percent for fiscal year 2013;

16 or

17 “(v) 40 percent for fiscal year 2014.

18 “(g) NO USE OF OTHER FEDERAL FUNDS FOR
19 STATE MATCH.—A State to which a grant is made under
20 this section may not expend any Federal funds to meet
21 the State share of the cost of an eligible expenditure for
22 which the State receives a payment under this section.

23 “(h) WAIVER AUTHORITY.—

24 “(1) IN GENERAL.—The Secretary may waive
25 or modify the application of any provision of this

1 section, other than subsection (b) or (f), to an In-
2 dian tribe if the failure to do so would impose an
3 undue burden on the Indian tribe.

4 “(2) SPECIAL RULE.—An Indian tribe is
5 deemed to meet the requirement of subsection (d)
6 for purposes of subsections (c) and (e) if—

7 “(A) the Secretary waives the requirement;

8 or

9 “(B) the Secretary modifies the require-
10 ment, and the Indian tribe meets the modified
11 requirement.

12 “(i) STATE REPORTS.—Each State to which a grant
13 is made under this section shall submit to the Secretary
14 an annual report on the progress made by the State in
15 addressing the purposes of this section. Each such report
16 shall include a description of—

17 “(1) the services delivered by the programs that
18 received funds from the grant;

19 “(2) the characteristics of each such program,
20 including information on the service model used by
21 the program and the performance of the program;

22 “(3) the characteristics of the providers of serv-
23 ices through the program, including staff qualifica-
24 tions, work experience, and demographic characteris-
25 tics;

1 “(4) the characteristics of the recipients of serv-
2 ices provided through the program, including the
3 number of the recipients, the demographic charac-
4 teristics of the recipients, and family retention;

5 “(5) the annual cost of implementing the pro-
6 gram, including the cost per family served under the
7 program;

8 “(6) the outcomes experienced by recipients of
9 services through the program;

10 “(7) the training and technical assistance pro-
11 vided to aid implementation of the program, and
12 how the training and technical assistance contrib-
13 uted to the outcomes achieved through the program;

14 “(8) the indicators and methods used to mon-
15 itor whether the program is being implemented as
16 designed; and

17 “(9) other information as determined necessary
18 by the Secretary.

19 “(j) EVALUATION.—

20 “(1) IN GENERAL.—The Secretary shall, by
21 grant or contract, provide for the conduct of an
22 independent evaluation of the effectiveness of home
23 visitation programs receiving funds provided under
24 this section, which shall examine the following:

1 “(A) The effect of home visitation pro-
2 grams on child and parent outcomes, including
3 child maltreatment, child health and develop-
4 ment, school readiness, and links to community
5 services.

6 “(B) The effectiveness of home visitation
7 programs on different populations, including
8 the extent to which the ability of programs to
9 improve outcomes varies across programs and
10 populations.

11 “(2) REPORTS TO THE CONGRESS.—

12 “(A) INTERIM REPORT.—Within 3 years
13 after the date of the enactment of this section,
14 the Secretary shall submit to the Congress an
15 interim report on the evaluation conducted pur-
16 suant to paragraph (1).

17 “(B) FINAL REPORT.—Within 5 years
18 after the date of the enactment of this section,
19 the Secretary shall submit to the Congress a
20 final report on the evaluation conducted pursu-
21 ant to paragraph (1).

22 “(k) ANNUAL REPORTS TO THE CONGRESS.—The
23 Secretary shall submit annually to the Congress a report
24 on the activities carried out using funds made available

1 under this section, which shall include a description of the
2 following:

3 “(1) The high need communities targeted by
4 States for programs carried out under this section.

5 “(2) The service delivery models used in the
6 programs receiving funds provided under this sec-
7 tion.

8 “(3) The characteristics of the programs, in-
9 cluding—

10 “(A) the qualifications and demographic
11 characteristics of program staff; and

12 “(B) recipient characteristics including the
13 number of families served, the demographic
14 characteristics of the families served, and fam-
15 ily retention and duration of services.

16 “(4) The outcomes reported by the programs.

17 “(5) The research-based instruction, materials,
18 and activities being used in the activities funded
19 under the grant.

20 “(6) The training and technical activities, in-
21 cluding on-going professional development, provided
22 to the programs.

23 “(7) The annual costs of implementing the pro-
24 grams, including the cost per family served under
25 the programs.

1 “(8) The indicators and methods used by States
2 to monitor whether the programs are being been im-
3 plemented as designed.

4 “(1) RESERVATIONS OF FUNDS.—From the amounts
5 appropriated for a fiscal year under subsection (m), the
6 Secretary shall reserve—

7 “(1) an amount equal to 5 percent of the
8 amounts to pay the cost of the evaluation provided
9 for in subsection (j), and the provision to States of
10 training and technical assistance, including the dis-
11 semination of best practices in early childhood home
12 visitation; and

13 “(2) after making the reservation required by
14 paragraph (1), an amount equal to 3 percent of the
15 amount so appropriated, to pay for grants to Indian
16 tribes under this section.

17 “(m) APPROPRIATIONS.—Out of any money in the
18 Treasury of the United States not otherwise appropriated,
19 there is appropriated to the Secretary to carry out this
20 section—

21 “(1) \$50,000,000 for fiscal year 2010;

22 “(2) \$100,000,000 for fiscal year 2011;

23 “(3) \$150,000,000 for fiscal year 2012;

24 “(4) \$200,000,000 for fiscal year 2013; and

25 “(5) \$250,000,000 for fiscal year 2014.

1 “(n) INDIAN TRIBES TREATED AS STATES.—In this
2 section, paragraphs (4), (5), and (6) of section 431(a)
3 shall apply.”.

4 **SEC. 1905. IMPROVED COORDINATION AND PROTECTION**
5 **FOR DUAL ELIGIBLES.**

6 Title XI of the Social Security Act is amended by
7 inserting after section 1150 the following new section:

8 “IMPROVED COORDINATION AND PROTECTION FOR DUAL
9 ELIGIBLES

10 “SEC. 1150A. (a) IN GENERAL.—The Secretary shall
11 provide, through an identifiable office or program within
12 the Centers for Medicare & Medicaid Services, for a fo-
13 cused effort to provide for improved coordination between
14 Medicare and Medicaid and protection in the case of dual
15 eligibles (as defined in subsection (g)). The office or pro-
16 gram shall—

17 “(1) review Medicare and Medicaid policies re-
18 lated to enrollment, benefits, service delivery, pay-
19 ment, and grievance and appeals processes under
20 parts A and B of title XVIII, under the Medicare
21 Advantage program under part C of such title, and
22 under title XIX;

23 “(2) identify areas of such policies where better
24 coordination and protection could improve care and
25 costs; and

1 “(3) issue guidance to States regarding improv-
2 ing such coordination and protection.

3 “(b) ELEMENTS.—The improved coordination and
4 protection under this section shall include efforts—

5 “(1) to simplify access of dual eligibles to bene-
6 fits and services under Medicare and Medicaid;

7 “(2) to improve care continuity for dual eligi-
8 bles and ensure safe and effective care transitions;

9 “(3) to harmonize regulatory conflicts between
10 Medicare and Medicaid rules with regard to dual eli-
11 gibles; and

12 “(4) to improve total cost and quality perform-
13 ance under Medicare and Medicaid for dual eligibles.

14 “(c) RESPONSIBILITIES.—In carrying out this sec-
15 tion, the Secretary shall provide for the following:

16 “(1) An examination of Medicare and Medicaid
17 payment systems to develop strategies to foster more
18 integrated and higher quality care.

19 “(2) Development of methods to facilitate ac-
20 cess to post-acute and community-based services and
21 to identify actions that could lead to better coordina-
22 tion of community-based care.

23 “(3) A study of enrollment of dual eligibles in
24 the Medicare Savings Program (as defined in section
25 1144(e)(7)), under Medicaid, and in the low-income

1 subsidy program under section 1860D–14 to identify
2 methods to more efficiently and effectively reach and
3 enroll dual eligibles.

4 “(4) An assessment of communication strate-
5 gies for dual eligibles to determine whether addi-
6 tional informational materials or outreach is needed,
7 including an assessment of the Medicare website, 1–
8 800–MEDICARE, and the Medicare handbook.

9 “(5) Research and evaluation of areas where
10 service utilization, quality, and access to cost sharing
11 protection could be improved and an assessment of
12 factors related to enrollee satisfaction with services
13 and care delivery.

14 “(6) Collection (and making available to the
15 public) of data and a database that describe the eli-
16 gibility, benefit and cost-sharing assistance available
17 to dual eligibles by State.

18 “(7) Support for coordination of State and Fed-
19 eral contracting and oversight for dual coordination
20 programs supportive of the goals described in sub-
21 section (b).

22 “(8) Support for State Medicaid agencies
23 through the provision of technical assistance for
24 Medicare and Medicaid coordination initiatives de-

1 signed to improve acute and long-term care for dual
2 eligibles.

3 “(9) Monitoring total combined Medicare and
4 Medicaid program costs in serving dual eligibles and
5 making recommendations for optimizing total quality
6 and cost performance across both programs.

7 “(10) Coordination of activities relating to
8 Medicare Advantage plans under 1859(b)(6)(B)(ii)
9 and Medicaid.

10 “(d) REPORTING.—The Office or program shall work
11 with relevant State agencies and any appropriate quality
12 measurement entities to improve and coordinate reporting
13 requirements for Medicare and Medicaid. In addition, the
14 Office or program shall seek to minimize duplication in
15 reporting requirements, where appropriate, and to identify
16 opportunities to combine assessment requirements, where
17 appropriate. The Office or program shall seek to identify
18 quality metrics and assessment requirements that facili-
19 tate comparisons of the quality of care received by bene-
20 ficiaries enrolled in or entitled to benefits under fee-for-
21 service Medicare, the Medicare Advantage program, fee-
22 for-service Medicaid, and Medicaid managed care, and
23 combinations thereof (including integrated Medicare-Med-
24 icaid programs for dual eligibles).

1 “(e) ENDORSEMENT.—The Secretary shall seek en-
2 dorsement by the entity with a contract under section
3 1890(a) of quality measures and benchmarks developed
4 under this section.

5 “(f) CONSULTATION WITH STAKEHOLDERS.—The
6 Office or program shall consult with relevant stakeholders,
7 including dual eligible beneficiaries representatives for
8 dual eligible beneficiaries, health plans, providers, and rel-
9 evant State agencies, in the development of policies related
10 to integrated Medicare-Medicaid programs for dual eligi-
11 bles.

12 “(g) PERIODIC REPORTS.—Not later than 1 year
13 after the date of the enactment of this section and every
14 3 years thereafter the Secretary shall submit to Congress
15 a report on progress in activities conducted under this sec-
16 tion.

17 “(h) DEFINITIONS.—In this section:

18 “(1) DUAL ELIGIBLE.—The term ‘dual eligible’
19 means an individual who is dually eligible for bene-
20 fits under title XVIII, and medical assistance under
21 title XIX, including such individuals who are eligible
22 for benefits under the Medicare Savings Program
23 (as defined in section 1144(c)(7)).

1 “(2) MEDICARE; MEDICAID.—The terms ‘Medi-
2 care’ and ‘Medicaid’ mean the programs under titles
3 XVIII and XIX, respectively.”.

4 **SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE**
5 **DISEASES AND CONDITIONS.**

6 (a) INITIAL ASSESSMENT.—

7 (1) IN GENERAL.—The Secretary of Health and
8 Human Services shall conduct an assessment of the
9 diseases and conditions that are the most cost-inten-
10 sive for the Medicare program and, to the extent
11 possible, assess the diseases and conditions that
12 could become cost-intensive for Medicare in the fu-
13 ture. In conducting the assessment, the Secretary
14 shall include the input of relevant research agencies,
15 including the National Institutes of Health, the
16 Agency for Healthcare Research and Quality, the
17 Food and Drug Administration, and the Centers for
18 Medicare & Medicaid Services.

19 (2) REPORT.—Not later than January 1, 2011,
20 the Secretary shall transmit a report to the Commit-
21 tees on Energy and Commerce, Ways and Means,
22 and Appropriations of the House of Representatives
23 and the Committees on Health, Education, Labor
24 and Pensions, Finance, and Appropriations of the

1 Senate on the assessment conducted under para-
2 graph (1). Such report shall—

3 (A) include the assessment of current and
4 future trends of cost-intensive diseases and con-
5 ditions described in such paragraph;

6 (B) address whether current research pri-
7 orities are appropriately addressing current and
8 future cost-intensive conditions so identified;
9 and

10 (C) include recommendations concerning
11 research in the Department of Health and
12 Human Services that should be funded to im-
13 prove the prevention, treatment, or cure of such
14 cost-intensive diseases and conditions.

15 (b) UPDATES OF ASSESSMENT.—Not later than Jan-
16 uary 1, 2013, and biennially thereafter, the Secretary
17 shall—

18 (1) review and update the assessment and rec-
19 ommendations described in subsection (a)(1); and

20 (2) submit a report described in subsection
21 (a)(2) to the Committees specified in subsection
22 (a)(2) on such updated assessment and rec-
23 ommendations.

1 **SEC. 1907. ESTABLISHMENT OF CENTER FOR MEDICARE**
2 **AND MEDICAID INNOVATION WITHIN CMS.**

3 (a) IN GENERAL.—Title XI of the Social Security Act
4 is amended by inserting after section 1115 the following
5 new section:

6 “CENTER FOR MEDICARE AND MEDICAID INNOVATION
7 “SEC. 1115A. (a) CENTER FOR MEDICARE AND
8 MEDICAID INNOVATION ESTABLISHED.—

9 “(1) IN GENERAL.—There is created within the
10 Centers for Medicare & Medicaid Services a Center
11 for Medicare and Medicaid Innovation (in this sec-
12 tion referred to as the ‘CMI’) to carry out the duties
13 described in this section. The purpose of the CMI is
14 to test innovative payment and service delivery mod-
15 els to improve the coordination, quality, and effi-
16 ciency of health care services provided to applicable
17 individuals defined in paragraph (4)(A).

18 “(2) DEADLINE.—The Secretary shall ensure
19 that the CMI is carrying out the duties described in
20 this section by not later than January 1, 2011.

21 “(3) CONSULTATION.—In carrying out the du-
22 ties under this section, the CMI shall consult rep-
23 resentatives of relevant Federal agencies, clinical
24 and analytical experts with expertise in medicine and
25 health care management, and States. The CMI shall

1 use open door forums or other mechanisms to seek
2 input from interested parties.

3 “(4) DEFINITIONS.—In this section:

4 “(A) APPLICABLE INDIVIDUAL.—The term
5 ‘applicable individual’ means—

6 “(i) an individual who is enrolled
7 under part B and entitled to benefits
8 under part A of title XVIII;

9 “(ii) an individual who is eligible for
10 medical assistance under title XIX; or

11 “(iii) an individual who meets the cri-
12 teria of both clauses (i) and (ii).

13 “(B) APPLICABLE TITLE.—The term ‘ap-
14 plicable title’ means title XVIII, title XIX, or
15 both.

16 “(b) TESTING OF MODELS (PHASE I).—

17 “(1) IN GENERAL.—The CMI shall test pay-
18 ment and service delivery models in accordance with
19 selection criteria under paragraph (2) to determine
20 the effect of applying such models under the applica-
21 ble title (as defined in subsection (a)(4)(B)) on pro-
22 gram expenditures under such titles and the quality
23 of care received by individuals receiving benefits
24 under such title.

25 “(2) SELECTION OF MODELS TO BE TESTED.—

1 “(A) IN GENERAL.—The Secretary shall
2 give preference to testing models for which, as
3 determined by the Administrator of the Centers
4 for Medicare & Medicaid Services and using
5 such input from outside the Centers as the Ad-
6 ministrator determines appropriate, there is evi-
7 dence that the model addresses a defined popu-
8 lation for which there are deficits in care lead-
9 ing to poor clinical outcomes or potentially
10 avoidable expenditures. The Administrator shall
11 focus on models expected to reduce program
12 costs under the applicable title while preserving
13 or enhancing the quality of care received by in-
14 dividuals receiving benefits under such title.

15 “(B) APPLICATION TO OTHER DEM-
16 ONSTRATIONS.—The Secretary shall operate the
17 demonstration programs under sections 1222
18 and 1236 of the Affordable Health Care for
19 America Act through the CMI in accordance
20 with the rules applicable under this section, in-
21 cluding those relating to evaluations, termi-
22 nations, and expansions.

23 “(3) BUDGET NEUTRALITY.—

24 “(A) INITIAL PERIOD.—The Secretary
25 shall not require, as a condition for testing a

1 model under paragraph (1), that the design of
2 such model ensure that such model is budget
3 neutral initially with respect to expenditures
4 under the applicable title.

5 “(B) TERMINATION.—The Secretary shall
6 terminate or modify the design and implemen-
7 tation of a model unless the Secretary deter-
8 mines (and the Chief Actuary of the Centers for
9 Medicare & Medicaid Services, with respect to
10 spending under the applicable title, certifies),
11 after testing has begun, that the model is ex-
12 pected to—

13 “(i) improve the quality of care (as
14 determined by the Administrator of the
15 Centers for Medicare & Medicaid Services)
16 without increasing spending under such
17 title;

18 “(ii) reduce spending under such titles
19 without reducing the quality of care; or

20 “(iii) do both.

21 Such termination may occur at any time after
22 such testing has begun and before completion of
23 the testing.

24 “(4) EVALUATION.—

1 “(A) IN GENERAL.—The Secretary shall
2 conduct an evaluation of each model tested
3 under this subsection. Such evaluation shall in-
4 clude an analysis of—

5 “(i) the quality of care furnished
6 under the model, including through the use
7 of patient-level outcomes measures; and

8 “(ii) the changes in spending under
9 the applicable titles by reason of the
10 model.

11 The Secretary shall make the results of each
12 evaluation under this paragraph available to the
13 public in a timely fashion.

14 “(B) MEASURE SELECTION.—To the ex-
15 tent feasible, the Secretary shall select meas-
16 ures under this paragraph that reflect national
17 priorities for quality improvement and patient-
18 centered care consistent with the measures de-
19 veloped under section 1192(c)(1).

20 “(5) TESTING PERIOD.—In no case shall a
21 model be tested under this subsection for more than
22 a 7-year period.

23 “(c) EXPANSION OF MODELS (PHASE II).—The Sec-
24 retary may expand the duration and the scope of a model

1 that is being tested under subsection (b) (including imple-
2 mentation on a nationwide basis), to the extent deter-
3 mined appropriate by the Secretary, if—

4 “(1) the Secretary determines that such expan-
5 sion is expected—

6 “(A) to improve the quality of patient care
7 without increasing spending under the applica-
8 ble titles;

9 “(B) to reduce spending under applicable
10 titles without reducing the quality of care; or

11 “(C) to do both;

12 “(2) the Chief Actuary of the Centers for Medi-
13 care & Medicaid Services certifies that such expan-
14 sion would reduce (or not result in any increase in)
15 net program spending under applicable titles; and

16 “(3) the Secretary determines that such expan-
17 sion would not deny or limit the coverage or provi-
18 sion of benefits under the applicable title for applica-
19 ble individuals.

20 “(d) IMPLEMENTATION.—

21 “(1) WAIVER AUTHORITY.—The Secretary may
22 waive such requirements of titles XI and XVIII and
23 of sections 1902 and 1903(m) as may be necessary
24 solely for purposes of carrying out this section with
25 respect to testing models described in subsection (b).

1 “(2) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of—

4 “(A) the selection of models for testing or
5 expansion under this section;

6 “(B) the elements, parameters, scope, and
7 duration of such models for testing or dissemi-
8 nation;

9 “(C) the termination or modification of the
10 design and implementation of a model under
11 subsection (b)(3)(B); and

12 “(D) determinations about expansion of
13 the duration and scope of a model under sub-
14 section (c) including the determination that a
15 model is not expected to meet criteria described
16 in paragraphs (1) or (2) of such subsection.

17 “(3) ADMINISTRATION.—Chapter 35 of title 44,
18 United States Code shall not apply to the testing
19 and evaluation of models or expansion of such mod-
20 els under this section.

21 “(4) FUNDING FOR TESTING ITEMS AND SERV-
22 ICES AND ADMINISTRATIVE COSTS.—

23 “(A) ADDITIONAL BENEFITS.—There shall
24 be available until expended, equally divided
25 from the Federal Supplementary Hospital In-

1 surance Trust Fund and Federal Supple-
2 mentary Medical Insurance Trust Fund for
3 payments for additional benefits for items and
4 services under models tested under subsection
5 (b) not otherwise covered under this title and
6 applicable to benefits under this title, and for
7 researching, designing, implementing, and eval-
8 uating such models, \$350,000,000 for fiscal
9 year 2010, \$440,000,000 for fiscal year 2011,
10 \$550,000,000 for fiscal year 2012, and, for a
11 subsequent fiscal year, the amount determined
12 under this subparagraph for the preceding fis-
13 cal year increased by the annual percentage
14 rate of increase in total expenditures under this
15 title for the subsequent fiscal year as estimated
16 in the latest available Annual Report of the
17 Board of Trustees as described in section
18 1841(b)(2).

19 “(B) MEDICAID.—For administrative costs
20 of the Centers for Medicare & Medicaid Serv-
21 ices for administering this section with respect
22 to title XIX, from any amounts in the Treasury
23 not otherwise appropriated there are appro-
24 priated to the Secretary for the Centers for
25 Medicare & Medicaid Services Program Man-

1 agement Account \$25,000,000 for each fiscal
2 year beginning with fiscal year 2010. Amounts
3 appropriated under this subparagraph for a fis-
4 cal year shall be available until expended.

5 “(e) REPORT TO CONGRESS.—Beginning in 2012,
6 and not less than once every other year thereafter, the
7 Secretary shall submit to Congress a report on activities
8 under this section. Each such report shall describe the
9 payment models tested under subsection (b), including the
10 number of individuals described in subsection (a)(4)(A)(i)
11 and of individuals described in subsection (a)(4)(A)(ii)
12 participating in such models and payments made under
13 applicable titles for services on behalf of such individuals,
14 any models chosen for expansion under subsection (c), and
15 the results from evaluations under subsection (b)(4). In
16 addition, each such report shall provide such recommenda-
17 tions as the Secretary believes are appropriate for legisla-
18 tive action to facilitate the development and expansion of
19 successful payment models.”.

20 (b) MEDICAID CONFORMING AMENDMENT.—Section
21 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
22 as amended by sections 1631(b), 1703(a), 1729, 1753,
23 1757(a), and 1759(a), is amended—

24 (1) in paragraph (78), by striking “and” at the
25 end;

1 (2) in paragraph (79), by striking the period at
2 the end and inserting “; and”; and

3 (3) by inserting after paragraph (79) the fol-
4 lowing new paragraph:

5 “(80) provide for implementation of the pay-
6 ment models specified by the Secretary under section
7 1115A(c) for implementation on a nationwide basis
8 unless the State demonstrates to the satisfaction of
9 the Secretary that implementation would not be ad-
10 ministratively feasible or appropriate to the health
11 care delivery system of the State.”.

12 **SEC. 1908. 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”).

18 **SEC. 1909. DISREGARD UNDER THE SUPPLEMENTAL SECU-
19 RITY INCOME PROGRAM OF COMPENSATION
20 FOR PARTICIPATION IN CLINICAL TRIALS
21 FOR RARE DISEASES OR CONDITIONS.**

22 (a) INCOME DISREGARD.—Section 1612(b) of the So-
23 cial Security Act (42 U.S.C. 1382a(b)) is amended—

24 (1) by striking “and” at the end of paragraph
25 (24);

1 (2) by striking the period at the end of para-
2 graph (25) and inserting “; and”; and

3 (3) by adding at the end the following:

4 “(26) The first \$2,000 per year received by
5 such individual (or such spouse) for participation in
6 a clinical trial to test a treatment for a rare disease
7 or condition (within the meaning of section 5(b)(2)
8 of the Orphan Drug Act (Public Law 97–414)),
9 that—

10 “(A) has been reviewed and approved by
11 an institutional review board that—

12 “(i) is established to protect the rights
13 and welfare of human subjects partici-
14 pating in research; and

15 “(ii) meet the standards for such bod-
16 ies set forth in part 46 of title 45, Code of
17 Federal Regulations; and

18 “(B) meets the standards for protection of
19 human subjects for clinical research (as set
20 forth in such part).”.

21 (b) RESOURCE DISREGARD.—Section 1613(a) of
22 such Act (42 U.S.C. 1382b(a)) is amended—

23 (1) by striking “and” at the end of paragraph
24 (15);

1 (2) by striking the period at the end of para-
2 graph (16) and inserting “; and”; and

3 (3) by inserting after paragraph (16) the fol-
4 lowing:

5 “(17) the first \$2,000 per year received by such
6 individual (or such spouse) for participation in a
7 clinical trial, as described in section 1612(b)(26).”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to benefits payable for calendar
10 months beginning after the earlier of—

11 (1) the date the Commissioner of Social Secu-
12 rity promulgates regulations to carry out the amend-
13 ments; or

14 (2) the 180-day period that begins with the
15 date of the enactment of this Act.

16 **DIVISION C—PUBLIC HEALTH**
17 **AND WORKFORCE DEVELOP-**
18 **MENT**

19 **SEC. 2001. TABLE OF CONTENTS; REFERENCES.**

20 (a) TABLE OF CONTENTS.—The table of contents of
21 this division is as follows:

Sec. 2001. Table of contents; references.
Sec. 2002. Public Health Investment Fund.
Sec. 2003. Deficit neutrality.

TITLE I—COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

- Sec. 2201. National Health Service Corps.
- Sec. 2202. Authorizations of appropriations.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

- Sec. 2211. Frontline health providers.

“SUBPART XI—HEALTH PROFESSIONAL NEEDS AREAS

- “Sec. 340H. In general.
- “Sec. 340I. Loan repayments.
- “Sec. 340J. Report.
- “Sec. 340K. Allocation.
- Sec. 2212. Primary care student loan funds.
- Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistants.
- Sec. 2214. Training of medical residents in community-based settings.
- Sec. 2215. Training for general, pediatric, and public health dentists and dental hygienists.
- Sec. 2216. Authorization of appropriations.
- Sec. 2217. Study on effectiveness of scholarships and loan repayments.

Subtitle B—Nursing Workforce

- Sec. 2221. Amendments to Public Health Service Act.

Subtitle C—Public Health Workforce

- Sec. 2231. Public Health Workforce Corps.

“SUBPART XII—PUBLIC HEALTH WORKFORCE

- “Sec. 340L. Public Health Workforce Corps.
- “Sec. 340M. Public Health Workforce Scholarship Program.
- “Sec. 340N. Public Health Workforce Loan Repayment Program.
- Sec. 2232. Enhancing the public health workforce.
- Sec. 2233. Public health training centers.
- Sec. 2234. Preventive medicine and public health training grant program.
- Sec. 2235. Authorization of appropriations.

Subtitle D—Adapting Workforce to Evolving Health System Needs

PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

- Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds.
- Sec. 2242. Nursing workforce diversity grants.
- Sec. 2243. Coordination of diversity and cultural competency programs.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

- Sec. 2251. Cultural and linguistic competency training for health professionals.
- Sec. 2252. Innovations in interdisciplinary care training.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

Sec. 2261. Health workforce evaluation and assessment.

PART 4—HEALTH WORKFORCE ASSESSMENT

Sec. 2271. Health workforce assessment.

PART 5—AUTHORIZATION OF APPROPRIATIONS

Sec. 2281. Authorization of appropriations.

TITLE III—PREVENTION AND WELLNESS

Sec. 2301. Prevention and wellness.

“TITLE XXXI—PREVENTION AND WELLNESS

“Subtitle A—Prevention and Wellness Trust

“Sec. 3111. Prevention and Wellness Trust.

“Subtitle B—National Prevention and Wellness Strategy

“Sec. 3121. National Prevention and Wellness Strategy.

“Subtitle C—Prevention Task Forces

“Sec. 3131. Task Force on Clinical Preventive Services.

“Sec. 3132. Task Force on Community Preventive Services.

“Subtitle D—Prevention and Wellness Research

“Sec. 3141. Prevention and wellness research activity coordination.

“Sec. 3142. Community prevention and wellness research grants.

“Sec. 3143. Research on subsidies and rewards to encourage wellness and healthy behaviors.

“Subtitle E—Delivery of Community Prevention and Wellness Services

“Sec. 3151. Community prevention and wellness services grants.

“Subtitle F—Core Public Health Infrastructure

“Sec. 3161. Core public health infrastructure for State, local, and tribal health departments.

“Sec. 3162. Core public health infrastructure and activities for CDC.

“Subtitle G—General Provisions

“Sec. 3171. Definitions.

TITLE IV—QUALITY AND SURVEILLANCE

Sec. 2401. Implementation of best practices in the delivery of health care.

Sec. 2402. Assistant Secretary for Health Information.

Sec. 2403. Authorization of appropriations.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

- Sec. 2501. Expanded participation in 340B program.
- Sec. 2502. Improvements to 340B program integrity.
- Sec. 2503. Effective date.

Subtitle B—Programs

PART 1—GRANTS FOR CLINICS AND CENTERS

- Sec. 2511. School-based health clinics.
- Sec. 2512. Nurse-Managed health centers.
- Sec. 2513. Federally qualified behavioral health centers.

PART 2—OTHER GRANT PROGRAMS

- Sec. 2521. Comprehensive programs to provide education to nurses and create a pipeline to nursing.
- Sec. 2522. Mental and behavioral health training.
- Sec. 2523. Reauthorization of telehealth and telemedicine grant programs.
- Sec. 2524. No child left unimmunized against influenza: demonstration program using elementary and secondary schools as influenza vaccination centers.
- Sec. 2525. Extension of Wisewoman Program.
- Sec. 2526. Healthy teen initiative to prevent teen pregnancy.
- Sec. 2527. National training initiatives on autism spectrum disorders.
- Sec. 2528. Implementation of medication management services in treatment of chronic diseases.
- Sec. 2529. Postpartum depression.
- Sec. 2530. Grants to promote positive health behaviors and outcomes.
- Sec. 2531. Medical liability alternatives.
- Sec. 2532. Infant mortality pilot programs.
- Sec. 2533. Secondary school health sciences training program.
- Sec. 2534. Community-based collaborative care networks.
- Sec. 2535. Community-based overweight and obesity prevention program.
- Sec. 2536. Reducing student-to-school nurse ratios.
- Sec. 2537. Medical-legal partnerships.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

- Sec. 2551. Trauma care centers.
- Sec. 2552. Emergency care coordination.
- Sec. 2553. Pilot programs to improve emergency medical care.
- Sec. 2554. Assisting veterans with military emergency medical training to become State-licensed or certified emergency medical technicians (EMTs).
- Sec. 2555. Dental emergency responders: public health and medical response.
- Sec. 2556. Dental emergency responders: homeland security.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

- Sec. 2561. Institute of Medicine Conference on Pain.
- Sec. 2562. Pain research at National Institutes of Health.
- Sec. 2563. Public awareness campaign on pain management.

Subtitle C—Food and Drug Administration

PART 1—IN GENERAL

- Sec. 2571. National medical device registry.
- Sec. 2572. Nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines.
- Sec. 2573. Protecting consumer access to generic drugs.

PART 2—BIOSIMILARS

- Sec. 2575. Licensure pathway for biosimilar biological products.
- Sec. 2576. Fees relating to biosimilar biological products.
- Sec. 2577. Amendments to certain patent provisions.

Subtitle D—Community Living Assistance Services and Supports

- Sec. 2581. Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).

“TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

- “Sec. 3201. Purpose.
- “Sec. 3202. Definitions.
- “Sec. 3203. CLASS Independence Benefit Plan.
- “Sec. 3204. Enrollment and disenrollment requirements.
- “Sec. 3205. Benefits.
- “Sec. 3206. CLASS Independence Fund.
- “Sec. 3207. CLASS Independence Advisory Council.
- “Sec. 3208. Regulations; annual report.
- “Sec. 3209. Inspector General’s report.

Subtitle E—Miscellaneous

- Sec. 2585. States failing to adhere to certain employment obligations.
- Sec. 2586. Health centers under Public Health Service Act; liability protections for volunteer practitioners.
- Sec. 2587. Report to Congress on the current state of parasitic diseases that have been overlooked among the poorest Americans.
- Sec. 2588. Office of Women’s Health.
- Sec. 2589. Long-Term Care and Family Caregiver Support.
- Sec. 2590. Web site on health care labor market and related educational and training opportunities.
- Sec. 2591. Online health workforce training programs.
- Sec. 2592. Access for individuals with disabilities.

- 1 (b) REFERENCES.—Except as otherwise specified,
- 2 whenever in this division an amendment is expressed in
- 3 terms of an amendment to a section or other provision,
- 4 the reference shall be considered to be made to a section

1 or other provision of the Public Health Service Act (42
2 U.S.C. 201 et seq.).

3 **SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.**

4 (a) ESTABLISHMENT OF FUNDS.—

5 (1) IN GENERAL.—Subject to section 2003,
6 there is hereby established in the Treasury a separate
7 account to be known as the “Public Health Investment
8 Fund” (referred to in this section and section
9 2003 as the “Fund”).

10 (2) FUNDING.—

11 (A) There shall be deposited into the
12 Fund—

13 (i) for fiscal year 2011,
14 \$4,600,000,000;

15 (ii) for fiscal year 2012,
16 \$5,600,000,000;

17 (iii) for fiscal year 2013,
18 \$6,900,000,000;

19 (iv) for fiscal year 2014,
20 \$7,800,000,000; and

21 (v) for fiscal year 2015,
22 \$9,000,000,000.

23 (B) Amounts deposited into the Fund shall
24 be derived from general revenues of the Treasury
25 only for the fiscal years set forth in this

1 section, and amounts appropriated from the
2 Fund shall remain available until expended.

3 (b) AUTHORIZATION OF APPROPRIATIONS FROM THE
4 FUND.—

5 (1) NEW FUNDING.—

6 (A) IN GENERAL.—Subject to section
7 2003, amounts in the Fund are authorized to
8 be appropriated for carrying out activities
9 under designated public health provisions.

10 (B) DESIGNATED PROVISIONS.—For pur-
11 poses of this paragraph, the term “designated
12 public health provisions” means the provisions
13 for which amounts are authorized to be appro-
14 priated under section 330(s), 338(c), 338H-1,
15 799C, 872, or 3111 of the Public Health Serv-
16 ice Act, as added by this division.

17 (2) BASELINE FUNDING.—

18 (A) IN GENERAL.—Amounts in the Fund
19 are authorized to be appropriated (as described
20 in paragraph (1)) for a fiscal year only if (ex-
21 cluding any amounts in or appropriated from
22 the Fund)—

23 (i) the amounts specified in subpara-
24 graph (B) for the fiscal year involved are
25 equal to or greater than the amounts spec-

1 ified in subparagraph (B) for fiscal year
2 2008; and

3 (ii) the amounts appropriated, out of
4 the general fund of the Treasury, to the
5 Prevention and Wellness Trust under sec-
6 tion 3111(a)(1) of the Public Health Serv-
7 ice Act, as added by this division, for the
8 fiscal year involved are equal to or greater
9 than the funds—

10 (I) appropriated under the head-
11 ing “Prevention and Wellness Fund”
12 in title VIII of division A of the Amer-
13 ican Recovery and Reinvestment Act
14 of 2009 (Public Law 111–5); and

15 (II) allocated by the second pro-
16 viso under such heading for evidence-
17 based clinical and community-based
18 prevention and wellness strategies.

19 (B) AMOUNTS SPECIFIED.—The amounts
20 specified in this subparagraph, with respect to
21 a fiscal year, are the amounts appropriated for
22 the following:

23 (i) Community health centers (includ-
24 ing funds appropriated under the authority

1 of section 330 of the Public Health Service
2 Act (42 U.S.C. 254b)).

3 (ii) The National Health Service
4 Corps Program (including funds appro-
5 priated under the authority of section 338
6 of such Act (42 U.S.C. 254k)).

7 (iii) The National Health Service
8 Corps Scholarship and Loan Repayment
9 Programs (including funds appropriated
10 under the authority of section 338H of
11 such Act (42 U.S.C. 254q)).

12 (iv) Primary care education programs
13 (including funds appropriated under the
14 authority of sections 736, 740, 741, and
15 747 of such Act (42 U.S.C. 293, 293d,
16 and 293k)).

17 (v) Sections 761 and 770 of such Act
18 (42 U.S.C. 294n and 295e).

19 (vi) Nursing workforce development
20 (including funds appropriated under the
21 authority of title VIII of such Act (42
22 U.S.C. 296 et seq.)).

23 (vii) The National Center for Health
24 Statistics (including funds appropriated
25 under the authority of sections 304, 306,

1 307, and 308 of such Act (42 U.S.C.
2 242b, 242k, 242l, and 242m)).

3 (viii) The Agency for Healthcare Re-
4 search and Quality (including funds appro-
5 priated under the authority of title IX of
6 such Act (42 U.S.C. 299 et seq.)).

7 **SEC. 2003. DEFICIT NEUTRALITY.**

8 (a) AVAILABILITY.—Funds appropriated or made
9 available pursuant to sections 330(s), 338(c), 338H–1,
10 799C, 872, or 3111 of the Public Health Service Act, as
11 added by this division, are only available for the purposes
12 set forth in this Act. Appropriations shall not be available
13 and are precluded from obligation for any other purpose.

14 (b) ESTIMATION OF BUDGETARY IMPACT.—For the
15 purposes of estimating the spending effects of this Act,
16 the authorization of appropriations from the Fund, to the
17 extent amounts in the Fund are derived from the general
18 revenues of the Treasury, shall be treated as new direct
19 spending and attributed to this Act.

20 (c) BUDGETARY TREATMENT.—For the purposes of
21 section 257 of the Balanced Budget and Emergency Def-
22 icit Control Act of 1985, the Fund, to the extent amounts
23 in the Fund are derived from the general revenues of the
24 Treasury, and not in excess of amounts subsequently ap-
25 propriated from the Fund, shall be deemed to be included

1 on the list of appropriations referenced under section
2 250(c)(17) of that Act.

3 **TITLE I—COMMUNITY HEALTH**
4 **CENTERS**

5 **SEC. 2101. INCREASED FUNDING.**

6 Section 330 of the Public Health Service Act (42
7 U.S.C. 254b) is amended—

8 (1) in subsection (r)(1)—

9 (A) in subparagraph (D), by striking
10 “and” at the end;

11 (B) in subparagraph (E), by striking the
12 period at the end and inserting “; and”; and

13 (C) by inserting at the end the following:

14 “(F) such sums as may be necessary for
15 each of fiscal years 2013 through 2015.”; and

16 (2) by inserting after subsection (r) the fol-
17 lowing:

18 “(s) **ADDITIONAL FUNDING.**—For the purpose of
19 carrying out this section, in addition to any other amounts
20 authorized to be appropriated for such purpose, there are
21 authorized to be appropriated, out of any monies in the
22 Public Health Investment Fund, the following:

23 “(1) For fiscal year 2011, \$1,000,000,000.

24 “(2) For fiscal year 2012, \$1,500,000,000.

25 “(3) For fiscal year 2013, \$2,500,000,000.

1 “(4) For fiscal year 2014, \$3,000,000,000.

2 “(5) For fiscal year 2015, \$4,000,000,000.”.

3 **TITLE II—WORKFORCE**
4 **Subtitle A—Primary Care**
5 **Workforce**

6 **PART 1—NATIONAL HEALTH SERVICE CORPS**

7 **SEC. 2201. NATIONAL HEALTH SERVICE CORPS.**

8 (a) FULFILLMENT OF OBLIGATED SERVICE RE-
9 QUIREMENT THROUGH HALF-TIME SERVICE.—

10 (1) WAIVERS.—Subsection (i) of section 331
11 (42 U.S.C. 254d) is amended—

12 (A) in paragraph (1), by striking “In car-
13 rying out subpart III” and all that follows
14 through the period and inserting “In carrying
15 out subpart III, the Secretary may, in accord-
16 ance with this subsection, issue waivers to indi-
17 viduals who have entered into a contract for ob-
18 ligated service under the Scholarship Program
19 or the Loan Repayment Program under which
20 the individuals are authorized to satisfy the re-
21 quirement of obligated service through pro-
22 viding clinical practice that is half-time.”;

23 (B) in paragraph (2)—

1 (i) in subparagraphs (A)(ii) and (B),
2 by striking “less than full time” each place
3 it appears and inserting “half time”;

4 (ii) in subparagraphs (C) and (F), by
5 striking “less than full-time service” each
6 place it appears and inserting “half-time
7 service”; and

8 (iii) by amending subparagraphs (D)
9 and (E) to read as follows:

10 “(D) the entity and the Corps member agree in
11 writing that the Corps member will perform half-
12 time clinical practice;

13 “(E) the Corps member agrees in writing to
14 fulfill all of the service obligations under section
15 338C through half-time clinical practice and ei-
16 ther—

17 “(i) double the period of obligated service
18 that would otherwise be required; or

19 “(ii) in the case of contracts entered into
20 under section 338B, accept a minimum service
21 obligation of 2 years with an award amount
22 equal to 50 percent of the amount that would
23 otherwise be payable for full-time service; and”;
24 and

1 (C) in paragraph (3), by striking “In eval-
2 uating a demonstration project described in
3 paragraph (1)” and inserting “In evaluating
4 waivers issued under paragraph (1)”.

5 (2) DEFINITIONS.—Subsection (j) of section
6 331 (42 U.S.C. 254d) is amended by adding at the
7 end the following:

8 “(5) The terms ‘full time’ and ‘full-time’ mean
9 a minimum of 40 hours per week in a clinical prac-
10 tice, for a minimum of 45 weeks per year.

11 “(6) The terms ‘half time’ and ‘half-time’ mean
12 a minimum of 20 hours per week (not to exceed 39
13 hours per week) in a clinical practice, for a min-
14 imum of 45 weeks per year.”.

15 (b) REAPPOINTMENT TO NATIONAL ADVISORY COUN-
16 CIL.—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amend-
17 ed by striking “Members may not be reappointed to the
18 Council.”.

19 (c) LOAN REPAYMENT AMOUNT.—Section
20 338B(g)(2)(A) (42 U.S.C. 254l–1(g)(2)(A)) is amended
21 by striking “\$35,000” and inserting “\$50,000, plus, be-
22 ginning with fiscal year 2012, an amount determined by
23 the Secretary on an annual basis to reflect inflation,”.

24 (d) TREATMENT OF TEACHING AS OBLIGATED SERV-
25 ICE.—Subsection (a) of section 338C (42 U.S.C. 254m)

1 is amended by adding at the end the following: “The Sec-
2 retary may treat teaching as clinical practice for up to
3 20 percent of such period of obligated service.”.

4 **SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.**

5 (a) NATIONAL HEALTH SERVICE CORPS PRO-
6 GRAM.—Section 338 (42 U.S.C. 254k) is amended—

7 (1) in subsection (a), by striking “2012” and
8 inserting “2015”; and

9 (2) by adding at the end the following:

10 “(c) For the purpose of carrying out this subpart,
11 in addition to any other amounts authorized to be appro-
12 priated for such purpose, there are authorized to be appro-
13 priated, out of any monies in the Public Health Invest-
14 ment Fund, the following:

15 “(1) \$63,000,000 for fiscal year 2011.

16 “(2) \$66,000,000 for fiscal year 2012.

17 “(3) \$70,000,000 for fiscal year 2013.

18 “(4) \$73,000,000 for fiscal year 2014.

19 “(5) \$77,000,000 for fiscal year 2015.”.

20 (b) SCHOLARSHIP AND LOAN REPAYMENT PRO-
21 GRAMS.—Subpart III of part D of title III of the Public
22 Health Service Act (42 U.S.C. 254l et seq.) is amended—

23 (1) in section 338H(a)—

24 (A) in paragraph (4), by striking “and” at
25 the end;

1 (B) in paragraph (5), by striking the pe-
2 riod at the end and inserting “; and”; and

3 (C) by adding at the end the following:

4 “(6) for each of fiscal years 2013 through
5 2015, such sums as may be necessary.”; and

6 (2) by inserting after section 338H the fol-
7 lowing:

8 **“SEC. 338H-1. ADDITIONAL FUNDING.**

9 “For the purpose of carrying out this subpart, in ad-
10 dition to any other amounts authorized to be appropriated
11 for such purpose, there are authorized to be appropriated,
12 out of any monies in the Public Health Investment Fund,
13 the following:

14 “(1) \$254,000,000 for fiscal year 2011.

15 “(2) \$266,000,000 for fiscal year 2012.

16 “(3) \$278,000,000 for fiscal year 2013.

17 “(4) \$292,000,000 for fiscal year 2014.

18 “(5) \$306,000,000 for fiscal year 2015.”.

19 **PART 2—PROMOTION OF PRIMARY CARE AND**
20 **DENTISTRY**

21 **SEC. 2211. FRONTLINE HEALTH PROVIDERS.**

22 Part D of title III (42 U.S.C. 254b et seq.) is amend-
23 ed by adding at the end the following:

1 **“Subpart XI—Health Professional Needs Areas**

2 **“SEC. 340H. IN GENERAL.**

3 “(a) PROGRAM.—The Secretary, acting through the
4 Administrator of the Health Resources and Services Ad-
5 ministration, shall establish a program, to be known as
6 the Frontline Health Providers Loan Repayment Pro-
7 gram, to address unmet health care needs in health profes-
8 sional needs areas through loan repayments under section
9 340I.

10 “(b) DESIGNATION OF HEALTH PROFESSIONAL
11 NEEDS AREAS.—

12 “(1) IN GENERAL.—In this subpart, the term
13 ‘health professional needs area’ means an area, pop-
14 ulation, or facility that is designated by the Sec-
15 retary in accordance with paragraph (2).

16 “(2) DESIGNATION.—To be designated by the
17 Secretary as a health professional needs area under
18 this subpart:

19 “(A) In the case of an area, the area must
20 be a rational area for the delivery of health
21 services.

22 “(B) The area, population, or facility must
23 have, in one or more health disciplines, special-
24 ties, or subspecialties for the population served,
25 as determined by the Secretary—

1 “(i) insufficient capacity of health
2 professionals; or

3 “(ii) high needs for health services, in-
4 cluding services to address health dispari-
5 ties.

6 “(C) With respect to the delivery of pri-
7 mary health services, the area, population, or
8 facility must not include a health professional
9 shortage area (as designated under section
10 332), except that the area, population, or facil-
11 ity may include such a health professional
12 shortage area in which there is an unmet need
13 for such services.

14 “(c) ELIGIBILITY.—To be eligible to participate in
15 the Program, an individual shall—

16 “(1) hold a degree in a course of study or pro-
17 gram (approved by the Secretary) from a school de-
18 fined in section 799B(1)(A) (other than a school of
19 public health);

20 “(2) hold a degree in a course of study or pro-
21 gram (approved by the Secretary) from a school or
22 program defined in subparagraph (C), (D), or
23 (E)(4) of section 799B(1), as designated by the Sec-
24 retary;

25 “(3) be enrolled as a full-time student—

1 “(A) in a school or program defined in
2 subparagraph (C), (D), or (E)(4) of section
3 799B(1), as designated by the Secretary, or a
4 school described in paragraph (1); and

5 “(B) in the final year of a course of study
6 or program, offered by such school or program
7 and approved by the Secretary, leading to a de-
8 gree in a discipline referred to in subparagraph
9 (A) (other than a graduate degree in public
10 health), (C), (D), or (E)(4) of section 799B(1);

11 “(4) be a practitioner described in section
12 1842(b)(18)(C) or 1848(k)(3)(B)(iii) or (iv) of the
13 Social Security Act; or

14 “(5) be a practitioner in the field of respiratory
15 therapy, medical technology, or radiologic tech-
16 nology.

17 “(d) DEFINITIONS.—In this subpart:

18 “(1) The term ‘health disparities’ has the
19 meaning given to the term in section 3171.

20 “(2) The term ‘primary health services’ has the
21 meaning given to such term in section 331(a)(3)(D).

22 **“SEC. 340I. LOAN REPAYMENTS.**

23 “(a) LOAN REPAYMENTS.—The Secretary, acting
24 through the Administrator of the Health Resources and

1 Services Administration, shall enter into contracts with in-
2 dividuals under which—

3 “(1) the individual agrees—

4 “(A) to serve as a full-time primary health
5 services provider or as a full-time or part-time
6 provider of other health services for a period of
7 time equal to 2 years or such longer period as
8 the individual may agree to;

9 “(B) to serve in a health professional
10 needs area in a health discipline, specialty, or a
11 subspecialty for which the area, population, or
12 facility is designated as a health professional
13 needs area under section 340H; and

14 “(C) in the case of an individual described
15 in section 340H(c)(3) who is in the final year
16 of study and who has accepted employment as
17 a primary health services provider or provider
18 of other health services in accordance with sub-
19 paragraphs (A) and (B), to complete the edu-
20 cation or training and maintain an acceptable
21 level of academic standing (as determined by
22 the educational institution offering the course
23 of study or training); and

24 “(2) the Secretary agrees to pay, for each year
25 of such service, an amount on the principal and in-

1 terest of the undergraduate or graduate educational
2 loans (or both) of the individual that is not more
3 than 50 percent of the average award made under
4 the National Health Service Corps Loan Repayment
5 Program under subpart III in that year.

6 “(b) PRACTICE SETTING.—A contract entered into
7 under this section shall allow the individual receiving the
8 loan repayment to satisfy the service requirement de-
9 scribed in subsection (a)(1) through employment in a solo
10 or group practice, a clinic, an accredited public or private
11 nonprofit hospital, or any other health care entity, as
12 deemed appropriate by the Secretary.

13 “(c) APPLICATION OF CERTAIN PROVISIONS.—The
14 provisions of subpart III of part D shall, except as incon-
15 sistent with this section, apply to the loan repayment pro-
16 gram under this subpart in the same manner and to the
17 same extent as such provisions apply to the National
18 Health Service Corps Loan Repayment Program estab-
19 lished under section 338B.

20 “(d) INSUFFICIENT NUMBER OF APPLICANTS.—If
21 there are an insufficient number of applicants for loan re-
22 payments under this section to obligate all appropriated
23 funds, the Secretary shall transfer the unobligated funds
24 to the National Health Service Corps for the purpose of
25 recruiting applicants and entering into contracts with indi-

1 viduals so as to ensure a sufficient number of participants
2 in the National Health Service Corps for the following
3 year.

4 **“SEC. 340J. REPORT.**

5 “The Secretary shall submit to the Congress an an-
6 nual report on the program carried out under this subpart.

7 **“SEC. 340K. ALLOCATION.**

8 “Of the amount of funds obligated under this subpart
9 each fiscal year for loan repayments—

10 “(1) 90 percent shall be for physicians and
11 other health professionals providing primary health
12 services; and

13 “(2) 10 percent shall be for health professionals
14 not described in paragraph (1).”.

15 **SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.**

16 (a) IN GENERAL.—Section 735 (42 U.S.C. 292y) is
17 amended—

18 (1) by redesignating subsection (f) as sub-
19 section (g); and

20 (2) by inserting after subsection (e) the fol-
21 lowing:

22 **“(f) DETERMINATION OF FINANCIAL NEED.—The**
23 **Secretary—**

24 “(1) may require, or authorize a school or other
25 entity to require, the submission of financial infor-

1 mation to determine the financial resources available
2 to any individual seeking assistance under this sub-
3 part; and

4 “(2) shall take into account the extent to which
5 such individual is financially independent in deter-
6 mining whether to require or authorize the submis-
7 sion of such information regarding such individual’s
8 family members.”.

9 (b) REVISED GUIDELINES.—The Secretary of Health
10 and Human Services shall—

11 (1) strike the second sentence of section
12 57.206(b)(1) of title 42, Code of Federal Regula-
13 tions; and

14 (2) make such other revisions to guidelines and
15 regulations in effect as of the date of the enactment
16 of this Act as may be necessary for consistency with
17 the amendments made by paragraph (1).

18 **SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL IN-**
19 **TERNAL MEDICINE, GENERAL PEDIATRICS,**
20 **GERIATRICS, AND PHYSICIAN ASSISTANTS.**

21 Section 747 (42 U.S.C. 293k) is amended—

22 (1) by amending the section heading to read as
23 follows: “**PRIMARY CARE TRAINING AND EN-**
24 **HANCEMENT**”;

1 (2) by redesignating subsection (e) as sub-
2 section (g); and

3 (3) by striking subsections (a) through (d) and
4 inserting the following:

5 “(a) PROGRAM.—The Secretary shall establish a pri-
6 mary care training and capacity building program con-
7 sisting of awarding grants and contracts under sub-
8 sections (b) and (c).

9 “(b) SUPPORT AND DEVELOPMENT OF PRIMARY
10 CARE TRAINING PROGRAMS.—

11 “(1) IN GENERAL.—The Secretary shall make
12 grants to, or enter into contracts with, eligible enti-
13 ties—

14 “(A) to plan, develop, operate, or partici-
15 pate in an accredited professional training pro-
16 gram, including an accredited residency or in-
17 ternship program, in the field of family medi-
18 cine, general internal medicine, general pediatri-
19 cs, or geriatrics for medical students, interns,
20 residents, or practicing physicians;

21 “(B) to provide financial assistance in the
22 form of traineeships and fellowships to medical
23 students, interns, residents, or practicing physi-
24 cians, who are participants in any such pro-
25 gram, and who plan to specialize or work in

1 family medicine, general internal medicine, gen-
2 eral pediatrics, or geriatrics;

3 “(C) to plan, develop, operate, or partici-
4 pate in an accredited program for the training
5 of physicians who plan to teach in family medi-
6 cine, general internal medicine, general pedi-
7 trics, or geriatrics training programs including
8 in community-based settings;

9 “(D) to provide financial assistance in the
10 form of traineeships and fellowships to prac-
11 ticing physicians who are participants in any
12 such programs and who plan to teach in a fam-
13 ily medicine, general internal medicine, general
14 pediatrics, or geriatrics training program; and

15 “(E) to plan, develop, operate, or partici-
16 pate in an accredited program for physician as-
17 sistant education, and for the training of indi-
18 viduals who plan to teach in programs to pro-
19 vide such training.

20 “(2) ELIGIBILITY.—To be eligible for a grant
21 or contract under paragraph (1), an entity shall
22 be—

23 “(A) an accredited school of medicine or
24 osteopathic medicine, public or nonprofit private

1 hospital, or physician assistant training pro-
2 gram;

3 “(B) a public or private nonprofit entity;

4 or

5 “(C) a consortium of 2 or more entities de-
6 scribed in subparagraphs (A) and (B).

7 “(c) CAPACITY BUILDING IN PRIMARY CARE.—

8 “(1) IN GENERAL.—The Secretary shall make
9 grants to or enter into contracts with eligible entities
10 to establish, maintain, or improve—

11 “(A) academic administrative units (in-
12 cluding departments, divisions, or other appro-
13 priate units) in the specialties of family medi-
14 cine, general internal medicine, general pedi-
15 atrics, or geriatrics; or

16 “(B) programs that improve clinical teach-
17 ing in such specialties.

18 “(2) ELIGIBILITY.—To be eligible for a grant
19 or contract under paragraph (1), an entity shall be
20 an accredited school of medicine or osteopathic med-
21 icine.

22 “(d) PREFERENCE.—In awarding grants or contracts
23 under this section, the Secretary shall give preference to
24 entities that have a demonstrated record of at least one
25 of the following:

1 “(1) Training a high or significantly improved
2 percentage of health professionals who provide pri-
3 mary care.

4 “(2) Training individuals who are from dis-
5 advantaged backgrounds (including racial and ethnic
6 minorities underrepresented among primary care
7 professionals).

8 “(3) A high rate of placing graduates in prac-
9 tice settings having the principal focus of serving in
10 underserved areas or populations experiencing health
11 disparities (including serving patients eligible for
12 medical assistance under title XIX of the Social Se-
13 curity Act or for child health assistance under title
14 XXI of such Act or those with special health care
15 needs).

16 “(4) Supporting teaching programs that ad-
17 dress the health care needs of vulnerable popu-
18 lations.

19 “(e) REPORT.—The Secretary shall submit to the
20 Congress an annual report on the program carried out
21 under this section.

22 “(f) DEFINITION.—In this section, the term ‘health
23 disparities’ has the meaning given the term in section
24 3171.”.

1 **SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN COMMU-**
2 **NITY-BASED SETTINGS.**

3 Title VII (42 U.S.C. 292 et seq.) is amended—

4 (1) by redesignating section 748 as 749A; and

5 (2) by inserting after section 747 the following:

6 **“SEC. 748. TRAINING OF MEDICAL RESIDENTS IN COMMU-**
7 **NITY-BASED SETTINGS.**

8 “(a) PROGRAM.—The Secretary shall establish a pro-
9 gram for the training of medical residents in community-
10 based settings consisting of awarding grants and contracts
11 under this section.

12 “(b) DEVELOPMENT AND OPERATION OF COMMU-
13 NITY-BASED PROGRAMS.—The Secretary shall make
14 grants to, or enter into contracts with, eligible entities—

15 “(1) to plan and develop a new primary care
16 residency training program, which may include—

17 “(A) planning and developing curricula;

18 “(B) recruiting and training residents and
19 faculty; and

20 “(C) other activities designated to result in
21 accreditation of such a program; or

22 “(2) to operate or participate in an established
23 primary care residency training program, which may
24 include—

25 “(A) planning and developing curricula;

1 “(B) recruitment and training of residents;

2 and

3 “(C) retention of faculty.

4 “(c) ELIGIBLE ENTITY.—To be eligible to receive a
5 grant or contract under subsection (b), an entity shall—

6 “(1) be designated as a recipient of payment
7 for the direct costs of medical education under sec-
8 tion 1886(k) of the Social Security Act;

9 “(2) be designated as an approved teaching
10 health center under section 1502(d) of the Afford-
11 able Health Care for America Act and continuing to
12 participate in the demonstration project under such
13 section;

14 “(3) be an applicant for designation described
15 in paragraph (1) or (2) and have demonstrated to
16 the Secretary appropriate involvement of an accred-
17 ited teaching hospital to carry out the inpatient re-
18 sponsibilities associated with a primary care resi-
19 dency training program; or

20 “(4) be eligible to be designated as described in
21 paragraph (1) or (2), not be an applicant as de-
22 scribed in paragraph (3), and have demonstrated ap-
23 propriate involvement of an accredited teaching hos-
24 pital to carry out the inpatient responsibilities asso-

1 ciated with a primary care residency training pro-
2 gram.

3 “(d) PREFERENCES.—In awarding grants and con-
4 tracts under paragraph (1) or (2) of subsection (b), the
5 Secretary shall give preference to entities that—

6 “(1) support teaching programs that address
7 the health care needs of vulnerable populations; or

8 “(2) are a Federally qualified health center (as
9 defined in section 1861(aa)(4) of the Social Security
10 Act) or a rural health clinic (as defined in section
11 1861(aa)(2) of such Act).

12 “(e) ADDITIONAL PREFERENCES FOR ESTABLISHED
13 PROGRAMS.—In awarding grants and contracts under
14 subsection (b)(2), the Secretary shall give preference to
15 entities that have a demonstrated record of training—

16 “(1) a high or significantly improved percentage
17 of health professionals who provide primary care;

18 “(2) individuals who are from disadvantaged
19 backgrounds (including racial and ethnic minorities
20 underrepresented among primary care professionals);
21 or

22 “(3) individuals who practice in settings having
23 the principal focus of serving underserved areas or
24 populations experiencing health disparities (including
25 serving patients eligible for medical assistance under

1 title XIX of the Social Security Act or for child
2 health assistance under title XXI of such Act or
3 those with special health care needs).

4 “(f) PERIOD OF AWARDS.—

5 “(1) IN GENERAL.—The period of a grant or
6 contract under this section—

7 “(A) shall not exceed 3 years for awards
8 under subsection (b)(1); and

9 “(B) shall not exceed 5 years for awards
10 under subsection (b)(2).

11 “(2) SPECIAL RULES.—

12 “(A) An award of a grant or contract
13 under subsection (b)(1) shall not be renewed.

14 “(B) The period of a grant or contract
15 awarded to an entity under subsection (b)(2)
16 shall not overlap with the period of any grant
17 or contract awarded to the same entity under
18 subsection (b)(1).

19 “(g) REPORT.—The Secretary shall submit to the
20 Congress an annual report on the program carried out
21 under this section.

22 “(h) DEFINITIONS.—In this section:

23 “(1) HEALTH DISPARITIES.—The term ‘health
24 disparities’ has the meaning given the term in sec-
25 tion 3171.

1 “(2) PRIMARY CARE RESIDENT.—The term ‘pri-
2 mary care resident’ has the meaning given the term
3 in section 1886(h)(5)(H) of the Social Security Act.

4 “(3) PRIMARY CARE RESIDENCY TRAINING PRO-
5 GRAM.—The term ‘primary care residency training
6 program’ means an approved medical residency
7 training program described in section 1886(h)(5)(A)
8 of the Social Security Act for primary care residents
9 that is—

10 “(A) in the case of entities seeking awards
11 under subsection (b)(1), actively applying to be
12 accredited by the Accreditation Council for
13 Graduate Medical Education or the American
14 Osteopathic Association; or

15 “(B) in the case of entities seeking awards
16 under subsection (b)(2), so accredited.

17 “(i) ALLOCATION OF FUNDS.—Of the amount appro-
18 priated pursuant to section 799C(a) for a fiscal year, not
19 more than 17 percent of such amount shall be made avail-
20 able to carry out this section.”.

21 **SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUB-**
22 **LIC HEALTH DENTISTS AND DENTAL HYGIEN-**
23 **ISTS.**

24 Title VII (42 U.S.C. 292 et seq.) is amended—

1 (1) in section 791(a)(1), by striking “747 and
2 750” and inserting “747, 749, and 750”; and
3 (2) by inserting after section 748, as added, the
4 following:

5 **“SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUB-**
6 **LIC HEALTH DENTISTS AND DENTAL HYGIEN-**
7 **ISTS.**

8 “(a) PROGRAM.—The Secretary shall establish a
9 training program for oral health professionals consisting
10 of awarding grants and contracts under this section.

11 “(b) SUPPORT AND DEVELOPMENT OF ORAL
12 HEALTH TRAINING PROGRAMS.—The Secretary shall
13 make grants to, or enter into contracts with, eligible enti-
14 ties—

15 “(1) to plan, develop, operate, or participate in
16 an accredited professional training program for oral
17 health professionals;

18 “(2) to provide financial assistance to oral
19 health professionals who are in need thereof, who
20 are participants in any such program, and who plan
21 to work in general, pediatric, or public health den-
22 tistry, or dental hygiene;

23 “(3) to plan, develop, operate, or participate in
24 a program for the training of oral health profes-

1 sionals who plan to teach in general, pediatric, or
2 public health dentistry, or dental hygiene;

3 “(4) to provide financial assistance in the form
4 of traineeships and fellowships to oral health profes-
5 sionals who plan to teach in general, pediatric, or
6 public health dentistry or dental hygiene;

7 “(5) to establish, maintain, or improve—

8 “(A) academic administrative units (in-
9 cluding departments, divisions, or other appro-
10 priate units) in the specialties of general, pedi-
11 atric, or public health dentistry; or

12 “(B) programs that improve clinical teach-
13 ing in such specialties;

14 “(6) to plan, develop, operate, or participate in
15 predoctoral and postdoctoral training in general, pe-
16 diatric, or public health dentistry programs;

17 “(7) to plan, develop, operate, or participate in
18 a loan repayment program for full-time faculty in a
19 program of general, pediatric, or public health den-
20 tistry; and

21 “(8) to provide technical assistance to pediatric
22 dental training programs in developing and imple-
23 menting instruction regarding the oral health status,
24 dental care needs, and risk-based clinical disease

1 management of all pediatric populations with an em-
2 phasis on underserved children.

3 “(c) ELIGIBILITY.—To be eligible for a grant or con-
4 tract under this section, an entity shall be—

5 “(1) an accredited school of dentistry, training
6 program in dental hygiene, or public or nonprofit
7 private hospital;

8 “(2) a training program in dental hygiene at an
9 accredited institution of higher education;

10 “(3) a public or private nonprofit entity; or

11 “(4) a consortium of—

12 “(A) 1 or more of the entities described in
13 paragraphs (1) through (3); and

14 “(B) an accredited school of public health.

15 “(d) PREFERENCE.—In awarding grants or contracts
16 under this section, the Secretary shall give preference to
17 entities that have a demonstrated record of at least one
18 of the following:

19 “(1) Training a high or significantly improved
20 percentage of oral health professionals who practice
21 general, pediatric, or public health dentistry.

22 “(2) Training individuals who are from dis-
23 advantaged backgrounds (including racial and ethnic
24 minorities underrepresented among oral health pro-
25 fessionals).

1 “(3) A high rate of placing graduates in prac-
2 tice settings having the principal focus of serving in
3 underserved areas or populations experiencing health
4 disparities (including serving patients eligible for
5 medical assistance under title XIX of the Social Se-
6 curity Act or for child health assistance under title
7 XXI of such Act or those with special health care
8 needs).

9 “(4) Supporting teaching programs that ad-
10 dress the oral health needs of vulnerable popu-
11 lations.

12 “(5) Providing instruction regarding the oral
13 health status, oral health care needs, and risk-based
14 clinical disease management of all pediatric popu-
15 lations with an emphasis on underserved children.

16 “(e) REPORT.—The Secretary shall submit to the
17 Congress an annual report on the program carried out
18 under this section.

19 “(f) DEFINITIONS.—In this section:

20 “(1) The term ‘health disparities’ has the
21 meaning given the term in section 3171.

22 “(2) The term ‘oral health professional’ means
23 an individual training or practicing—

1 “(A) in general dentistry, pediatric den-
2 tistry, public health dentistry, or dental hy-
3 giene; or

4 “(B) another oral health specialty, as
5 deemed appropriate by the Secretary.”.

6 **SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.**

7 (a) IN GENERAL.—Part F of title VII (42 U.S.C.
8 295j et seq.) is amended by adding at the end the fol-
9 lowing:

10 **“SEC. 799C. FUNDING THROUGH PUBLIC HEALTH INVEST-**
11 **MENT FUND.**

12 “(a) PROMOTION OF PRIMARY CARE AND DEN-
13 TISTRY.—For the purpose of carrying out subpart XI of
14 part D of title III and sections 747, 748, and 749, in addi-
15 tion to any other amounts authorized to be appropriated
16 for such purpose, there are authorized to be appropriated,
17 out of any monies in the Public Health Investment Fund,
18 the following:

19 “(1) \$240,000,000 for fiscal year 2011.

20 “(2) \$253,000,000 for fiscal year 2012.

21 “(3) \$265,000,000 for fiscal year 2013.

22 “(4) \$278,000,000 for fiscal year 2014.

23 “(5) \$292,000,000 for fiscal year 2015.”.

24 (b) EXISTING AUTHORIZATION OF APPROPRIA-
25 TIONS.—Subsection (g)(1), as so redesignated, of section

1 747 (42 U.S.C. 293k) is amended by striking “2002” and
2 inserting “2015”.

3 **SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS**
4 **AND LOAN REPAYMENTS.**

5 (a) STUDY.—The Comptroller General of the United
6 States shall conduct a study to determine the effectiveness
7 of scholarship and loan repayment programs under sub-
8 parts III and XI of part D of title III of the Public Health
9 Service Act, as amended or added by sections 2201 and
10 2211, including whether scholarships or loan repayments
11 are more effective in—

12 (1) incentivizing physicians, and other pro-
13 viders, to pursue careers in primary care specialties;

14 (2) retaining such primary care providers; and

15 (3) encouraging such primary care providers to
16 practice in underserved areas.

17 (b) REPORT.—Not later than 12 months after the
18 date of the enactment of this Act, the Comptroller General
19 shall submit to the Congress a report on the results of
20 the study under subsection (a).

21 **Subtitle B—Nursing Workforce**

22 **SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.**

23 (a) DEFINITIONS.—Section 801 (42 U.S.C. 296 et
24 seq.) is amended—

1 (1) in paragraph (1), by inserting “nurse-man-
2 aged health centers,” after “nursing centers,”; and

3 (2) by adding at the end the following:

4 “(16) NURSE-MANAGED HEALTH CENTER.—

5 The term ‘nurse-managed health center’—

6 “(A) means a nurse-practice arrangement,
7 managed by one or more advanced practice
8 nurses, that provides primary care or wellness
9 services to underserved or vulnerable popu-
10 lations and is associated with an accredited
11 school of nursing, Federally qualified health
12 center, or independent nonprofit health or social
13 services agency; and

14 “(B) shall not be construed as changing
15 State law requirements applicable to an ad-
16 vanced practice nurse or the authorized scope of
17 practice of such a nurse.”.

18 (b) GRANTS FOR HEALTH PROFESSIONS EDU-
19 CATION.—Title VIII (42 U.S.C. 296 et seq.) is amended
20 by striking section 807.

21 (c) REPORTS.—Part A of title VIII (42 U.S.C. 296
22 et seq.) is amended by adding at the end the following:

1 **“SEC. 809. REPORTS.**

2 “The Secretary shall submit to the Congress a sepa-
3 rate annual report on the activities carried out under each
4 of sections 811, 821, 836, 846A, and 861.”.

5 (d) **ADVANCED EDUCATION NURSING GRANTS.**—Sec-
6 tion 811(f) (42 U.S.C. 296j(f)) is amended—

7 (1) by striking paragraph (2);

8 (2) by redesignating paragraph (3) as para-
9 graph (2); and

10 (3) in paragraph (2), as so redesignated, by
11 striking “that agrees” and all that follows through
12 the end and inserting: “that agrees to expend the
13 award—

14 “(A) to train advanced education nurses
15 who will practice in health professional shortage
16 areas designated under section 332; or

17 “(B) to increase diversity among advanced
18 education nurses.”.

19 (e) **NURSE EDUCATION, PRACTICE, AND RETENTION**
20 **GRANTS.**—Section 831 (42 U.S.C. 296p) is amended—

21 (1) in subsection (b), by amending paragraph
22 (3) to read as follows:

23 “(3) providing coordinated care, quality care,
24 and other skills needed to practice nursing; or”; and

1 (2) by striking subsection (e) and redesignating
2 subsections (f) through (h) as subsections (e)
3 through (g), respectively.

4 (f) STUDENT LOANS.—Subsection (a) of section 836
5 (42 U.S.C. 297b) is amended—

6 (1) by striking “\$2,500” and inserting
7 “\$3,300”;

8 (2) by striking “\$4,000” and inserting
9 “\$5,200”;

10 (3) by striking “\$13,000” and inserting
11 “\$17,000”; and

12 (4) by adding at the end the following: “Begin-
13 ning with fiscal year 2012, the dollar amounts speci-
14 fied in this subsection shall be adjusted by an
15 amount determined by the Secretary on an annual
16 basis to reflect inflation.”.

17 (g) LOAN REPAYMENT.—Section 846 (42 U.S.C.
18 297n) is amended—

19 (1) in subsection (a), by amending paragraph
20 (3) to read as follows:

21 “(3) who enters into an agreement with the
22 Secretary to serve for a period of not less than 2
23 years—

24 “(A) as a nurse at a health care facility
25 with a critical shortage of nurses; or

1 “(B) as a faculty member at an accredited
2 school of nursing;” and

3 (2) in subsection (g)(1), by striking “to provide
4 health services” each place it appears and inserting
5 “to provide health services or serve as a faculty
6 member”.

7 (h) NURSE FACULTY LOAN PROGRAM.—Paragraph
8 (2) of section 846A(c) (42 U.S.C. 297n–1(c)) is amended
9 by striking “\$30,000” and all that follows through the
10 semicolon and inserting “\$35,000, plus, beginning with
11 fiscal year 2012, an amount determined by the Secretary
12 on an annual basis to reflect inflation;”.

13 (i) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII
14 (42 U.S.C. 296 et seq.) is amended by striking part H.

15 (j) TECHNICAL AND CONFORMING AMENDMENTS.—
16 Title VIII (42 U.S.C. 296 et seq.) is amended—

17 (1) by moving section 810 (relating to prohibi-
18 tion against discrimination by schools on the basis of
19 sex) so that it follows section 809, as added by sub-
20 section (c);

21 (2) in sections 835, 836, 838, 840, and 842, by
22 striking the term “this subpart” each place it ap-
23 pears and inserting “this part”;

24 (3) in section 836(h), by striking the last sen-
25 tence;

1 (4) in section 836, by redesignating subsection
2 (l) as subsection (k);

3 (5) in section 839, by striking “839” and all
4 that follows through “(a)” and inserting “839. (a)”;

5 (6) in section 835(b), by striking “841” each
6 place it appears and inserting “871”;

7 (7) by redesignating section 841 as section 871,
8 moving part F to the end of the title, and redesign-
9 ating such part as part H;

10 (8) in part G—

11 (A) by redesignating section 845 as section
12 851; and

13 (B) by redesignating part G as part F; and

14 (9) in part I—

15 (A) by redesignating section 855 as section
16 861; and

17 (B) by redesignating part I as part G.

18 (k) FUNDING.—

19 (1) IN GENERAL.—Part H, as redesignated, of
20 title VIII is amended by adding at the end the fol-
21 lowing:

22 **“SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVEST-**
23 **MENT FUND.**

24 “For the purpose of carrying out this title, in addi-
25 tion to any other amounts authorized to be appropriated

1 for such purpose, there are authorized to be appropriated,
2 out of any monies in the Public Health Investment Fund,
3 the following:

4 “(1) \$115,000,000 for fiscal year 2011.

5 “(2) \$122,000,000 for fiscal year 2012.

6 “(3) \$127,000,000 for fiscal year 2013.

7 “(4) \$134,000,000 for fiscal year 2014.

8 “(5) \$140,000,000 for fiscal year 2015.”.

9 (2) EXISTING AUTHORIZATIONS OF APPROPRIA-
10 TIONS.—

11 (A) SECTIONS 831, 846, 846A, AND 861.—
12 Sections 831(g) (as so redesignated), 846(i)(1)
13 (42 U.S.C. 297n(i)(1)), 846A(f) (42 U.S.C.
14 297n–1(f)), and 861(e) (as so redesignated) are
15 amended by striking “2007” each place it ap-
16 pears and inserting “2015”.

17 (B) SECTION 871.—Section 871, as so re-
18 designated by subsection (j), is amended to read
19 as follows:

20 **“SEC. 871. FUNDING.**

21 “For the purpose of carrying out parts B, C, and D
22 (subject to section 851(g)), there are authorized to be ap-
23 propriated such sums as may be necessary for each fiscal
24 year through fiscal year 2015.”.

1 **Subtitle C—Public Health**
2 **Workforce**

3 **SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.**

4 Part D of title III (42 U.S.C. 254b et seq.), as
5 amended by section 2211, is amended by adding at the
6 end the following:

7 **“Subpart XII—Public Health Workforce**

8 **“SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.**

9 “(a) ESTABLISHMENT.—There is established, within
10 the Service, the Public Health Workforce Corps (in this
11 subpart referred to as the ‘Corps’), for the purpose of en-
12 suring an adequate supply of public health professionals
13 throughout the Nation. The Corps shall consist of—

14 “(1) such officers of the Regular and Reserve
15 Corps of the Service as the Secretary may designate;

16 “(2) such civilian employees of the United
17 States as the Secretary may appoint; and

18 “(3) such other individuals who are not employ-
19 ees of the United States.

20 “(b) ADMINISTRATION.—Except as provided in sub-
21 section (c), the Secretary shall carry out this subpart act-
22 ing through the Administrator of the Health Resources
23 and Services Administration.

24 “(c) PLACEMENT AND ASSIGNMENT.—The Secretary,
25 acting through the Director of the Centers for Disease

1 Control and Prevention, shall develop a methodology for
2 placing and assigning Corps participants as public health
3 professionals. Such methodology may allow for placing and
4 assigning such participants in State, local, and tribal
5 health departments and Federally qualified health centers
6 (as defined in section 1861(aa)(4) of the Social Security
7 Act).

8 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
9 provisions of subpart II shall, except as inconsistent with
10 this subpart, apply to the Public Health Workforce Corps
11 in the same manner and to the same extent as such provi-
12 sions apply to the National Health Service Corps estab-
13 lished under section 331.

14 “(e) REPORT.—The Secretary shall submit to the
15 Congress an annual report on the programs carried out
16 under this subpart.

17 **“SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP**
18 **PROGRAM.**

19 “(a) ESTABLISHMENT.—The Secretary shall estab-
20 lish the Public Health Workforce Scholarship Program
21 (referred to in this section as the ‘Program’) for the pur-
22 pose described in section 340L(a).

23 “(b) ELIGIBILITY.—To be eligible to participate in
24 the Program, an individual shall—

1 “(1)(A) be accepted for enrollment, or be en-
2 rolled, as a full-time or part-time student in a course
3 of study or program (approved by the Secretary) at
4 an accredited graduate school or program of public
5 health; or

6 “(B) have demonstrated expertise in public
7 health and be accepted for enrollment, or be en-
8 rolled, as a full-time or part-time student in a course
9 of study or program (approved by the Secretary)
10 at—

11 “(i) an accredited graduate school or pro-
12 gram of nursing; health administration, man-
13 agement, or policy; preventive medicine; labora-
14 tory science; veterinary medicine; or dental
15 medicine; or

16 “(ii) another accredited graduate school or
17 program, as deemed appropriate by the Sec-
18 retary;

19 “(2) be eligible for, or hold, an appointment as
20 a commissioned officer in the Regular or Reserve
21 Corps of the Service or be eligible for selection for
22 civilian service in the Corps; and

23 “(3) sign and submit to the Secretary a written
24 contract (described in subsection (c)) to serve full-
25 time as a public health professional, upon the com-

1 pletion of the course of study or program involved,
2 for the period of obligated service described in sub-
3 section (c)(2)(E).

4 “(c) CONTRACT.—The written contract between the
5 Secretary and an individual under subsection (b)(3) shall
6 contain—

7 “(1) an agreement on the part of the Secretary
8 that the Secretary will—

9 “(A) provide the individual with a scholar-
10 ship for a period of years (not to exceed 4 aca-
11 demic years) during which the individual shall
12 pursue an approved course of study or program
13 to prepare the individual to serve in the public
14 health workforce; and

15 “(B) accept (subject to the availability of
16 appropriated funds) the individual into the
17 Corps;

18 “(2) an agreement on the part of the individual
19 that the individual will—

20 “(A) accept provision of such scholarship
21 to the individual;

22 “(B) maintain full-time or part-time enroll-
23 ment in the approved course of study or pro-
24 gram described in subsection (b)(1) until the in-

1 individual completes that course of study or pro-
2 gram;

3 “(C) while enrolled in the approved course
4 of study or program, maintain an acceptable
5 level of academic standing (as determined by
6 the educational institution offering such course
7 of study or program);

8 “(D) if applicable, complete a residency or
9 internship; and

10 “(E) serve full-time as a public health pro-
11 fessional for a period of time equal to the great-
12 er of—

13 “(i) 1 year for each academic year for
14 which the individual was provided a schol-
15 arship under the Program; or

16 “(ii) 2 years; and

17 “(3) an agreement by both parties as to the na-
18 ture and extent of the scholarship assistance, which
19 may include—

20 “(A) payment of reasonable educational ex-
21 penses of the individual, including tuition, fees,
22 books, equipment, and laboratory expenses; and

23 “(B) payment of a stipend of not more
24 than \$1,269 (plus, beginning with fiscal year
25 2012, an amount determined by the Secretary

1 study or program (approved by the Secretary)
2 from—

3 “(i) an accredited school or program of
4 nursing; health administration, management, or
5 policy; preventive medicine; laboratory science;
6 veterinary medicine; or dental medicine; or

7 “(ii) another accredited school or program
8 approved by the Secretary; or

9 “(C) be enrolled as a full-time or part-time stu-
10 dent in the final year of a course of study or pro-
11 gram (approved by the Secretary) offered by a
12 school or program described in subparagraph (A) or
13 (B), leading to a graduate degree;

14 “(2) be eligible for, or hold, an appointment as
15 a commissioned officer in the Regular or Reserve
16 Corps of the Service or be eligible for selection for
17 civilian service in the Corps;

18 “(3) if applicable, complete a residency or in-
19 ternship; and

20 “(4) sign and submit to the Secretary a written
21 contract (described in subsection (c)) to serve full-
22 time as a public health professional for the period of
23 obligated service described in subsection (c)(2).

1 “(c) CONTRACT.—The written contract between the
2 Secretary and an individual under subsection (b)(4) shall
3 contain—

4 “(1) an agreement by the Secretary to repay on
5 behalf of the individual loans incurred by the indi-
6 vidual in the pursuit of the relevant public health
7 workforce educational degree in accordance with the
8 terms of the contract;

9 “(2) an agreement by the individual to serve
10 full-time as a public health professional for a period
11 of time equal to 2 years or such longer period as the
12 individual may agree to; and

13 “(3) in the case of an individual described in
14 subsection (b)(1)(C) who is in the final year of study
15 and who has accepted employment as a public health
16 professional, in accordance with section 340L(e), an
17 agreement on the part of the individual to complete
18 the education or training, maintain an acceptable
19 level of academic standing (as determined by the
20 educational institution offering the course of study
21 or training), and serve the period of obligated service
22 described in paragraph (2).

23 “(d) PAYMENTS.—

24 “(1) IN GENERAL.—A loan repayment provided
25 for an individual under a written contract under the

1 Program shall consist of payment, in accordance
2 with paragraph (2), on behalf of the individual of
3 the principal, interest, and related expenses on gov-
4 ernment and commercial loans received by the indi-
5 vidual regarding the undergraduate or graduate edu-
6 cation of the individual (or both), which loans were
7 made for reasonable educational expenses, including
8 tuition, fees, books, equipment, and laboratory ex-
9 penses, incurred by the individual.

10 “(2) PAYMENTS FOR YEARS SERVED.—

11 “(A) IN GENERAL.—For each year of obli-
12 gated service that an individual contracts to
13 serve under subsection (c), the Secretary may
14 pay up to \$35,000 (plus, beginning with fiscal
15 year 2012, an amount determined by the Sec-
16 retary on an annual basis to reflect inflation)
17 on behalf of the individual for loans described
18 in paragraph (1).

19 “(B) REPAYMENT SCHEDULE.—Any ar-
20 rangement made by the Secretary for the mak-
21 ing of loan repayments in accordance with this
22 subsection shall provide that any repayments
23 for a year of obligated service shall be made no
24 later than the end of the fiscal year in which
25 the individual completes such year of service.

1 “(e) APPLICATION OF CERTAIN PROVISIONS.—The
2 provisions of subpart III shall, except as inconsistent with
3 this subpart, apply to the loan repayment program under
4 this section in the same manner and to the same extent
5 as such provisions apply to the National Health Service
6 Corps Loan Repayment Program established under sec-
7 tion 338B.”.

8 **SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

9 Section 765 (42 U.S.C. 295) is amended to read as
10 follows:

11 **“SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

12 “(a) PROGRAM.—The Secretary, acting through the
13 Administrator of the Health Resources and Services Ad-
14 ministration and in consultation with the Director of the
15 Centers for Disease Control and Prevention, shall estab-
16 lish a public health workforce training and enhancement
17 program consisting of awarding grants and contracts
18 under subsection (b).

19 “(b) GRANTS AND CONTRACTS.—The Secretary shall
20 award grants to, or enter into contracts with, eligible enti-
21 ties—

22 “(1) to plan, develop, operate, or participate in,
23 an accredited professional training program in the
24 field of public health (including such a program in
25 nursing; health administration, management, or pol-

1 icy; preventive medicine; laboratory science; veteri-
2 nary medicine; or dental medicine) for members of
3 the public health workforce, including midcareer pro-
4 fessionals;

5 “(2) to provide financial assistance in the form
6 of traineeships and fellowships to students who are
7 participants in any such program and who plan to
8 specialize or work in the field of public health;

9 “(3) to plan, develop, operate, or participate in
10 a program for the training of public health profes-
11 sionals who plan to teach in any program described
12 in paragraph (1); and

13 “(4) to provide financial assistance in the form
14 of traineeships and fellowships to public health pro-
15 fessionals who are participants in any program de-
16 scribed in paragraph (1) and who plan to teach in
17 the field of public health, including nursing; health
18 administration, management, or policy; preventive
19 medicine; laboratory science; veterinary medicine; or
20 dental medicine.

21 “(c) ELIGIBILITY.—To be eligible for a grant or con-
22 tract under this section, an entity shall be—

23 “(1) an accredited health professions school, in-
24 cluding an accredited school or program of public
25 health; nursing; health administration, management,

1 or policy; preventive medicine; laboratory science;
2 veterinary medicine; or dental medicine;

3 “(2) a State, local, or tribal health department;

4 “(3) a public or private nonprofit entity; or

5 “(4) a consortium of 2 or more entities de-
6 scribed in paragraphs (1) through (3).

7 “(d) PREFERENCE.—In awarding grants or contracts
8 under this section, the Secretary shall give preference to
9 entities that have a demonstrated record of at least one
10 of the following:

11 “(1) Training a high or significantly improved
12 percentage of public health professionals who serve
13 in underserved communities.

14 “(2) Training individuals who are from dis-
15 advantaged backgrounds (including racial and ethnic
16 minorities underrepresented among public health
17 professionals).

18 “(3) Training individuals in public health spe-
19 cialties experiencing a significant shortage of public
20 health professionals (as determined by the Sec-
21 retary).

22 “(4) Training a high or significantly improved
23 percentage of public health professionals serving in
24 the Federal Government or a State, local, or tribal
25 government.

1 “(e) REPORT.—The Secretary shall submit to the
2 Congress an annual report on the program carried out
3 under this section.”.

4 **SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.**

5 Section 766 (42 U.S.C. 295a) is amended—

6 (1) in subsection (b)(1), by striking “in further-
7 ance of the goals established by the Secretary for
8 the year 2000” and inserting “in furtherance of the
9 goals established by the Secretary in the national
10 prevention and wellness strategy under section
11 3121”; and

12 (2) by adding at the end the following:

13 “(d) REPORT.—The Secretary shall submit to the
14 Congress an annual report on the program carried out
15 under this section.”.

16 **SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH**
17 **TRAINING GRANT PROGRAM.**

18 Section 768 (42 U.S.C. 295c) is amended to read as
19 follows:

20 **“SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH**
21 **TRAINING GRANT PROGRAM.**

22 “(a) GRANTS.—The Secretary, acting through the
23 Administrator of the Health Resources and Services Ad-
24 ministration and in consultation with the Director of the
25 Centers for Disease Control and Prevention, shall award

1 grants to, or enter into contracts with, eligible entities to
2 provide training to graduate medical residents in preven-
3 tive medicine specialties.

4 “(b) ELIGIBILITY.—To be eligible for a grant or con-
5 tract under subsection (a), an entity shall be—

6 “(1) an accredited school of public health or
7 school of medicine or osteopathic medicine;

8 “(2) an accredited public or private nonprofit
9 hospital;

10 “(3) a State, local, or tribal health department;
11 or

12 “(4) a consortium of 2 or more entities de-
13 scribed in paragraphs (1) through (3).

14 “(c) USE OF FUNDS.—Amounts received under a
15 grant or contract under this section shall be used to—

16 “(1) plan, develop (including the development of
17 curricula), operate, or participate in an accredited
18 residency or internship program in preventive medi-
19 cine or public health;

20 “(2) defray the costs of practicum experiences,
21 as required in such a program; and

22 “(3) establish, maintain, or improve—

23 “(A) academic administrative units (in-
24 cluding departments, divisions, or other appro-

1 priate units) in preventive medicine and public
2 health; or

3 “(B) programs that improve clinical teach-
4 ing in preventive medicine and public health.

5 “(d) REPORT.—The Secretary shall submit to the
6 Congress an annual report on the program carried out
7 under this section.”.

8 **SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.**

9 (a) IN GENERAL.—Section 799C, as added by section
10 2216 of this Act, is amended by adding at the end the
11 following:

12 “(b) PUBLIC HEALTH WORKFORCE.—For the pur-
13 pose of carrying out subpart XII of part D of title III
14 and sections 765, 766, and 768, in addition to any other
15 amounts authorized to be appropriated for such purpose,
16 there are authorized to be appropriated, out of any monies
17 in the Public Health Investment Fund, the following:

18 “(1) \$51,000,000 for fiscal year 2011.

19 “(2) \$54,000,000 for fiscal year 2012.

20 “(3) \$57,000,000 for fiscal year 2013.

21 “(4) \$59,000,000 for fiscal year 2014.

22 “(5) \$62,000,000 for fiscal year 2015.”.

23 (b) EXISTING AUTHORIZATION OF APPROPRIA-
24 TIONS.—Subsection (a) of section 770 (42 U.S.C. 295e)
25 is amended by striking “2002” and inserting “2015”.

1 **Subtitle D—Adapting Workforce to**
2 **Evolving Health System Needs**

3 **PART 1—HEALTH PROFESSIONS TRAINING FOR**
4 **DIVERSITY**

5 **SEC. 2241. SCHOLARSHIPS FOR DISADVANTAGED STU-**
6 **DENTS, LOAN REPAYMENTS AND FELLOW-**
7 **SHIPS REGARDING FACULTY POSITIONS, AND**
8 **EDUCATIONAL ASSISTANCE IN THE HEALTH**
9 **PROFESSIONS REGARDING INDIVIDUALS**
10 **FROM DISADVANTAGED BACKGROUNDS.**

11 Paragraph (1) of section 738(a) (42 U.S.C. 293b(a))
12 is amended by striking “not more than \$20,000” and all
13 that follows through the end of the paragraph and insert-
14 ing: “not more than \$35,000 (plus, beginning with fiscal
15 year 2012, an amount determined by the Secretary on an
16 annual basis to reflect inflation) of the principal and inter-
17 est of the educational loans of such individuals.”.

18 **SEC. 2242. NURSING WORKFORCE DIVERSITY GRANTS.**

19 Subsection (b) of section 821 (42 U.S.C. 296m) is
20 amended—

21 (1) in the heading, by striking “GUIDANCE”
22 and inserting “CONSULTATION”; and

23 (2) by striking “shall take into consideration”
24 and all that follows through “consult with nursing

1 **PART 2—INTERDISCIPLINARY TRAINING**

2 **PROGRAMS**

3 **SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY**

4 **TRAINING FOR HEALTH PROFESSIONALS.**

5 Section 741 (42 U.S.C. 293e) is amended—

6 (1) in the section heading, by striking

7 **“GRANTS FOR HEALTH PROFESSIONS EDU-**

8 **CATION”** and inserting **“CULTURAL AND LIN-**

9 **GUISTIC COMPETENCY TRAINING FOR HEALTH**

10 **PROFESSIONALS”**;

11 (2) by redesignating subsection (b) as sub-

12 section (h); and

13 (3) by striking subsection (a) and inserting the

14 following:

15 **“(a) PROGRAM.—**The Secretary shall establish a cul-

16 tural and linguistic competency training program for

17 health professionals, including nurse professionals, con-

18 sisting of awarding grants and contracts under subsection

19 (b).

20 **“(b) CULTURAL AND LINGUISTIC COMPETENCY**

21 **TRAINING.—**The Secretary shall award grants to, or enter

22 into contracts with, eligible entities—

23 (1) to test, develop, and evaluate models of

24 cultural and linguistic competency training (includ-

25 ing continuing education) for health professionals;

26 and

1 “(2) to implement cultural and linguistic com-
2 petency training programs for health professionals
3 developed under paragraph (1) or otherwise.

4 “(c) ELIGIBILITY.—To be eligible for a grant or con-
5 tract under subsection (b), an entity shall be—

6 “(1) an accredited health professions school or
7 program;

8 “(2) an academic health center;

9 “(3) a public or private nonprofit entity; or

10 “(4) a consortium of 2 or more entities de-
11 scribed in paragraphs (1) through (3).

12 “(d) PREFERENCE.—In awarding grants and con-
13 tracts under this section, the Secretary shall give pref-
14 erence to entities that have a demonstrated record of at
15 least one of the following:

16 “(1) Addressing, or partnering with an entity
17 with experience addressing, the cultural and lin-
18 guistic competency needs of the population to be
19 served through the grant or contract.

20 “(2) Addressing health disparities.

21 “(3) Placing health professionals in regions ex-
22 periencing significant changes in the cultural and
23 linguistic demographics of populations, including
24 communities along the United States-Mexico border.

1 “(b) TRAINING PROGRAMS.—The Secretary shall
2 award grants to, or enter into contracts with, eligible enti-
3 ties—

4 “(1) to test, develop, and evaluate health pro-
5 fessional training programs (including continuing
6 education) designed to promote—

7 “(A) the delivery of health services through
8 interdisciplinary and team-based models, which
9 may include patient-centered medical home
10 models, medication therapy management mod-
11 els, and models integrating physical, mental, or
12 oral health services; and

13 “(B) coordination of the delivery of health
14 care within and across settings, including health
15 care institutions, community-based settings,
16 and the patient’s home; and

17 “(2) to implement such training programs de-
18 veloped under paragraph (1) or otherwise.

19 “(c) ELIGIBILITY.—To be eligible for a grant or con-
20 tract under subsection (b), an entity shall be—

21 “(1) an accredited health professions school or
22 program;

23 “(2) an academic health center;

1 “(3) a public or private nonprofit entity (includ-
2 ing an area health education center or a geriatric
3 education center); or

4 “(4) a consortium of 2 or more entities de-
5 scribed in paragraphs (1) through (3).

6 “(d) PREFERENCES.—In awarding grants and con-
7 tracts under this section, the Secretary shall give pref-
8 erence to entities that have a demonstrated record of at
9 least one of the following:

10 “(1) Training a high or significantly improved
11 percentage of health professionals who serve in un-
12 derserved communities.

13 “(2) Broad interdisciplinary team-based collabo-
14 rations.

15 “(3) Addressing health disparities.

16 “(e) REPORT.—The Secretary shall submit to the
17 Congress an annual report on the program carried out
18 under this section.

19 “(f) DEFINITIONS.—In this section:

20 “(1) The term ‘health disparities’ has the
21 meaning given the term in section 3171.

22 “(2) The term ‘interdisciplinary’ means collabo-
23 ration across health professions and specialties,
24 which may include public health, nursing, allied

1 health, dietetics or nutrition, and appropriate health
2 specialties.”.

3 **PART 3—ADVISORY COMMITTEE ON HEALTH**

4 **WORKFORCE EVALUATION AND ASSESSMENT**

5 **SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESS-**
6 **MENT.**

7 Subpart 1 of part E of title VII (42 U.S.C. 294n
8 et seq.) is amended by adding at the end the following:

9 **“SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESS-**
10 **MENT.**

11 “(a) **ADVISORY COMMITTEE.**—The Secretary, acting
12 through the Assistant Secretary for Health, shall establish
13 a permanent advisory committee to be known as the Advi-
14 sory Committee on Health Workforce Evaluation and As-
15 sessment (referred to in this section as the ‘Advisory Com-
16 mittee’) to develop and implement an integrated, coordi-
17 nated, and strategic national health workforce policy re-
18 flective of current and evolving health workforce needs.

19 “(b) **RESPONSIBILITIES.**—The Advisory Committee
20 shall—

21 “(1) not later than 1 year after the date of the
22 establishment of the Advisory Committee, submit
23 recommendations to the Secretary on—

1 “(A) classifications of the health workforce
2 to ensure consistency of data collection on the
3 health workforce; and

4 “(B) based on such classifications, stand-
5 ardized methodologies and procedures to enu-
6 merate the health workforce;

7 “(2) not later than 2 years after the date of the
8 establishment of the Advisory Committee, submit
9 recommendations to the Secretary on—

10 “(A) the supply, diversity, and geographic
11 distribution of the health workforce;

12 “(B) the retention and expansion of the
13 health workforce (on a short- and long-term
14 basis) to ensure quality and adequacy of such
15 workforce; and

16 “(C) policies to carry out the recommenda-
17 tions made pursuant to subparagraphs (A) and
18 (B); and

19 “(3) not later than 4 years after the date of the
20 establishment of the Advisory Committee, and every
21 2 years thereafter, submit updated recommendations
22 to the Secretary under paragraphs (1) and (2).

23 “(c) ROLE OF AGENCY.—The Secretary shall provide
24 ongoing administrative, research, and technical support
25 for the operations of the Advisory Committee, including

1 coordinating and supporting the dissemination of the rec-
2 ommendations of the Advisory Committee.

3 “(d) MEMBERSHIP.—

4 “(1) NUMBER; APPOINTMENT.—The Secretary
5 shall appoint 15 members to serve on the Advisory
6 Committee.

7 “(2) TERMS.—

8 “(A) IN GENERAL.—The Secretary shall
9 appoint members of the Advisory Committee for
10 a term of 3 years and may reappoint such
11 members, but the Secretary may not appoint
12 any member to serve more than a total of 6
13 years.

14 “(B) STAGGERED TERMS.—Notwith-
15 standing subparagraph (A), of the members
16 first appointed to the Advisory Committee
17 under paragraph (1)—

18 “(i) 5 shall be appointed for a term of
19 1 year;

20 “(ii) 5 shall be appointed for a term
21 of 2 years; and

22 “(iii) 5 shall be appointed for a term
23 of 3 years.

24 “(3) QUALIFICATIONS.—Members of the Advi-
25 sory Committee shall be appointed from among indi-

1 viduals who possess expertise in at least one of the
2 following areas:

3 “(A) Conducting and interpreting health
4 workforce market analysis, including health
5 care labor workforce analysis.

6 “(B) Conducting and interpreting health
7 finance and economics research.

8 “(C) Delivering and administering health
9 care services.

10 “(D) Delivering and administering health
11 workforce education and training.

12 “(4) REPRESENTATION.—In appointing mem-
13 bers of the Advisory Committee, the Secretary
14 shall—

15 “(A) include no less than one representa-
16 tive of each of—

17 “(i) health professionals within the
18 health workforce;

19 “(ii) health care patients and con-
20 sumers;

21 “(iii) employers;

22 “(iv) labor unions; and

23 “(v) third-party health payors; and

24 “(B) ensure that—

1 “(i) all areas of expertise described in
2 paragraph (3) are represented;

3 “(ii) the members of the Advisory
4 Committee include members who, collec-
5 tively, have significant experience working
6 with—

7 “(I) populations in urban and
8 federally designated rural and non-
9 metropolitan areas; and

10 “(II) populations who are under-
11 represented in the health professions,
12 including underrepresented minority
13 groups; and

14 “(iii) individuals who are directly in-
15 volved in health professions education or
16 practice do not constitute a majority of the
17 members of the Advisory Committee.

18 “(5) DISCLOSURE AND CONFLICTS OF INTER-
19 EST.—Members of the Advisory Committee shall not
20 be considered employees of the Federal Government
21 by reason of service on the Advisory Committee, ex-
22 cept members of the Advisory Committee shall be
23 considered to be special Government employees with-
24 in the meaning of section 107 of the Ethics in Gov-
25 ernment Act of 1978 (5 U.S.C. App.) and section

1 208 of title 18, United States Code, for the purposes
2 of disclosure and management of conflicts of interest
3 under those sections.

4 “(6) NO PAY; RECEIPT OF TRAVEL EX-
5 PENSES.—Members of the Advisory Committee shall
6 not receive any pay for service on the Committee,
7 but may receive travel expenses, including a per
8 diem, in accordance with applicable provisions of
9 subchapter I of chapter 57 of title 5, United States
10 Code.

11 “(e) CONSULTATION.—In carrying out this section,
12 the Secretary shall consult with the Secretary of Edu-
13 cation and the Secretary of Labor.

14 “(f) COLLABORATION.—The Advisory Committee
15 shall collaborate with the advisory bodies at the Health
16 Resources and Services Administration, the National Ad-
17 visory Council (as authorized in section 337), the Advisory
18 Committee on Training in Primary Care Medicine and
19 Dentistry (as authorized in section 749A), the Advisory
20 Committee on Interdisciplinary, Community-Based Link-
21 ages (as authorized in section 756), the Advisory Council
22 on Graduate Medical Education (as authorized in section
23 762), and the National Advisory Council on Nurse Edu-
24 cation and Practice (as authorized in section 851).

1 “(g) FACA.—The Federal Advisory Committee Act
2 (5 U.S.C. App.) except for section 14 of such Act shall
3 apply to the Advisory Committee under this section only
4 to the extent that the provisions of such Act do not conflict
5 with the requirements of this section.

6 “(h) REPORT.—The Secretary shall submit to the
7 Congress an annual report on the activities of the Advisory
8 Committee.

9 “(i) DEFINITION.—In this section, the term ‘health
10 workforce’ includes all health care providers with direct
11 patient care and support responsibilities, including physi-
12 cians, nurses, physician assistants, pharmacists, oral
13 health professionals (as defined in section 749(f)(2)), al-
14 lied health professionals, mental and behavioral health
15 professionals (as defined in section 775(f)(2)), and public
16 health professionals (including veterinarians engaged in
17 public health practice).”.

18 **PART 4—HEALTH WORKFORCE ASSESSMENT**

19 **SEC. 2271. HEALTH WORKFORCE ASSESSMENT.**

20 (a) IN GENERAL.—Section 761 (42 U.S.C. 294n) is
21 amended—

22 (1) by redesignating subsection (c) as sub-
23 section (e); and

24 (2) by striking subsections (a) and (b) and in-
25 serting the following:

1 “(a) IN GENERAL.—The Secretary shall, based upon
2 the classifications and standardized methodologies and
3 procedures developed by the Advisory Committee on
4 Health Workforce Evaluation and Assessment under sec-
5 tion 764(b)—

6 “(1) collect data on the health workforce (as
7 defined in section 764(i)), disaggregated by field,
8 discipline, and specialty, with respect to—

9 “(A) the supply (including retention) of
10 health professionals relative to the demand for
11 such professionals;

12 “(B) the diversity of health professionals
13 (including with respect to race, ethnic back-
14 ground, and sex); and

15 “(C) the geographic distribution of health
16 professionals; and

17 “(2) collect such data on individuals partici-
18 pating in the programs authorized by subtitles A, B,
19 and C and part 1 of subtitle D of title II of division
20 C of the Affordable Health Care for America Act.

21 “(b) GRANTS AND CONTRACTS FOR HEALTH WORK-
22 FORCE ANALYSIS.—

23 “(1) IN GENERAL.—The Secretary may award
24 grants to, or enter into contracts with, eligible enti-
25 ties to carry out subsection (a).

1 “(2) ELIGIBILITY.—To be eligible for a grant
2 or contract under this subsection, an entity shall
3 be—

4 “(A) an accredited health professions
5 school or program;

6 “(B) an academic health center;

7 “(C) a State, local, or tribal government;

8 “(D) a public or private entity; or

9 “(E) a consortium of 2 or more entities de-
10 scribed in subparagraphs (A) through (D).

11 “(c) COLLABORATION AND DATA SHARING.—The
12 Secretary shall collaborate with Federal departments and
13 agencies, health professions organizations (including
14 health professions education organizations), and profes-
15 sional medical societies for the purpose of carrying out
16 subsection (a).

17 “(d) REPORT.—The Secretary shall submit to the
18 Congress an annual report on the data collected under
19 subsection (a).”.

20 (b) PERIOD BEFORE COMPLETION OF NATIONAL
21 STRATEGY.—Pending completion of the classifications and
22 standardized methodologies and procedures developed by
23 the Advisory Committee on Health Workforce Evaluation
24 and Assessment under section 764(b) of the Public Health
25 Service Act, as added by section 2261, the Secretary of

1 Health and Human Services, acting through the Adminis-
2 trator of the Health Resources and Services Administra-
3 tion and in consultation with such Advisory Committee,
4 may make a judgment about the classifications, meth-
5 odologies, and procedures to be used for collection of data
6 under section 761(a) of the Public Health Service Act, as
7 amended by this section.

8 **PART 5—AUTHORIZATION OF APPROPRIATIONS**

9 **SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.**

10 (a) IN GENERAL.—Section 799C, as added and
11 amended, is further amended by adding at the end the
12 following:

13 “(c) HEALTH PROFESSIONS TRAINING FOR DIVER-
14 SITY.—For the purpose of carrying out sections 736, 737,
15 738, 739, and 739A, in addition to any other amounts
16 authorized to be appropriated for such purpose, there are
17 authorized to be appropriated, out of any monies in the
18 Public Health Investment Fund, the following:

19 “(1) \$90,000,000 for fiscal year 2011.

20 “(2) \$97,000,000 for fiscal year 2012.

21 “(3) \$100,000,000 for fiscal year 2013.

22 “(4) \$104,000,000 for fiscal year 2014.

23 “(5) \$110,000,000 for fiscal year 2015.

24 “(d) INTERDISCIPLINARY TRAINING PROGRAMS, AD-
25 VISORY COMMITTEE ON HEALTH WORKFORCE EVALUA-

1 TION AND ASSESSMENT, AND HEALTH WORKFORCE AS-
2 SESSMENT.—For the purpose of carrying out sections
3 741, 759, 761, and 764, in addition to any other amounts
4 authorized to be appropriated for such purpose, there are
5 authorized to be appropriated, out of any monies in the
6 Public Health Investment Fund, the following:

7 “(1) \$87,000,000 for fiscal year 2011.

8 “(2) \$97,000,000 for fiscal year 2012.

9 “(3) \$103,000,000 for fiscal year 2013.

10 “(4) \$105,000,000 for fiscal year 2014.

11 “(5) \$113,000,000 for fiscal year 2015.”.

12 (b) EXISTING AUTHORIZATIONS OF APPROPRIA-
13 TIONS.—

14 (1) SECTION 736.—Paragraph (1) of section
15 736(i) (42 U.S.C. 293(h)), as redesignated, is
16 amended by striking “2002” and inserting “2015”.

17 (2) SECTIONS 737, 738, AND 739.—Subsections
18 (a), (b), and (c) of section 740 are amended by
19 striking “2002” each place it appears and inserting
20 “2015”.

21 (3) SECTION 741.—Subsection (h), as so redesi-
22 gnated, of section 741 is amended—

23 (A) by striking “and” after “fiscal year
24 2003,”; and

1 (B) by inserting “, and such sums as may
2 be necessary for each subsequent fiscal year
3 through the end of fiscal year 2015” before the
4 period at the end.

5 (4) SECTION 761.—Subsection (e)(1), as so re-
6 designated, of section 761 is amended by striking
7 “2002” and inserting “2015”.

8 **TITLE III—PREVENTION AND** 9 **WELLNESS**

10 **SEC. 2301. PREVENTION AND WELLNESS.**

11 (a) IN GENERAL.—The Public Health Service Act
12 (42 U.S.C. 201 et seq.) is amended by inserting after title
13 XXX the following:

14 **“TITLE XXXI—PREVENTION AND** 15 **WELLNESS**

16 **“Subtitle A—Prevention and** 17 **Wellness Trust**

18 **“SEC. 3111. PREVENTION AND WELLNESS TRUST.**

19 “(a) DEPOSITS INTO TRUST.—There is established
20 a Prevention and Wellness Trust. There are authorized
21 to be appropriated to the Trust—

22 “(1) out of the general fund of the Treasury,
23 amounts described in section 2002(b)(2)(A)(ii) of
24 the Affordable Health Care for America Act for each
25 fiscal year; and

1 “(2) in addition, out of any monies in the Pub-
2 lic Health Investment Fund—

3 “(A) for fiscal year 2011, \$2,400,000,000;

4 “(B) for fiscal year 2012, \$2,845,000,000;

5 “(C) for fiscal year 2013, \$3,100,000,000;

6 “(D) for fiscal year 2014, \$3,455,000,000;

7 and

8 “(E) for fiscal year 2015, \$3,600,000,000.

9 “(b) AVAILABILITY OF FUNDS.—Amounts in the Pre-
10 vention and Wellness Trust shall be available, as provided
11 in advance in appropriation Acts, for carrying out this
12 title.

13 “(c) ALLOCATION.—Of the amounts authorized to be
14 appropriated in subsection (a)(2), there are authorized to
15 be appropriated—

16 “(1) for carrying out subtitle C (Prevention
17 Task Forces), \$30,000,000 for each of fiscal years
18 2011 through 2015;

19 “(2) for carrying out subtitle D (Prevention
20 and Wellness Research)—

21 “(A) for fiscal year 2011, \$155,000,000;

22 “(B) for fiscal year 2012, \$205,000,000;

23 “(C) for fiscal year 2013, \$255,000,000;

24 “(D) for fiscal year 2014, \$305,000,000;

25 and

1 “(E) for fiscal year 2015, \$355,000,000;

2 “(3) for carrying out subtitle E (Delivery of
3 Community Preventive and Wellness Services)—

4 “(A) for fiscal year 2011, \$1,065,000,000;

5 “(B) for fiscal year 2012, \$1,260,000,000;

6 “(C) for fiscal year 2013, \$1,365,000,000;

7 “(D) for fiscal year 2014, \$1,570,000,000;

8 and

9 “(E) for fiscal year 2015, \$1,600,000,000;

10 “(4) for carrying out section 3161 (Core Public
11 Health Infrastructure for State, Local, and Tribal
12 Health Departments)—

13 “(A) for fiscal year 2011, \$800,000,000;

14 “(B) for fiscal year 2012, \$1,000,000,000;

15 “(C) for fiscal year 2013, \$1,100,000,000;

16 “(D) for fiscal year 2014, \$1,200,000,000;

17 and

18 “(E) for fiscal year 2015, \$1,265,000,000;

19 and

20 “(5) for carrying out section 3162 (Core Public
21 Health Infrastructure and Activities for CDC),
22 \$350,000,000 for each of fiscal years 2011 through
23 2015.

1 **“Subtitle B—National Prevention**
2 **and Wellness Strategy**

3 **“SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRAT-**
4 **EGY.**

5 “(a) IN GENERAL.—The Secretary shall submit to
6 the Congress within one year after the date of the enact-
7 ment of this section, and at least every 2 years thereafter,
8 a national strategy that is designed to improve the Na-
9 tion’s health through evidence-based clinical and commu-
10 nity prevention and wellness activities (in this section re-
11 ferred to as ‘prevention and wellness activities’), including
12 core public health infrastructure improvement activities.

13 “(b) CONTENTS.—The strategy under subsection (a)
14 shall include each of the following:

15 “(1) Identification of specific national goals and
16 objectives in prevention and wellness activities that
17 take into account appropriate public health measures
18 and standards, including departmental measures and
19 standards (including Healthy People and National
20 Public Health Performance Standards).

21 “(2) Establishment of national priorities for
22 prevention and wellness, taking into account unmet
23 prevention and wellness needs.

24 “(3) Establishment of national priorities for re-
25 search on prevention and wellness, taking into ac-

1 count unanswered research questions on prevention
2 and wellness.

3 “(4) Identification of health disparities in pre-
4 vention and wellness.

5 “(5) Review of prevention payment incentives,
6 the prevention workforce, and prevention delivery
7 system capacity.

8 “(6) A plan for addressing and implementing
9 paragraphs (1) through (5).

10 “(c) CONSULTATION.—In developing or revising the
11 strategy under subsection (a), the Secretary shall consult
12 with the following:

13 “(1) The heads of appropriate health agencies
14 and offices in the Department, including the Office
15 of the Surgeon General of the Public Health Service,
16 the Office of Minority Health, the Office on Wom-
17 en’s Health, and the Substance Abuse and Mental
18 Health Services Administration.

19 “(2) As appropriate, the heads of other Federal
20 departments and agencies whose programs have a
21 significant impact upon health (as determined by the
22 Secretary).

23 “(3) As appropriate, nonprofit and for-profit
24 entities.

1 “(4) The Association of State and Territorial
2 Health Officials and the National Association of
3 County and City Health Officials.

4 “(5) The Task Force on Community Preventive
5 Services and the Task Force on Clinical Preventive
6 Services.

7 **“Subtitle C—Prevention Task**
8 **Forces**

9 **“SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERV-**
10 **ICES.**

11 “(a) IN GENERAL.—The Secretary, acting through
12 the Director of the Agency for Healthcare Research and
13 Quality, shall establish a permanent task force to be
14 known as the Task Force on Clinical Preventive Services
15 (in this section referred to as the ‘Task Force’).

16 “(b) RESPONSIBILITIES.—The Task Force shall—

17 “(1) identify clinical preventive services for re-
18 view;

19 “(2) review the scientific evidence related to the
20 benefits, effectiveness, appropriateness, and costs of
21 clinical preventive services identified under para-
22 graph (1) for the purpose of developing, updating,
23 publishing, and disseminating evidence-based rec-
24 ommendations on the use of such services;

1 “(3) as appropriate, take into account health
2 disparities in developing, updating, publishing, and
3 disseminating evidence-based recommendations on
4 the use of such services;

5 “(4) identify gaps in clinical preventive services
6 research and evaluation and recommend priority
7 areas for such research and evaluation;

8 “(5) pursuant to section 3143(c), determine
9 whether subsidies and rewards meet the Task
10 Force’s standards for a grade of A or B;

11 “(6) as appropriate, consult with the clinical
12 prevention stakeholders board in accordance with
13 subsection (f);

14 “(7) consult with the Task Force on Commu-
15 nity Preventive Services established under section
16 3132; and

17 “(8) as appropriate, in carrying out this sec-
18 tion, consider the national strategy under section
19 3121.

20 “(c) **ROLE OF AGENCY.**—The Secretary shall provide
21 ongoing administrative, research, and technical support
22 for the operations of the Task Force, including coordi-
23 nating and supporting the dissemination of the rec-
24 ommendations of the Task Force.

25 “(d) **MEMBERSHIP.**—

1 “(1) NUMBER; APPOINTMENT.—The Task
2 Force shall be composed of 30 members, appointed
3 by the Secretary.

4 “(2) TERMS.—

5 “(A) IN GENERAL.—The Secretary shall
6 appoint members of the Task Force for a term
7 of 6 years and may reappoint such members,
8 but the Secretary may not appoint any member
9 to serve more than a total of 12 years.

10 “(B) STAGGERED TERMS.—Notwith-
11 standing subparagraph (A), of the members
12 first appointed to serve on the Task Force after
13 the enactment of this title—

14 “(i) 10 shall be appointed for a term
15 of 2 years;

16 “(ii) 10 shall be appointed for a term
17 of 4 years; and

18 “(iii) 10 shall be appointed for a term
19 of 6 years.

20 “(3) QUALIFICATIONS.—Members of the Task
21 Force shall be appointed from among individuals
22 who possess expertise in at least one of the following
23 areas:

24 “(A) Health promotion and disease preven-
25 tion.

1 “(B) Evaluation of research and system-
2 atic evidence reviews.

3 “(C) Application of systematic evidence re-
4 views to clinical decisionmaking or health pol-
5 icy.

6 “(D) Clinical primary care in child and ad-
7 olescent health.

8 “(E) Clinical primary care in adult health,
9 including women’s health.

10 “(F) Clinical primary care in geriatrics.

11 “(G) Clinical counseling and behavioral
12 services for primary care patients.

13 “(4) REPRESENTATION.—In appointing mem-
14 bers of the Task Force, the Secretary shall ensure
15 that—

16 “(A) all areas of expertise described in
17 paragraph (3) are represented; and

18 “(B) the members of the Task Force in-
19 clude individuals with expertise in health dis-
20 parities.

21 “(e) SUBGROUPS.—As appropriate to maximize effi-
22 ciency, the Task Force may delegate authority for con-
23 ducting reviews and making recommendations to sub-
24 groups consisting of Task Force members, subject to final
25 approval by the Task Force.

1 “(f) CLINICAL PREVENTION STAKEHOLDERS
2 BOARD.—

3 “(1) IN GENERAL.—The Task Force shall con-
4 vene a clinical prevention stakeholders board com-
5 posed of representatives of appropriate public and
6 private entities with an interest in clinical preventive
7 services to advise the Task Force on developing, up-
8 dating, publishing, and disseminating evidence-based
9 recommendations on the use of clinical preventive
10 services.

11 “(2) MEMBERSHIP.—The members of the clin-
12 ical prevention stakeholders board shall include rep-
13 resentatives of the following:

14 “(A) Health care consumers and patient
15 groups.

16 “(B) Providers of clinical preventive serv-
17 ices, including community-based providers.

18 “(C) Federal departments and agencies,
19 including—

20 “(i) appropriate health agencies and
21 offices in the Department, including the
22 Office of the Surgeon General of the Pub-
23 lic Health Service, the Office of Minority
24 Health, the National Center on Minority

1 Health and Health Disparities, and the Of-
2 fice on Women’s Health; and

3 “(ii) as appropriate, other Federal de-
4 partments and agencies whose programs
5 have a significant impact upon health (as
6 determined by the Secretary).

7 “(D) Private health care payors.

8 “(3) RESPONSIBILITIES.—In accordance with
9 subsection (b)(6), the clinical prevention stake-
10 holders board shall—

11 “(A) recommend clinical preventive serv-
12 ices for review by the Task Force;

13 “(B) suggest scientific evidence for consid-
14 eration by the Task Force related to reviews
15 undertaken by the Task Force;

16 “(C) provide feedback regarding draft rec-
17 ommendations by the Task Force; and

18 “(D) assist with efforts regarding dissemi-
19 nation of recommendations by the Director of
20 the Agency for Healthcare Research and Qual-
21 ity.

22 “(g) DISCLOSURE AND CONFLICTS OF INTEREST.—
23 Members of the Task Force or the clinical prevention
24 stakeholders board shall not be considered employees of
25 the Federal Government by reason of service on the Task

1 Force or the clinical prevention stakeholders board, except
2 members of the Task Force or the clinical prevention
3 stakeholders board shall be considered to be special Gov-
4 ernment employees within the meaning of section 107 of
5 the Ethics in Government Act of 1978 (5 U.S.C. App.)
6 and section 208 of title 18, United States Code, for the
7 purposes of disclosure and management of conflicts of in-
8 terest under those sections.

9 “(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—
10 Members of the Task Force or the clinical prevention
11 stakeholders board shall not receive any pay for service
12 on the Task Force, but may receive travel expenses, in-
13 cluding a per diem, in accordance with applicable provi-
14 sions of subchapter I of chapter 57 of title 5, United
15 States Code.

16 “(i) APPLICATION OF FACA.—The Federal Advisory
17 Committee Act (5 U.S.C. App.) except for section 14 of
18 such Act shall apply to the Task Force to the extent that
19 the provisions of such Act do not conflict with the provi-
20 sions of this title.

21 “(j) REPORT.—The Secretary shall submit to the
22 Congress an annual report on the Task Force, including
23 with respect to gaps identified and recommendations made
24 under subsection (b)(4).

1 **“SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE**
2 **SERVICES.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Centers for Disease Control and Pre-
5 vention, shall establish a permanent task force to be
6 known as the Task Force on Community Preventive Serv-
7 ices (in this section referred to as the ‘Task Force’).

8 “(b) RESPONSIBILITIES.—The Task Force shall—

9 “(1) identify community preventive services for
10 review;

11 “(2) review the scientific evidence related to the
12 benefits, effectiveness, appropriateness, and costs of
13 community preventive services identified under para-
14 graph (1) for the purpose of developing, updating,
15 publishing, and disseminating evidence-based rec-
16 ommendations on the use of such services;

17 “(3) as appropriate, take into account health
18 disparities in developing, updating, publishing, and
19 disseminating evidence-based recommendations on
20 the use of such services;

21 “(4) identify gaps in community preventive
22 services research and evaluation and recommend pri-
23 ority areas for such research and evaluation;

24 “(5) pursuant to section 3143(d), determine
25 whether subsidies and rewards are effective;

1 “(6) as appropriate, consult with the commu-
2 nity prevention stakeholders board in accordance
3 with subsection (f);

4 “(7) consult with the Task Force on Clinical
5 Preventive Services established under section 3131;
6 and

7 “(8) as appropriate, in carrying out this sec-
8 tion, consider the national strategy under section
9 3121.

10 “(c) ROLE OF AGENCY.—The Secretary shall provide
11 ongoing administrative, research, and technical support
12 for the operations of the Task Force, including coordi-
13 nating and supporting the dissemination of the rec-
14 ommendations of the Task Force.

15 “(d) MEMBERSHIP.—

16 “(1) NUMBER; APPOINTMENT.—The Task
17 Force shall be composed of 30 members, appointed
18 by the Secretary.

19 “(2) TERMS.—

20 “(A) IN GENERAL.—The Secretary shall
21 appoint members of the Task Force for a term
22 of 6 years and may reappoint such members,
23 but the Secretary may not appoint any member
24 to serve more than a total of 12 years.

1 “(B) STAGGERED TERMS.—Notwith-
2 standing subparagraph (A), of the members
3 first appointed to serve on the Task Force after
4 the enactment of this section—

5 “(i) 10 shall be appointed for a term
6 of 2 years;

7 “(ii) 10 shall be appointed for a term
8 of 4 years; and

9 “(iii) 10 shall be appointed for a term
10 of 6 years.

11 “(3) QUALIFICATIONS.—Members of the Task
12 Force shall be appointed from among individuals
13 who possess expertise in at least one of the following
14 areas:

15 “(A) Public health.

16 “(B) Evaluation of research and system-
17 atic evidence reviews.

18 “(C) Disciplines relevant to community
19 preventive services, including health promotion;
20 disease prevention; chronic disease; worksite
21 health; school-site health; qualitative and quan-
22 titative analysis; and health economics, policy,
23 law, and statistics.

24 “(4) REPRESENTATION.—In appointing mem-
25 bers of the Task Force, the Secretary—

1 “(A) shall ensure that all areas of exper-
2 tise described in paragraph (3) are represented;

3 “(B) shall ensure that such members in-
4 clude sufficient representatives of each of—

5 “(i) State health officers;

6 “(ii) local health officers;

7 “(iii) health care practitioners; and

8 “(iv) public health practitioners; and

9 “(C) shall appoint individuals who have ex-
10 pertise in health disparities.

11 “(e) SUBGROUPS.—As appropriate to maximize effi-
12 ciency, the Task Force may delegate authority for con-
13 ducting reviews and making recommendations to sub-
14 groups consisting of Task Force members, subject to final
15 approval by the Task Force.

16 “(f) COMMUNITY PREVENTION STAKEHOLDERS
17 BOARD.—

18 “(1) IN GENERAL.—The Task Force shall con-
19 vene a community prevention stakeholders board
20 composed of representatives of appropriate public
21 and private entities with an interest in community
22 preventive services to advise the Task Force on de-
23 veloping, updating, publishing, and disseminating
24 evidence-based recommendations on the use of com-
25 munity preventive services.

1 “(2) MEMBERSHIP.—The members of the com-
2 munity prevention stakeholders board shall include
3 representatives of the following:

4 “(A) Health care consumers and patient
5 groups.

6 “(B) Providers of community preventive
7 services, including community-based providers.

8 “(C) Federal departments and agencies,
9 including—

10 “(i) appropriate health agencies and
11 offices in the Department, including the
12 Office of the Surgeon General of the Pub-
13 lic Health Service, the Office of Minority
14 Health, the National Center on Minority
15 Health and Health Disparities, and the Of-
16 fice on Women’s Health; and

17 “(ii) as appropriate, other Federal de-
18 partments and agencies whose programs
19 have a significant impact upon health (as
20 determined by the Secretary).

21 “(D) Private health care payors.

22 “(3) RESPONSIBILITIES.—In accordance with
23 subsection (b)(6), the community prevention stake-
24 holders board shall—

1 “(A) recommend community preventive
2 services for review by the Task Force;

3 “(B) suggest scientific evidence for consid-
4 eration by the Task Force related to reviews
5 undertaken by the Task Force;

6 “(C) provide feedback regarding draft rec-
7 ommendations by the Task Force; and

8 “(D) assist with efforts regarding dissemi-
9 nation of recommendations by the Director of
10 the Centers for Disease Control and Prevention.

11 “(g) DISCLOSURE AND CONFLICTS OF INTEREST.—
12 Members of the Task Force or the community prevention
13 stakeholders board shall not be considered employees of
14 the Federal Government by reason of service on the Task
15 Force or the community prevention stakeholders board,
16 except members of the Task Force or the community pre-
17 vention stakeholders board shall be considered to be spe-
18 cial Government employees within the meaning of section
19 107 of the Ethics in Government Act of 1978 (5 U.S.C.
20 App.) and section 208 of title 18, United States Code, for
21 the purposes of disclosure and management of conflicts
22 of interest under those sections.

23 “(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—
24 Members of the Task Force or the community prevention
25 stakeholders board shall not receive any pay for service

1 on the Task Force, but may receive travel expenses, in-
2 cluding a per diem, in accordance with applicable provi-
3 sions of subchapter I of chapter 57 of title 5, United
4 States Code.

5 “(i) APPLICATION OF FACA.—The Federal Advisory
6 Committee Act (5 U.S.C. App.) except for section 14 of
7 such Act shall apply to the Task Force to the extent that
8 the provisions of such Act do not conflict with the provi-
9 sions of this title.

10 “(j) REPORT.—The Secretary shall submit to the
11 Congress an annual report on the Task Force, including
12 with respect to gaps identified and recommendations made
13 under subsection (b)(4).

14 **“Subtitle D—Prevention and** 15 **Wellness Research**

16 **“SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIV-**
17 **ITY COORDINATION.**

18 “In conducting or supporting research on prevention
19 and wellness, the Director of the Centers for Disease Con-
20 trol and Prevention, the Director of the National Insti-
21 tutes of Health, and the heads of other agencies within
22 the Department of Health and Human Services con-
23 ducting or supporting such research, shall take into con-
24 sideration the national strategy under section 3121 and
25 the recommendations of the Task Force on Clinical Pre-

1 ventive Services under section 3131 and the Task Force
2 on Community Preventive Services under section 3132.

3 **“SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RE-**
4 **SEARCH GRANTS.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Director of the Centers for Disease Control and Pre-
7 vention, shall conduct, or award grants to eligible entities
8 to conduct, research in priority areas identified by the Sec-
9 retary in the national strategy under section 3121 or by
10 the Task Force on Community Preventive Services as re-
11 quired by section 3132.

12 “(b) ELIGIBILITY.—To be eligible for a grant under
13 this section, an entity shall be—

14 “(1) a State, local, or tribal department of
15 health;

16 “(2) a public or private nonprofit entity; or

17 “(3) a consortium of 2 or more entities de-
18 scribed in paragraphs (1) and (2).

19 “(c) REPORT.—The Secretary shall submit to the
20 Congress an annual report on the program of research
21 under this section.

22 **“SEC. 3143. RESEARCH ON SUBSIDIES AND REWARDS TO**
23 **ENCOURAGE WELLNESS AND HEALTHY BE-**
24 **HAVIORS.**

25 “(a) RESEARCH AND DEMONSTRATION PROJECTS.—

1 “(1) IN GENERAL.—The Secretary shall con-
2 duct, or award grants to public or nonprofit private
3 entities to conduct, research and demonstration
4 projects on the use of financial and in-kind subsidies
5 and rewards to encourage individuals and commu-
6 nities to promote wellness, adopt healthy behaviors,
7 and use evidence-based preventive health services.

8 “(2) FOCUS.—Research and demonstration
9 projects under paragraph (1) shall focus on—

10 “(A) tobacco use, obesity, and other pre-
11 vention and wellness priorities identified by the
12 Secretary in the national strategy under section
13 3121;

14 “(B) the initiation, maintenance, and long-
15 term sustainability of wellness promotion; adop-
16 tion of healthy behaviors; and use of evidence-
17 based preventive health services; and

18 “(C) populations at high risk of prevent-
19 able diseases and conditions.

20 “(b) FINDINGS; REPORT.—

21 “(1) SUBMISSION OF FINDINGS.—The Secretary
22 shall submit the findings of research and demonstra-
23 tion projects under subsection (a) to—

24 “(A) the Task Force on Clinical Preventive
25 Services established under section 3131 or the

1 Task Force on Community Preventive Services
2 established under section 3132, as appropriate;
3 and

4 “(B) the Health Benefits Advisory Com-
5 mittee established by section 223 of the Afford-
6 able Health Care for America Act.

7 “(2) REPORT TO CONGRESS.—Not later than
8 18 months after the initiation of research and dem-
9 onstration projects under subsection (a), the Sec-
10 retary shall submit a report to the Congress on the
11 progress of such research and projects, including
12 any preliminary findings.

13 “(c) INCLUSION IN ESSENTIAL BENEFITS PACK-
14 AGE.—If, on the basis of the findings of research and dem-
15 onstration projects under subsection (a) or other sources
16 consistent with section 3131, the Task Force on Clinical
17 Preventive Services determines that a subsidy or reward
18 meets the Task Force’s standards for a grade A or B,
19 the Secretary shall ensure that the subsidy or reward is
20 included in the essential benefits package under section
21 222.

22 “(d) INCLUSION AS ALLOWABLE USE OF COMMUNITY
23 PREVENTION AND WELLNESS SERVICES GRANTS.—If, on
24 the basis of the findings of research and demonstration
25 projects under subsection (a) or other sources consistent

1 with section 3132, the Task Force on Community Preven-
2 tive Services determines that a subsidy or reward is effec-
3 tive, the Secretary shall ensure that the subsidy or reward
4 becomes an allowable use of grant funds under section
5 3151.

6 “(e) NONDISCRIMINATION; NO TIE TO PREMIUM OR
7 COST SHARING.—In carrying out this section, the Sec-
8 retary shall ensure that any subsidy or reward—

9 “(1) does not have a discriminatory effect on
10 the basis of any personal characteristic extraneous
11 to the provision of high-quality health care or related
12 services; and

13 “(2) is not tied to the premium or cost sharing
14 of an individual under any qualified health benefits
15 plan (as defined in section 100(c)).

16 **“Subtitle E—Delivery of Commu-**
17 **nity Prevention and Wellness**
18 **Services**

19 **“SEC. 3151. COMMUNITY PREVENTION AND WELLNESS**
20 **SERVICES GRANTS.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Director of the Centers for Disease Control and Pre-
23 vention, shall establish a program for the delivery of com-
24 munity prevention and wellness services consisting of
25 awarding grants to eligible entities—

1 “(1) to provide evidence-based, community pre-
2 vention and wellness services in priority areas identi-
3 fied by the Secretary in the national strategy under
4 section 3121; or

5 “(2) to plan such services.

6 “(b) ELIGIBILITY.—

7 “(1) DEFINITION.—To be eligible for a grant
8 under this section, an entity shall be—

9 “(A) a State, local, or tribal department of
10 health;

11 “(B) a public or private entity; or

12 “(C) a consortium that—

13 “(i) consists of 2 or more entities de-
14 scribed in subparagraph (A) or (B); and

15 “(ii) may be a community partnership
16 representing a Health Empowerment Zone.

17 “(2) HEALTH EMPOWERMENT ZONE.—In this
18 subsection, the term ‘Health Empowerment Zone’
19 means an area—

20 “(A) in which multiple community preven-
21 tion and wellness services are implemented in
22 order to address one or more health disparities,
23 including those identified by the Secretary in
24 the national strategy under section 3121; and

1 “(B) which is represented by a community
2 partnership that demonstrates community sup-
3 port and coordination with State, local, or tribal
4 health departments and includes—

5 “(i) a broad cross section of stake-
6 holders;

7 “(ii) residents of the community; and

8 “(iii) representatives of entities that
9 have a history of working within and serv-
10 ing the community.

11 “(c) PREFERENCES.—In awarding grants under this
12 section, the Secretary shall give preference to entities
13 that—

14 “(1) will address one or more goals or objec-
15 tives identified by the Secretary in the national
16 strategy under section 3121;

17 “(2) will address significant health disparities,
18 including those identified by the Secretary in the na-
19 tional strategy under section 3121;

20 “(3) will address unmet community prevention
21 and wellness needs and avoid duplication of effort;

22 “(4) have been demonstrated to be effective in
23 communities comparable to the proposed target com-
24 munity;

1 “(5) will contribute to the evidence base for
2 community prevention and wellness services;

3 “(6) demonstrate that the community preven-
4 tion and wellness services to be funded will be sus-
5 tainable; and

6 “(7) demonstrate coordination or collaboration
7 across governmental and nongovernmental partners.

8 “(d) HEALTH DISPARITIES.—Of the funds awarded
9 under this section for a fiscal year, the Secretary shall
10 award not less than 50 percent for planning or imple-
11 menting community prevention and wellness services
12 whose primary purpose is to achieve a measurable reduc-
13 tion in one or more health disparities, including those
14 identified by the Secretary in the national strategy under
15 section 3121.

16 “(e) EMPHASIS ON RECOMMENDED SERVICES.—For
17 fiscal year 2014 and subsequent fiscal years, the Secretary
18 shall award grants under this section only for planning
19 or implementing services recommended by the Task Force
20 on Community Preventive Services under section 3132 or
21 deemed effective based on a review of comparable rigor
22 (as determined by the Director of the Centers for Disease
23 Control and Prevention).

1 “(f) PROHIBITED USES OF FUNDS.—An entity that
2 receives a grant under this section may not use funds pro-
3 vided through the grant—

4 “(1) to build or acquire real property or for
5 construction; or

6 “(2) for services or planning to the extent that
7 payment has been made, or can reasonably be ex-
8 pected to be made—

9 “(A) under any insurance policy;

10 “(B) under any Federal or State health
11 benefits program (including titles XIX and XXI
12 of the Social Security Act); or

13 “(C) by an entity which provides health
14 services on a prepaid basis.

15 “(g) REPORT.—The Secretary shall submit to the
16 Congress an annual report on the program of grants
17 awarded under this section.

18 “(h) DEFINITIONS.—In this section, the term ‘evi-
19 dence-based’ means that methodologically sound research
20 has demonstrated a beneficial health effect, in the judg-
21 ment of the Director of the Centers for Disease Control
22 and Prevention.

1 **“Subtitle F—Core Public Health**
2 **Infrastructure**

3 **“SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR**
4 **STATE, LOCAL, AND TRIBAL HEALTH DEPART-**
5 **MENTS.**

6 “(a) PROGRAM.—The Secretary, acting through the
7 Director of the Centers for Disease Control and Preven-
8 tion, shall establish a core public health infrastructure
9 program consisting of awarding grants under subsection
10 (b).

11 “(b) GRANTS.—

12 “(1) AWARD.—For the purpose of addressing
13 core public health infrastructure needs, the Sec-
14 retary—

15 “(A) shall award a grant to each State
16 health department; and

17 “(B) may award grants on a competitive
18 basis to State, local, or tribal health depart-
19 ments.

20 “(2) ALLOCATION.—Of the total amount of
21 funds awarded as grants under this subsection for a
22 fiscal year—

23 “(A) not less than 50 percent shall be for
24 grants to State health departments under para-
25 graph (1)(A); and

1 “(B) not less than 30 percent shall be for
2 grants to State, local, or tribal health depart-
3 ments under paragraph (1)(B).

4 “(c) USE OF FUNDS.—The Secretary may award a
5 grant to an entity under subsection (b)(1) only if the enti-
6 ty agrees to use the grant to address core public health
7 infrastructure needs, including those identified in the ac-
8 creditation process under subsection (g).

9 “(d) FORMULA GRANTS TO STATE HEALTH DEPART-
10 MENTS.—In making grants under subsection (b)(1)(A),
11 the Secretary shall award funds to each State health de-
12 partment in accordance with—

13 “(1) a formula based on population size; burden
14 of preventable disease and disability; and core public
15 health infrastructure gaps, including those identified
16 in the accreditation process under subsection (g);
17 and

18 “(2) application requirements established by the
19 Secretary, including a requirement that the State
20 submit a plan that demonstrates to the satisfaction
21 of the Secretary that the State’s health department
22 will—

23 “(A) address its highest priority core pub-
24 lic health infrastructure needs; and

1 “(B) as appropriate, allocate funds to local
2 health departments within the State.

3 “(e) COMPETITIVE GRANTS TO STATE, LOCAL, AND
4 TRIBAL HEALTH DEPARTMENTS.—In making grants
5 under subsection (b)(1)(B), the Secretary shall give pri-
6 ority to applicants demonstrating core public health infra-
7 structure needs identified in the accreditation process
8 under subsection (g).

9 “(f) MAINTENANCE OF EFFORT.—The Secretary
10 may award a grant to an entity under subsection (b) only
11 if the entity demonstrates to the satisfaction of the Sec-
12 retary that—

13 “(1) funds received through the grant will be
14 expended only to supplement, and not supplant, non-
15 Federal and Federal funds otherwise available to the
16 entity for the purpose of addressing core public
17 health infrastructure needs; and

18 “(2) with respect to activities for which the
19 grant is awarded, the entity will maintain expendi-
20 tures of non-Federal amounts for such activities at
21 a level not less than the level of such expenditures
22 maintained by the entity for the fiscal year pre-
23 ceding the fiscal year for which the entity receives
24 the grant.

1 “(g) ESTABLISHMENT OF A PUBLIC HEALTH AC-
2 CREDITATION PROGRAM.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Director of the Centers for Disease
5 Control and Prevention, shall—

6 “(A) develop, and periodically review and
7 update, standards for voluntary accreditation of
8 State, local, or tribal health departments and
9 public health laboratories for the purpose of ad-
10 vancing the quality and performance of such de-
11 partments and laboratories; and

12 “(B) implement a program to accredit
13 such health departments and laboratories in ac-
14 cordance with such standards.

15 “(2) COOPERATIVE AGREEMENT.—The Sec-
16 retary may enter into a cooperative agreement with
17 a private nonprofit entity to carry out paragraph
18 (1).

19 “(h) REPORT.—The Secretary shall submit to the
20 Congress an annual report on progress being made to ac-
21 credit entities under subsection (g), including—

22 “(1) a strategy, including goals and objectives,
23 for accrediting entities under subsection (g) and
24 achieving the purpose described in subsection (g)(1);
25 and

1 “(2) identification of gaps in research related to
2 core public health infrastructure and recommenda-
3 tions of priority areas for such research.

4 **“SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND**
5 **ACTIVITIES FOR CDC.**

6 “(a) IN GENERAL.—The Secretary, acting through
7 the Director of the Centers for Disease Control and Pre-
8 vention, shall expand and improve the core public health
9 infrastructure and activities of the Centers for Disease
10 Control and Prevention to address unmet and emerging
11 public health needs.

12 “(b) REPORT.—The Secretary shall submit to the
13 Congress an annual report on the activities funded
14 through this section.

15 **“Subtitle G—General Provisions**

16 **“SEC. 3171. DEFINITIONS.**

17 “In this title:

18 “(1) The term ‘core public health infrastruc-
19 ture’ includes workforce capacity and competency;
20 laboratory systems; health information, health infor-
21 mation systems, and health information analysis;
22 communications; financing; other relevant compo-
23 nents of organizational capacity; and other related
24 activities.

1 “(2) The terms ‘Department’ and ‘depart-
2 mental’ refer to the Department of Health and
3 Human Services.

4 “(3) The term ‘health disparities’ includes
5 health and health care disparities and means popu-
6 lation-specific differences in the presence of disease,
7 health outcomes, or access to health care. For pur-
8 poses of the preceding sentence, a population may be
9 delineated by race, ethnicity, primary language, sex,
10 sexual orientation, gender identity, disability, socio-
11 economic status, or rural, urban, or other geographic
12 setting, and any other population or subpopulation
13 determined by the Secretary to experience significant
14 gaps in disease, health outcomes, or access to health
15 care.

16 “(4) The term ‘tribal’ refers to an Indian tribe,
17 a Tribal organization, or an Urban Indian organiza-
18 tion, as such terms are defined in section 4 of the
19 Indian Health Care Improvement Act.”.

20 (b) TRANSITION PROVISIONS APPLICABLE TO TASK
21 FORCES.—

22 (1) FUNCTIONS, PERSONNEL, ASSETS, LIABIL-
23 ITIES, AND ADMINISTRATIVE ACTIONS.—All func-
24 tions, personnel, assets, and liabilities of, and ad-
25 ministrative actions applicable to, the Preventive

1 Services Task Force convened under section 915(a)
2 of the Public Health Service Act and the Task Force
3 on Community Preventive Services (as such section
4 and Task Forces were in existence on the day before
5 the date of the enactment of this Act) shall be trans-
6 ferred to the Task Force on Clinical Preventive
7 Services and the Task Force on Community Preven-
8 tive Services, respectively, established under sections
9 3131 and 3132 of the Public Health Service Act, as
10 added by subsection (a).

11 (2) RECOMMENDATIONS.—All recommendations
12 of the Preventive Services Task Force and the Task
13 Force on Community Preventive Services, as in ex-
14 istence on the day before the date of the enactment
15 of this Act, shall be considered to be recommenda-
16 tions of the Task Force on Clinical Preventive Serv-
17 ices and the Task Force on Community Preventive
18 Services, respectively, established under sections
19 3131 and 3132 of the Public Health Service Act, as
20 added by subsection (a).

21 (3) MEMBERS ALREADY SERVING.—

22 (A) INITIAL MEMBERS.—The Secretary of
23 Health and Human Services may select those
24 individuals already serving on the Preventive
25 Services Task Force and the Task Force on

1 Community Preventive Services, as in existence
2 on the day before the date of the enactment of
3 this Act, to be among the first members ap-
4 pointed to the Task Force on Clinical Preven-
5 tive Services and the Task Force on Commu-
6 nity Preventive Services, respectively, under sec-
7 tions 3131 and 3132 of the Public Health Serv-
8 ice Act, as added by subsection (a).

9 (B) CALCULATION OF TOTAL SERVICE.—In
10 calculating the total years of service of a mem-
11 ber of a task force for purposes of section
12 3131(d)(2)(A) or 3132(d)(2)(A) of the Public
13 Health Service Act, as added by subsection (a),
14 the Secretary of Health and Human Services
15 shall not include any period of service by the
16 member on the Preventive Services Task Force
17 or the Task Force on Community Preventive
18 Services, respectively, as in existence on the day
19 before the date of the enactment of this Act.

20 (c) PERIOD BEFORE COMPLETION OF NATIONAL
21 STRATEGY.—Pending completion of the national strategy
22 under section 3121 of the Public Health Service Act, as
23 added by subsection (a), the Secretary of Health and
24 Human Services, acting through the relevant agency head,
25 may make a judgment about how the strategy will address

1 an issue and rely on such judgment in carrying out any
2 provision of subtitle C, D, E, or F of title XXXI of such
3 Act, as added by subsection (a), that requires the Sec-
4 retary—

5 (1) to take into consideration such strategy;

6 (2) to conduct or support research or provide
7 services in priority areas identified in such strategy;
8 or

9 (3) to take any other action in reliance on such
10 strategy.

11 (d) CONFORMING AMENDMENTS.—

12 (1) Paragraph (61) of section 3(b) of the In-
13 dian Health Care Improvement Act (25 U.S.C.
14 1602) is amended by striking “United States Pre-
15 ventive Services Task Force” and inserting “Task
16 Force on Clinical Preventive Services”.

17 (2) Section 126 of the Medicare, Medicaid, and
18 SCHIP Benefits Improvement and Protection Act of
19 2000 (Appendix F of Public Law 106–554) is
20 amended by striking “United States Preventive
21 Services Task Force” each place it appears and in-
22 serting “Task Force on Clinical Preventive Serv-
23 ices”.

24 (3) Paragraph (7) of section 317D(a) of the
25 Public Health Service Act (42 U.S.C. 247b–5(a)) is

1 amended by striking “United States Preventive
2 Services Task Force” and inserting “Task Force on
3 Clinical Preventive Services”.

4 (4) Section 915 of the Public Health Service
5 Act (42 U.S.C. 299b–4) is amended by striking sub-
6 section (a).

7 (5) Subsections (s)(2)(AA)(iii)(II), (xx)(1), and
8 (ddd)(1)(B) of section 1861 of the Social Security
9 Act (42 U.S.C. 1395x) are amended by striking
10 “United States Preventive Services Task Force”
11 each place it appears and inserting “Task Force on
12 Clinical Preventive Services”.

13 **TITLE IV—QUALITY AND** 14 **SURVEILLANCE**

15 **SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE** 16 **DELIVERY OF HEALTH CARE.**

17 (a) IN GENERAL.—Title IX of the Public Health
18 Service Act (42 U.S.C. 299 et seq.) is amended—

19 (1) by redesignating part D as part E;

20 (2) by redesignating sections 931 through 938
21 as sections 941 through 948, respectively;

22 (3) in section 948(1), as redesignated, by strik-
23 ing “931” and inserting “941”; and

24 (4) by inserting after part C the following:

1 **“PART D—IMPLEMENTATION OF BEST**
2 **PRACTICES IN THE DELIVERY OF HEALTH CARE**
3 **“SEC. 931. CENTER FOR QUALITY IMPROVEMENT.**

4 “(a) IN GENERAL.—There is established the Center
5 for Quality Improvement (referred to in this part as the
6 ‘Center’), to be headed by the Director.

7 “(b) PRIORITIZATION.—

8 “(1) IN GENERAL.—The Director shall
9 prioritize areas for the identification, development,
10 evaluation, and implementation of best practices (in-
11 cluding innovative methodologies and strategies) for
12 quality improvement activities in the delivery of
13 health care services (in this section referred to as
14 ‘best practices’).

15 “(2) CONSIDERATIONS.—In prioritizing areas
16 under paragraph (1), the Director shall consider—

17 “(A) the priorities established under sec-
18 tion 1191 of the Social Security Act; and

19 “(B) the key health indicators identified by
20 the Assistant Secretary for Health Information
21 under section 1709.

22 “(3) LIMITATIONS.—In conducting its duties
23 under this subsection, the Center for Quality Im-
24 provement shall not develop quality-adjusted life
25 year measures or any other methodologies that can
26 be used to deny benefits to a beneficiary against the

1 beneficiary's wishes on the basis of the beneficiary's
2 age, life expectancy, present or predicted disability,
3 or expected quality of life.

4 “(c) OTHER RESPONSIBILITIES.—The Director, act-
5 ing directly or by awarding a grant or contract to an eligi-
6 ble entity, shall—

7 “(1) identify existing best practices under sub-
8 section (e);

9 “(2) develop new best practices under sub-
10 section (f);

11 “(3) evaluate best practices under subsection
12 (g);

13 “(4) implement best practices under subsection
14 (h);

15 “(5) ensure that best practices are identified,
16 developed, evaluated, and implemented under this
17 section consistent with standards adopted by the
18 Secretary under section 3004 for health information
19 technology used in the collection and reporting of
20 quality information (including for purposes of the
21 demonstration of meaningful use of certified elec-
22 tronic health record (EHR) technology by physicians
23 and hospitals under the Medicare program (under
24 sections 1848(o)(2) and 1886(n)(3), respectively, of
25 the Social Security Act)); and

1 “(6) provide for dissemination of information
2 and reporting under subsections (i) and (j).

3 “(d) ELIGIBILITY.—To be eligible for a grant or con-
4 tract under subsection (c), an entity shall—

5 “(1) be a nonprofit entity;

6 “(2) agree to work with a variety of institu-
7 tional health care providers, physicians, nurses, and
8 other health care practitioners; and

9 “(3) if the entity is not the organization holding
10 a contract under section 1153 of the Social Security
11 Act for the area to be served, agree to cooperate
12 with and avoid duplication of the activities of such
13 organization.

14 “(e) IDENTIFYING EXISTING BEST PRACTICES.—The
15 Director shall identify best practices that are—

16 “(1) currently utilized by health care providers
17 (including hospitals, physician and other clinician
18 practices, community cooperatives, and other health
19 care entities) that deliver consistently high-quality,
20 efficient health care services; and

21 “(2) easily adapted for use by other health care
22 providers and for use across a variety of health care
23 settings.

24 “(f) DEVELOPING NEW BEST PRACTICES.—The Di-
25 rector shall develop best practices that are—

1 “(1) based on a review of existing scientific evi-
2 dence;

3 “(2) sufficiently detailed for implementation
4 and incorporation into the workflow of health care
5 providers; and

6 “(3) designed to be easily adapted for use by
7 health care providers across a variety of health care
8 settings.

9 “(g) EVALUATION OF BEST PRACTICES.—The Direc-
10 tor shall evaluate best practices identified or developed
11 under this section. Such evaluation—

12 “(1) shall include determinations of which best
13 practices—

14 “(A) most reliably and effectively achieve
15 significant progress in improving the quality of
16 patient care; and

17 “(B) are easily adapted for use by health
18 care providers across a variety of health care
19 settings;

20 “(2) shall include regular review, updating, and
21 improvement of such best practices; and

22 “(3) may include in-depth case studies or em-
23 pirical assessments of health care providers (includ-
24 ing hospitals, physician and other clinician practices,
25 community cooperatives, and other health care enti-

1 ties) and simulations of such best practices for de-
2 terminations under paragraph (1).

3 “(h) IMPLEMENTATION OF BEST PRACTICES.—

4 “(1) IN GENERAL.—The Director shall enter
5 into arrangements with entities in a State or region
6 to implement best practices identified or developed
7 under this section. Such implementation—

8 “(A) may include forming collaborative
9 multi-institutional teams; and

10 “(B) shall include an evaluation of the best
11 practices being implemented, including the
12 measurement of patient outcomes before, dur-
13 ing, and after implementation of such best
14 practices.

15 “(2) PREFERENCES.—In carrying out this sub-
16 section, the Director shall give priority to health
17 care providers implementing best practices that—

18 “(A) have the greatest impact on patient
19 outcomes and satisfaction;

20 “(B) are the most easily adapted for use
21 by health care providers across a variety of
22 health care settings;

23 “(C) promote coordination of health care
24 practitioners across the continuum of care; and

1 “(D) engage patients and their families in
2 improving patient care and outcomes.

3 “(i) PUBLIC DISSEMINATION OF INFORMATION.—

4 The Director shall provide for the public dissemination of
5 information with respect to best practices and activities
6 under this section. Such information shall be made avail-
7 able in appropriate formats and languages to reflect the
8 varying needs of consumers and diverse levels of health
9 literacy.

10 “(j) REPORT.—

11 “(1) IN GENERAL.—The Director shall submit
12 an annual report to the Congress and the Secretary
13 on activities under this section.

14 “(2) CONTENT.—Each report under paragraph
15 (1) shall include—

16 “(A) information on activities conducted
17 pursuant to grants and contracts awarded;

18 “(B) summary data on patient outcomes
19 before, during, and after implementation of best
20 practices; and

21 “(C) recommendations on the adaptability
22 of best practices for use by health providers.”.

23 “(b) INITIAL QUALITY IMPROVEMENT ACTIVITIES AND
24 INITIATIVES TO BE IMPLEMENTED.—Until the Director
25 of the Agency for Healthcare Research and Quality has

1 established initial priorities under section 931(b) of the
2 Public Health Service Act, as added by subsection (a), the
3 Director shall, for purposes of such section, prioritize the
4 following:

5 (1) HEALTH CARE-ASSOCIATED INFECTIONS.—

6 Reducing health care-associated infections, including
7 infections in nursing homes and outpatient settings.

8 (2) SURGERY.—Increasing hospital and out-
9 patient perioperative patient safety, including reduc-
10 ing surgical-site infections and surgical errors (such
11 as wrong-site surgery and retained foreign bodies).

12 (3) EMERGENCY ROOM.—Improving care in
13 hospital emergency rooms, including through the use
14 of principles of efficiency of design and delivery to
15 improve patient flow.

16 (4) OBSTETRICS.—Improving the provision of
17 obstetrical and neonatal care, including the identi-
18 fication of interventions that are effective in reduc-
19 ing the risk of preterm and premature labor and the
20 implementation of best practices for labor and deliv-
21 ery care.

22 (5) PEDIATRICS.—Improving the provision of
23 preventive and developmental child health services,
24 including interventions that can reduce child health
25 disparities (as defined in section 3171 of the Public

1 Health Service Act, as added by section 2301) and
2 reduce the risk of developing chronic health-threat-
3 ening conditions that affect an individual's life
4 course development.

5 (c) REPORT.—Not later than 18 months after the
6 date of the enactment of this Act, the Director of the
7 Agency for Healthcare Research and Quality shall submit
8 a report to the Congress on the impact of the nurse-to-
9 patient ratio on the quality of care and patient outcomes,
10 including recommendations for further integration into
11 quality measurement and quality improvement activities.

12 **SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMA-**
13 **TION.**

14 (a) ESTABLISHMENT.—Title XVII (42 U.S.C. 300u
15 et seq.) is amended—

16 (1) by redesignating sections 1709 and 1710 as
17 sections 1710 and 1711, respectively; and

18 (2) by inserting after section 1708 the fol-
19 lowing:

20 **“SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMA-**
21 **TION.**

22 “(a) IN GENERAL.—There is established within the
23 Department an Assistant Secretary for Health Informa-
24 tion (in this section referred to as the ‘Assistant Sec-
25 retary’), to be appointed by the Secretary.

1 “(b) RESPONSIBILITIES.—The Assistant Secretary
2 shall—

3 “(1) ensure the collection, collation, reporting,
4 and publishing of information (including full and
5 complete statistics) on key health indicators regard-
6 ing the Nation’s health and the performance of the
7 Nation’s health care;

8 “(2) facilitate and coordinate the collection, col-
9 lation, reporting, and publishing of information re-
10 garding the Nation’s health and the performance of
11 the Nation’s health care (other than information de-
12 scribed in paragraph (1));

13 “(3)(A) develop standards for the collection of
14 data regarding the Nation’s health and the perform-
15 ance of the Nation’s health care; and

16 “(B) in carrying out subparagraph (A)—

17 “(i) ensure appropriate specificity and
18 standardization for data collection at the na-
19 tional, regional, State, and local levels;

20 “(ii) include standards, as appropriate, for
21 the collection of accurate data on health dis-
22 parities;

23 “(iii) ensure, with respect to data on race
24 and ethnicity, consistency with the 1997 Office
25 of Management and Budget Standards for

1 Maintaining, Collecting and Presenting Federal
2 Data on Race and Ethnicity (or any successor
3 standards); and

4 “(iv) in consultation with the Director of
5 the Office of Minority Health, and the Director
6 of the Office of Civil Rights of the Department,
7 develop standards for the collection of data on
8 health and health care with respect to primary
9 language;

10 “(4) provide support to Federal departments
11 and agencies whose programs have a significant im-
12 pact upon health (as determined by the Secretary)
13 for the collection and collation of information de-
14 scribed in paragraphs (1) and (2);

15 “(5) ensure the sharing of information de-
16 scribed in paragraphs (1) and (2) among the agen-
17 cies of the Department;

18 “(6) facilitate the sharing of information de-
19 scribed in paragraphs (1) and (2) by Federal depart-
20 ments and agencies whose programs have a signifi-
21 cant impact upon health (as determined by the Sec-
22 retary);

23 “(7) identify gaps in information described in
24 paragraphs (1) and (2) and the appropriate agency
25 or entity to address such gaps;

1 “(8) facilitate and coordinate identification and
2 monitoring of health disparities by the agencies of
3 the Department to inform program and policy ef-
4 forts to reduce such disparities, including facilitating
5 and funding analyses conducted in cooperation with
6 the Social Security Administration, the Bureau of
7 the Census, and other appropriate agencies and enti-
8 ties;

9 “(9) consistent with privacy, proprietary, and
10 other appropriate safeguards, facilitate public acces-
11 sibility of datasets (such as de-identified Medicare
12 datasets or publicly available data on key health in-
13 dicators) by means of the Internet; and

14 “(10) award grants or contracts for the collec-
15 tion and collation of information described in para-
16 graphs (1) and (2) (including through statewide sur-
17 veys that provide standardized information).

18 “(c) KEY HEALTH INDICATORS.—

19 “(1) IN GENERAL.—In carrying out subsection
20 (b)(1), the Assistant Secretary shall—

21 “(A) identify, and reassess at least once
22 every 3 years, key health indicators described in
23 such subsection;

24 “(B) publish statistics on such key health
25 indicators for the public—

1 “(i) not less than annually; and

2 “(ii) on a supplemental basis when-
3 ever warranted by—

4 “(I) the rate of change for a key
5 health indicator; or

6 “(II) the need to inform policy
7 regarding the Nation’s health and the
8 performance of the Nation’s health
9 care; and

10 “(C) ensure consistency with the national
11 strategy developed by the Secretary under sec-
12 tion 3121 and consideration of the indicators
13 specified in the reports under sections 308,
14 903(a)(6), and 913(b)(2).

15 “(2) RELEASE OF KEY HEALTH INDICATORS.—

16 The regulations, rules, processes, and procedures of
17 the Office of Management and Budget governing the
18 review, release, and dissemination of key health indi-
19 cators shall be the same as the regulations, rules,
20 processes, and procedures of the Office of Manage-
21 ment and Budget governing the review, release, and
22 dissemination of Principal Federal Economic Indica-
23 tors (or equivalent statistical data) by the Bureau of
24 Labor Statistics.

1 “(d) COORDINATION.—In carrying out this section,
2 the Assistant Secretary shall coordinate with—

3 “(1) public and private entities that collect and
4 disseminate information on health and health care,
5 including foundations; and

6 “(2) the head of the Office of the National Co-
7 ordinator for Health Information Technology to en-
8 sure optimal use of health information technology.

9 “(e) REQUEST FOR INFORMATION FROM DEPART-
10 MENTS AND AGENCIES.—Consistent with applicable law,
11 the Assistant Secretary may secure directly from any Fed-
12 eral department or agency information necessary to enable
13 the Assistant Secretary to carry out this section.

14 “(f) REPORT.—

15 “(1) SUBMISSION.—The Assistant Secretary
16 shall submit to the Secretary and the Congress an
17 annual report containing—

18 “(A) a description of national, regional, or
19 State changes in health or health care, as re-
20 flected by the key health indicators identified
21 under subsection (c)(1);

22 “(B) a description of gaps in the collection,
23 collation, reporting, and publishing of informa-
24 tion regarding the Nation’s health and the per-
25 formance of the Nation’s health care;

1 “(C) recommendations for addressing such
2 gaps and identification of the appropriate agen-
3 cy within the Department or other entity to ad-
4 dress such gaps;

5 “(D) a description of analyses of health
6 disparities, including the results of completed
7 analyses, the status of ongoing longitudinal
8 studies, and proposed or planned research; and

9 “(E) a plan for actions to be taken by the
10 Assistant Secretary to address gaps described
11 in subparagraph (B).

12 “(2) CONSIDERATION.—In preparing a report
13 under paragraph (1), the Assistant Secretary shall
14 take into consideration the findings and conclusions
15 in the reports under sections 308, 903(a)(6), and
16 913(b)(2).

17 “(g) PROPRIETARY AND PRIVACY PROTECTIONS.—
18 Nothing in this section shall be construed to affect appli-
19 cable proprietary or privacy protections.

20 “(h) CONSULTATION.—In carrying out this section,
21 the Assistant Secretary shall consult with—

22 “(1) the heads of appropriate health agencies
23 and offices in the Department, including the Office
24 of the Surgeon General of the Public Health Service,

1 the Office of Minority Health, and the Office on
2 Women’s Health; and

3 “(2) as appropriate, the heads of other Federal
4 departments and agencies whose programs have a
5 significant impact upon health (as determined by the
6 Secretary).

7 “(i) DEFINITION.—In this section:

8 “(1) The terms ‘agency’ and ‘agencies’ include
9 an epidemiology center established under section 214
10 of the Indian Health Care Improvement Act.

11 “(2) The term ‘Department’ means the Depart-
12 ment of Health and Human Services.

13 “(3) The term ‘health disparities’ has the
14 meaning given to such term in section 3171.”.

15 (b) OTHER COORDINATION RESPONSIBILITIES.—
16 Title III (42 U.S.C. 241 et seq.) is amended—

17 (1) in paragraphs (1) and (2) of section 304(c)
18 (42 U.S.C. 242b(c)), by inserting “, acting through
19 the Assistant Secretary for Health Information,”
20 after “The Secretary” each place it appears; and

21 (2) in section 306(j) (42 U.S.C. 242k(j)), by in-
22 sserting “, acting through the Assistant Secretary for
23 Health Information,” after “of this section, the Sec-
24 retary”.

1 **SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.**

2 Section 799C, as added and amended, is further
3 amended by adding at the end the following:

4 “(e) **QUALITY AND SURVEILLANCE.**—For the pur-
5 pose of carrying out part D of title IX and section 1709,
6 in addition to any other amounts authorized to be appro-
7 priated for such purpose, there are authorized to be appro-
8 priated, out of any monies in the Public Health Invest-
9 ment Fund, \$300,000,000 for each of fiscal years 2011
10 through 2015.”.

11 **TITLE V—OTHER PROVISIONS**
12 **Subtitle A—Drug Discount for**
13 **Rural and Other Hospitals; 340B**
14 **Program Integrity**

15 **SEC. 2501. EXPANDED PARTICIPATION IN 340B PROGRAM.**

16 (a) **EXPANSION OF COVERED ENTITIES RECEIVING**
17 **DISCOUNTED PRICES.**—Section 340B(a)(4) (42 U.S.C.
18 256b(a)(4)) is amended by adding at the end the fol-
19 lowing:

20 “(M) A children’s hospital excluded from
21 the Medicare prospective payment system pur-
22 suant to section 1886(d)(1)(B)(iii) of the Social
23 Security Act, or a free-standing cancer hospital
24 excluded from the Medicare prospective pay-
25 ment system pursuant to section
26 1886(d)(1)(B)(v) of the Social Security Act

1 that would meet the requirements of subpara-
2 graph (L), including the disproportionate share
3 adjustment percentage requirement under
4 clause (ii) of such subparagraph, if the hospital
5 were a subsection (d) hospital as defined by sec-
6 tion 1886(d)(1)(B) of the Social Security Act.

7 “(N) An entity that is a critical access hos-
8 pital (as determined under section 1820(e)(2)
9 of the Social Security Act).

10 “(O) An entity receiving funds under title
11 V of the Social Security Act (relating to mater-
12 nal and child health) for the provision of health
13 services.

14 “(P) An entity receiving funds under sub-
15 part I of part B of title XIX of the Public
16 Health Service Act (relating to comprehensive
17 mental health services) for the provision of com-
18 munity mental health services.

19 “(Q) An entity receiving funds under sub-
20 part II of such part B (relating to the preven-
21 tion and treatment of substance abuse) for the
22 provision of treatment services for substance
23 abuse.

1 “(R) An entity that is a Medicare-depend-
2 ent, small rural hospital (as defined in section
3 1886(d)(5)(G)(iv) of the Social Security Act).

4 “(S) An entity that is a sole community
5 hospital (as defined in section
6 1886(d)(5)(D)(iii) of the Social Security Act).

7 “(T) An entity that is classified as a rural
8 referral center under section 1886(d)(5)(C) of
9 the Social Security Act.”.

10 (b) PROHIBITION ON GROUP PURCHASING ARRANGE-
11 MENTS.—Section 340B(a) (42 U.S.C. 256b(a)) is amend-
12 ed—

13 (1) in paragraph (4)(L)—

14 (A) by adding “and” at the end of clause
15 (i);

16 (B) by striking “; and” at the end of
17 clause (ii) and inserting a period; and

18 (C) by striking clause (iii); and

19 (2) in paragraph (5), by redesignating subpara-
20 graphs (C) and (D) as subparagraphs (D) and (E),
21 respectively, and by inserting after subparagraph
22 (B) the following:

23 “(C) PROHIBITING USE OF GROUP PUR-
24 CHASING ARRANGEMENTS.—A hospital de-
25 scribed in subparagraph (L), (M), (N), (R),

1 (S), or (T) of paragraph (4) shall not obtain
2 covered outpatient drugs through a group pur-
3 chasing organization or other group purchasing
4 arrangement.”.

5 **SEC. 2502. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.**

6 (a) INTEGRITY IMPROVEMENTS.—Section 340B (42
7 U.S.C. 256b) is amended—

8 (1) by striking subsections (c) and (d); and

9 (2) by inserting after subsection (b) the fol-
10 lowing:

11 “(c) IMPROVEMENTS IN PROGRAM INTEGRITY.—

12 “(1) MANUFACTURER COMPLIANCE.—

13 “(A) IN GENERAL.—From amounts appro-
14 priated under paragraph (4), the Secretary
15 shall provide for improvements in compliance by
16 manufacturers with the requirements of this
17 section in order to prevent overcharges and
18 other violations of the discounted pricing re-
19 quirements specified in this section.

20 “(B) IMPROVEMENTS.—The improvements
21 described in subparagraph (A) shall include the
22 following:

23 “(i) The establishment of a process to
24 enable the Secretary to verify the accuracy
25 of ceiling prices calculated by manufactur-

1 ers under subsection (a)(1) and charged to
2 covered entities, which shall include the
3 following:

4 “(I) Developing and publishing,
5 through an appropriate policy or regu-
6 latory issuance, standards and meth-
7 odology for the calculation of ceiling
8 prices under such subsection.

9 “(II) Comparing regularly the
10 ceiling prices calculated by the Sec-
11 retary with the quarterly pricing data
12 that is reported by manufacturers to
13 the Secretary.

14 “(III) Conducting periodic moni-
15 toring of sales transactions to covered
16 entities.

17 “(IV) Inquiring into any discrep-
18 ancies between ceiling prices and
19 manufacturer pricing data that may
20 be identified and taking, or requiring
21 manufacturers to take, corrective ac-
22 tion in response to such discrepancies,
23 including the issuance of refunds pur-
24 suant to the procedures set forth in
25 clause (ii).

1 “(ii) The establishment of procedures
2 for the issuance of refunds to covered enti-
3 ties by manufacturers in the event that the
4 Secretary finds there has been an over-
5 charge, including the following:

6 “(I) Submission to the Secretary
7 by manufacturers of an explanation of
8 why and how the overcharge occurred,
9 how the refunds will be calculated,
10 and to whom the refunds will be
11 issued.

12 “(II) Oversight by the Secretary
13 to ensure that the refunds are issued
14 accurately and within a reasonable pe-
15 riod of time.

16 “(iii) Notwithstanding any other pro-
17 vision of law prohibiting the disclosure of
18 ceiling prices or data used to calculate the
19 ceiling price, the provision of access to cov-
20 ered entities and State Medicaid agencies
21 through an Internet website of the Depart-
22 ment of Health and Human Services or
23 contractor to the applicable ceiling prices
24 for covered drugs as calculated and verified
25 by the Secretary in a manner that ensures

1 protection of privileged pricing data from
2 unauthorized disclosure.

3 “(iv) The development of a mecha-
4 nism by which—

5 “(I) rebates, discounts, or other
6 price concessions provided by manu-
7 facturers to other purchasers subse-
8 quent to the sale of covered drugs to
9 covered entities are reported to the
10 Secretary; and

11 “(II) appropriate credits and re-
12 funds are issued to covered entities if
13 such rebates, discounts, or other price
14 concessions have the effect of lowering
15 the applicable ceiling price for the rel-
16 evant quarter for the drugs involved.

17 “(v) In addition to authorities under
18 section 1927(b)(3) of the Social Security
19 Act, the Secretary may conduct audits of
20 manufacturers and wholesalers to ensure
21 the integrity of the program under this
22 section, including audits on the market
23 price of covered drugs.

24 “(vi) The establishment of a require-
25 ment that manufacturers and wholesalers

1 use the identification system developed by
2 the Secretary for purposes of facilitating
3 the ordering, purchasing, and delivery of
4 covered drugs under this section, including
5 the processing of chargebacks for such
6 drugs.

7 “(vii) The imposition of sanctions in
8 the form of civil monetary penalties,
9 which—

10 “(I) shall be assessed according
11 to standards and procedures estab-
12 lished in regulations to be promul-
13 gated by the Secretary within one
14 year of the date of the enactment of
15 the Affordable Health Care for Amer-
16 ica Act; and

17 “(II) shall apply to any manufac-
18 turer with an agreement under this
19 section and shall not exceed \$100,000
20 for each instance where a manufac-
21 turer knowingly charges a covered en-
22 tity a price for purchase of a drug
23 that exceeds the maximum applicable
24 price under subsection (a)(1) or that
25 knowingly violates any other provision

1 of this section, or withholds or pro-
2 vides false information to the Sec-
3 retary or to covered entities under
4 this section.

5 “(2) COVERED ENTITY COMPLIANCE.—

6 “(A) IN GENERAL.—From amounts appro-
7 priated under paragraph (4), the Secretary
8 shall provide for improvements in compliance by
9 covered entities with the requirements of this
10 section in order to prevent diversion and viola-
11 tions of the duplicate discount provision and
12 other requirements under subsection (a)(5).

13 “(B) IMPROVEMENTS.—The improvements
14 described in subparagraph (A) shall include the
15 following:

16 “(i) The development of procedures to
17 enable and require covered entities to up-
18 date at least annually the information on
19 the Internet Web site of the Department of
20 Health and Human Services relating to
21 this section.

22 “(ii) The development of procedures
23 for the Secretary to verify the accuracy of
24 information regarding covered entities that

1 is listed on the Web site described in
2 clause (i).

3 “(iii) The development of more de-
4 tailed guidance describing methodologies
5 and options available to covered entities for
6 billing covered drugs to State Medicaid
7 agencies in a manner that avoids duplicate
8 discounts pursuant to subsection (a)(5)(A).

9 “(iv) The establishment of a single,
10 universal, and standardized identification
11 system by which each covered entity site
12 can be identified by manufacturers, dis-
13 tributors, covered entities, and the Sec-
14 retary for purposes of facilitating the or-
15 dering, purchasing, and delivery of covered
16 drugs under this section, including the
17 processing of chargebacks for such drugs.

18 “(v) The imposition of sanctions in
19 the form of civil monetary penalties,
20 which—

21 “(I) shall be assessed according
22 to standards and procedures estab-
23 lished in regulations promulgated by
24 the Secretary;

1 “(II) shall not exceed \$5,000 for
2 each violation; and

3 “(III) shall apply to any covered
4 entity that knowingly violates sub-
5 paragraph (a)(5)(B) or knowingly vio-
6 lates any other provision of this sec-
7 tion.

8 “(vi) The exclusion of a covered entity
9 from participation in the program under
10 this section, for a period of time to be de-
11 termined by the Secretary, in cases in
12 which the Secretary determines, in accord-
13 ance with standards and procedures estab-
14 lished in regulations, that—

15 “(I) a violation of a requirement
16 of this section was repeated and
17 knowing; and

18 “(II) imposition of a monetary
19 penalty would be insufficient to rea-
20 sonably ensure compliance.

21 “(vii) The referral of matters as ap-
22 propriate to the Food and Drug Adminis-
23 tration, the Office of Inspector General of
24 Department of Health and Human Serv-
25 ices, or other Federal agencies.

1 “(3) ADMINISTRATIVE DISPUTE RESOLUTION
2 PROCESS.—From amounts appropriated under para-
3 graph (4), the Secretary may establish and imple-
4 ment an administrative process for the resolution of
5 the following:

6 “(A) Claims by covered entities that manu-
7 facturers have violated the terms of their agree-
8 ment with the Secretary under subsection
9 (a)(1).

10 “(B) Claims by manufacturers that cov-
11 ered entities have violated subsection (a)(5)(A)
12 or (a)(5)(B).

13 “(4) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated to carry out
15 this subsection, such sums as may be necessary for
16 fiscal year 2011 and each succeeding fiscal year.”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) Section 340B(a) (42 U.S.C. 256b(a)) is
19 amended—

20 (A) by adding at the end of paragraph (1)
21 the following: “Such agreement shall require
22 that the manufacturer offer each covered entity
23 covered drugs for purchase at or below the ap-
24 plicable ceiling price if such drug is made avail-
25 able to any other purchaser at any price. Such

1 agreement shall require that, if the supply of a
2 covered drug is insufficient to meet demand,
3 then the manufacturer may utilize an allocation
4 method that is reported in writing to the Sec-
5 retary and does not discriminate on the basis of
6 the price paid by covered entities or on any
7 other basis related to an entity's participation
8 in the program under this section. Notwith-
9 standing any other provision of law, if the Sec-
10 retary requests a manufacturer to enter into a
11 new or amended agreement under this section
12 that complies with current law and if the manu-
13 facturer opts not to sign the new or amended
14 agreement, then any existing agreement be-
15 tween the manufacturer and the Secretary
16 under this section is deemed to no longer meet
17 the requirements of this section for purposes of
18 this section and section 1927 of the Social Se-
19 curity Act.”; and

20 (B) by adding at the end the following
21 paragraph:

22 “(11) QUARTERLY REPORTS.—An agreement
23 described in paragraph (1) shall require that the
24 manufacturer furnish the Secretary with reports on

1 a quarterly basis that include the following informa-
2 tion:

3 “(A) The price for each covered drug sub-
4 ject to the agreement that, according to the
5 manufacturer, represents the maximum price
6 that covered entities may permissibly be re-
7 quired to pay for the drug (referred to in this
8 section as the ‘ceiling price’).

9 “(B) The component information used to
10 calculate the ceiling price as determined nec-
11 essary to administer the requirements of the
12 program under this section.

13 “(C) Rebates, discounts, and other price
14 concessions provided by manufacturers to other
15 purchasers subsequent to the sale of covered
16 drugs to covered entities.”.

17 (2) Section 1927(a)(5) of the Social Security
18 Act (42 U.S.C. 1396r-8(a)(5)) is amended by strik-
19 ing subparagraph (D).

20 **SEC. 2503. EFFECTIVE DATE.**

21 (a) IN GENERAL.—The amendments made by this
22 subtitle shall take effect on the date of the enactment of
23 this Act, and sections 2501, 2502(a)(1), and 2502(b)(2)
24 shall apply to drugs dispensed on or after such date.

1 (b) EFFECTIVENESS.—The amendments made by
2 this subtitle shall be effective, and shall be taken into ac-
3 count in determining whether a manufacturer is deemed
4 to meet the requirements of section 340B(a) of the Public
5 Health Service Act (42 U.S.C. 256b(a)), and of section
6 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r-
7 8(a)(5)), notwithstanding any other provision of law.

8 **Subtitle B—Programs**

9 **PART 1—GRANTS FOR CLINICS AND CENTERS**

10 **SEC. 2511. SCHOOL-BASED HEALTH CLINICS.**

11 (a) IN GENERAL.—Part Q of title III (42 U.S.C.
12 280h et seq.) is amended by adding at the end the fol-
13 lowing:

14 **“SEC. 399Z-1. SCHOOL-BASED HEALTH CLINICS.**

15 “(a) PROGRAM.—The Secretary shall establish a
16 school-based health clinic program consisting of awarding
17 grants to eligible entities to support the operation of
18 school-based health clinics (referred to in this section as
19 ‘SBHCs’).

20 “(b) ELIGIBILITY.—To be eligible for a grant under
21 this section, an entity shall—

22 “(1) be an SBHC (as defined in subsection
23 (l)(3)); and

24 “(2) submit an application at such time, in
25 such manner, and containing such information as

1 the Secretary may require, including at a min-
2 imum—

3 “(A) evidence that the applicant meets all
4 criteria necessary to be designated as an
5 SBHC;

6 “(B) evidence of local need for the services
7 to be provided by the SBHC;

8 “(C) an assurance that—

9 “(i) SBHC services will be provided in
10 accordance with Federal, State, and local
11 laws;

12 “(ii) the SBHC has established and
13 maintains collaborative relationships with
14 other health care providers in the
15 catchment area of the SBHC;

16 “(iii) the SBHC will provide onsite ac-
17 cess during the academic day when school
18 is in session and has an established net-
19 work of support and access to services with
20 backup health providers when the school or
21 SBHC is closed;

22 “(iv) the SBHC will be integrated into
23 the school environment and will coordinate
24 health services with appropriate school per-

1 sonnel and other community providers co-
2 located at the school; and

3 “(v) the SBHC sponsoring facility as-
4 sumes all responsibility for the SBHC ad-
5 ministration, operations, and oversight;
6 and

7 “(D) such other information as the Sec-
8 retary may require.

9 “(c) USE OF FUNDS.—Funds awarded under a grant
10 under this section—

11 “(1) may be used for—

12 “(A) providing training related to the pro-
13 vision of comprehensive primary health services
14 and additional health services;

15 “(B) the management and operation of
16 SBHC programs, including through sub-
17 contracts; and

18 “(C) the payment of salaries for health
19 professionals and other appropriate SBHC per-
20 sonnel; and

21 “(2) may not be used to provide abortions.

22 “(d) CONSIDERATION OF NEED.—In determining the
23 amount of a grant under this section, the Secretary shall
24 take into consideration—

25 “(1) the financial need of the SBHC;

1 “(2) State, local, or other sources of funding
2 provided to the SBHC; and

3 “(3) other factors as determined appropriate by
4 the Secretary.

5 “(e) PREFERENCES.—In awarding grants under this
6 section, the Secretary shall give preference to SBHCs that
7 have a demonstrated record of service to at least one of
8 the following:

9 “(1) A high percentage of medically under-
10 served children and adolescents.

11 “(2) Communities or populations in which chil-
12 dren and adolescents have difficulty accessing health
13 and mental health services.

14 “(3) Communities with high percentages of chil-
15 dren and adolescents who are uninsured, under-
16 insured, or eligible for medical assistance under Fed-
17 eral or State health benefits programs (including ti-
18 tles XIX and XXI of the Social Security Act).

19 “(f) MATCHING REQUIREMENT.—The Secretary may
20 award a grant to an SBHC under this section only if the
21 SBHC agrees to provide, from non-Federal sources, an
22 amount equal to 20 percent of the amount of the grant
23 (which may be provided in cash or in kind) to carry out
24 the activities supported by the grant.

1 “(g) SUPPLEMENT, NOT SUPPLANT.—The Secretary
2 may award a grant to an SBHC under this section only
3 if the SBHC demonstrates to the satisfaction of the Sec-
4 retary that funds received through the grant will be ex-
5 pended only to supplement, and not supplant, non-Federal
6 and Federal funds otherwise available to the SBHC for
7 operation of the SBHC (including each activity described
8 in paragraph (1) or (2) of subsection (c)).

9 “(h) PAYOR OF LAST RESORT.—The Secretary may
10 award a grant to an SBHC under this section only if the
11 SBHC demonstrates to the satisfaction of the Secretary
12 that funds received through the grant will not be expended
13 for any activity to the extent that payment has been made,
14 or can reasonably be expected to be made—

15 “(1) under any insurance policy;

16 “(2) under any Federal or State health benefits
17 program (including titles XIX and XXI of the Social
18 Security Act); or

19 “(3) by an entity which provides health services
20 on a prepaid basis.

21 “(i) REGULATIONS REGARDING REIMBURSEMENT
22 FOR HEALTH SERVICES.—The Secretary shall issue regu-
23 lations regarding the reimbursement for health services
24 provided by SBHCs to individuals eligible to receive such
25 services through the program under this section, including

1 reimbursement under any insurance policy or any Federal
2 or State health benefits program (including titles XIX and
3 XXI of the Social Security Act).

4 “(j) TECHNICAL ASSISTANCE.—The Secretary shall
5 provide (either directly or by grant or contract) technical
6 and other assistance to SBHCs to assist such SBHCs to
7 meet the requirements of this section. Such assistance
8 may include fiscal and program management assistance,
9 training in fiscal and program management, operational
10 and administrative support, and the provision of informa-
11 tion to the SBHCs of the variety of resources available
12 under this title and how those resources can be best used
13 to meet the health needs of the communities served by
14 the SBHCs.

15 “(k) EVALUATION; REPORT.—The Secretary shall—

16 “(1) develop and implement a plan for evalu-
17 ating SBHCs and monitoring quality performances
18 under the awards made under this section; and

19 “(2) submit to the Congress on an annual basis
20 a report on the program under this section.

21 “(l) DEFINITIONS.—In this section:

22 “(1) COMPREHENSIVE PRIMARY HEALTH SERV-
23 ICES.—The term ‘comprehensive primary health
24 services’ means the core services offered by SBHCs,
25 which—

1 “(A) shall include—

2 “(i) comprehensive health assess-
3 ments, diagnosis, and treatment of minor,
4 acute, and chronic medical conditions and
5 referrals to, and followup for, specialty
6 care; and

7 “(ii) mental health assessments, crisis
8 intervention, counseling, treatment, and re-
9 ferral to a continuum of services including
10 emergency psychiatric care, community
11 support programs, inpatient care, and out-
12 patient programs; and

13 “(B) may include additional services, such
14 as oral health, social, and age-appropriate
15 health education services, including nutritional
16 counseling.

17 “(2) **MEDICALLY UNDERSERVED CHILDREN**
18 **AND ADOLESCENTS.**—The term ‘medically under-
19 served children and adolescents’ means a population
20 of children and adolescents who are residents of an
21 area designated by the Secretary as an area with a
22 shortage of personal health services and health in-
23 frastructure for such children and adolescents.

1 “(3) SCHOOL-BASED HEALTH CLINIC.—The
2 term ‘school-based health clinic’ means a health clin-
3 ic that—

4 “(A) is located in, or is adjacent to, a
5 school facility of a local educational agency;

6 “(B) is organized through school, commu-
7 nity, and health provider relationships;

8 “(C) is administered by a sponsoring facil-
9 ity;

10 “(D) provides comprehensive primary
11 health services during school hours to children
12 and adolescents by health professionals in ac-
13 cordance with State and local laws and regula-
14 tions, established standards, and community
15 practice; and

16 “(E) does not perform abortion services.

17 “(4) SPONSORING FACILITY.—The term ‘spon-
18 soring facility’ is—

19 “(A) a hospital;

20 “(B) a public health department;

21 “(C) a community health center;

22 “(D) a nonprofit health care entity whose
23 mission is to provide access to comprehensive
24 primary health care services;

25 “(E) a local educational agency; or

1 “(F) a program administered by the In-
2 dian Health Service or the Bureau of Indian
3 Affairs or operated by an Indian tribe or a trib-
4 al organization under the Indian Self-Deter-
5 mination and Education Assistance Act, a Na-
6 tive Hawaiian entity, or an urban Indian pro-
7 gram under title V of the Indian Health Care
8 Improvement Act.

9 “(m) AUTHORIZATION OF APPROPRIATIONS.—For
10 purposes of carrying out this section, there are authorized
11 to be appropriated \$50,000,000 for fiscal year 2011 and
12 such sums as may be necessary for each of fiscal years
13 2012 through 2015.”.

14 (b) EFFECTIVE DATE.—The Secretary of Health and
15 Human Services shall begin awarding grants under section
16 399Z–1 of the Public Health Service Act, as added by sub-
17 section (a), not later than July 1, 2010, without regard
18 to whether or not final regulations have been issued under
19 section 399Z–1(i) of such Act.

20 (c) TERMINATION OF STUDY.—Section 2(b) of the
21 Health Care Safety Net Act of 2008 (42 U.S.C. 254b
22 note) is amended by striking paragraph (2) (relating to
23 a school-based health center study).

1 **SEC. 2512. NURSE-MANAGED HEALTH CENTERS.**

2 Title III (42 U.S.C. 241 et seq.) is amended by add-
3 ing at the end the following:

4 **“PART S—NURSE-MANAGED HEALTH CENTERS**

5 **“SEC. 399FF. NURSE-MANAGED HEALTH CENTERS.**

6 “(a) PROGRAM.—The Secretary, acting through the
7 Administrator of the Health Resources and Services Ad-
8 ministration, shall establish a nurse-managed health cen-
9 ter program consisting of awarding grants to entities
10 under subsection (b).

11 “(b) GRANT.—The Secretary shall award grants to
12 entities—

13 “(1) to plan and develop a nurse-managed
14 health center; or

15 “(2) to operate a nurse-managed health center.

16 “(c) USE OF FUNDS.—Amounts received as a grant
17 under subsection (b) may be used for activities including
18 the following:

19 “(1) Purchasing or leasing equipment.

20 “(2) Training and technical assistance related
21 to the provision of comprehensive primary care serv-
22 ices and wellness services.

23 “(3) Other activities for planning, developing,
24 or operating, as applicable, a nurse-managed health
25 center.

1 “(d) ASSURANCES APPLICABLE TO BOTH PLANNING
2 AND OPERATION GRANTS.—

3 “(1) IN GENERAL.—The Secretary may award
4 a grant under this section to an entity only if the
5 entity demonstrates to the Secretary’s satisfaction
6 that—

7 “(A) nurses, in addition to managing the
8 center, will be adequately represented as pro-
9 viders at the center; and

10 “(B) not later than 90 days after receiving
11 the grant, the entity will establish a community
12 advisory committee composed of individuals, a
13 majority of whom are being served by the cen-
14 ter, to provide input into the nurse-managed
15 health center’s operations.

16 “(2) MATCHING REQUIREMENT.—The Sec-
17 retary may award a grant under this section to an
18 entity only if the entity agrees to provide, from non-
19 Federal sources, an amount equal to 20 percent of
20 the amount of the grant (which may be provided in
21 cash or in kind) to carry out the activities supported
22 by the grant.

23 “(3) PAYOR OF LAST RESORT.—The Secretary
24 may award a grant under this section to an entity
25 only if the entity demonstrates to the satisfaction of

1 the Secretary that funds received through the grant
2 will not be expended for any activity to the extent
3 that payment has been made, or can reasonably be
4 expected to be made—

5 “(A) under any insurance policy;

6 “(B) under any Federal or State health
7 benefits program (including titles XIX and XXI
8 of the Social Security Act); or

9 “(C) by an entity which provides health
10 services on a prepaid basis.

11 “(4) MAINTENANCE OF EFFORT.—The Sec-
12 retary may award a grant under this section to an
13 entity only if the entity demonstrates to the satisfac-
14 tion of the Secretary that—

15 “(A) funds received through the grant will
16 be expended only to supplement, and not sup-
17 plant, non-Federal and Federal funds otherwise
18 available to the entity for the activities to be
19 funded through the grant; and

20 “(B) with respect to such activities, the en-
21 tity will maintain expenditures of non-Federal
22 amounts for such activities at a level not less
23 than the lesser of such expenditures maintained
24 by the entity for the fiscal year preceding the

1 fiscal year for which the entity receives the
2 grant.

3 “(e) ADDITIONAL ASSURANCE FOR PLANNING
4 GRANTS.—The Secretary may award a grant under sub-
5 section (b)(1) to an entity only if the entity agrees—

6 “(1) to assess the needs of the medically under-
7 served populations proposed to be served by the
8 nurse-managed health center; and

9 “(2) to design services and operations of the
10 nurse-managed health center for such populations
11 based on such assessment.

12 “(f) ADDITIONAL ASSURANCE FOR OPERATION
13 GRANTS.—The Secretary may award a grant under sub-
14 section (b)(2) to an entity only if the entity assures that
15 the nurse-managed health center will provide—

16 “(1) comprehensive primary care services,
17 wellness services, and other health care services
18 deemed appropriate by the Secretary;

19 “(2) care without respect to insurance status or
20 income of the patient; and

21 “(3) direct access to client-centered services of-
22 fered by advanced practice nurses, other nurses,
23 physicians, physician assistants, or other qualified
24 health professionals.

1 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide (either directly or by grant or contract) technical
3 and other assistance to nurse-managed health centers to
4 assist such centers in meeting the requirements of this
5 section. Such assistance may include fiscal and program
6 management assistance, training in fiscal and program
7 management, operational and administrative support, and
8 the provision of information to nurse-managed health cen-
9 ters regarding the various resources available under this
10 section and how those resources can best be used to meet
11 the health needs of the communities served by nurse-man-
12 aged health centers.

13 “(h) REPORT.—The Secretary shall submit to the
14 Congress an annual report on the program under this sec-
15 tion.

16 “(i) DEFINITIONS.—In this section:

17 “(1) COMPREHENSIVE PRIMARY CARE SERV-
18 ICES.—The term ‘comprehensive primary care serv-
19 ices’ has the meaning given to the term ‘required
20 primary health services’ in section 330(b)(1).

21 “(2) MEDICALLY UNDERSERVED POPU-
22 LATION.—The term ‘medically underserved popu-
23 lation’ has the meaning given to such term in section
24 330(b)(3).

1 “(3) NURSE-MANAGED HEALTH CENTER.—The
2 term ‘nurse-managed health center’ has the meaning
3 given to such term in section 801.

4 “(4) WELLNESS SERVICES.—The term ‘wellness
5 services’ means any health-related service or inter-
6 vention, not including primary care, which is de-
7 signed to reduce identifiable health risks and in-
8 crease healthy behaviors intended to prevent the
9 onset of disease or lessen the impact of existing
10 chronic conditions by teaching more effective man-
11 agement techniques that focus on individual self-care
12 and patient-driven decisionmaking.

13 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
14 carry out this section, there are authorized to be appro-
15 priated such sums as may be necessary for each of fiscal
16 years 2011 through 2015.”.

17 **SEC. 2513. FEDERALLY QUALIFIED BEHAVIORAL HEALTH**
18 **CENTERS.**

19 Section 1913 (42 U.S.C. 300x-3) is amended—

20 (1) in subsection (a)(2)(A), by striking “com-
21 munity mental health services” and inserting “be-
22 havioral health services (of the type offered by feder-
23 ally qualified behavioral health centers consistent
24 with subsection (c)(3))”;

25 (2) in subsection (b)—

1 (A) by striking paragraph (1) and insert-
2 ing the following:

3 “(1) services under the plan will be provided
4 only through appropriate, qualified community pro-
5 grams (which may include federally qualified behav-
6 ioral health centers, child mental health programs,
7 psychosocial rehabilitation programs, mental health
8 peer-support programs, and mental health primary
9 consumer-directed programs); and”;

10 (B) in paragraph (2), by striking “commu-
11 nity mental health centers” and inserting “fed-
12 erally qualified behavioral health centers”;

13 (3) by striking subsection (c) and inserting the
14 following:

15 “(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAV-
16 IORAL HEALTH CENTERS.—

17 “(1) IN GENERAL.—The Administrator shall
18 certify, and recertify at least every 5 years, federally
19 qualified behavioral health centers as meeting the
20 criteria specified in this subsection.

21 “(2) REGULATIONS.—Not later than 18 months
22 after the date of the enactment of the Affordable
23 Health Care for America Act, the Administrator
24 shall issue final regulations for certifying centers
25 under paragraph (1).

1 “(3) CRITERIA.—The criteria referred to in
2 subsection (b)(2) are that the center performs each
3 of the following:

4 “(A) Provide services in locations that en-
5 sure services will be available and accessible
6 promptly and in a manner which preserves
7 human dignity and assures continuity of care.

8 “(B) Provide services in a mode of service
9 delivery appropriate for the target population.

10 “(C) Provide individuals with a choice of
11 service options where there is more than one ef-
12 ficacious treatment.

13 “(D) Employ a core staff of clinical staff
14 that is multidisciplinary and culturally and lin-
15 guistically competent.

16 “(E) Provide services, within the limits of
17 the capacities of the center, to any individual
18 residing or employed in the service area of the
19 center.

20 “(F) Provide, directly or through contract,
21 to the extent covered for adults in the State
22 Medicaid plan and for children in accordance
23 with section 1905(r) of the Social Security Act
24 regarding early and periodic screening, diag-

1 nosis, and treatment, each of the following serv-
2 ices:

3 “(i) Screening, assessment, and diag-
4 nosis, including risk assessment.

5 “(ii) Person-centered treatment plan-
6 ning or similar processes, including risk as-
7 sessment and crisis planning.

8 “(iii) Outpatient clinic mental health
9 services, including screening, assessment,
10 diagnosis, psychotherapy, substance abuse
11 counseling, medication management, and
12 integrated treatment for mental illness and
13 substance abuse which shall be evidence-
14 based (including cognitive behavioral ther-
15 apy, dialectical behavioral therapy, motiva-
16 tional interviewing, and other such thera-
17 pies which are evidence-based).

18 “(iv) Outpatient clinic primary care
19 services, including screening and moni-
20 toring of key health indicators and health
21 risk (including screening for diabetes, hy-
22 pertension, and cardiovascular disease and
23 monitoring of weight, height, body mass
24 index (BMI), blood pressure, blood glucose
25 or HbA1C, and lipid profile).

1 “(v) Crisis mental health services, in-
2 cluding 24-hour mobile crisis teams, emer-
3 gency crisis intervention services, and cri-
4 sis stabilization.

5 “(vi) Targeted case management
6 (services to assist individuals gaining ac-
7 cess to needed medical, social, educational,
8 and other services and applying for income
9 security and other benefits to which they
10 may be entitled).

11 “(vii) Psychiatric rehabilitation serv-
12 ices including skills training, assertive com-
13 munity treatment, family psychoeducation,
14 disability self-management, supported em-
15 ployment, supported housing services,
16 therapeutic foster care services, multisys-
17 temic therapy, and such other evidence-
18 based practices as the Secretary may re-
19 quire.

20 “(viii) Peer support and counselor
21 services and family supports.

22 “(G) Maintain linkages, and where possible
23 enter into formal contracts with, inpatient psy-
24 chiatric facilities and substance abuse detoxi-
25 fication and residential programs.

1 “(H) Make available to individuals served
2 by the center, directly, through contract, or
3 through linkages with other programs, each of
4 the following:

5 “(i) Adult and youth peer support and
6 counselor services.

7 “(ii) Family support services for fami-
8 lies of children with serious mental dis-
9 orders.

10 “(iii) Other community or regional
11 services, supports, and providers, including
12 schools, child welfare agencies, juvenile and
13 criminal justice agencies and facilities,
14 housing agencies and programs, employers,
15 and other social services.

16 “(iv) Onsite or offsite access to pri-
17 mary care services.

18 “(v) Enabling services, including out-
19 reach, transportation, and translation.

20 “(vi) Health and wellness services, in-
21 cluding services for tobacco cessation.”.

1 **PART 2—OTHER GRANT PROGRAMS**
2 **SEC. 2521. COMPREHENSIVE PROGRAMS TO PROVIDE EDU-**
3 **CATION TO NURSES AND CREATE A PIPELINE**
4 **TO NURSING.**

5 (a) **PURPOSES.**—It is the purpose of this section to
6 authorize grants to—

7 (1) address the projected shortage of nurses by
8 funding comprehensive programs to create a career
9 ladder to nursing (including certified nurse assist-
10 ants, licensed practical nurses, licensed vocational
11 nurses, and registered nurses) for incumbent ancil-
12 lary health care workers;

13 (2) increase the capacity for educating nurses
14 by increasing both nurse faculty and clinical oppor-
15 tunities through collaborative programs between
16 staff nurse organizations, health care providers, and
17 accredited schools of nursing; and

18 (3) provide training programs through edu-
19 cation and training organizations jointly adminis-
20 tered by health care providers and health care labor
21 organizations or other organizations representing
22 staff nurses and frontline health care workers, work-
23 ing in collaboration with accredited schools of nurs-
24 ing and academic institutions.

25 (b) **GRANTS.**—Not later than 6 months after the date
26 of the enactment of this Act, the Secretary of Labor (re-

1 ferred to in this section as the “Secretary”) shall establish
2 a partnership grant program to award grants to eligible
3 entities to carry out comprehensive programs to provide
4 education to nurses and create a pipeline to nursing for
5 incumbent ancillary health care workers who wish to ad-
6 vance their careers, and to otherwise carry out the pur-
7 poses of this section.

8 (c) ELIGIBILITY.—To be eligible for a grant under
9 this section, an entity shall be—

10 (1) a health care entity that is jointly adminis-
11 tered by a health care employer and a labor union
12 representing the health care employees of the em-
13 ployer and that carries out activities using labor-
14 management training funds as provided for under
15 section 302(c)(6) of the Labor Management Rela-
16 tions Act, 1947 (29 U.S.C. 186(c)(6));

17 (2) an entity that operates a training program
18 that is jointly administered by—

19 (A) one or more health care providers or
20 facilities, or a trade association of health care
21 providers; and

22 (B) one or more organizations which rep-
23 resent the interests of direct care health care
24 workers or staff nurses and in which the direct
25 care health care workers or staff nurses have

1 direct input as to the leadership of the organi-
2 zation;

3 (3) a State training partnership program that
4 consists of nonprofit organizations that include equal
5 participation from industry, including public or pri-
6 vate employers, and labor organizations including
7 joint labor-management training programs, and
8 which may include representatives from local govern-
9 ments, worker investment agency one-stop career
10 centers, community-based organizations, community
11 colleges, and accredited schools of nursing; or

12 (4) a school of nursing (as defined in section
13 801 of the Public Health Service Act (42 U.S.C.
14 296)).

15 (d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE
16 EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligi-
17 ble for a grant under this section, a health care employer
18 described in subsection (c) shall demonstrate that it—

19 (1) has an established program within its facil-
20 ity to encourage the retention of existing nurses;

21 (2) provides wages and benefits to its nurses
22 that are competitive for its market or that have been
23 collectively bargained with a labor organization; and

24 (3) supports programs funded under this sec-
25 tion through 1 or more of the following:

1 (A) The provision of paid leave time and
2 continued health coverage to incumbent health
3 care workers to allow their participation in
4 nursing career ladder programs, including cer-
5 tified nurse assistants, licensed practical nurses,
6 licensed vocational nurses, and registered
7 nurses.

8 (B) Contributions to a joint labor-manage-
9 ment training fund which administers the pro-
10 gram involved.

11 (C) The provision of paid release time, in-
12 centive compensation, or continued health cov-
13 erage to staff nurses who desire to work full- or
14 part-time in a faculty position.

15 (D) The provision of paid release time for
16 staff nurses to enable them to obtain a bachelor
17 of science in nursing degree, other advanced
18 nursing degrees, specialty training, or certifi-
19 cation program.

20 (E) The payment of tuition assistance
21 which is managed by a joint labor-management
22 training fund or other jointly administered pro-
23 gram.

24 (e) OTHER REQUIREMENTS.—

25 (1) MATCHING REQUIREMENT.—

1 (A) IN GENERAL.—The Secretary may not
2 make a grant under this section unless the ap-
3 plicant involved agrees, with respect to the costs
4 to be incurred by the applicant in carrying out
5 the program under the grant, to make available
6 non-Federal contributions (in cash or in kind
7 under subparagraph (B)) toward such costs in
8 an amount equal to not less than \$1 for each
9 \$1 of Federal funds provided in the grant. Such
10 contributions may be made directly or through
11 donations from public or private entities, or
12 may be provided through the cash equivalent of
13 paid release time provided to incumbent worker
14 students.

15 (B) DETERMINATION OF AMOUNT OF NON-
16 FEDERAL CONTRIBUTION.—Non-Federal con-
17 tributions required in subparagraph (A) may be
18 in cash or in kind (including paid release time),
19 fairly evaluated, including equipment or services
20 (and excluding indirect or overhead costs).
21 Amounts provided by the Federal Government,
22 or services assisted or subsidized to any signifi-
23 cant extent by the Federal Government, may
24 not be included in determining the amount of
25 such non-Federal contributions.

1 (2) REQUIRED COLLABORATION.—Entities car-
2 rying out or overseeing programs carried out with
3 assistance provided under this section shall dem-
4 onstrate collaboration with accredited schools of
5 nursing which may include community colleges and
6 other academic institutions providing associate's,
7 bachelor's, or advanced nursing degree programs or
8 specialty training or certification programs.

9 (f) USE OF FUNDS.—Amounts awarded to an entity
10 under a grant under this section shall be used for the fol-
11 lowing:

12 (1) To carry out programs that provide edu-
13 cation and training to establish nursing career lad-
14 ders to educate incumbent health care workers to be-
15 come nurses (including certified nurse assistants, li-
16 censed practical nurses, licensed vocational nurses,
17 and registered nurses). Such programs shall include
18 one or more of the following:

19 (A) Preparing incumbent workers to return
20 to the classroom through English-as-a-second-
21 language education, GED education, precollege
22 counseling, college preparation classes, and sup-
23 port with entry level college classes that are a
24 prerequisite to nursing.

1 (B) Providing tuition assistance with pref-
2 erence for dedicated cohort classes in commu-
3 nity colleges, universities, and accredited
4 schools of nursing with supportive services in-
5 cluding tutoring and counseling.

6 (C) Providing assistance in preparing for
7 and meeting all nursing licensure tests and re-
8 quirements.

9 (D) Carrying out orientation and
10 mentorship programs that assist newly grad-
11 uated nurses in adjusting to working at the
12 bedside to ensure their retention
13 postgraduation, and ongoing programs to sup-
14 port nurse retention.

15 (E) Providing stipends for release time and
16 continued health care coverage to enable incum-
17 bent health care workers to participate in these
18 programs.

19 (2) To carry out programs that assist nurses in
20 obtaining advanced degrees and completing specialty
21 training or certification programs and to establish
22 incentives for nurses to assume nurse faculty posi-
23 tions on a part-time or full-time basis. Such pro-
24 grams shall include one or more of the following:

1 (A) Increasing the pool of nurses with ad-
2 vanced degrees who are interested in teaching
3 by funding programs that enable incumbent
4 nurses to return to school.

5 (B) Establishing incentives for advanced
6 degree bedside nurses who wish to teach in
7 nursing programs so they can obtain a leave
8 from their bedside position to assume a full- or
9 part-time position as adjunct or full-time fac-
10 ulty without the loss of salary or benefits.

11 (C) Collaboration with accredited schools
12 of nursing which may include community col-
13 leges and other academic institutions providing
14 associate's, bachelor's, or advanced nursing de-
15 gree programs, or specialty training or certifi-
16 cation programs, for nurses to carry out innova-
17 tive nursing programs which meet the needs of
18 bedside nursing and health care providers.

19 (g) PREFERENCE.—In awarding grants under this
20 section the Secretary shall give preference to programs
21 that—

22 (1) provide for improving nurse retention;

23 (2) provide for improving the diversity of the
24 new nurse graduates to reflect changes in the demo-
25 graphics of the patient population;

1 (3) provide for improving the quality of nursing
2 education to improve patient care and safety;

3 (4) have demonstrated success in upgrading in-
4 cumbent health care workers to become nurses or
5 which have established effective programs or pilots
6 to increase nurse faculty; or

7 (5) are modeled after or affiliated with such
8 programs described in paragraph (4).

9 (h) EVALUATION.—

10 (1) PROGRAM EVALUATIONS.—An entity that
11 receives a grant under this section shall annually
12 evaluate, and submit to the Secretary a report on,
13 the activities carried out under the grant and the
14 outcomes of such activities. Such outcomes may in-
15 clude—

16 (A) an increased number of incumbent
17 workers entering an accredited school of nurs-
18 ing and in the pipeline for nursing programs;

19 (B) an increasing number of graduating
20 nurses and improved nurse graduation and li-
21 censure rates;

22 (C) improved nurse retention;

23 (D) an increase in the number of staff
24 nurses at the health care facility involved;

1 (E) an increase in the number of nurses
2 with advanced degrees in nursing;

3 (F) an increase in the number of nurse
4 faculty;

5 (G) improved measures of patient quality
6 (which may include staffing ratios of nurses,
7 patient satisfaction rates, and patient safety
8 measures); and

9 (H) an increase in the diversity of new
10 nurse graduates relative to the patient popu-
11 lation.

12 (2) GENERAL REPORT.—Not later than 2 years
13 after the date of the enactment of this Act, and an-
14 nually thereafter, the Secretary of Labor shall, using
15 data and information from the reports received
16 under paragraph (1), submit to the Congress a re-
17 port concerning the overall effectiveness of the grant
18 program carried out under this section.

19 (i) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2011 through 2015.

23 **SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.**

24 Part E of title VII (42 U.S.C. 294n et seq.) is amend-
25 ed by adding at the end the following:

1 **“Subpart 3—Mental and Behavioral Health Training**

2 **“SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING**
3 **PROGRAM.**

4 “(a) PROGRAM.—The Secretary, acting through the
5 Administrator of the Health Resources and Services Ad-
6 ministration and in consultation with the Administrator
7 of the Substance Abuse and Mental Health Services Ad-
8 ministration, shall establish an interdisciplinary mental
9 and behavioral health training program consisting of
10 awarding grants and contracts under subsection (b).

11 “(b) SUPPORT AND DEVELOPMENT OF MENTAL AND
12 BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Sec-
13 retary shall make grants to, or enter into contracts with,
14 eligible entities—

15 “(1) to plan, develop, operate, or participate in
16 an accredited professional training program for men-
17 tal and behavioral health professionals to promote—

18 “(A) interdisciplinary training; and

19 “(B) coordination of the delivery of health
20 care within and across settings, including health
21 care institutions, community-based settings,
22 and the patient’s home;

23 “(2) to provide financial assistance to mental
24 and behavioral health professionals, who are partici-
25 pants in any such program, and who plan to work
26 in the field of mental and behavioral health;

1 “(3) to plan, develop, operate, or participate in
2 an accredited program for the training of mental
3 and behavioral health professionals who plan to
4 teach in the field of mental and behavioral health;
5 and

6 “(4) to provide financial assistance in the form
7 of traineeships and fellowships to mental and behav-
8 ioral health professionals who are participants in any
9 such program and who plan to teach in the field of
10 mental and behavioral health.

11 “(c) ELIGIBILITY.—To be eligible for a grant or con-
12 tract under subsection (b), an entity shall be—

13 “(1) an accredited health professions school, in-
14 cluding an accredited school or program of psy-
15 chology, psychiatry, social work, marriage and family
16 therapy, professional mental health or substance
17 abuse counseling, or addiction medicine;

18 “(2) an accredited public or nonprofit private
19 hospital;

20 “(3) a public or private nonprofit entity; or

21 “(4) a consortium of 2 or more entities de-
22 scribed in paragraphs (1) through (3).

23 “(d) PREFERENCE.—In awarding grants or contracts
24 under this section, the Secretary shall give preference to

1 entities that have a demonstrated record of at least one
2 of the following:

3 “(1) Training a high or significantly improved
4 percentage of health professionals who serve in un-
5 derserved communities.

6 “(2) Supporting teaching programs that ad-
7 dress the health care needs of vulnerable popu-
8 lations.

9 “(3) Training individuals who are from dis-
10 advantaged backgrounds (including racial and ethnic
11 minorities underrepresented among mental and be-
12 havioral health professionals).

13 “(4) Training individuals who serve geriatric
14 populations with an emphasis on underserved elder-
15 ly.

16 “(5) Training individuals who serve pediatric
17 populations with an emphasis on underserved chil-
18 dren.

19 “(e) REPORT.—The Secretary shall submit to the
20 Congress an annual report on the program under this sec-
21 tion.

22 “(f) DEFINITION.—In this section:

23 “(1) The term ‘interdisciplinary’ means collabo-
24 ration across health professions, specialties, and sub-
25 specialties, which may include public health, nursing,

1 allied health, dietetics or nutrition, and appropriate
2 health specialties.

3 “(2) The term ‘mental and behavioral health
4 professional’ means an individual training or prac-
5 ticing—

6 “(A) in psychology; general, geriatric, child
7 or adolescent psychiatry; social work; marriage
8 and family therapy; professional mental health
9 or substance abuse counseling; or addiction
10 medicine; or

11 “(B) another mental and behavioral health
12 specialty, as deemed appropriate by the Sec-
13 retary.

14 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this section, there is authorized to be appro-
16 priated \$60,000,000 for each of fiscal years 2011 through
17 2015. Of the amounts appropriated to carry out this sec-
18 tion for a fiscal year, not less than 15 percent shall be
19 used for training programs in psychology.”.

20 **SEC. 2523. REAUTHORIZATION OF TELEHEALTH AND TELE-**
21 **MEDICINE GRANT PROGRAMS.**

22 (a) TELEHEALTH NETWORK AND TELEHEALTH RE-
23 SOURCE CENTERS GRANT PROGRAMS.—Section 330I (42
24 U.S.C. 254c-14) is amended—

25 (1) in subsection (a)—

1 (A) by striking paragraph (3) (relating to
2 frontier communities); and

3 (B) by inserting after paragraph (2) the
4 following:

5 “(3) HEALTH DISPARITIES.—The term ‘health
6 disparities’ has the meaning given such term in sec-
7 tion 3171.”;

8 (2) in subsection (d)(1)—

9 (A) in subparagraph (B), by striking
10 “and” at the end;

11 (B) in subparagraph (C), by striking the
12 period at the end and inserting “; and”; and

13 (C) by adding at the end the following:

14 “(D) reduce health disparities.”;

15 (3) in subsection (f)(1)(B)(iii)—

16 (A) in subclause (VII), by inserting “, in-
17 cluding skilled nursing facilities” before the pe-
18 riod at the end;

19 (B) in subclause (IX), by inserting “, in-
20 cluding county mental health and public mental
21 health facilities” before the period at the end;
22 and

23 (C) by adding at the end the following:

24 “(XIII) Renal dialysis facilities.”;

1 (4) by amending subsection (i) to read as fol-
2 lows:

3 “(i) PREFERENCES.—

4 “(1) TELEHEALTH NETWORKS.—In awarding
5 grants under subsection (d)(1) for projects involving
6 telehealth networks, the Secretary shall give pref-
7 erence to eligible entities meeting at least one of the
8 following:

9 “(A) NETWORK.—The eligible entity is a
10 health care provider in, or proposing to form, a
11 health care network that furnishes services in a
12 medically underserved area or a health profes-
13 sional shortage area.

14 “(B) BROAD GEOGRAPHIC COVERAGE.—
15 The eligible entity demonstrates broad geo-
16 graphic coverage in the rural or medically un-
17 derserved areas of the State or States in which
18 the entity is located.

19 “(C) HEALTH DISPARITIES.—The eligible
20 entity demonstrates how the project to be fund-
21 ed through the grant will address health dis-
22 parities.

23 “(D) LINKAGES.—The eligible entity
24 agrees to use the grant to establish or develop
25 plans for telehealth systems that will link rural

1 hospitals and rural health care providers to
2 other hospitals, health care providers, and pa-
3 tients.

4 “(E) EFFICIENCY.—The eligible entity
5 agrees to use the grant to promote greater effi-
6 ciency in the use of health care resources.

7 “(F) VIABILITY.—The eligible entity dem-
8 onstrates the long-term viability of projects
9 through—

10 “(i) availability of non-Federal fund-
11 ing sources; or

12 “(ii) institutional and community sup-
13 port for the telehealth network.

14 “(G) SERVICES.—The eligible entity pro-
15 vides a plan for coordinating system use by eli-
16 gible entities and prioritizes use of grant funds
17 for health care services over nonclinical uses.

18 “(2) TELEHEALTH RESOURCE CENTERS.—In
19 awarding grants under subsection (d)(2) for projects
20 involving telehealth resource centers, the Secretary
21 shall give preference to eligible entities meeting at
22 least one of the following:

23 “(A) PROVISION OF A BROAD RANGE OF
24 SERVICES.—The eligible entity has a record of
25 success in the provision of a broad range of

1 telehealth services to medically underserved
2 areas or populations.

3 “(B) PROVISION OF TELEHEALTH TECH-
4 NICAL ASSISTANCE.—The eligible entity has a
5 record of success in the provision of technical
6 assistance to providers serving medically under-
7 served communities or populations in the estab-
8 lishment and implementation of telehealth serv-
9 ices.

10 “(C) COLLABORATION AND SHARING OF
11 EXPERTISE.—The eligible entity has a dem-
12 onstrated record of collaborating and sharing
13 expertise with providers of telehealth services at
14 the national, regional, State, and local levels.”;

15 (5) in subsection (j)(2)(B), by striking “such
16 projects for fiscal year 2001” and all that follows
17 through the period and inserting “such projects for
18 fiscal year 2010.”;

19 (6) in subsection (k)(1)—

20 (A) in subparagraph (E)(i), by striking
21 “transmission of medical data” and inserting
22 “transmission and electronic archival of medical
23 data”; and

24 (B) by amending subparagraph (F) to read
25 as follows:

1 “(F) developing projects to use telehealth
2 technology to—

3 “(i) facilitate collaboration between
4 health care providers;

5 “(ii) promote telenursing services; or

6 “(iii) promote patient understanding
7 and adherence to national guidelines for
8 chronic disease and self-management of
9 such conditions;”;

10 (7) in subsection (q), by striking “Not later
11 than September 30, 2005” and inserting “Not later
12 than 1 year after the date of the enactment of the
13 Affordable Health Care for America Act, and annu-
14 ally thereafter”;

15 (8) by striking subsection (r);

16 (9) by redesignating subsection (s) as sub-
17 section (r); and

18 (10) in subsection (r) (as so redesignated)—

19 (A) in paragraph (1)—

20 (i) by striking “and” before “such
21 sums”; and

22 (ii) by inserting “, \$10,000,000 for
23 fiscal year 2011, and such sums as may be
24 necessary for each of fiscal years 2012
25 through 2015” before the semicolon; and

1 (B) in paragraph (2)—

2 (i) by striking “and” before “such
3 sums”; and

4 (ii) by inserting “, \$10,000,000 for
5 fiscal year 2011, and such sums as may be
6 necessary for each of fiscal years 2012
7 through 2015” before the period.

8 (b) **TELEMEDICINE; INCENTIVE GRANTS REGARDING**
9 **COORDINATION AMONG STATES.**—Subsection (b) of sec-
10 tion 330L (42 U.S.C. 254c–18) is amended by inserting
11 “, \$10,000,000 for fiscal year 2011, and such sums as
12 may be necessary for each of fiscal years 2012 through
13 2015” before the period at the end.

14 **SEC. 2524. NO CHILD LEFT UNIMMUNIZED AGAINST INFLU-**
15 **ENZA: DEMONSTRATION PROGRAM USING EL-**
16 **EMENTARY AND SECONDARY SCHOOLS AS IN-**
17 **FLUENZA VACCINATION CENTERS.**

18 (a) **PURPOSE.**—The Secretary of Health and Human
19 Services in consultation with the Secretary of Education,
20 shall award grants to eligible partnerships to carry out
21 demonstration programs designed to test the feasibility of
22 using the Nation’s elementary schools and secondary
23 schools as influenza vaccination centers.

24 (b) **IN GENERAL.**—The Secretary shall coordinate
25 with the Secretary of Labor, the Secretary of Education,

1 State Medicaid agencies, State insurance agencies, and
2 private insurers to carry out a program consisting of
3 awarding grants under subsection (c) to ensure that chil-
4 dren have coverage for all reasonable and customary ex-
5 penses related to influenza vaccinations, including the
6 costs of purchasing and administering the vaccine in-
7 curred when influenza vaccine is administered outside of
8 the physician's office in a school or other related setting.

9 (c) PROGRAM DESCRIPTION.—

10 (1) GRANTS.—From amounts appropriated pur-
11 suant to subsection (l), the Secretary shall award
12 grants to eligible partnerships to be used to provide
13 influenza vaccinations to children in elementary and
14 secondary schools, in coordination with school
15 nurses, school health care programs, community
16 health care providers, State insurance agencies, or
17 private insurers.

18 (2) ACIP RECOMMENDATIONS.—The program
19 under this section shall be designed to administer
20 vaccines consistent with the recommendations of the
21 Centers for Disease Control and Prevention's Advi-
22 sory Committee on Immunization Practices (ACIP)
23 for the annual vaccination of all children 5 through
24 19 years of age.

1 (3) PARTICIPATION VOLUNTARY.—Participation
2 by a school or an individual shall be voluntary.

3 (d) USE OF FUNDS.—Eligible partnerships receiving
4 a grant under this section shall ensure the maximum num-
5 ber of children access influenza vaccinations as follows:

6 (1) COVERED CHILDREN.—To the extent to
7 which payment of the costs of purchasing or admin-
8 istering the influenza vaccine for children is not cov-
9 ered through other federally funded programs or
10 through private insurance, eligible partnerships re-
11 ceiving a grant shall use funds to purchase and ad-
12 minister influenza vaccinations.

13 (2) CHILDREN COVERED BY OTHER FEDERAL
14 PROGRAMS.—For children who are eligible under
15 other federally funded programs for payment of the
16 costs of purchasing or administering the influenza
17 vaccine, eligible partnerships receiving a grant shall
18 not use funds provided under this section for such
19 costs.

20 (3) CHILDREN COVERED BY PRIVATE HEALTH
21 INSURANCE.—For children who have private insur-
22 ance, eligible partnerships receiving a grant shall
23 offer assistance in accessing coverage for vaccina-
24 tions administered through the program under this
25 section.

1 (e) PRIVACY.—The Secretary shall ensure that the
2 program under this section adheres to confidentiality and
3 privacy requirements of section 264 of the Health Insur-
4 ance Portability and Accountability Act of 1996 (42
5 U.S.C. 1320d–2 note) and section 444 of the General
6 Education Provisions Act (20 U.S.C. 1232g; commonly re-
7 ferred to as the “Family Educational Rights and Privacy
8 Act of 1974”).

9 (f) APPLICATION.—An eligible partnership desiring a
10 grant under this section shall submit an application to the
11 Secretary at such time, in such manner, and containing
12 such information as the Secretary may require.

13 (g) DURATION.—Eligible partnerships receiving a
14 grant shall administer a demonstration program funded
15 through this section over a period of 2 consecutive school
16 years.

17 (h) CHOICE OF VACCINE.—The program under this
18 section shall not restrict the discretion of a health care
19 provider to administer any influenza vaccine approved by
20 the Food and Drug Administration for use in pediatric
21 populations.

22 (i) AWARDS.—The Secretary shall award—

23 (1) a minimum of 10 grants in 10 different
24 States to eligible partnerships that each include one

1 or more public schools serving primarily low-income
2 students; and

3 (2) a minimum of 5 grants in 5 different States
4 to eligible partnerships that each include one or
5 more public schools located in a rural local edu-
6 cational agency.

7 (j) REPORT.—Not later than 90 days following the
8 completion of the program under this section, the Sec-
9 retary shall submit to the Committees on Education and
10 Labor, Energy and Commerce, and Appropriations of the
11 House of Representatives and to the Committees on
12 Health, Education, Labor, and Pensions and Appropria-
13 tions of the Senate a report on the results of the program.
14 The report shall include—

15 (1) an assessment of the influenza vaccination
16 rates of school-age children in localities where the
17 program is implemented, compared to the national
18 average influenza vaccination rates for school-aged
19 children, including whether school-based vaccination
20 assists in achieving the recommendations of the Ad-
21 visory Committee on Immunization Practices;

22 (2) an assessment of the utility of employing el-
23 elementary schools and secondary schools as a part of
24 a multistate, community-based pandemic response

1 program that is consistent with existing Federal and
2 State pandemic response plans;

3 (3) an assessment of the feasibility of using ex-
4 isting Federal and private insurance funding in es-
5 tablishing a multistate, school-based vaccination pro-
6 gram for seasonal influenza vaccination;

7 (4) an assessment of the number of education
8 days gained by students as a result of seasonal vac-
9 cinations based on absenteeism rates;

10 (5) a determination of whether the program
11 under this section—

12 (A) increased vaccination rates in the par-
13 ticipating localities; and

14 (B) was implemented for sufficient time
15 for gathering enough valid data; and

16 (6) a recommendation on whether the program
17 should be continued, expanded, or terminated.

18 (k) DEFINITIONS.—In this section:

19 (1) ELIGIBLE PARTNERSHIP.—The term “eligi-
20 ble partnership” means a local public health depart-
21 ment, or another health organization defined by the
22 Secretary as eligible to submit an application, and
23 one or more elementary and secondary schools.

24 (2) ELEMENTARY SCHOOL.—The terms “ele-
25 mentary school” and “secondary school” have the

1 meanings given such terms in section 9101 of the
2 Elementary and Secondary Education Act of 1965
3 (20 U.S.C. 7801).

4 (3) LOW-INCOME.—The term “low-income”
5 means a student, age 5 through 19, eligible for free
6 or reduced-price lunch under the National School
7 Lunch Act (42 U.S.C. 1751 et seq.).

8 (4) RURAL LOCAL EDUCATIONAL AGENCY.—
9 The term “rural local educational agency” means an
10 eligible local educational agency described in section
11 6211(b)(1) of the Elementary and Secondary Edu-
12 cation Act of 1965 (20 U.S.C. 7345(b)(1)).

13 (5) SECRETARY.—Except as otherwise speci-
14 fied, the term “Secretary” means the Secretary of
15 Health and Human Services.

16 (l) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there are authorized to be appropriated
18 such sums as may be necessary for each of fiscal years
19 2011 through 2015.

20 **SEC. 2525. EXTENSION OF WISEWOMAN PROGRAM.**

21 Section 1509 of the Public Health Service Act (42
22 U.S.C. 300n-4a) is amended—

23 (1) in subsection (a)—

24 (A) by striking the heading and inserting

25 “IN GENERAL.—”; and

1 (B) in the matter preceding paragraph (1),
2 by striking “may make grants” and all that fol-
3 lows through “purpose” and inserting the fol-
4 lowing: “may make grants to such States for
5 the purpose”; and

6 (2) in subsection (d)(1), by striking “there are
7 authorized” and all that follows through the period
8 and inserting “there are authorized to be appro-
9 priated \$70,000,000 for fiscal year 2011,
10 \$73,500,000 for fiscal year 2012, \$77,000,000 for
11 fiscal year 2013, \$81,000,000 for fiscal year 2014,
12 and \$85,000,000 for fiscal year 2015.”.

13 **SEC. 2526. HEALTHY TEEN INITIATIVE TO PREVENT TEEN**
14 **PREGNANCY.**

15 Part B of title III (42 U.S.C. 243 et seq.) is amended
16 by inserting after section 317T the following:

17 **“SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN**
18 **PREGNANCY.**

19 “(a) PROGRAM.—To the extent and in the amount
20 of appropriations made in advance in appropriations Acts,
21 the Secretary, acting through the Director of the Centers
22 for Disease Control and Prevention, shall establish a pro-
23 gram consisting of making grants, in amounts determined
24 under subsection (c), to each State that submits an appli-

1 cation in accordance with subsection (d) for an evidence-
2 based education program described in subsection (b).

3 “(b) USE OF FUNDS.—Amounts received by a State
4 under this section shall be used to conduct or support evi-
5 dence-based education programs (directly or through
6 grants or contracts to public or private nonprofit entities,
7 including schools and community-based and faith-based
8 organizations) to reduce teen pregnancy or sexually trans-
9 mitted diseases.

10 “(c) DISTRIBUTION OF FUNDS.—The Director shall,
11 for fiscal year 2011 and each subsequent fiscal year, make
12 a grant to each State described in subsection (a) in an
13 amount equal to the product of—

14 “(1) the amount appropriated to carry out this
15 section for the fiscal year; and

16 “(2) the percentage determined for the State
17 under section 502(c)(1)(B)(ii) of the Social Security
18 Act.

19 “(d) APPLICATION.—To seek a grant under this sec-
20 tion, a State shall submit an application at such time, in
21 such manner, and containing such information and assur-
22 ance of compliance with this section as the Secretary may
23 require. At a minimum, an application shall to the satis-
24 faction of the Secretary—

1 “(1) describe how the State’s proposal will ad-
2 dress the needs of at-risk teens in the State;

3 “(2) identify the evidence-based education pro-
4 gram or programs selected from the registry devel-
5 oped under subsection (g) that will be used to ad-
6 dress risks in priority populations;

7 “(3) describe how the program or programs will
8 be implemented and any adaptations to the evidence-
9 based model that will be made;

10 “(4) list any private and public entities with
11 whom the State proposes to work, including schools
12 and community-based and faith-based organizations,
13 and demonstrate their capacity to implement the
14 proposed program or programs; and

15 “(5) identify an independent entity that will
16 evaluate the impact of the program or programs.

17 “(e) EVALUATION.—

18 “(1) REQUIREMENT.—As a condition on receipt
19 of a grant under this section, a State shall agree—

20 “(A) to arrange for an independent evalua-
21 tion of the impact of the programs to be con-
22 ducted or supported through the grant; and

23 “(B) submit reports to the Secretary on
24 such programs and the results of evaluation of
25 such programs.

1 “(2) FUNDING LIMITATION.—Of the amounts
2 made available to a State through a grant under this
3 section for any fiscal year, not more than 10 percent
4 may be used for such evaluation.

5 “(f) RULE OF CONSTRUCTION.—This section shall
6 not be construed to preempt or limit any State law regard-
7 ing parental involvement and decisionmaking in children’s
8 education.

9 “(g) REGISTRY OF ELIGIBLE PROGRAMS.—The Sec-
10 retary shall develop not later than 180 days after the date
11 of the enactment of the Affordable Health Care for Amer-
12 ica Act, and periodically update thereafter, a publicly
13 available registry of programs described in subsection (b)
14 that, as determined by the Secretary—

15 “(1) meet the definition of the term ‘evidence-
16 based’ in subsection (i);

17 “(2) are medically and scientifically accurate;
18 and

19 “(3) provide age-appropriate information.

20 “(h) MATCHING FUNDS.—The Secretary may award
21 a grant to a State under this section for a fiscal year only
22 if the State agrees to provide, from non-Federal sources,
23 an amount equal to \$1 (in cash or in kind) for each \$4
24 provided through the grant to carry out the activities sup-
25 ported by the grant.

1 “(i) DEFINITION.—In this section, the term ‘evi-
2 dence-based’ means based on a model that has been found,
3 in methodologically sound research—

4 “(1) to delay initiation of sex;

5 “(2) to decrease number of partners;

6 “(3) to reduce teen pregnancy;

7 “(4) to reduce sexually transmitted infection
8 rates; or

9 “(5) to improve rates of contraceptive use.

10 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
11 carry out this section, there is authorized to be appro-
12 priated \$50,000,000 for each of fiscal years 2011 through
13 2015.”.

14 **SEC. 2527. NATIONAL TRAINING INITIATIVES ON AUTISM**
15 **SPECTRUM DISORDERS.**

16 Title I of the Developmental Disabilities Assistance
17 and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
18 is amended by adding at the end the following:

19 **“Subtitle F—National Training Ini-**
20 **tiative on Autism Spectrum Dis-**
21 **orders**

22 **“SEC. 171. NATIONAL TRAINING INITIATIVE.**

23 “(a) GRANTS AND TECHNICAL ASSISTANCE.—

24 “(1) GRANTS.—

1 “(A) IN GENERAL.—The Secretary, in con-
2 sultation with the Interagency Autism Coordi-
3 nating Committee, shall award multiyear grants
4 to eligible entities to provide individuals (includ-
5 ing parents and health, allied health, vocational,
6 and educational professionals) with interdiscipli-
7 nary training, continuing education, technical
8 assistance, and information for the purpose of
9 improving services rendered to children and
10 adults with autism, and their families, to ad-
11 dress unmet needs related to autism.

12 “(B) ELIGIBLE ENTITY.—To be eligible to
13 receive a grant under this subsection, an entity
14 shall be—

15 “(i) a University Center for Excel-
16 lence in Developmental Disabilities Edu-
17 cation, Research, and Service; or

18 “(ii) a comparable interdisciplinary
19 education, research, and service entity.

20 “(C) APPLICATION REQUIREMENTS.—An
21 entity that desires to receive a grant for a pro-
22 gram under this paragraph shall submit to the
23 Secretary an application—

24 “(i) demonstrating that the entity has
25 capacity to—

1 “(I) provide training and tech-
2 nical assistance in evidence-based
3 practices to evaluate, and provide ef-
4 fective interventions, services, treat-
5 ments, and supports to, children and
6 adults with autism and their families;

7 “(II) include individuals with au-
8 tism and their families as part of the
9 program to ensure that an individual-
10 and family-centered approach is used;

11 “(III) share and disseminate ma-
12 terials and practices that are devel-
13 oped for, and evaluated to be effective
14 in, the provision of training and tech-
15 nical assistance; and

16 “(IV) provide training, technical
17 assistance, interventions, services,
18 treatments, and supports under this
19 subsection statewide.

20 “(ii) providing assurances that the en-
21 tity will—

22 “(I) provide trainees under this
23 subsection with an appropriate bal-
24 ance of interdisciplinary academic and
25 community-based experiences; and

1 “(II) provide to the Secretary, in
2 the manner prescribed by the Sec-
3 retary, data regarding the number of
4 individuals who have benefitted from,
5 and outcomes of, the provision of
6 training and technical assistance
7 under this subsection;

8 “(iii) providing assurances that train-
9 ing, technical assistance, dissemination of
10 information, and services under this sub-
11 section will be—

12 “(I) consistent with the goals of
13 this Act, the Americans with Disabil-
14 ities Act of 1990, the Individuals with
15 Disabilities Education Act, and the
16 Elementary and Secondary Education
17 Act of 1965; and

18 “(II) conducted in coordination
19 with relevant State agencies, institu-
20 tions of higher education, and service
21 providers; and

22 “(iv) containing such other informa-
23 tion and assurances as the Secretary may
24 require.

1 “(D) USE OF FUNDS.—A grant received
2 under this subsection shall be used to provide
3 individuals (including parents and health, allied
4 health, vocational, and educational profes-
5 sionals) with interdisciplinary training, con-
6 tinuing education, technical assistance, and in-
7 formation for the purpose of improving services
8 rendered to children and adults with autism,
9 and their families, to address unmet needs re-
10 lated to autism. Such training, education, as-
11 sistance, and information shall include each of
12 the following:

13 “(i) Training health, allied health, vo-
14 cational, and educational professionals to
15 identify, evaluate the needs of, and develop
16 interventions, services, treatments, and
17 supports for, children and adults with au-
18 tism.

19 “(ii) Developing model services and
20 supports that demonstrate evidence-based
21 practices.

22 “(iii) Developing systems and prod-
23 ucts that allow for the interventions, serv-
24 ices, treatments, and supports to be evalu-
25 ated for fidelity of implementation.

1 “(iv) Working to expand the avail-
2 ability of evidence-based, lifelong interven-
3 tions; educational, employment, and transi-
4 tion services; and community supports.

5 “(v) Providing statewide technical as-
6 sistance in collaboration with relevant
7 State agencies, institutions of higher edu-
8 cation, autism advocacy groups, and com-
9 munity-based service providers.

10 “(vi) Working to develop comprehen-
11 sive systems of supports and services for
12 individuals with autism and their families,
13 including seamless transitions between
14 education and health systems across the
15 lifespan.

16 “(vii) Promoting training, technical
17 assistance, dissemination of information,
18 supports, and services.

19 “(viii) Developing mechanisms to pro-
20 vide training and technical assistance, in-
21 cluding for-credit courses, intensive sum-
22 mer institutes, continuing education pro-
23 grams, distance based programs, and Web-
24 based information dissemination strategies.

1 “(ix) Promoting activities that sup-
2 port community-based family and indi-
3 vidual services and enable individuals with
4 autism and related developmental disabili-
5 ties to fully participate in society and
6 achieve good quality-of-life outcomes.

7 “(x) Collecting data on the outcomes
8 of training and technical assistance pro-
9 grams to meet statewide needs for the ex-
10 pansion of services to children and adults
11 with autism.

12 “(E) AMOUNT OF GRANTS.—The amount
13 of a grant to any entity for a fiscal year under
14 this section shall be not less than \$250,000.

15 “(2) TECHNICAL ASSISTANCE.—The Secretary
16 shall reserve 2 percent of the amount appropriated
17 to carry out this subsection for a fiscal year to make
18 a grant to a national organization with dem-
19 onstrated capacity for providing training and tech-
20 nical assistance to—

21 “(A) assist in national dissemination of
22 specific information, including evidence-based
23 best practices, from interdisciplinary training
24 programs, and when appropriate, other entities

1 whose findings would inform the work per-
2 formed by entities awarded grants;

3 “(B) compile and disseminate strategies
4 and materials that prove to be effective in the
5 provision of training and technical assistance so
6 that the entire network can benefit from the
7 models, materials, and practices developed in
8 individual centers;

9 “(C) assist in the coordination of activities
10 of grantees under this subsection;

11 “(D) develop a Web portal that will pro-
12 vide linkages to each of the individual training
13 initiatives and provide access to training mod-
14 ules, promising training, and technical assist-
15 ance practices and other materials developed by
16 grantees;

17 “(E) serve as a research-based resource for
18 Federal and State policymakers on information
19 concerning the provision of training and tech-
20 nical assistance for the assessment, and provi-
21 sion of supports and services for, children and
22 adults with autism;

23 “(F) convene experts from multiple inter-
24 disciplinary training programs, individuals with
25 autism, and the families of such individuals to

1 discuss and make recommendations with regard
2 to training issues related to assessment, inter-
3 ventions, services, treatment, and supports for
4 children and adults with autism; and

5 “(H) undertake any other functions that
6 the Secretary determines to be appropriate.

7 “(3) AUTHORIZATION OF APPROPRIATIONS.—
8 To carry out this subsection, there are authorized to
9 be appropriated \$17,000,000 for fiscal year 2011
10 and such sums as may be necessary for each of fis-
11 cal years 2012 through 2015.

12 “(b) EXPANSION OF THE NUMBER OF UNIVERSITY
13 CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DIS-
14 ABILITIES EDUCATION, RESEARCH, AND SERVICE.—

15 “(1) GRANTS.—To provide for the establish-
16 ment of up to 4 new University Centers for Excel-
17 lence in Developmental Disabilities Education, Re-
18 search, and Service, the Secretary shall award up to
19 4 grants to institutions of higher education.

20 “(2) APPLICABLE PROVISIONS.—Except for
21 subsection (a)(3), the provisions of subsection (a)
22 shall apply with respect to grants under this sub-
23 section to the same extent and in the same manner
24 as such provisions apply with respect to grants
25 under subsection (a).

1 “(3) PRIORITY.—In awarding grants under this
2 subsection, the Secretary shall give priority to appli-
3 cants that—

4 “(A) are minority institutions that have
5 demonstrated capacity to meet the requirements
6 of this section and provide services to individ-
7 uals with autism and their families; or

8 “(B) are located in a State with one or
9 more underserved populations.

10 “(4) AUTHORIZATION OF APPROPRIATIONS.—
11 To carry out this subsection, there is authorized to
12 be appropriated \$2,000,000 for each of fiscal years
13 2011 through 2015.

14 “(c) DEFINITIONS.—In this section:

15 “(1) The term ‘autism’ means an autism spec-
16 trum disorder or a related developmental disability.

17 “(2) The term ‘interventions’ means edu-
18 cational methods and positive behavioral support
19 strategies designed to improve or ameliorate symp-
20 toms associated with autism.

21 “(3) The term ‘minority institution’ has the
22 meaning given to such term in section 365 of the
23 Higher Education Act of 1965.

1 eases for targeted individuals, to improve the quality of
2 care and reduce overall cost in the treatment of such dis-
3 eases. The Secretary shall commence the grant program
4 not later than May 1, 2011.

5 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
6 grant under subsection (a), an entity shall—

7 (1) provide a setting appropriate for MTM serv-
8 ices, as recommended by the experts described in
9 subsection (e);

10 (2) submit to the Secretary a plan for achieving
11 long-term financial sustainability;

12 (3) where applicable, submit a plan for coordi-
13 nating MTM services with other local providers and
14 where applicable, through or in collaboration with
15 the Medicare Medical Home Pilot program as estab-
16 lished by section 1866F of the Social Security Act,
17 as added by section 1302(a) of this Act;

18 (4) submit a plan for meeting the requirements
19 under subsection (c); and

20 (5) submit to the Secretary such other informa-
21 tion as the Secretary may require.

22 (c) MTM SERVICES TO TARGETED INDIVIDUALS.—
23 The MTM services provided with the assistance of a grant
24 awarded under subsection (a) shall, as allowed by State

1 law (including applicable collaborative pharmacy practice
2 agreements), include—

3 (1) performing or obtaining necessary assess-
4 ments of the health and functional status of each
5 patient receiving such MTM services;

6 (2) formulating a medication treatment plan ac-
7 cording to therapeutic goals agreed upon by the pre-
8 scriber and the patient or caregiver or authorized
9 representative of the patient;

10 (3) selecting, initiating, modifying, recom-
11 mending changes to, or administering medication
12 therapy;

13 (4) monitoring, which may include access to, or-
14 dering, or performing laboratory assessments, and
15 evaluating the response of the patient to therapy, in-
16 cluding safety and effectiveness;

17 (5) performing an initial comprehensive medica-
18 tion review to identify, resolve, and prevent medica-
19 tion-related problems, including adverse drug events,
20 quarterly targeted medication reviews for ongoing
21 monitoring, and additional followup interventions on
22 a schedule developed collaboratively with the pre-
23 scriber;

24 (6) documenting the care delivered and commu-
25 nicating essential information about such care (in-

1 including a summary of the medication review) and
2 the recommendations of the pharmacist to other ap-
3 propriate health care providers of the patient in a
4 timely fashion;

5 (7) providing education and training designed
6 to enhance the understanding and appropriate use of
7 the medications by the patient, caregiver, and other
8 authorized representative;

9 (8) providing information, support services, and
10 resources and strategies designed to enhance patient
11 adherence with therapeutic regimens;

12 (9) coordinating and integrating MTM services
13 within the broader health care management services
14 provided to the patient; and

15 (10) such other patient care services as are al-
16 lowed under the scopes of practice for pharmacists
17 for purposes of other Federal programs.

18 (d) TARGETED INDIVIDUALS.—MTM services pro-
19 vided by licensed pharmacists under a grant awarded
20 under subsection (a) shall be offered to targeted individ-
21 uals who—

22 (1) take 4 or more prescribed medications (in-
23 cluding over-the-counter and dietary supplements);

24 (2) take any high-risk medications;

1 (3) have 2 or more chronic diseases, as identi-
2 fied by the Secretary; or

3 (4) have undergone a transition of care, or
4 other factors, as determined by the Secretary, that
5 are likely to create a high risk of medication-related
6 problems.

7 (e) CONSULTATION WITH EXPERTS.—In designing
8 and implementing MTM services provided under grants
9 awarded under subsection (a), the Secretary shall consult
10 with Federal, State, private, public-private, and academic
11 entities, pharmacy and pharmacist organizations, health
12 care organizations, consumer advocates, chronic disease
13 groups, and other stakeholders involved with the research,
14 dissemination, and implementation of pharmacist-deliv-
15 ered MTM services, as the Secretary determines appro-
16 priate. The Secretary, in collaboration with this group,
17 shall determine whether it is possible to incorporate rapid
18 cycle process improvement concepts in use in other Fed-
19 eral programs that have implemented MTM services.

20 (f) REPORTING TO THE SECRETARY.—An entity that
21 receives a grant under subsection (a) shall submit to the
22 Secretary a report that describes and evaluates, as re-
23 quested by the Secretary, the activities carried out under
24 subsection (e), including quality measures, as determined
25 by the Secretary.

1 (g) EVALUATION AND REPORT.—The Secretary shall
2 submit to the relevant committees of Congress a report
3 which shall—

4 (1) assess the clinical effectiveness of phar-
5 macist-provided services under the MTM services
6 program, as compared to usual care, including an
7 evaluation of whether enrollees maintained better
8 health with fewer hospitalizations and emergency
9 room visits than similar patients not enrolled in the
10 program;

11 (2) assess changes in overall health care re-
12 source of targeted individuals;

13 (3) assess patient and prescriber satisfaction
14 with MTM services;

15 (4) assess the impact of patient-cost-sharing re-
16 quirements on medication adherence and rec-
17 ommendations for modifications;

18 (5) identify and evaluate other factors that may
19 impact clinical and economic outcomes, including de-
20 mographic characteristics, clinical characteristics,
21 and health services use of the patient, as well as
22 characteristics of the regimen, pharmacy benefit,
23 and MTM services provided; and

24 (6) evaluate the extent to which participating
25 pharmacists who maintain a dispensing role have a

1 conflict of interest in the provision of MTM services,
2 and if such conflict is found, provide recommenda-
3 tions on how such a conflict might be appropriately
4 addressed.

5 (h) GRANT TO FUND DEVELOPMENT OF PERFORM-
6 ANCE MEASURES.—The Secretary may award grants or
7 contracts to eligible entities for the purpose of funding the
8 development of performance measures that assess the use
9 and effectiveness of medication therapy management serv-
10 ices.

11 **SEC. 2529. POSTPARTUM DEPRESSION.**

12 (a) EXPANSION AND INTENSIFICATION OF ACTIVI-
13 TIES.—

14 (1) CONTINUATION OF ACTIVITIES.—The Sec-
15 retary is encouraged to expand and intensify activi-
16 ties on postpartum conditions.

17 (2) PROGRAMS FOR POSTPARTUM CONDI-
18 TIONS.—In carrying out paragraph (1), the Sec-
19 retary is encouraged to continue research to expand
20 the understanding of the causes of, and treatments
21 for, postpartum conditions, including conducting and
22 supporting the following:

23 (A) Basic research concerning the etiology
24 and causes of the conditions.

1 (B) Epidemiological studies to address the
2 frequency and natural history of the conditions
3 and the differences among racial and ethnic
4 groups with respect to the conditions.

5 (C) The development of improved screen-
6 ing and diagnostic techniques.

7 (D) Clinical research for the development
8 and evaluation of new treatments.

9 (E) Information and education programs
10 for health professionals and the public, which
11 may include a coordinated national campaign
12 that—

13 (i) is designed to increase the aware-
14 ness and knowledge of postpartum condi-
15 tions;

16 (ii) may include public service an-
17 nouncements through television, radio, and
18 other means; and

19 (iii) may focus on—

20 (I) raising awareness about
21 screening;

22 (II) educating new mothers and
23 their families about postpartum condi-
24 tions to promote earlier diagnosis and
25 treatment; and

1 (III) ensuring that such edu-
2 cation includes complete information
3 concerning postpartum conditions, in-
4 cluding its symptoms, methods of cop-
5 ing with the illness, and treatment re-
6 sources.

7 (b) REPORT BY THE SECRETARY.—

8 (1) STUDY.—The Secretary shall conduct a
9 study on the benefits of screening for postpartum
10 conditions.

11 (2) REPORT.—Not later than 2 years after the
12 date of the enactment of this Act, the Secretary
13 shall complete the study required by paragraph (1)
14 and submit a report to the Congress on the results
15 of such study.

16 (c) SENSE OF CONGRESS REGARDING LONGITU-
17 DINAL STUDY OF RELATIVE MENTAL HEALTH CON-
18 SEQUENCES FOR WOMEN OF RESOLVING A PREG-
19 NANCY.—

20 (1) SENSE OF CONGRESS.—It is the sense of
21 the Congress that the Director of the National Insti-
22 tute of Mental Health may conduct a nationally rep-
23 resentative longitudinal study (during the period of
24 fiscal years 2011 through 2020) on the relative men-
25 tal health consequences for women of resolving a

1 pregnancy (intended and unintended) in various
2 ways, including carrying the pregnancy to term and
3 parenting the child, carrying the pregnancy to term
4 and placing the child for adoption, miscarriage, and
5 having an abortion. This study may assess the inci-
6 dence, timing, magnitude, and duration of the imme-
7 diate and long-term mental health consequences
8 (positive or negative) of these pregnancy outcomes.

9 (2) REPORT.—Beginning not later than 3 years
10 after the date of the enactment of this Act, and peri-
11 odically thereafter for the duration of the study,
12 such Director may prepare and submit to the Con-
13 gress reports on the findings of the study.

14 (d) DEFINITIONS.—In this section:

15 (1) The term “postpartum condition” means
16 postpartum depression or postpartum psychosis.

17 (2) The term “Secretary” means the Secretary
18 of Health and Human Services.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
20 purpose of carrying out this section, in addition to any
21 other amounts authorized to be appropriated for such pur-
22 pose, there are authorized to be appropriated such sums
23 as may be necessary for each of fiscal years 2011 through
24 2013.

1 **SEC. 2530. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**
2 **IORS AND OUTCOMES.**

3 Part P of title III (42 U.S.C. 280g et seq.) is amend-
4 ed by adding at the end the following:

5 **“SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
6 **HAVIORS AND OUTCOMES.**

7 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
8 laboration with the Director of the Centers for Disease
9 Control and Prevention and other Federal officials deter-
10 mined appropriate by the Secretary, is authorized to
11 award grants to eligible entities to promote positive health
12 behaviors for populations in medically underserved com-
13 munities through the use of community health workers.

14 “(b) USE OF FUNDS.—Grants awarded under sub-
15 section (a) shall be used to support community health
16 workers—

17 “(1) to educate, guide, and provide outreach in
18 a community setting regarding health problems prev-
19 alent in medically underserved communities, espe-
20 cially racial and ethnic minority populations;

21 “(2) to educate, guide, and provide experiential
22 learning opportunities that target behavioral risk
23 factors including—

24 “(A) poor nutrition;

25 “(B) physical inactivity;

26 “(C) being overweight or obese;

- 1 “(D) tobacco use;
- 2 “(E) alcohol and substance use;
- 3 “(F) injury and violence;
- 4 “(G) risky sexual behavior;
- 5 “(H) untreated mental health problems;
- 6 “(I) untreated dental and oral health prob-
- 7 lems; and
- 8 “(J) understanding informed consent;
- 9 “(3) to educate and provide guidance regarding
- 10 effective strategies to promote positive health behav-
- 11 iors within the family;
- 12 “(4) to educate and provide outreach regarding
- 13 enrollment in health insurance including the State
- 14 Children’s Health Insurance Program under title
- 15 XXI of the Social Security Act, Medicare under title
- 16 XVIII of such Act, and Medicaid under title XIX of
- 17 such Act;
- 18 “(5) to educate and refer underserved popu-
- 19 lations to appropriate health care agencies and com-
- 20 munity-based programs and organizations in order
- 21 to increase access to quality health care services, in-
- 22 cluding preventive health services, and to eliminate
- 23 duplicative care; or

1 “(6) to educate, guide, and provide home visita-
2 tion services regarding maternal health and prenatal
3 care.

4 “(c) APPLICATION.—

5 “(1) IN GENERAL.—Each eligible entity that
6 desires to receive a grant under subsection (a) shall
7 submit an application to the Secretary, at such time,
8 in such manner, and accompanied by such informa-
9 tion as the Secretary may require.

10 “(2) CONTENTS.—Each application submitted
11 pursuant to paragraph (1) shall—

12 “(A) describe the activities for which as-
13 sistance is sought under this section;

14 “(B) contain an assurance that, with re-
15 spect to each community health worker pro-
16 gram receiving funds under the grant, such pro-
17 gram will provide training and supervision to
18 community health workers to enable such work-
19 ers to provide authorized program services;

20 “(C) contain an assurance that the appli-
21 cant will evaluate the effectiveness of commu-
22 nity health worker programs receiving funds
23 under the grant;

24 “(D) contain an assurance that each com-
25 munity health worker program receiving funds

1 under the grant will provide services in the cul-
2 tural context most appropriate for the individ-
3 uals served by the program;

4 “(E) contain a plan to document and dis-
5 seminate project descriptions and results to
6 other States and organizations as identified by
7 the Secretary; and

8 “(F) describe plans to enhance the capac-
9 ity of individuals to utilize health services and
10 health-related social services under Federal,
11 State, and local programs by—

12 “(i) assisting individuals in estab-
13 lishing eligibility under the programs and
14 in receiving the services or other benefits
15 of the programs; and

16 “(ii) providing other services as the
17 Secretary determines to be appropriate,
18 that may include transportation and trans-
19 lation services.

20 “(d) PRIORITY.—In awarding grants under sub-
21 section (a), the Secretary shall give priority to applicants
22 that—

23 “(1) propose to target geographic areas—

1 “(A) with a high percentage of residents
2 who are eligible for health insurance but are
3 uninsured or underinsured;

4 “(B) with a high percentage of residents
5 who suffer from chronic diseases including pul-
6 monary conditions, hypertension, heart disease,
7 mental disorders, diabetes, and asthma; and

8 “(C) with a high infant mortality rate;

9 “(2) have experience in providing health or
10 health-related social services to individuals who are
11 underserved with respect to such services; and

12 “(3) have documented community activity and
13 experience with community health workers.

14 “(e) COLLABORATION WITH ACADEMIC INSTITU-
15 TIONS.—The Secretary shall encourage community health
16 worker programs receiving funds under this section to col-
17 laborate with academic institutions, especially those that
18 graduate a disproportionate number of health and health
19 care students from underrepresented racial and ethnic mi-
20 nority backgrounds. Nothing in this section shall be con-
21 strued to require such collaboration.

22 “(f) EVIDENCE-BASED INTERVENTIONS.—The Sec-
23 retary shall encourage community health worker programs
24 receiving funding under this section to implement an out-
25 come-based payment system that rewards community

1 health workers for connecting underserved populations
2 with the most appropriate services at the most appropriate
3 time. Nothing in this section shall be construed to require
4 such payment.

5 “(g) QUALITY ASSURANCE AND COST EFFECTIVE-
6 NESS.—The Secretary shall establish guidelines for assur-
7 ing the quality of the training and supervision of commu-
8 nity health workers under the programs funded under this
9 section and for assuring the cost-effectiveness of such pro-
10 grams.

11 “(h) MONITORING.—The Secretary shall monitor
12 community health worker programs identified in approved
13 applications under this section and shall determine wheth-
14 er such programs are in compliance with the guidelines
15 established under subsection (g).

16 “(i) TECHNICAL ASSISTANCE.—The Secretary may
17 provide technical assistance to community health worker
18 programs identified in approved applications under this
19 section with respect to planning, developing, and operating
20 programs under the grant.

21 “(j) REPORT TO CONGRESS.—

22 “(1) IN GENERAL.—Not later than 4 years
23 after the date on which the Secretary first awards
24 grants under subsection (a), the Secretary shall sub-

1 mit to Congress a report regarding the grant
2 project.

3 “(2) CONTENTS.—The report required under
4 paragraph (1) shall include the following:

5 “(A) A description of the programs for
6 which grant funds were used.

7 “(B) The number of individuals served
8 under such programs.

9 “(C) An evaluation of—

10 “(i) the effectiveness of such pro-
11 grams;

12 “(ii) the cost of such programs; and

13 “(iii) the impact of the programs on
14 the health outcomes of the community resi-
15 dents.

16 “(D) Recommendations for sustaining the
17 community health worker programs developed
18 or assisted under this section.

19 “(E) Recommendations regarding training
20 to enhance career opportunities for community
21 health workers.

22 “(k) DEFINITIONS.—In this section:

23 “(1) COMMUNITY HEALTH WORKER.—The term
24 ‘community health worker’ means an individual who

1 promotes health or nutrition within the community
2 in which the individual resides—

3 “(A) by serving as a liaison between com-
4 munities and health care agencies;

5 “(B) by providing guidance and social as-
6 sistance to community residents;

7 “(C) by enhancing community residents’
8 ability to effectively communicate with health
9 care providers;

10 “(D) by providing culturally and linguis-
11 tically appropriate health or nutrition edu-
12 cation;

13 “(E) by advocating for individual and com-
14 munity health, including oral and mental, or
15 nutrition needs; and

16 “(F) by providing referral and followup
17 services or otherwise coordinating care.

18 “(2) COMMUNITY SETTING.—The term ‘commu-
19 nity setting’ means a home or a community organi-
20 zation located in the neighborhood in which a partic-
21 ipant resides.

22 “(3) MEDICALLY UNDERSERVED COMMUNITY.—
23 The term ‘medically underserved community’ means
24 a community identified by a State, United States

1 territory or possession, or federally recognized In-
2 dian tribe—

3 “(A) that has a substantial number of in-
4 dividuals who are members of a medically un-
5 derserved population, as defined by section
6 330(b)(3); and

7 “(B) a significant portion of which is a
8 health professional shortage area as designated
9 under section 332.

10 “(4) SUPPORT.—The term ‘support’ means the
11 provision of training, supervision, and materials
12 needed to effectively deliver the services described in
13 subsection (b), reimbursement for services, and
14 other benefits.

15 “(5) ELIGIBLE ENTITY.—The term ‘eligible en-
16 tity’ means a public or private nonprofit entity (in-
17 cluding a State or public subdivision of a State, a
18 public health department, or a federally qualified
19 health center), or a consortium of any of such enti-
20 ties, located in the United States or territory there-
21 of.

22 “(1) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 \$30,000,000 for each of fiscal years 2011 through 2015.”.

1 **SEC. 2531. MEDICAL LIABILITY ALTERNATIVES.**

2 (a) INCENTIVE PAYMENTS FOR MEDICAL LIABILITY
3 REFORM.—

4 (1) IN GENERAL.—To the extent and in the
5 amounts made available in advance in appropriations
6 Acts, the Secretary shall make an incentive payment,
7 in an amount determined by the Secretary, to each
8 State that has an alternative medical liability law in
9 compliance with this section.

10 (2) DETERMINATION BY SECRETARY.—The
11 Secretary shall determine that a State has an alter-
12 native medical liability law in compliance with this
13 section if the Secretary is satisfied that—

14 (A) the State enacted the law after the
15 date of the enactment of this Act and is imple-
16 menting the law;

17 (B) the law is effective; and

18 (C) the contents of the law are in accord-
19 ance with paragraph (4).

20 (3) CONSIDERATIONS FOR DETERMINING EF-
21 FECTIVENESS.—In determining whether an alter-
22 native medical liability law is effective under para-
23 graph (2)(B), the Secretary shall consider whether
24 the law—

1 (A) makes the medical liability system
2 more reliable through prevention of, or prompt
3 and fair resolution of, disputes;

4 (B) encourages the disclosure of health
5 care errors; and

6 (C) maintains access to affordable liability
7 insurance.

8 (4) CONTENTS OF ALTERNATIVE MEDICAL LI-
9 ABILITY LAW.—The contents of an alternative liabil-
10 ity law are in accordance with this paragraph if—

11 (A) the litigation alternatives contained in
12 the law consist of certificate of merit, early
13 offer, or both; and

14 (B) the law does not limit attorneys' fees
15 or impose caps on damages.

16 (b) USE OF INCENTIVE PAYMENTS.—Amounts re-
17 ceived by a State as an incentive payment under this sec-
18 tion shall be used to improve health care in that State.

19 (c) TECHNICAL ASSISTANCE.—The Secretary may
20 provide technical assistance to the States applying for or
21 receiving an incentive payment under this section.

22 (d) REPORTS.—Beginning not later than one year
23 after the date of the enactment of this Act, the Secretary
24 shall submit to the Congress an annual report on the
25 progress States have made in enacting and implementing

1 alternative medical liability laws in compliance with this
2 section. Such reports shall contain sufficient documenta-
3 tion regarding the effectiveness of such laws to enable an
4 objective comparative analysis of such laws.

5 (e) DEFINITION.—In this section—

6 (1) the term “Secretary” means the Secretary
7 of Health and Human Services; and

8 (2) the term “State” includes the several
9 States, District of Columbia, the Commonwealth of
10 Puerto Rico, and each other territory or possession
11 of the United States.

12 (f) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary, to remain available until
15 expended.

16 **SEC. 2532. INFANT MORTALITY PILOT PROGRAMS.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the “Sec-
19 retary”), acting through the Director, shall award grants
20 to eligible entities to create, implement, and oversee infant
21 mortality pilot programs.

22 (b) PERIOD OF A GRANT.—The period of a grant
23 under this section shall be 5 consecutive fiscal years.

24 (c) PREFERENCE.—In awarding grants under this
25 section, the Secretary shall give preference to eligible enti-

1 ties proposing to serve any of the 15 counties or groups
2 of counties with the highest rates of infant mortality in
3 the United States in the past 3 years.

4 (d) USE OF FUNDS.—Any infant mortality pilot pro-
5 gram funded under this section may—

6 (1) include the development of a plan that iden-
7 tifies the individual needs of each community to be
8 served and strategies to address those needs;

9 (2) provide outreach to at-risk mothers through
10 programs deemed appropriate by the Director;

11 (3) develop and implement standardized sys-
12 tems for improved access, utilization, and quality of
13 social, educational, and clinical services to promote
14 healthy pregnancies, full term births, and healthy in-
15 fancies delivered to women and their infants, such
16 as—

17 (A) counseling on infant care, feeding, and
18 parenting;

19 (B) postpartum care;

20 (C) prevention of premature delivery; and

21 (D) additional counseling for at-risk moth-
22 ers, including smoking cessation programs,
23 drug treatment programs, alcohol treatment
24 programs, nutrition and physical activity pro-
25 grams, postpartum depression and domestic vio-

1 lence programs, social and psychological serv-
2 ices, dental care, and parenting programs;

3 (4) establish a rural outreach program to pro-
4 vide care to at-risk mothers in rural areas;

5 (5) establish a regional public education cam-
6 paign, including a campaign to—

7 (A) prevent preterm births; and

8 (B) educate the public about infant mor-
9 tality; and

10 (6) provide for any other activities, programs,
11 or strategies as identified by the community plan.

12 (e) LIMITATION.—Of the funds received through a
13 grant under this section for a fiscal year, an eligible entity
14 shall not use more than 10 percent for program evalua-
15 tion.

16 (f) REPORTS ON PILOT PROGRAMS.—

17 (1) IN GENERAL.—Not later than 1 year after
18 receiving a grant, and annually thereafter for the
19 duration of the grant period, each entity that re-
20 ceives a grant under subsection (a) shall submit a
21 report to the Secretary detailing its infant mortality
22 pilot program.

23 (2) CONTENTS OF REPORT.—The reports re-
24 quired under paragraph (1) shall include informa-
25 tion such as the methodology of, and outcomes and

1 statistics from, the grantee's infant mortality pilot
2 program.

3 (3) EVALUATION.—The Secretary shall use the
4 reports required under paragraph (1) to evaluate,
5 and conduct statistical research on, infant mortality
6 pilot programs funded through this section.

7 (g) DEFINITIONS.—For the purposes of this section:

8 (1) DIRECTOR.—The term “Director” means
9 the Director of the Centers for Disease Control and
10 Prevention.

11 (2) ELIGIBLE ENTITY.—The term “eligible enti-
12 ty” means a State, county, city, territorial, or tribal
13 health department that has submitted a proposal to
14 the Secretary that the Secretary deems likely to re-
15 duce infant mortality rates within the standard met-
16 ropolitan statistical area involved.

17 (3) TRIBAL.—The term “tribal” refers to an
18 Indian tribe, a Tribal organization, or an Urban In-
19 dian organization, as such terms are defined in sec-
20 tion 4 of the Indian Health Care Improvement Act.

21 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
22 out this section, there are authorized to be appropriated
23 \$10,000,000 for each of fiscal years 2011 through 2015.

1 **SEC. 2533. SECONDARY SCHOOL HEALTH SCIENCES TRAIN-**
2 **ING PROGRAM.**

3 (a) PROGRAM.—The Secretary of Health and Human
4 Services, acting through the Administrator of the Health
5 Resources and Services Administration, and in consulta-
6 tion with the Secretary of Education, may establish a
7 health sciences training program consisting of awarding
8 grants and contracts under subsection (b) to prepare sec-
9 ondary school students for careers in health professions.

10 (b) DEVELOPMENT AND IMPLEMENTATION OF
11 HEALTH SCIENCES CURRICULA.—The Secretary may
12 make grants to, or enter into contracts with, eligible enti-
13 ties—

14 (1) to plan, develop, or implement secondary
15 school health sciences curricula, including curricula
16 in biology, chemistry, physiology, mathematics, nu-
17 trition, and other courses deemed appropriate by the
18 Secretary to prepare students for associate's or
19 bachelor's degree programs in health professions or
20 bachelor's degree programs in health professions-re-
21 lated majors; and

22 (2) to increase the interest of secondary school
23 students in applying to, and enrolling in, accredited
24 associate's or bachelor's degree programs in health
25 professions or bachelor's degree programs in health
26 professions-related majors, including through—

1 (A) work-study programs;

2 (B) programs to increase awareness of ca-
3 reers in health professions; and

4 (C) other activities to increase such inter-
5 est.

6 (c) ELIGIBILITY.—To be eligible for a grant or con-
7 tract under subsection (b), an entity shall—

8 (1) be a local educational agency; and

9 (2) provide assurances that activities under the
10 grant or contract will be carried out in partnership
11 with an accredited health professions school or pro-
12 gram, public or private nonprofit hospital, or public
13 or private nonprofit entity.

14 (d) PREFERENCE.—In awarding grants and con-
15 tracts under subsection (b), the Secretary shall give pref-
16 erence to entities that have a demonstrated record of at
17 least one of the following:

18 (1) Graduating a high or significantly improved
19 percentage of students who have exhibited mastery
20 in secondary school State science standards.

21 (2) Graduating students from disadvantaged
22 backgrounds, including racial and ethnic minorities
23 who are underrepresented in—

24 (A) associate's or bachelor's degree pro-
25 grams in health professions or bachelor's degree

1 programs in health professions-related majors;
2 or

3 (B) health professions.

4 (e) REPORT.—The Secretary shall submit to the Con-
5 gress an annual report on the program carried out under
6 this section.

7 (f) DEFINITIONS.—In this section:

8 (1) The term “health profession” means the
9 profession of any member of the health workforce,
10 as defined in section 764(i) of the Public Health
11 Service Act, as added by section 2261.

12 (2) The term “local educational agency” has
13 the meaning given to the term in section 9101 of the
14 Elementary and Secondary Education Act of 1965
15 (20 U.S.C. 7801).

16 (3) The term “secondary school”—

17 (A) means a secondary school, as defined
18 in section 9101 of the Elementary and Sec-
19 ondary Education Act of 1965 (20 U.S.C.
20 7801); and

21 (B) includes any such school that is a mid-
22 dle school.

23 (4) The term “Secretary” means the Secretary
24 of Health and Human Services except as otherwise
25 specified.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for each of fiscal years
4 2011 through 2015.

5 **SEC. 2534. COMMUNITY-BASED COLLABORATIVE CARE NET-**
6 **WORKS.**

7 (a) PURPOSE.—The purpose of this subtitle is to es-
8 tablish and provide assistance to community-based col-
9 laborative care networks—

10 (1) to develop or strengthen coordination of
11 services to allow all individuals, including the unin-
12 sured and low-income, to receive efficient and higher
13 quality care and to gain entry into and receive serv-
14 ices from a comprehensive system of care;

15 (2) to develop efficient and sustainable infra-
16 structure for a health care delivery system charac-
17 terized by effective collaboration, information shar-
18 ing, and clinical and financial coordination among
19 providers of care in the community;

20 (3) to develop or strengthen activities related to
21 providing coordinated care for individuals with
22 chronic conditions; and

23 (4) to reduce the use of emergency depart-
24 ments, inpatient and other expensive resources of
25 hospitals and other providers.

1 (b) CREATION OF THE COMMUNITY-BASED COL-
2 LABORATIVE CARE NETWORK PROGRAM.—Part D of title
3 III (42 U.S.C. 254b et seq.), as amended, is further
4 amended by inserting after subpart XII the following new
5 subpart:

6 **“Subpart XIII—Community-Based Collaborative Care**
7 **Network Program**

8 **“SEC. 3400. COMMUNITY-BASED COLLABORATIVE CARE**
9 **NETWORK PROGRAM.**

10 “(a) IN GENERAL.—The Secretary may award grants
11 to eligible entities for the purpose of establishing model
12 projects to accomplish the following goals:

13 “(1) To reduce unnecessary use of items and
14 services furnished in emergency departments of hos-
15 pitals (especially to ensure that individuals without
16 health insurance coverage or with inadequate health
17 insurance coverage do not use the services of such
18 department instead of the services of a primary care
19 provider) through methods such as—

20 “(A) screening individuals who seek emer-
21 gency department services for possible eligibility
22 under relevant governmental health programs
23 or for subsidies under such programs; and

24 “(B) providing such individuals referrals
25 for followup care and chronic condition care.

1 “(2) To manage chronic conditions to reduce
2 their severity, negative health outcomes, and ex-
3 pense.

4 “(3) To encourage health care providers to co-
5 ordinate their efforts so that the most vulnerable pa-
6 tient populations seek and obtain primary care.

7 “(4) To provide more comprehensive and co-
8 ordinated care to vulnerable low-income individuals
9 and individuals without health insurance coverage or
10 with inadequate coverage.

11 “(5) To provide mechanisms for improving both
12 quality and efficiency of care for low-income individ-
13 uals and families, with an emphasis on those most
14 likely to remain uninsured despite the existence of
15 government programs to make health insurance
16 more affordable.

17 “(6) To increase preventive services, including
18 screening and counseling, to those who would other-
19 wise not receive such screening, in order to improve
20 health status and reduce long-term complications
21 and costs.

22 “(7) To ensure the availability of community-
23 wide safety net services, including emergency and
24 trauma care.

25 “(b) ELIGIBILITY AND GRANTEE SELECTION.—

1 “(1) APPLICATION.—A community-based col-
2 laborative care network described in subsection (d)
3 shall submit to the Secretary an application in such
4 form and manner and containing such information
5 as specified by the Secretary. Such information shall
6 at least—

7 “(A) identify the health care providers par-
8 ticipating in the community-based collaborative
9 care network proposed by the applicant and, if
10 a provider designated in paragraph (d)(1)(B) is
11 not included, the reason such provider is not so
12 included;

13 “(B) include a description of how the pro-
14 viders plan to collaborate to provide comprehen-
15 sive and integrated care for low-income individ-
16 uals, including uninsured and underinsured in-
17 dividuals;

18 “(C) include a description of the organiza-
19 tional and joint governance structure of the
20 community-based collaborative care network in
21 a manner so that it is clear how decisions will
22 be made, and how the decisionmaking process
23 of the network will include appropriate rep-
24 resentation of the participating entities;

1 “(D) define the geographic areas and pop-
2 ulations that the network intends to serve;

3 “(E) define the scope of services that the
4 network intends to provide and identify any
5 reasons why such services would not include a
6 suggested core service identified by the Sec-
7 retary under paragraph (3);

8 “(F) demonstrate the network’s ability to
9 meet the requirements of this section; and

10 “(G) provide assurances that grant funds
11 received shall be used to support the entire
12 community-based collaborative care network.

13 “(2) SELECTION OF GRANTEES.—

14 “(A) IN GENERAL.—The Secretary shall
15 select community-based collaborative care net-
16 works to receive grants from applications sub-
17 mitted under paragraph (1) on the basis of
18 quality of the proposal involved, geographic di-
19 versity (including different States and regions
20 served and urban and rural diversity), and the
21 number of low-income and uninsured individ-
22 uals that the proposal intends to serve.

23 “(B) PRIORITY.—The Secretary shall give
24 priority to proposals from community-based col-
25 laborative care networks that—

1 “(i) include the capability to provide
2 the broadest range of services to low-in-
3 come individuals; and

4 “(ii) include providers that currently
5 serve a high volume of low-income individ-
6 uals.

7 “(C) RENEWAL.—In subsequent years,
8 based on the performance of grantees, the Sec-
9 retary may provide renewal grants to prior year
10 grant recipients.

11 “(3) SUGGESTED CORE SERVICES.—For pur-
12 poses of paragraph (1)(E), the Secretary shall de-
13 velop a list of suggested core patient and core net-
14 work services to be provided by a community-based
15 collaborative care network. The Secretary may select
16 a community-based collaborative care network under
17 paragraph (2), the application of which does not in-
18 clude all such services, if such application provides
19 a reasonable explanation why such services are not
20 proposed to be included, and the Secretary deter-
21 mines that the application is otherwise high quality.

22 “(4) TERMINATION AUTHORITY.—The Sec-
23 retary may terminate selection of a community-
24 based collaborative care network under this section

1 for good cause. Such good cause shall include a de-
2 termination that the network—

3 “(A) has failed to provide a comprehensive
4 range of coordinated and integrated health care
5 services as required under subsection (d)(2);

6 “(B) has failed to meet reasonable quality
7 standards;

8 “(C) has misappropriated funds provided
9 under this section; or

10 “(D) has failed to make progress toward
11 accomplishing goals set out in subsection (a).

12 “(c) USE OF FUNDS.—

13 “(1) USE BY GRANTEES.—Grant funds are pro-
14 vided to community-based collaborative care net-
15 works to carry out the following activities:

16 “(A) Assist low-income individuals without
17 adequate health care coverage to—

18 “(i) access and appropriately use
19 health services;

20 “(ii) enroll in applicable public or pri-
21 vate health insurance programs;

22 “(iii) obtain referrals to and see a pri-
23 mary care provider in case such an indi-
24 vidual does not have a primary care pro-
25 vider; and

1 “(iv) obtain appropriate care for
2 chronic conditions.

3 “(B) Improve health care by providing case
4 management, application assistance, and appro-
5 priate referrals such as through methods to—

6 “(i) create and meaningfully use a
7 health information technology network to
8 track patients across collaborative pro-
9 viders;

10 “(ii) perform health outreach, such as
11 by using neighborhood health workers who
12 may inform individuals about the avail-
13 ability of safety net and primary care pro-
14 viders available through the community-
15 based collaborative care network;

16 “(iii) provide for followup outreach to
17 remind patients of appointments or follow-
18 up care instructions;

19 “(iv) provide transportation to individ-
20 uals to and from the site of care;

21 “(v) expand the capacity to provide
22 care at any provider participating in the
23 community-based collaborative care net-
24 work, including telehealth, hiring new clin-
25 ical or administrative staff, providing ac-

1 cess to services after-hours, on weekends,
2 or otherwise providing an urgent care al-
3 ternative to an emergency department; and

4 “(vi) provide a primary care provider
5 or medical home for each network patient.

6 “(C) Provide direct patient care services as
7 described in their application and approved by
8 the Secretary.

9 “(2) GRANT FUNDS TO HRSA GRANTEES.—The
10 Secretary may limit the percent of grant funding
11 that may be spent on direct care services provided
12 by grantees of programs administered by the Health
13 Resources and Services Administration (in this sec-
14 tion referred to as ‘HRSA’) or impose other require-
15 ments on HRSA grantees participating in a commu-
16 nity-based collaborative care network as may be nec-
17 essary for consistency with the requirements of such
18 programs.

19 “(3) RESERVATION OF FUNDS FOR NATIONAL
20 PROGRAM PURPOSES.—The Secretary may use not
21 more than 7 percent of funds appropriated to carry
22 out this section for providing technical assistance to
23 grantees, obtaining assistance of experts and con-
24 sultants, holding meetings, developing of tools, dis-
25 seminating of information, and evaluation.

1 “(d) COMMUNITY-BASED COLLABORATIVE CARE
2 NETWORKS.—

3 “(1) IN GENERAL.—

4 “(A) DESCRIPTION.—A community-based
5 collaborative care network described in this sub-
6 section is a consortium of health care providers
7 with a joint governance structure that provides
8 a comprehensive range of coordinated and inte-
9 grated health care services for low-income pa-
10 tient populations or medically underserved com-
11 munities (whether or not such individuals re-
12 ceive benefits under title XVIII, XIX, or XXI
13 of the Social Security Act, private or other
14 health insurance or are uninsured or under-
15 insured) and that complies with any applicable
16 minimum eligibility requirements that the Sec-
17 retary may determine appropriate.

18 “(B) REQUIRED INCLUSION.—Each such
19 network shall include the following providers
20 that serve the community (unless such provider
21 does not exist within the community, declines or
22 refuses to participate, or places unreasonable
23 conditions on their participation)—

24 “(i) A safety net hospital that pro-
25 vides services to a high volume of low-in-

1 come patients, as demonstrated by meeting
2 the criteria in section 1923(b)(1) of the
3 Social Security Act, or other similar cri-
4 teria determined by the Secretary; and

5 “(ii) All Federally qualified health
6 centers (as defined in section 1861(aa) of
7 the Social Security Act (42 U.S.C.
8 1395x(aa))) located in the geographic area
9 served by the Coordinated Care Network;

10 “(C) ADDITIONAL INCLUSIONS.—Each
11 such network may include any of the following
12 additional providers:

13 “(i) A hospital, including a critical ac-
14 cess hospital (as defined in section
15 1820(c)(2) of the Social Security Act (42
16 U.S.C. 1395i-4(c)(2))).

17 “(ii) A county or municipal depart-
18 ment of health.

19 “(iii) A rural health clinic or a rural
20 health network (as defined in sections
21 1861(aa) and 1820(d) of the Social Secu-
22 rity Act, respectively (42 U.S.C.
23 1395x(aa), 1395i-4(d))).

1 “(iv) A community clinic, including a
2 mental health clinic, substance abuse clin-
3 ic, or a reproductive health clinic.

4 “(v) A health center controlled net-
5 work as defined by section 330(e)(1)(C) of
6 the Public Health Service Act

7 “(vi) A private practice physician or
8 group practice.

9 “(vii) A nurse or physician assistant
10 or group practice.

11 “(viii) An adult day care center.

12 “(ix) A home health provider.

13 “(x) Any other type of provider speci-
14 fied by the Secretary, which has a desire to
15 serve low-income and uninsured patients.

16 “(D) CONSTRUCTION.—

17 “(i) Nothing in this section shall pro-
18 hibit a single entity from qualifying as
19 community-based collaborative care net-
20 work so long as such single entity meets
21 the criteria of a community-based collabo-
22 rative care network. If the network does
23 not include the providers referenced in
24 clauses (i) and (ii) of subparagraph (B) of
25 this paragraph, the application must ex-

1 plain the reason pursuant to subsection
2 (b)(1)(A).

3 “(ii) Participation in a community-
4 based collaborative care network shall not
5 affect Federally qualified health centers’
6 obligation to comply with the governance
7 requirements under section 330 of the
8 Public Health Service Act (42 U.S.C.
9 254b).

10 “(iii) Federally qualified health cen-
11 ters participating in a community-based
12 collaborative care network may not be re-
13 quired to provide services beyond their
14 Federal Health Center scope of project ap-
15 proved by HRSA.

16 “(iv) Nothing in this section shall be
17 construed to expand medical malpractice li-
18 ability protection under the Federal Tort
19 Claims Act for Section 330-funded Feder-
20 ally qualified health centers.

21 “(2) COMPREHENSIVE RANGE OF COORDINATED
22 AND INTEGRATED HEALTH CARE SERVICES.—The
23 Secretary shall define criteria for evaluating whether
24 the services offered by a community-based collabo-
25 rative care network qualify as a comprehensive range

1 of coordinated and integrated health care services.
2 Such criteria may vary based on the needs of the ge-
3 ographic areas and populations to be served by the
4 network and may include the following:

5 “(A) Requiring community-based collabo-
6 rative care networks to include at least the sug-
7 gested core services identified under subsection
8 (b)(3), or whichever subset of the suggested
9 core services is applicable to a particular net-
10 work.

11 “(B) Requiring such networks to assign
12 each patient of the network to a primary care
13 provider responsible for managing that patient’s
14 care.

15 “(C) Requiring the services provided by a
16 community-based collaborative care network to
17 include support services appropriate to meet the
18 health needs of low-income populations in the
19 network’s community, which may include chron-
20 ic care management, nutritional counseling,
21 transportation, language services, enrollment
22 counselors, social services and other services as
23 proposed by the network.

24 “(D) Providing that the services provided
25 by a community-based collaborative care net-

1 work may also include long-term care services
2 and other services not specified in this sub-
3 section.

4 “(E) Providing for the approval by the
5 Secretary of a scope of community-based col-
6 laborative care network services for each net-
7 work that addresses an appropriate minimum
8 scope of work consistent with the setting of the
9 network and the health professionals available
10 in the community the network serves.

11 “(3) CLARIFICATION.—Participation in a com-
12 munity-based collaborative care network shall not
13 disqualify a health care provider from reimburse-
14 ment under title XVIII, XIX, or XXI of the Social
15 Security Act with respect to services otherwise reim-
16 bursable under such title. Nothing in this section
17 shall prevent a community-based collaborative care
18 network that is otherwise eligible to contract with
19 Medicare, a private health insurer, or any other ap-
20 propriate entity to provide care under Medicare,
21 under health insurance coverage offered by the in-
22 surer, or otherwise.

23 “(e) EVALUATIONS.—

24 “(1) GRANTEE REPORTS.—Beginning in the
25 third year following an initial grant, each commu-

1 nity-based collaborative care network shall submit to
2 the Secretary, with respect to each year the grantee
3 has received a grant, an evaluation on the activities
4 carried out by the community-based collaborative
5 care network under the community-based collabo-
6 rative care network program and shall include—

7 “(A) the number of people served;

8 “(B) the most common health problems
9 treated;

10 “(C) any reductions in emergency depart-
11 ment use;

12 “(D) any improvements in access to pri-
13 mary care;

14 “(E) an accounting of how amounts re-
15 ceived were used, including identification of
16 amounts used for patient care services as may
17 be required for HRSA grantees; and

18 “(F) to the extent requested by the Sec-
19 retary, any quality measures or any other meas-
20 ures specified by the Secretary.

21 “(2) PROGRAM REPORTS.—The Secretary shall
22 submit to Congress an annual evaluation (beginning
23 not later than 6 months after the first reports under
24 paragraph (1) are submitted) on the extent to which
25 emergency department use was reduced as a result

1 of the activities carried out by the community-based
2 collaborative care network under the program. Each
3 such evaluation shall also include information on—

4 “(A) the prevalence of certain chronic con-
5 ditions in various populations, including a com-
6 parison of such prevalence in the general popu-
7 lation versus in the population of individuals
8 with inadequate health insurance coverage;

9 “(B) demographic characteristics of the
10 population of uninsured and underinsured indi-
11 viduals served by the community-based collabo-
12 rative care network involved; and

13 “(C) the conditions of such individuals for
14 whom services were requested at such emer-
15 gency departments of participating hospitals.

16 “(3) AUDIT AUTHORITY.—The Secretary may
17 conduct periodic audits and request periodic spend-
18 ing reports of community-based collaborative care
19 networks under the community-based collaborative
20 care network program.

21 “(f) CLARIFICATION.—Nothing in this section re-
22 quires a provider to report individually identifiable infor-
23 mation of an individual to government agencies, unless the
24 individual consents, consistent with HIPAA privacy and
25 security law, as defined in section 3009(a)(2).

1 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2011 through 2015.”.

5 **SEC. 2535. COMMUNITY-BASED OVERWEIGHT AND OBESITY**
6 **PREVENTION PROGRAM.**

7 Part Q of title III (42 U.S.C. 280h et seq.) is amend-
8 ed by inserting after section 399W the following:

9 **“SEC. 399W-1. COMMUNITY-BASED OVERWEIGHT AND OBE-**
10 **SITY PREVENTION PROGRAM.**

11 “(a) PROGRAM.—The Secretary shall establish a
12 community-based overweight and obesity prevention pro-
13 gram consisting of awarding grants and contracts under
14 subsection (b).

15 “(b) GRANTS.—The Secretary shall award grants to,
16 or enter into contracts with, eligible entities—

17 “(1) to plan evidence-based programs for the
18 prevention of overweight and obesity among children
19 and their families through improved nutrition and
20 increased physical activity; or

21 “(2) to implement such programs.

22 “(c) ELIGIBILITY.—To be eligible for a grant or con-
23 tract under subsection (b), an entity shall be a community
24 partnership that demonstrates community support and in-
25 cludes—

1 “(1) a broad cross section of stakeholders, such
2 as—

3 “(A) hospitals, health care systems, com-
4 munity health centers, or other health care pro-
5 viders;

6 “(B) universities, local educational agen-
7 cies, or childcare providers;

8 “(C) State, local, and tribal health depart-
9 ments;

10 “(D) State, local, and tribal park and
11 recreation departments;

12 “(E) employers; and

13 “(F) health insurance companies;

14 “(2) residents of the community; and

15 “(3) representatives of public and private enti-
16 ties that have a history of working within and serv-
17 ing the community.

18 “(d) PERIOD OF AWARDS.—

19 “(1) IN GENERAL.—The period of a grant or
20 contract under this section shall be 5 years, subject
21 to renewal under paragraph (2).

22 “(2) RENEWAL.—At the end of each fiscal year,
23 the Secretary may renew a grant or contract award
24 under this section only if the grant or contract re-
25 cipient demonstrates to the Secretary’s satisfaction

1 that the recipient has made appropriate, measurable
2 progress in preventing overweight and obesity.

3 “(e) REQUIREMENTS.—

4 “(1) IN GENERAL.—The Secretary may award
5 a grant or contract under this section to an entity
6 only if the entity demonstrates to the Secretary’s
7 satisfaction that—

8 “(A) not later than 90 days after receiving
9 the grant or contract, the entity will establish
10 a steering committee to provide input on the as-
11 sessment of, and recommendations on improve-
12 ments to, the entity’s program funded through
13 the grant or contract; and

14 “(B) the entity has conducted or will con-
15 duct an assessment of the overweight and obe-
16 sity problem in its community, including the ex-
17 tent of the problem and factors contributing to
18 the problem.

19 “(2) MATCHING REQUIREMENT.—The Sec-
20 retary may award a grant or contract to an eligible
21 entity under this section only if the entity agrees to
22 provide, from non-Federal sources, an amount equal
23 to \$1 (in cash or in kind) for each \$9 provided
24 through the grant or contract to carry out the activi-
25 ties supported by the grant or contract.

1 “(3) PAYOR OF LAST RESORT.—The Secretary
2 may award a grant or contract under this section to
3 an entity only if the entity demonstrates to the satis-
4 faction of the Secretary that funds received through
5 the grant or contract will not be expended for any
6 activity to the extent that payment has been made,
7 or can reasonably be expected to be made—

8 “(A) under any insurance policy;

9 “(B) under any Federal or State health
10 benefits program (including titles XIX and XXI
11 of the Social Security Act); or

12 “(C) by an entity which provides health
13 services on a prepaid basis.

14 “(4) MAINTENANCE OF EFFORT.—The Sec-
15 retary may award a grant or contract under this sec-
16 tion to an entity only if the entity demonstrates to
17 the satisfaction of the Secretary that—

18 “(A) funds received through the grant or
19 contract will be expended only to supplement,
20 and not supplant, non-Federal and Federal
21 funds otherwise available to the entity for the
22 activities to be funded through the grant or
23 contract; and

24 “(B) with respect to such activities, the en-
25 tity will maintain expenditures of non-Federal

1 amounts for such activities at a level not less
2 than the lesser of such expenditures maintained
3 by the entity for the fiscal year preceding the
4 fiscal year for which the entity receives the
5 grant or contract.

6 “(f) PREFERENCES.—In awarding grants and con-
7 tracts under this section, the Secretary shall give pref-
8 erence to eligible entities that—

9 “(1) will serve communities with high levels of
10 overweight and obesity and related chronic diseases;
11 or

12 “(2) will plan or implement activities for the
13 prevention of overweight and obesity in school or
14 workplace settings.

15 “(g) REPORT.—The Secretary shall submit to the
16 Congress an annual report on the program of grants and
17 contracts awarded under this section.

18 “(h) DEFINITIONS.—In this section:

19 “(1) The term ‘evidence-based’ means that
20 methodologically sound research has demonstrated a
21 beneficial health effect in the judgment of the Sec-
22 retary and includes the Ways to Enhance Children’s
23 Activity and Nutrition (We Can) program and cur-
24 riculum of the National Institutes of Health.

1 “(2) The term ‘local educational agency’ has
2 the meaning given to the term in section 9101 of the
3 Elementary and Secondary Education Act of 1965.

4 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are authorized to be appro-
6 priated \$10,000,000 for fiscal year 2011 and such sums
7 as may be necessary for each of fiscal years 2012 through
8 2015.”.

9 **SEC. 2536. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.**

10 (a) DEMONSTRATION GRANTS.—

11 (1) IN GENERAL.—The Secretary of Education,
12 in consultation with the Secretary of Health and
13 Human Services and the Director of the Centers for
14 Disease Control and Prevention, may make dem-
15 onstration grants to eligible local educational agen-
16 cies for the purpose of reducing the student-to-
17 school nurse ratio in public elementary and sec-
18 ondary schools.

19 (2) SPECIAL CONSIDERATION.—In awarding
20 grants under this section, the Secretary of Edu-
21 cation shall give special consideration to applications
22 submitted by high-need local educational agencies
23 that demonstrate the greatest need for new or addi-
24 tional nursing services among children in the public
25 elementary and secondary schools served by the

1 agency, in part by providing information on current
2 ratios of students to school nurses.

3 (3) MATCHING FUNDS.—The Secretary of Edu-
4 cation may require recipients of grants under this
5 subsection to provide matching funds from non-Fed-
6 eral sources, and shall permit the recipients to
7 match funds in whole or in part with in-kind con-
8 tributions.

9 (b) REPORT.—Not later than 24 months after the
10 date on which assistance is first made available to local
11 educational agencies under this section, the Secretary of
12 Education shall submit to the Congress a report on the
13 results of the demonstration grant program carried out
14 under this section, including an evaluation of the effective-
15 ness of the program in improving the student-to-school
16 nurse ratios described in subsection (a) and an evaluation
17 of the impact of any resulting enhanced health of students
18 on learning.

19 (c) DEFINITIONS.—For purposes of this section:

20 (1) The terms “elementary school”, “local edu-
21 cational agency”, and “secondary school” have the
22 meanings given to those terms in section 9101 of the
23 Elementary and Secondary Education Act of 1965
24 (20 U.S.C. 7801).

1 (2) The term “eligible local educational agency”
2 means a local educational agency in which the stu-
3 dent-to-school nurse ratio in the public elementary
4 and secondary schools served by the agency is 750
5 or more students to every school nurse.

6 (3) The term “high-need local educational agen-
7 cy” means a local educational agency—

8 (A) that serves not fewer than 10,000 chil-
9 dren from families with incomes below the pov-
10 erty line; or

11 (B) for which not less than 20 percent of
12 the children served by the agency are from fam-
13 ilies with incomes below the poverty line.

14 (4) The term “nurse” means a licensed nurse,
15 as defined under State law.

16 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there are authorized to be appropriated
18 such sums as may be necessary for each of fiscal years
19 2011 through 2015.

20 **SEC. 2537. MEDICAL-LEGAL PARTNERSHIPS.**

21 (a) IN GENERAL.—The Secretary shall establish a
22 nationwide demonstration project consisting of—

23 (1) awarding grants to, and entering into con-
24 tracts with, medical-legal partnerships to assist pa-

1 tients and their families to navigate health-related
2 programs and activities; and

3 (2) evaluating the effectiveness of such partner-
4 ships.

5 (b) USE OF FUNDS.—Amounts received as a grant
6 or contract under this section shall be used to assist pa-
7 tients and their families to navigate health care-related
8 programs and activities and thereby achieve one or more
9 of the following goals:

10 (1) Enhancing access to health care services.

11 (2) Improving health outcomes for low-income
12 individuals.

13 (3) Reducing health disparities.

14 (4) Enhancing wellness and prevention of
15 chronic conditions.

16 (c) PROHIBITION.—No funds under this section may
17 be used—

18 (1) for any medical malpractice or other civil
19 action or proceeding; or

20 (2) to assist individuals who are not lawfully
21 present in the United States.

22 (d) REPORT.—Not later than 5 years after the date
23 of the enactment of this Act, the Secretary shall submit
24 a report to the Congress on the results of the demonstra-

1 tion project under this section. Such report shall include
2 the following:

3 (1) A description of the extent to which med-
4 ical-legal partnerships funded through this section
5 achieved the goals described in subsection (b).

6 (2) Recommendations on the possibility of ex-
7 tending or expanding the demonstration project.

8 (e) DEFINITIONS.—In this section:

9 (1) The term “health disparities” has the
10 meaning given to the term in section 3171 of the
11 Public Health Service Act, as added by section
12 2301.

13 (2) The term “medical-legal partnership”
14 means an entity—

15 (A) that is a collaboration between—

16 (i) a community health center, public
17 hospital, children’s hospital, or other pro-
18 vider of health care services to a signifi-
19 cant number of low-income beneficiaries;
20 and

21 (ii) one or more attorneys; and

22 (B) whose primary mission is to assist pa-
23 tients and their families navigate health care-re-
24 lated programs and activities.

1 (3) The term “Secretary” means the Secretary
2 of Health and Human Services.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 such sums as may be necessary for each of fiscal years
6 2011 through 2015.

7 **PART 3—EMERGENCY CARE-RELATED**
8 **PROGRAMS**

9 **SEC. 2551. TRAUMA CARE CENTERS.**

10 (a) GRANTS FOR TRAUMA CARE CENTERS.—Section
11 1241 (42 U.S.C. 300d–41) is amended to read as follows:

12 **“SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.**

13 “(a) IN GENERAL.—The Secretary shall establish a
14 trauma center program consisting of awarding grants
15 under section (b).

16 “(b) GRANTS.—The Secretary shall award grants as
17 follows:

18 “(1) EXISTING CENTERS.—Grants to public,
19 private nonprofit, Indian Health Service, Indian
20 tribal, and urban Indian trauma centers—

21 “(A) to further the core missions of such
22 centers; or

23 “(B) to provide emergency relief to ensure
24 the continued and future availability of trauma
25 services by trauma centers—

1 “(i) at risk of closing or operating in
2 an area where a closing has occurred with-
3 in their primary service area; or

4 “(ii) in need of financial assistance
5 following a natural disaster or other cata-
6 strophic event, such as a terrorist attack.

7 “(2) NEW CENTERS.—Grants to local govern-
8 ments and public or private nonprofit entities to es-
9 tablish new trauma centers in urban areas with a
10 substantial degree of trauma resulting from violent
11 crimes.

12 “(c) MINIMUM QUALIFICATIONS OF TRAUMA CEN-
13 TERS.—

14 “(1) PARTICIPATION IN TRAUMA CARE SYSTEM
15 OPERATING UNDER CERTAIN PROFESSIONAL GUIDE-
16 LINES.—

17 “(A) LIMITATION.—Subject to subpara-
18 graph (B), the Secretary may not award a
19 grant to an existing trauma center under this
20 section unless the center is a participant in a
21 trauma care system that substantially complies
22 with section 1213.

23 “(B) EXEMPTION.—Subparagraph (A)
24 shall not apply to trauma centers that are lo-

1 cated in States with no existing trauma care
2 system.

3 “(2) DESIGNATION.—The Secretary may not
4 award a grant under this section to an existing trauma
5 center unless the center is—

6 “(A) verified as a trauma center by the
7 American College of Surgeons; or

8 “(B) designated as a trauma center by the
9 applicable State health or emergency medical
10 services authority.”.

11 (b) CONSIDERATIONS IN MAKING GRANTS.—Section
12 1242 (42 U.S.C. 300d–42) is amended to read as follows:

13 **“SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.**

14 **“(a) CORE MISSION AWARDS.—**

15 **“(1) IN GENERAL.—**In awarding grants under
16 section 1241(b)(1)(A), the Secretary shall—

17 **“(A) reserve a minimum of 25 percent of**
18 **the amount allocated for such grants for level**
19 **III and level IV trauma centers in rural or un-**
20 **derserved areas;**

21 **“(B) reserve a minimum of 25 percent of**
22 **the amount allocated for such grants for level**
23 **I and level II trauma centers in urban areas;**
24 **and**

1 “(C) give preference to any application
2 made by a trauma center—

3 “(i) in a geographic area where
4 growth in demand for trauma services ex-
5 ceeds capacity;

6 “(ii) that demonstrates the financial
7 support of the State or political subdivision
8 involved;

9 “(iii) that has at least 1 graduate
10 medical education fellowship in trauma or
11 trauma-related specialties, including neuro-
12 logical surgery, surgical critical care, vas-
13 cular surgery, and spinal cord injury, for
14 which demand is exceeding supply; or

15 “(iv) that demonstrates a substantial
16 commitment to serving vulnerable popu-
17 lations.

18 “(2) FINANCIAL SUPPORT.—For purposes of
19 paragraph (1)(C)(ii), financial support may be dem-
20 onstrated by State or political subdivision funding
21 for the trauma center’s capital or operating expenses
22 (including through State trauma regional advisory
23 coordination activities, Medicaid funding designated
24 for trauma services, or other governmental funding).
25 State funding derived from Federal support shall

1 not constitute State or local financial support for
2 purposes of preferential treatment under this sub-
3 section.

4 “(3) USE OF FUNDS.—The recipient of a grant
5 under section 1241(b)(1)(A) shall carry out, con-
6 sistent with furthering the core missions of the cen-
7 ter, one or more of the following activities:

8 “(A) Providing 24-hour-a-day, 7-day-a-
9 week trauma care availability.

10 “(B) Reducing overcrowding related to
11 throughput of trauma patients.

12 “(C) Enhancing trauma surge capacity.

13 “(D) Ensuring physician and essential per-
14 sonnel availability.

15 “(E) Trauma education and outreach.

16 “(F) Coordination with local and regional
17 trauma care systems.

18 “(G) Such other activities as the Secretary
19 may deem appropriate.

20 “(b) EMERGENCY AWARDS; NEW CENTERS.—In
21 awarding grants under paragraphs (1)(B) and (2) of sec-
22 tion 1241(b), the Secretary shall—

23 “(1) give preference to any application sub-
24 mitted by an applicant that demonstrates the finan-
25 cial support (in accordance with subsection (a)(2))

1 of the State or political subdivision involved for the
2 activities to be funded through the grant for each
3 fiscal year during which payments are made to the
4 center under the grant; and

5 “(2) give preference to any application sub-
6 mitted for a trauma center that—

7 “(A) is providing or will provide trauma
8 care in a geographic area in which the avail-
9 ability of trauma care has either significantly
10 decreased as a result of a trauma center in the
11 area permanently ceasing participation in a sys-
12 tem described in section 1241(c)(1) as of a date
13 occurring during the 2-year period preceding
14 the fiscal year for which the trauma center is
15 applying to receive a grant, or in geographic
16 areas where growth in demand for trauma serv-
17 ices exceeds capacity;

18 “(B) will, in providing trauma care during
19 the 1-year period beginning on the date on
20 which the application for the grant is sub-
21 mitted, incur substantial uncompensated care
22 costs in an amount that renders the center un-
23 able to continue participation in such system
24 and results in a significant decrease in the

1 availability of trauma care in the geographic
2 area;

3 “(C) operates or will operate in rural areas
4 where trauma care availability will significantly
5 decrease if the center is forced to close or down-
6 grade service and substantial costs are contrib-
7 uting to a likelihood of such closure or
8 downgradation;

9 “(D) is in a geographic location substan-
10 tially affected by a natural disaster or other
11 catastrophic event such as a terrorist attack; or

12 “(E) will establish a new trauma service in
13 an urban area with a substantial degree of
14 trauma resulting from violent crimes.

15 “(c) DESIGNATIONS OF LEVELS OF TRAUMA CEN-
16 TERS IN CERTAIN STATES.—In the case of a State which
17 has not designated 4 levels of trauma centers, any ref-
18 erence in this section to—

19 “(1) a level I or level II trauma center is
20 deemed to be a reference to a trauma center within
21 the highest 2 levels of trauma centers designated
22 under State guidelines; and

23 “(2) a level III or IV trauma center is deemed
24 to be a reference to a trauma center not within such
25 highest 2 levels.”.

1 (c) CERTAIN AGREEMENTS.—Section 1243 (42
2 U.S.C. 300d–43) is amended to read as follows:

3 **“SEC. 1243. CERTAIN AGREEMENTS.**

4 “(a) COMMITMENT REGARDING CONTINUED PAR-
5 TICIPATION IN TRAUMA CARE SYSTEM.—The Secretary
6 may not award a grant to an applicant under section
7 1241(b) unless the applicant agrees that—

8 “(1) the trauma center involved will continue
9 participation, or in the case of a new center will par-
10 ticipate, in the system described in section
11 1241(c)(1), except as provided in section
12 1241(c)(1)(B), throughout the grant period begin-
13 ning on the date that the center first receives pay-
14 ments under the grant; and

15 “(2) if the agreement made pursuant to para-
16 graph (1) is violated by the center, the center will
17 be liable to the United States for an amount equal
18 to the sum of—

19 “(A) the amount of assistance provided to
20 the center under section 1241; and

21 “(B) an amount representing interest on
22 the amount specified in subparagraph (A).

23 “(b) MAINTENANCE OF FINANCIAL SUPPORT.—With
24 respect to activities for which funds awarded through a
25 grant under section 1241 are authorized to be expended,

1 the Secretary may not award such a grant unless the ap-
2 plicant agrees that, during the period in which the trauma
3 center involved is receiving payments under the grant, the
4 center will maintain access to trauma services at levels not
5 less than the levels for the prior year, taking into ac-
6 count—

7 “(1) reasonable volume fluctuation that is not
8 caused by intentional trauma boundary reduction;

9 “(2) downgrading of the level of services; and

10 “(3) whether such center diverts its incoming
11 patients away from such center 5 percent or more
12 of the time during which the center is in operation
13 over the course of the year.

14 “(c) TRAUMA CARE REGISTRY.—The Secretary may
15 not award a grant to a trauma center under section
16 1241(b)(1) unless the center agrees that—

17 “(1) not later than 6 months after the date on
18 which the center submits a grant application to the
19 Secretary, the center will establish and operate a
20 registry of trauma cases in accordance with guide-
21 lines developed by the American College of Surgeons;
22 and

23 “(2) in carrying out paragraph (1), the center
24 will maintain information on the number of trauma
25 cases treated by the center and, for each such case,

1 the extent to which the center incurs uncompensated
2 costs in providing trauma care.”.

3 (d) GENERAL PROVISIONS.—Section 1244 (42
4 U.S.C. 300d–44) is amended to read as follows:

5 **“SEC. 1244. GENERAL PROVISIONS.**

6 “(a) LIMITATION ON DURATION OF SUPPORT.—The
7 period during which a trauma center receives payments
8 under a grant under section 1241(b)(1) shall be for 3 fis-
9 cal years, except that the Secretary may waive such re-
10 quirement for the center and authorize the center to re-
11 ceive such payments for 1 additional fiscal year.

12 “(b) ELIGIBILITY.—The acquisition of, or eligibility
13 for, a grant under section 1241(b) shall not preclude a
14 trauma center’s eligibility for another grant described in
15 such section.

16 “(c) FUNDING DISTRIBUTION.—Of the total amount
17 appropriated for a fiscal year under section 1245—

18 “(1) 90 percent shall be used for grants under
19 paragraph (1)(A) of section 1241(b); and

20 “(2) 10 percent shall be used for grants under
21 paragraphs (1)(B) and (2) of section 1241(b).

22 “(d) REPORT.—Beginning 2 years after the date of
23 the enactment of the Affordable Health Care for America
24 Act, and every 2 years thereafter, the Secretary shall bien-
25 nially—

1 “(1) report to Congress on the status of the
2 grants made pursuant to section 1241;

3 “(2) evaluate and report to Congress on the
4 overall financial stability of trauma centers in the
5 United States;

6 “(3) report on the populations using trauma
7 care centers and include aggregate patient data on
8 income, race, ethnicity, and geography; and

9 “(4) evaluate the effectiveness and efficiency of
10 trauma care center activities using standard public
11 health measures and evaluation methodologies.”.

12 (e) AUTHORIZATION OF APPROPRIATIONS.—Section
13 1245 (42 U.S.C. 300d–45) is amended to read as follows:

14 **“SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.**

15 “(a) IN GENERAL.—For the purpose of carrying out
16 this part, there are authorized to be appropriated
17 \$100,000,000 for fiscal year 2011, and such sums as may
18 be necessary for each of fiscal years 2012 through 2015.

19 Such authorization of appropriations is in addition to any
20 other authorization of appropriations or amounts that are
21 available for such purpose.

22 “(b) REALLOCATION.—The Secretary shall reallocate
23 for grants under section 1241(b)(1)(A) any funds appro-
24 priated for grants under paragraph (1)(B) or (2) of sec-

1 tion 1241(b), but not obligated due to insufficient applica-
2 tions eligible for funding.”.

3 **SEC. 2552. EMERGENCY CARE COORDINATION.**

4 (a) IN GENERAL.—Subtitle B of title XXVIII (42
5 U.S.C. 300hh–10 et seq.) is amended by adding at the
6 end the following:

7 **“SEC. 2816. EMERGENCY CARE COORDINATION.**

8 “(a) EMERGENCY CARE COORDINATION CENTER.—

9 “(1) ESTABLISHMENT.—The Secretary shall es-
10 tablish, within the Office of the Assistant Secretary
11 for Preparedness and Response, an Emergency Care
12 Coordination Center (in this section referred to as
13 the ‘Center’), to be headed by a director.

14 “(2) DUTIES.—The Secretary, acting through
15 the Director of the Center, in coordination with the
16 Federal Interagency Committee on Emergency Med-
17 ical Services, shall—

18 “(A) promote and fund research in emer-
19 gency medicine and trauma health care;

20 “(B) promote regional partnerships and
21 more effective emergency medical systems in
22 order to enhance appropriate triage, distribu-
23 tion, and care of routine community patients;
24 and

1 “(C) promote local, regional, and State
2 emergency medical systems’ preparedness for
3 and response to public health events.

4 “(b) COUNCIL OF EMERGENCY CARE.—

5 “(1) ESTABLISHMENT.—The Secretary, acting
6 through the Director of the Center, shall establish a
7 Council of Emergency Care to provide advice and
8 recommendations to the Director on carrying out
9 this section.

10 “(2) COMPOSITION.—The Council shall be com-
11 prised of employees of the departments and agencies
12 of the Federal Government who are experts in emer-
13 gency care and management.

14 “(c) REPORT.—

15 “(1) SUBMISSION.—Not later than 12 months
16 after the date of the enactment of the Affordable
17 Health Care for America Act, the Secretary shall
18 submit to the Congress an annual report on the ac-
19 tivities carried out under this section.

20 “(2) CONSIDERATIONS.—In preparing a report
21 under paragraph (1), the Secretary shall consider
22 factors including—

23 “(A) emergency department crowding and
24 boarding; and

25 “(B) delays in care following presentation.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are authorized to be appro-
3 priated such sums as may be necessary for each of fiscal
4 years 2011 through 2015.”.

5 (b) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES,
6 AND ADMINISTRATIVE ACTIONS.—All functions, per-
7 sonnel, assets, and liabilities of, and administrative actions
8 applicable to, the Emergency Care Coordination Center,
9 as in existence on the day before the date of the enactment
10 of this Act, shall be transferred to the Emergency Care
11 Coordination Center established under section 2816(a) of
12 the Public Health Service Act, as added by subsection (a).

13 **SEC. 2553. PILOT PROGRAMS TO IMPROVE EMERGENCY**
14 **MEDICAL CARE.**

15 Part B of title III (42 U.S.C. 243 et seq.) is amended
16 by inserting after section 314 the following:

17 **“SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR**
18 **EMERGENCY CARE RESPONSE.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Assistant Secretary for Preparedness and Response,
21 shall award not fewer than 4 multiyear contracts or com-
22 petitive grants to eligible entities to support demonstration
23 programs that design, implement, and evaluate innovative
24 models of regionalized, comprehensive, and accountable
25 emergency care systems.

1 “(b) ELIGIBLE ENTITY; REGION.—

2 “(1) ELIGIBLE ENTITY.—In this section, the
3 term ‘eligible entity’ means a State or a partnership
4 of 1 or more States and 1 or more local govern-
5 ments.

6 “(2) REGION.—In this section, the term ‘re-
7 gion’ means an area within a State, an area that lies
8 within multiple States, or a similar area (such as a
9 multicounty area), as determined by the Secretary.

10 “(c) DEMONSTRATION PROGRAM.—The Secretary
11 shall award a contract or grant under subsection (a) to
12 an eligible entity that proposes a demonstration program
13 to design, implement, and evaluate an emergency medical
14 system that—

15 “(1) coordinates with public safety services,
16 public health services, emergency medical services,
17 medical facilities, and other entities within a region;

18 “(2) coordinates an approach to emergency
19 medical system access throughout the region, includ-
20 ing 9–1–1 public safety answering points and emer-
21 gency medical dispatch;

22 “(3) includes a mechanism, such as a regional
23 medical direction or transport communications sys-
24 tem, that operates throughout the region to ensure
25 that the correct patient is taken to the medically ap-

1 appropriate facility (whether an initial facility or a
2 higher level facility) in a timely fashion;

3 “(4) allows for the tracking of prehospital and
4 hospital resources, including inpatient bed capacity,
5 emergency department capacity, on-call specialist
6 coverage, ambulance diversion status, and the co-
7 ordination of such tracking with regional commu-
8 nications and hospital destination decisions; and

9 “(5) includes a consistent regionwide
10 prehospital, hospital, and interfacility data manage-
11 ment system that—

12 “(A) complies with the National EMS In-
13 formation System, the National Trauma Data
14 Bank, and others;

15 “(B) reports data to appropriate Federal
16 and State databanks and registries; and

17 “(C) contains information sufficient to
18 evaluate key elements of prehospital care, hos-
19 pital destination decisions, including initial hos-
20 pital and interfacility decisions, and relevant
21 outcomes of hospital care.

22 “(d) APPLICATION.—

23 “(1) IN GENERAL.—An eligible entity that
24 seeks a contract or grant described in subsection (a)
25 shall submit to the Secretary an application at such

1 time and in such manner as the Secretary may re-
2 quire.

3 “(2) APPLICATION INFORMATION.—Each appli-
4 cation shall include—

5 “(A) an assurance from the eligible entity
6 that the proposed system—

7 “(i) has been coordinated with the ap-
8 plicable State office of emergency medical
9 services (or equivalent State office);

10 “(ii) is compatible with the applicable
11 State emergency medical services system;

12 “(iii) includes consistent indirect and
13 direct medical oversight of prehospital,
14 hospital, and interfacility transport
15 throughout the region;

16 “(iv) coordinates prehospital treat-
17 ment and triage, hospital destination, and
18 interfacility transport throughout the re-
19 gion;

20 “(v) includes a categorization or des-
21 ignation system for special medical facili-
22 ties throughout the region that is—

23 “(I) consistent with State laws
24 and regulations; and

1 “(II) integrated with the proto-
2 cols for transport and destination
3 throughout the region; and

4 “(vi) includes a regional medical di-
5 rection system, a patient tracking system,
6 and a resource allocation system that—

7 “(I) support day-to-day emer-
8 gency care system operation;

9 “(II) can manage surge capacity
10 during a major event or disaster; and

11 “(III) are integrated with other
12 components of the national and State
13 emergency preparedness system;

14 “(B) an agreement to make available non-
15 Federal contributions in accordance with sub-
16 section (e); and

17 “(C) such other information as the Sec-
18 retary may require.

19 “(e) MATCHING FUNDS.—

20 “(1) IN GENERAL.—With respect to the costs of
21 the activities to be carried out each year with a con-
22 tract or grant under subsection (a), a condition for
23 the receipt of the contract or grant is that the eligi-
24 ble entity involved agrees to make available (directly
25 or through donations from public or private entities)

1 non-Federal contributions toward such costs in an
2 amount that is not less than 25 percent of such
3 costs.

4 “(2) DETERMINATION OF AMOUNT CONTRIB-
5 UTED.—Non-Federal contributions required in para-
6 graph (1) may be in cash or in kind, fairly evalu-
7 ated, including plant, equipment, or services.
8 Amounts provided by the Federal Government, or
9 services assisted or subsidized to any significant ex-
10 tent by the Federal Government, may not be in-
11 cluded in determining the amount of such non-Fed-
12 eral contributions.

13 “(f) PRIORITY.—The Secretary shall give priority for
14 the award of the contracts or grants described in sub-
15 section (a) to any eligible entity that serves a medically
16 underserved population (as defined in section 330(b)(3)).

17 “(g) REPORT.—Not later than 90 days after the com-
18 pletion of a demonstration program under subsection (a),
19 the recipient of such contract or grant described in such
20 subsection shall submit to the Secretary a report con-
21 taining the results of an evaluation of the program, includ-
22 ing an identification of—

23 “(1) the impact of the regional, accountable
24 emergency care system on patient outcomes for var-

1 ious critical care categories, such as trauma, stroke,
2 cardiac emergencies, and pediatric emergencies;

3 “(2) the system characteristics that contribute
4 to the effectiveness and efficiency of the program (or
5 lack thereof);

6 “(3) methods of assuring the long-term finan-
7 cial sustainability of the emergency care system;

8 “(4) the State and local legislation necessary to
9 implement and to maintain the system; and

10 “(5) the barriers to developing regionalized, ac-
11 countable emergency care systems, as well as the
12 methods to overcome such barriers.

13 “(h) EVALUATION.—The Secretary, acting through
14 the Assistant Secretary for Preparedness and Response,
15 shall enter into a contract with an academic institution
16 or other entity to conduct an independent evaluation of
17 the demonstration programs funded under subsection (a),
18 including an evaluation of—

19 “(1) the performance of the eligible entities re-
20 ceiving the funds; and

21 “(2) the impact of the demonstration programs.

22 “(i) DISSEMINATION OF FINDINGS.—The Secretary
23 shall, as appropriate, disseminate to the public and to the
24 appropriate committees of the Congress, the information
25 contained in a report made under subsection (h).

1 “(j) AUTHORIZATION OF APPROPRIATIONS.—

2 “(1) IN GENERAL.—There is authorized to be
3 appropriated to carry out this section \$12,000,000
4 for each of fiscal years 2011 through 2015.

5 “(2) RESERVATION.—Of the amount appro-
6 priated to carry out this section for a fiscal year, the
7 Secretary shall reserve 3 percent of such amount to
8 carry out subsection (h) (relating to an independent
9 evaluation).”.

10 **SEC. 2554. ASSISTING VETERANS WITH MILITARY EMER-**
11 **GENCY MEDICAL TRAINING TO BECOME**
12 **STATE-LICENSED OR CERTIFIED EMERGENCY**
13 **MEDICAL TECHNICIANS (EMTS).**

14 (a) IN GENERAL.—Part B of title III (42 U.S.C. 243
15 et seq.), as amended, is amended by inserting after section
16 315 the following:

17 **“SEC. 315A. ASSISTING VETERANS WITH MILITARY EMER-**
18 **GENCY MEDICAL TRAINING TO BECOME**
19 **STATE-LICENSED OR CERTIFIED EMERGENCY**
20 **MEDICAL TECHNICIANS (EMTS).**

21 “(a) PROGRAM.—The Secretary shall establish a pro-
22 gram consisting of awarding grants to States to assist vet-
23 erans who received and completed military emergency
24 medical training while serving in the Armed Forces of the
25 United States to become, upon their discharge or release

1 from active duty service, State-licensed or certified emer-
2 gency medical technicians.

3 “(b) USE OF FUNDS.—Amounts received as a grant
4 under this section may be used to assist veterans described
5 in subsection (a) to become State-licensed or certified
6 emergency medical technicians as follows:

7 “(1) Providing training.

8 “(2) Providing reimbursement for costs associ-
9 ated with—

10 “(A) training; or

11 “(B) applying for licensure or certification.

12 “(3) Expediting the licensing or certification
13 process.

14 “(c) ELIGIBILITY.—To be eligible for a grant under
15 this section, a State shall demonstrate to the Secretary’s
16 satisfaction that the State has a shortage of emergency
17 medical technicians.

18 “(d) REPORT.—The Secretary shall submit to the
19 Congress an annual report on the program under this sec-
20 tion.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there are authorized to be appro-
23 priated such sums as may be necessary for each of fiscal
24 years 2011 through 2015.”.

1 (b) GAO STUDY AND REPORT.—The Comptroller
2 General of the United States shall—

3 (1) conduct a study on the barriers experienced
4 by veterans who received training as medical per-
5 sonnel while serving in the Armed Forces of the
6 United States and, upon their discharge or release
7 from active duty service, seek to become licensed or
8 certified in a State as civilian health professionals;
9 and

10 (2) not later than 2 years after the date of the
11 enactment of this Act, submit to the Congress a re-
12 port on the results of such study, including rec-
13 ommendations on whether the program established
14 under section 315A of the Public Health Service
15 Act, as added by subsection (a), should be expanded
16 to assist veterans seeking to become licensed or cer-
17 tified in a State as health providers other than emer-
18 gency medical technicians.

19 **SEC. 2555. DENTAL EMERGENCY RESPONDERS: PUBLIC**
20 **HEALTH AND MEDICAL RESPONSE.**

21 (a) NATIONAL HEALTH SECURITY STRATEGY.—Sec-
22 tion 2802(b)(3) (42 U.S.C. 300hh–1(b)(3)) is amended—

23 (1) in the matter preceding subparagraph (A),
24 by inserting “dental and” before “mental health fa-
25 cilities”; and

1 **PART 4—PAIN CARE AND MANAGEMENT**

2 **PROGRAMS**

3 **SEC. 2561. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.**

4 (a) **CONVENING.**—Not later than June 30, 2011, the
5 Secretary of Health and Human Services shall seek to
6 enter into an agreement with the Institute of Medicine of
7 the National Academies to convene a Conference on Pain
8 (in this section referred to as “the Conference”).

9 (b) **PURPOSES.**—The purposes of the Conference
10 shall be to—

11 (1) increase the recognition of pain as a signifi-
12 cant public health problem in the United States;

13 (2) evaluate the adequacy of assessment, diag-
14 nosis, treatment, and management of acute and
15 chronic pain in the general population, and in identi-
16 fied racial, ethnic, gender, age, and other demo-
17 graphic groups that may be disproportionately af-
18 fected by inadequacies in the assessment, diagnosis,
19 treatment, and management of pain;

20 (3) identify barriers to appropriate pain care,
21 including—

22 (A) lack of understanding and education
23 among employers, patients, health care pro-
24 viders, regulators, and third-party payors;

1 (B) barriers to access to care at the pri-
2 mary, specialty, and tertiary care levels, includ-
3 ing barriers—

4 (i) specific to those populations that
5 are disproportionately undertreated for
6 pain;

7 (ii) related to physician concerns over
8 regulatory and law enforcement policies
9 applicable to some pain therapies; and

10 (iii) attributable to benefit, coverage,
11 and payment policies in both the public
12 and private sectors; and

13 (C) gaps in basic and clinical research on
14 the symptoms and causes of pain, and potential
15 assessment methods and new treatments to im-
16 prove pain care; and

17 (4) establish an agenda for action in both the
18 public and private sectors that will reduce such bar-
19 riers and significantly improve the state of pain care
20 research, education, and clinical care in the United
21 States.

22 (c) OTHER APPROPRIATE ENTITY.—If the Institute
23 of Medicine declines to enter into an agreement under sub-
24 section (a), the Secretary of Health and Human Services

1 may enter into such agreement with another appropriate
2 entity.

3 (d) REPORT.—A report summarizing the Con-
4 ference’s findings and recommendations shall be sub-
5 mitted to the Congress not later than June 30, 2012.

6 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
7 purpose of carrying out this section, there is authorized
8 to be appropriated \$500,000 for each of fiscal years 2011
9 and 2012.

10 **SEC. 2562. PAIN RESEARCH AT NATIONAL INSTITUTES OF**
11 **HEALTH.**

12 Part B of title IV (42 U.S.C. 284 et seq.) is amended
13 by adding at the end the following:

14 **“SEC. 409J. PAIN RESEARCH.**

15 “(a) RESEARCH INITIATIVES.—

16 “(1) IN GENERAL.—The Director of NIH is en-
17 couraged to continue and expand, through the Pain
18 Consortium, an aggressive program of basic and
19 clinical research on the causes of and potential treat-
20 ments for pain.

21 “(2) ANNUAL RECOMMENDATIONS.—Not less
22 than annually, the Pain Consortium, in consultation
23 with the Division of Program Coordination, Plan-
24 ning, and Strategic Initiatives, shall develop and
25 submit to the Director of NIH recommendations on

1 appropriate pain research initiatives that could be
2 undertaken with funds reserved under section
3 402A(c)(1) for the Common Fund or otherwise
4 available for such initiatives.

5 “(3) DEFINITION.—In this subsection, the term
6 ‘Pain Consortium’ means the Pain Consortium of
7 the National Institutes of Health or a similar trans-
8 National Institutes of Health coordinating entity
9 designated by the Secretary for purposes of this sub-
10 section.

11 “(b) INTERAGENCY PAIN RESEARCH COORDINATING
12 COMMITTEE.—

13 “(1) ESTABLISHMENT.—The Secretary shall es-
14 tablish not later than 1 year after the date of the
15 enactment of this section and as necessary maintain
16 a committee, to be known as the Interagency Pain
17 Research Coordinating Committee (in this section
18 referred to as the ‘Committee’), to coordinate all ef-
19 forts within the Department of Health and Human
20 Services and other Federal agencies that relate to
21 pain research.

22 “(2) MEMBERSHIP.—

23 “(A) IN GENERAL.—The Committee shall
24 be composed of the following voting members:

1 “(i) Not more than 7 voting Federal
2 representatives as follows:

3 “(I) The Director of the Centers
4 for Disease Control and Prevention.

5 “(II) The Director of the Na-
6 tional Institutes of Health and the di-
7 rectors of such national research insti-
8 tutes and national centers as the Sec-
9 retary determines appropriate.

10 “(III) The heads of such other
11 agencies of the Department of Health
12 and Human Services as the Secretary
13 determines appropriate.

14 “(IV) Representatives of other
15 Federal agencies that conduct or sup-
16 port pain care research and treat-
17 ment, including the Department of
18 Defense and the Department of Vet-
19 erans Affairs.

20 “(ii) Twelve additional voting mem-
21 bers appointed under subparagraph (B).

22 “(B) ADDITIONAL MEMBERS.—The Com-
23 mittee shall include additional voting members
24 appointed by the Secretary as follows:

1 “(i) Six members shall be appointed
2 from among scientists, physicians, and
3 other health professionals, who—

4 “(I) are not officers or employees
5 of the United States;

6 “(II) represent multiple dis-
7 ciplines, including clinical, basic, and
8 public health sciences;

9 “(III) represent different geo-
10 graphical regions of the United
11 States; and

12 “(IV) are from practice settings,
13 academia, manufacturers, or other re-
14 search settings.

15 “(ii) Six members shall be appointed
16 from members of the general public, who
17 are representatives of leading research, ad-
18 vocacy, and service organizations for indi-
19 viduals with pain-related conditions.

20 “(C) NONVOTING MEMBERS.—The Com-
21 mittee shall include such nonvoting members as
22 the Secretary determines to be appropriate.

23 “(3) CHAIRPERSON.—The voting members of
24 the Committee shall select a chairperson from
25 among such members. The selection of a chairperson

1 shall be subject to the approval of the Director of
2 NIH.

3 “(4) MEETINGS.—The Committee shall meet at
4 the call of the chairperson of the Committee or upon
5 the request of the Director of NIH, but in no case
6 less often than once each year.

7 “(5) DUTIES.—The Committee shall—

8 “(A) develop a summary of advances in
9 pain care research supported or conducted by
10 the Federal agencies relevant to the diagnosis,
11 prevention, and treatment of pain and diseases
12 and disorders associated with pain;

13 “(B) identify critical gaps in basic and
14 clinical research on the symptoms and causes of
15 pain;

16 “(C) make recommendations to ensure that
17 the activities of the National Institutes of
18 Health and other Federal agencies, including
19 the Department of Defense and the Department
20 of Veteran Affairs, are free of unnecessary du-
21 plication of effort;

22 “(D) make recommendations on how best
23 to disseminate information on pain care; and

24 “(E) make recommendations on how to ex-
25 pand partnerships between public entities, in-

1 including Federal agencies, and private entities to
2 expand collaborative, crosscutting research.

3 “(6) REVIEW.—The Secretary shall review the
4 necessity of the Committee at least once every 2
5 years.”.

6 **SEC. 2563. PUBLIC AWARENESS CAMPAIGN ON PAIN MAN-**
7 **AGEMENT.**

8 Part B of title II (42 U.S.C. 238 et seq.) is amended
9 by adding at the end the following:

10 **“SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARE-**
11 **NESS CAMPAIGN ON PAIN MANAGEMENT.**

12 “(a) ESTABLISHMENT.—Not later than 12 months
13 after the date of the enactment of this section, the Sec-
14 retary shall establish and implement a national pain care
15 education outreach and awareness campaign described in
16 subsection (b).

17 “(b) REQUIREMENTS.—The Secretary shall design
18 the public awareness campaign under this section to edu-
19 cate consumers, patients, their families, and other care-
20 givers with respect to—

21 “(1) the incidence and importance of pain as a
22 national public health problem;

23 “(2) the adverse physical, psychological, emo-
24 tional, societal, and financial consequences that can

1 result if pain is not appropriately assessed, diag-
2 nosed, treated, or managed;

3 “(3) the availability, benefits, and risks of all
4 pain treatment and management options;

5 “(4) having pain promptly assessed, appro-
6 priately diagnosed, treated, and managed, and regu-
7 larly reassessed with treatment adjusted as needed;

8 “(5) the role of credentialed pain management
9 specialists and subspecialists, and of comprehensive
10 interdisciplinary centers of treatment expertise;

11 “(6) the availability in the public, nonprofit,
12 and private sectors of pain management-related in-
13 formation, services, and resources for consumers,
14 employers, third-party payors, patients, their fami-
15 lies, and caregivers, including information on—

16 “(A) appropriate assessment, diagnosis,
17 treatment, and management options for all
18 types of pain and pain-related symptoms; and

19 “(B) conditions for which no treatment op-
20 tions are yet recognized; and

21 “(7) other issues the Secretary deems appro-
22 priate.

23 “(c) CONSULTATION.—In designing and imple-
24 menting the public awareness campaign required by this
25 section, the Secretary shall consult with organizations rep-

1 resenting patients in pain and other consumers, employ-
2 ers, physicians including physicians specializing in pain
3 care, other pain management professionals, medical device
4 manufacturers, and pharmaceutical companies.

5 “(d) COORDINATION.—

6 “(1) LEAD OFFICIAL.—The Secretary shall des-
7 ignate one official in the Department of Health and
8 Human Services to oversee the campaign established
9 under this section.

10 “(2) AGENCY COORDINATION.—The Secretary
11 shall ensure the involvement in the public awareness
12 campaign under this section of the Surgeon General
13 of the Public Health Service, the Director of the
14 Centers for Disease Control and Prevention, and
15 such other representatives of offices and agencies of
16 the Department of Health and Human Services as
17 the Secretary determines appropriate.

18 “(e) UNDERSERVED AREAS AND POPULATIONS.—In
19 designing the public awareness campaign under this sec-
20 tion, the Secretary shall—

21 “(1) take into account the special needs of geo-
22 graphic areas and racial, ethnic, gender, age, and
23 other demographic groups that are currently under-
24 served; and

1 “(2) provide resources that will reduce dispari-
2 ties in access to appropriate diagnosis, assessment,
3 and treatment.

4 “(f) GRANTS AND CONTRACTS.—The Secretary may
5 make awards of grants, cooperative agreements, and con-
6 tracts to public agencies and private nonprofit organiza-
7 tions to assist with the development and implementation
8 of the public awareness campaign under this section.

9 “(g) EVALUATION AND REPORT.—Not later than the
10 end of fiscal year 2012, the Secretary shall prepare and
11 submit to the Congress a report evaluating the effective-
12 ness of the public awareness campaign under this section
13 in educating the general public with respect to the matters
14 described in subsection (b).

15 “(h) AUTHORIZATION OF APPROPRIATIONS.—For
16 purposes of carrying out this section, there are authorized
17 to be appropriated \$2,000,000 for fiscal year 2011 and
18 \$4,000,000 for each of fiscal years 2012 and 2015.”.

19 **Subtitle C—Food and Drug** 20 **Administration**

21 **PART 1—IN GENERAL**

22 **SEC. 2571. NATIONAL MEDICAL DEVICE REGISTRY.**

23 (a) REGISTRY.—

1 (1) IN GENERAL.—Section 519 of the Federal
2 Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is
3 amended—

4 (A) by redesignating subsection (g) as sub-
5 section (h); and

6 (B) by inserting after subsection (f) the
7 following:

8 “National Medical Device Registry

9 “(g)(1)(A) The Secretary shall establish a national
10 medical device registry (in this subsection referred to as
11 the ‘registry’) to facilitate analysis of postmarket safety
12 and outcomes data on each covered device.

13 “(B) In this subsection, the term ‘covered device’—

14 “(i) shall include each class III device; and

15 “(ii) may include, as the Secretary determines
16 appropriate and specifies in regulation, a class II de-
17 vice that is life-supporting or life-sustaining.

18 “(C) Notwithstanding subparagraph (B)(i), the Sec-
19 retary may by order exempt a class III device from the
20 provisions of this subsection if the Secretary concludes
21 that inclusion of information on the device in the registry
22 will not provide useful information on safety or effective-
23 ness.

24 “(2) In developing the registry, the Secretary shall,
25 in consultation with the Commissioner of Food and Drugs,

1 the Administrator of the Centers for Medicare & Medicaid
2 Services, the Administrator of the Agency for Healthcare
3 Research and Quality, the head of the Office of the Na-
4 tional Coordinator for Health Information Technology,
5 and the Secretary of Veterans Affairs, determine the best
6 methods for—

7 “(A) including in the registry, in a manner con-
8 sistent with subsection (f), appropriate information
9 to identify each covered device by type, model, and
10 serial number or other unique identifier;

11 “(B) validating methods for analyzing patient
12 safety and outcomes data from multiple sources and
13 for linking such data with the information included
14 in the registry as described in subparagraph (A), in-
15 cluding, to the extent feasible, use of—

16 “(i) data provided to the Secretary under
17 other provisions of this chapter; and

18 “(ii) information from public and private
19 sources identified under paragraph (3);

20 “(C) integrating the activities described in this
21 subsection (so as to avoid duplication) with—

22 “(i) activities under paragraph (3) of sec-
23 tion 505(k) (relating to active postmarket risk
24 identification);

1 “(ii) activities under paragraph (4) of sec-
2 tion 505(k) (relating to advanced analysis of
3 drug safety data);

4 “(iii) other postmarket device surveillance
5 activities of the Secretary authorized by this
6 chapter; and

7 “(iv) registries carried out by or for the
8 Agency for Healthcare Research and Quality;
9 and

10 “(D) providing public access to the data and
11 analysis collected or developed through the registry
12 in a manner and form that protects patient privacy
13 and proprietary information and is comprehensive,
14 useful, and not misleading to patients, physicians,
15 and scientists.

16 “(3)(A) To facilitate analyses of postmarket safety
17 and patient outcomes for covered devices, the Secretary
18 shall, in collaboration with public, academic, and private
19 entities, develop methods to—

20 “(i) obtain access to disparate sources of
21 patient safety and outcomes data, including—

22 “(I) Federal health-related electronic
23 data (such as data from the Medicare pro-
24 gram under title XVIII of the Social Secu-

1 rity Act or from the health systems of the
2 Department of Veterans Affairs);

3 “(II) private sector health-related
4 electronic data (such as pharmaceutical
5 purchase data and health insurance claims
6 data); and

7 “(III) other data as the Secretary
8 deems necessary to permit postmarket as-
9 sessment of device safety and effectiveness;
10 and

11 “(ii) link data obtained under clause (i)
12 with information in the registry.

13 “(B) In this paragraph, the term ‘data’ refers to in-
14 formation respecting a covered device, including claims
15 data, patient survey data, standardized analytic files that
16 allow for the pooling and analysis of data from disparate
17 data environments, electronic health records, and any
18 other data deemed appropriate by the Secretary.

19 “(4) The Secretary shall promulgate regulations for
20 establishment and operation of the registry under para-
21 graph (1). Such regulations—

22 “(A)(i) in the case of covered devices that are
23 sold on or after the date of the enactment of this
24 subsection, shall require manufacturers of such de-
25 vices to submit information to the registry, includ-

1 ing, for each such device, the type, model, and serial
2 number or, if required under subsection (f), other
3 unique device identifier; and

4 “(ii) in the case of covered devices that are sold
5 before such date, may require manufacturers of such
6 devices to submit such information to the registry,
7 if deemed necessary by the Secretary to protect the
8 public health;

9 “(B) shall establish procedures—

10 “(i) to permit linkage of information sub-
11 mitted pursuant to subparagraph (A) with pa-
12 tient safety and outcomes data obtained under
13 paragraph (3); and

14 “(ii) to permit analyses of linked data;

15 “(C) may require covered device manufacturers
16 to submit such other information as is necessary to
17 facilitate postmarket assessments of device safety
18 and effectiveness and notification of device risks;

19 “(D) shall establish requirements for regular
20 and timely reports to the Secretary, which shall be
21 included in the registry, concerning adverse event
22 trends, adverse event patterns, incidence and preva-
23 lence of adverse events, and other information the
24 Secretary determines appropriate, which may include

1 data on comparative safety and outcomes trends;
2 and

3 “(E) shall establish procedures to permit public
4 access to the information in the registry in a manner
5 and form that protects patient privacy and propri-
6 etary information and is comprehensive, useful, and
7 not misleading to patients, physicians, and sci-
8 entists.

9 “(5)(A) The Secretary shall promulgate final regula-
10 tions under paragraph (4) not later than 36 months after
11 the date of the enactment of this subsection.

12 “(B) Before issuing the notice of proposed rule-
13 making preceding the final regulations described in sub-
14 paragraph (A), the Secretary shall hold a public hearing
15 before an advisory committee on the issue of which class
16 II devices to include in the definition of covered devices.

17 “(C) The Secretary shall include in any regulation
18 under this subsection an explanation demonstrating that
19 the requirements of such regulation—

20 “(i) do not duplicate other Federal require-
21 ments; and

22 “(ii) do not impose an undue burden on device
23 manufacturers.

24 “(6) With respect to any entity that submits or is
25 required to submit a safety report or other information

1 in connection with the safety of a device under this section
2 (and any release by the Secretary of that report or infor-
3 mation), such report or information shall not be construed
4 to reflect necessarily a conclusion by the entity or the Sec-
5 retary that the report or information constitutes an admis-
6 sion that the product involved malfunctioned, caused or
7 contributed to an adverse experience, or otherwise caused
8 or contributed to a death, serious injury, or serious illness.
9 Such an entity need not admit, and may deny, that the
10 report or information submitted by the entity constitutes
11 an admission that the product involved malfunctioned,
12 caused or contributed to an adverse experience, or caused
13 or contributed to a death, serious injury, or serious illness.

14 “(7) To carry out this subsection, there are author-
15 ized to be appropriated such sums as may be necessary
16 for each of fiscal years 2011 and 2012.”.

17 (2) EFFECTIVE DATE.—The Secretary of
18 Health and Human Services shall establish and
19 begin implementation of the registry under section
20 519(g) of the Federal Food, Drug, and Cosmetic
21 Act, as added by paragraph (1), by not later than
22 the date that is 36 months after the date of the en-
23 actment of this Act, without regard to whether or
24 not final regulations to establish and operate the
25 registry have been promulgated by such date.

1 (3) CONFORMING AMENDMENT.—Section
2 303(f)(1)(B)(ii) of the Federal Food, Drug, and
3 Cosmetic Act (21 U.S.C. 333(f)(1)(B)(ii)) is amend-
4 ed by striking “519(g)” and inserting “519(h)”.

5 (b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED
6 ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE
7 IDENTIFIERS.—

8 (1) RECOMMENDATIONS.—The HIT Policy
9 Committee established under section 3002 of the
10 Public Health Service Act (42 U.S.C. 300jj–12)
11 shall recommend to the head of the Office of the Na-
12 tional Coordinator for Health Information Tech-
13 nology standards, implementation specifications, and
14 certification criteria for the electronic exchange and
15 use in certified electronic health records of a unique
16 device identifier for each covered device (as defined
17 under section 519(g)(1)(B) of the Federal Food,
18 Drug, and Cosmetic Act, as added by subsection
19 (a)).

20 (2) STANDARDS, IMPLEMENTATION CRITERIA,
21 AND CERTIFICATION CRITERIA.—The Secretary of
22 Health and Human Services, acting through the
23 head of the Office of the National Coordinator for
24 Health Information Technology, shall adopt stand-
25 ards, implementation specifications, and certification

1 criteria for the electronic exchange and use in cer-
2 tified electronic health records of a unique device
3 identifier for each covered device referred to in para-
4 graph (1), if such an identifier is required by section
5 519(f) of the Federal Food, Drug, and Cosmetic Act
6 (21 U.S.C. 360i(f)) for the device.

7 (c) UNIQUE DEVICE IDENTIFICATION SYSTEM.—The
8 Secretary of Health and Human Services, acting through
9 the Commissioner of Food and Drugs, shall issue proposed
10 regulations to implement section 519(f) of the Federal
11 Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) not
12 later than 6 months after the date of the enactment of
13 this Act.

14 **SEC. 2572. NUTRITION LABELING OF STANDARD MENU**
15 **ITEMS AT CHAIN RESTAURANTS AND OF AR-**
16 **TICLES OF FOOD SOLD FROM VENDING MA-**
17 **CHINES.**

18 (a) TECHNICAL AMENDMENTS.—Section
19 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic
20 Act (21 U.S.C. 343(q)(5)(A)) is amended—

21 (1) in subclause (i), by inserting “except as pro-
22 vided in clause (H)(ii)(III),” after “(i)” ; and

23 (2) in subclause (ii), by inserting “except as
24 provided in clause (H)(ii)(III),” after “(ii)”.

1 (b) LABELING REQUIREMENTS.—Section 403(q)(5)
2 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.
3 343(q)(5)) is amended by adding at the end the following:

4 “(H) RESTAURANTS, RETAIL FOOD ESTABLISH-
5 MENTS, AND VENDING MACHINES.—

6 “(i) GENERAL REQUIREMENTS FOR RES-
7 TAURANTS AND SIMILAR RETAIL FOOD ESTABLISH-
8 MENTS.—Except for food described in subclause
9 (vii), in the case of food that is a standard menu
10 item that is offered for sale in a restaurant or simi-
11 lar retail food establishment that is part of a chain
12 with 20 or more locations doing business under the
13 same name (regardless of the type of ownership of
14 the locations) and offering for sale substantially the
15 same menu items, the restaurant or similar retail
16 food establishment shall disclose the information de-
17 scribed in subclauses (ii) and (iii).

18 “(ii) INFORMATION REQUIRED TO BE DIS-
19 CLOSED BY RESTAURANTS AND RETAIL FOOD ES-
20 TABLISHMENTS.—Except as provided in subclause
21 (vii), the restaurant or similar retail food establish-
22 ment shall disclose in a clear and conspicuous man-
23 ner—

24 “(I)(aa) in a nutrient content disclosure
25 statement adjacent to the name of the standard

1 menu item, so as to be clearly associated with
2 the standard menu item, on the menu listing
3 the item for sale, the number of calories con-
4 tained in the standard menu item, as usually
5 prepared and offered for sale; and

6 “(bb) a succinct statement concerning sug-
7 gested daily caloric intake, as specified by the
8 Secretary by regulation and posted prominently
9 on the menu and designed to enable the public
10 to understand, in the context of a total daily
11 diet, the significance of the caloric information
12 that is provided on the menu;

13 “(II)(aa) in a nutrient content disclosure
14 statement adjacent to the name of the standard
15 menu item, so as to be clearly associated with
16 the standard menu item, on the menu board,
17 including a drive-through menu board, the
18 number of calories contained in the standard
19 menu item, as usually prepared and offered for
20 sale; and

21 “(bb) a succinct statement concerning sug-
22 gested daily caloric intake, as specified by the
23 Secretary by regulation and posted prominently
24 on the menu board, designed to enable the pub-
25 lic to understand, in the context of a total daily

1 diet, the significance of the nutrition informa-
2 tion that is provided on the menu board;

3 “(III) in a written form, available on the
4 premises of the restaurant or similar retail es-
5 tablishment and to the consumer upon request,
6 the nutrition information required under
7 clauses (C) and (D) of subparagraph (1); and

8 “(IV) on the menu or menu board, a
9 prominent, clear, and conspicuous statement re-
10 garding the availability of the information de-
11 scribed in item (III).

12 “(iii) SELF-SERVICE FOOD AND FOOD ON DIS-
13 PLAY.—Except as provided in subclause (vii), in the
14 case of food sold at a salad bar, buffet line, cafeteria
15 line, or similar self-service facility, and for self-serv-
16 ice beverages or food that is on display and that is
17 visible to customers, a restaurant or similar retail
18 food establishment shall place adjacent to each food
19 offered a sign that lists calories per displayed food
20 item or per serving.

21 “(iv) REASONABLE BASIS.—For the purposes of
22 this clause, a restaurant or similar retail food estab-
23 lishment shall have a reasonable basis for its nutri-
24 ent content disclosures, including nutrient databases,
25 cookbooks, laboratory analyses, and other reasonable

1 means, as described in section 101.10 of title 21,
2 Code of Federal Regulations (or any successor regu-
3 lation) or in a related guidance of the Food and
4 Drug Administration.

5 “(v) MENU VARIABILITY AND COMBINATION
6 MEALS.—The Secretary shall establish by regulation
7 standards for determining and disclosing the nutri-
8 ent content for standard menu items that come in
9 different flavors, varieties, or combinations, but
10 which are listed as a single menu item, such as soft
11 drinks, ice cream, pizza, doughnuts, or children’s
12 combination meals, through means determined by
13 the Secretary, including ranges, averages, or other
14 methods.

15 “(vi) ADDITIONAL INFORMATION.—If the Sec-
16 retary determines that a nutrient, other than a nu-
17 trient required under subclause (ii)(III), should be
18 disclosed for the purpose of providing information to
19 assist consumers in maintaining healthy dietary
20 practices, the Secretary may require, by regulation,
21 disclosure of such nutrient in the written form re-
22 quired under subclause (ii)(III).

23 “(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

24 “(I) IN GENERAL.—Subclauses (i) through
25 (vi) do not apply to—

1 “(aa) items that are not listed on a
2 menu or menu board (such as condiments
3 and other items placed on the table or
4 counter for general use);

5 “(bb) daily specials, temporary menu
6 items appearing on the menu for less than
7 60 days per calendar year, or custom or-
8 ders; or

9 “(cc) such other food that is part of
10 a customary market test appearing on the
11 menu for less than 90 days, under terms
12 and conditions established by the Sec-
13 retary.

14 “(II) WRITTEN FORMS.—Clause (C) shall
15 apply to any regulations promulgated under
16 subclauses (ii)(III) and (vi).

17 “(viii) VENDING MACHINES.—In the case of an
18 article of food sold from a vending machine that—

19 “(I) does not permit a prospective pur-
20 chaser to examine the Nutrition Facts Panel
21 before purchasing the article or does not other-
22 wise provide visible nutrition information at the
23 point of purchase; and

1 “(II) is operated by a person who is en-
2 gaged in the business of owning or operating 20
3 or more vending machines,
4 the vending machine operator shall provide a sign in
5 close proximity to each article of food or the selec-
6 tion button that includes a clear and conspicuous
7 statement disclosing the number of calories con-
8 tained in the article.

9 “(ix) VOLUNTARY PROVISION OF NUTRITION IN-
10 FORMATION.—

11 “(I) IN GENERAL.—An authorized official
12 of any restaurant or similar retail food estab-
13 lishment or vending machine operator not sub-
14 ject to the requirements of this clause may elect
15 to be subject to the requirements of such
16 clause, by registering biannually the name and
17 address of such restaurant or similar retail food
18 establishment or vending machine operator with
19 the Secretary, as specified by the Secretary by
20 regulation.

21 “(II) REGISTRATION.—Within 120 days of
22 the enactment of this clause, the Secretary shall
23 publish a notice in the Federal Register speci-
24 fying the terms and conditions for implementa-

1 tion of item (I), pending promulgation of regu-
2 lations.

3 “(III) RULE OF CONSTRUCTION.—Nothing
4 in this subclause shall be construed to authorize
5 the Secretary to require an application, review,
6 or licensing process for any entity to register
7 with the Secretary, as described in such item.

8 “(x) REGULATIONS.—

9 “(I) PROPOSED REGULATION.—Not later
10 than 1 year after the date of the enactment of
11 this clause, the Secretary shall promulgate pro-
12 posed regulations to carry out this clause.

13 “(II) CONTENTS.—In promulgating regula-
14 tions, the Secretary shall—

15 “(aa) consider standardization of rec-
16 ipes and methods of preparation, reason-
17 able variation in serving size and formula-
18 tion of menu items, space on menus and
19 menu boards, inadvertent human error,
20 training of food service workers, variations
21 in ingredients, and other factors, as the
22 Secretary determines; and

23 “(bb) specify the format and manner
24 of the nutrient content disclosure require-
25 ments under this subclause.

1 “(III) REPORTING.—The Secretary shall
2 submit to the Committee on Health, Education,
3 Labor, and Pensions of the Senate and the
4 Committee on Energy and Commerce of the
5 House of Representatives a quarterly report
6 that describes the Secretary’s progress toward
7 promulgating final regulations under this sub-
8 paragraph.

9 “(xi) DEFINITION.—In this clause, the term
10 ‘menu’ or ‘menu board’ means the primary writing
11 of the restaurant or other similar retail food estab-
12 lishment from which a consumer makes an order se-
13 lection.”.

14 (c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of
15 the Federal Food, Drug, and Cosmetic Act (21 U.S.C.
16 343–1(a)(4)) is amended by striking “except a require-
17 ment for nutrition labeling of food which is exempt under
18 subclause (i) or (ii) of section 403(q)(5)(A)” and inserting
19 “except that this paragraph does not apply to food that
20 is offered for sale in a restaurant or similar retail food
21 establishment that is not part of a chain with 20 or more
22 locations doing business under the same name (regardless
23 of the type of ownership of the locations) and offering for
24 sale substantially the same menu items unless such res-
25 taurant or similar retail food establishment complies with

1 the voluntary provision of nutrition information require-
2 ments under section 403(q)(5)(H)(ix)”.

3 (d) RULE OF CONSTRUCTION.—Nothing in the
4 amendments made by this section shall be construed—

5 (1) to preempt any provision of State or local
6 law, unless such provision establishes or continues
7 into effect nutrient content disclosures of the type
8 required under section 403(q)(5)(H) of the Federal
9 Food, Drug, and Cosmetic Act (as added by sub-
10 section (b)) and is expressly preempted under sec-
11 tion 403A(a)(4) of such Act;

12 (2) to apply to any State or local requirement
13 respecting a statement in the labeling of food that
14 provides for a warning concerning the safety of the
15 food or component of the food; or

16 (3) except as provided in section
17 403(q)(5)(H)(ix) of the Federal Food, Drug, and
18 Cosmetic Act (as added by subsection (b)), to apply
19 to any restaurant or similar retail food establish-
20 ment other than a restaurant or similar retail food
21 establishment described in section 403(q)(5)(H)(i) of
22 such Act.

23 **SEC. 2573. PROTECTING CONSUMER ACCESS TO GENERIC**
24 **DRUGS.**

25 (a) FINDINGS; PURPOSE.—

1 (1) FINDINGS.—The Congress finds the fol-
2 lowing:

3 (A) In 1984, the Drug Price Competition
4 and Patent Term Restoration Act (Pub. L. 98–
5 417; in this subsection referred to as the “1984
6 Act”) was enacted with the intent of facilitating
7 the early entry of generic drugs while pre-
8 serving incentives for innovation.

9 (B) Prescription drugs make up 10 percent
10 of national health care spending, but for the
11 past decade have been one of the fastest grow-
12 ing segments of health care expenditures.

13 (C) Until recently, the 1984 Act was suc-
14 cessful in facilitating generic competition to the
15 benefit of consumers and health care payers—
16 although 67 percent of all prescriptions dis-
17 pensed in the United States are generic drugs,
18 they account for only 20 percent of all expendi-
19 tures.

20 (D) In recent years, the intent of the 1984
21 Act has been subverted by certain settlement
22 agreements between brand companies and their
23 potential generic competitors that make reverse
24 payments, i.e., payments by the brand company
25 to the generic company.

1 (E) These settlement agreements have un-
2 duly delayed the marketing of low-cost generic
3 drugs contrary to free competition and the in-
4 terests of consumers.

5 (F) The state of antitrust law relating to
6 such settlement agreements is unsettled.

7 (2) PURPOSE.—The purpose of this section is
8 to provide an additional means to effectuate the in-
9 tent of the 1984 Act by enhancing competition in
10 the pharmaceutical market by stopping agreements
11 between brand name and generic drug manufactur-
12 ers that limit, delay, or otherwise prevent competi-
13 tion from generic drugs.

14 (b) IN GENERAL.—Section 505 of the Federal Food,
15 Drug, and Cosmetic Act (21 U.S.C. 355) is amended by
16 adding at the end the following:

17 “(w) PROTECTING CONSUMER ACCESS TO GENERIC
18 DRUGS.—

19 “(1) UNFAIR AND DECEPTIVE ACTS AND PRAC-
20 TICES RELATED TO NEW DRUG APPLICATIONS.—

21 “(A) CONDUCT PROHIBITED.—It shall be
22 unlawful for any person to directly or indirectly
23 be a party to any agreement resolving or set-
24 tling a patent infringement claim in which—

1 “(i) an ANDA filer receives anything
2 of value; and

3 “(ii) the ANDA filer agrees to limit or
4 forego research, development, manufac-
5 turing, marketing, or sales, for any period
6 of time, of the drug that is to be manufac-
7 tured under the ANDA involved and is the
8 subject of the patent infringement claim.

9 “(B) EXCEPTIONS.—Notwithstanding sub-
10 paragraph (A)(i), subparagraph (A) does not
11 prohibit a resolution or settlement of a patent
12 infringement claim in which the value received
13 by the ANDA filer includes no more than—

14 “(i) the right to market the drug that
15 is to be manufactured under the ANDA in-
16 volved and is the subject of the patent in-
17 fringement claim, before the expiration
18 of—

19 “(I) the patent that is the basis
20 for the patent infringement claim; or

21 “(II) any other statutory exclu-
22 sivity that would prevent the mar-
23 keting of such drug; and

1 “(ii) the waiver of a patent infringe-
2 ment claim for damages based on prior
3 marketing of such drug.

4 “(C) ENFORCEMENT.—

5 “(i) IN GENERAL.—A violation of sub-
6 paragraph (A) shall be treated as an un-
7 fair and deceptive act or practice and an
8 unfair method of competition in or affect-
9 ing interstate commerce prohibited under
10 section 5 of the Federal Trade Commission
11 Act and shall be enforced by the Federal
12 Trade Commission in the same manner, by
13 the same means, and with the same juris-
14 diction as though all applicable terms and
15 provisions of the Federal Trade Commis-
16 sion Act were incorporated into and made
17 a part of this subsection.

18 “(ii) INAPPLICABILITY.—Subchapter
19 A of chapter VII shall not apply with re-
20 spect to this subsection.

21 “(D) DEFINITIONS.—In this subsection:

22 “(i) AGREEMENT.—The term ‘agree-
23 ment’ means anything that would con-
24 stitute an agreement under section 5 of the
25 Federal Trade Commission Act.

1 “(ii) AGREEMENT RESOLVING OR SET-
2 TLING.—The term ‘agreement resolving or
3 settling’, in reference to a patent infringe-
4 ment claim, includes any agreement that is
5 contingent upon, provides a contingent
6 condition for, or is otherwise related to the
7 resolution or settlement of the claim.

8 “(iii) ANDA.—The term ‘ANDA’
9 means an abbreviated new drug application
10 for the approval of a new drug under sec-
11 tion (j).

12 “(iv) ANDA FILER.—The term
13 ‘ANDA filer’ means a party that has filed
14 an ANDA with the Food and Drug Admin-
15 istration.

16 “(v) PATENT INFRINGEMENT.—The
17 term ‘patent infringement’ means infringe-
18 ment of any patent or of any filed patent
19 application, extension, reissuance, renewal,
20 division, continuation, continuation in part,
21 reexamination, patent term restoration,
22 patent of addition, or extension thereof.

23 “(vi) PATENT INFRINGEMENT
24 CLAIM.—The term ‘patent infringement
25 claim’ means any allegation made to an

1 ANDA filer, whether or not included in a
2 complaint filed with a court of law, that its
3 ANDA or drug to be manufactured under
4 such ANDA may infringe any patent.

5 “(2) FTC RULEMAKING.—The Federal Trade
6 Commission may, by rule promulgated under section
7 553 of title 5, United States Code, exempt certain
8 agreements described in paragraph (1) from the re-
9 quirements of this subsection if the Commission
10 finds such agreements to be in furtherance of mar-
11 ket competition and for the benefit of consumers.
12 Consistent with the authority of the Commission,
13 such rules may include interpretive rules and general
14 statements of policy with respect to the practices
15 prohibited under paragraph (1).”.

16 (c) NOTICE AND CERTIFICATION OF AGREEMENTS.—

17 (1) NOTICE OF ALL AGREEMENTS.—Section
18 1112(c)(2) of the Medicare Prescription Drug, Im-
19 provement, and Modernization Act of 2003 (21
20 U.S.C. 3155 note) is amended by—

21 (A) striking “the Commission the” and in-
22 serting the following: “the Commission—

23 “(A) the”;

24 (B) striking the period at the end and in-
25 serting “; and”; and

1 (C) adding at the end the following:

2 “(B) any other agreement the parties enter
3 into within 30 days of entering into an agree-
4 ment covered by subsection (a) or (b).”.

5 (2) CERTIFICATION OF AGREEMENTS.—Section
6 1112 of such Act is amended by adding at the end
7 the following:

8 “(d) CERTIFICATION.—The chief executive officer or
9 the company official responsible for negotiating any agree-
10 ment required to be filed under subsection (a), (b), or (c)
11 shall execute and file with the Assistant Attorney General
12 and the Commission a certification as follows: ‘I declare
13 under penalty of perjury that the following is true and
14 correct: The materials filed with the Federal Trade Com-
15 mission and the Department of Justice under section 1112
16 of subtitle B of title XI of the Medicare Prescription Drug,
17 Improvement, and Modernization Act of 2003, with re-
18 spect to the agreement referenced in this certification: (1)
19 represent the complete, final, and exclusive agreement be-
20 tween the parties; (2) include any ancillary agreements
21 that are contingent upon, provide a contingent condition
22 for, or are otherwise related to, the referenced agreement;
23 and (3) include written descriptions of any oral agree-
24 ments, representations, commitments, or promises be-
25 tween the parties that are responsive to subsection (a) or

1 (b) of such section 1112 and have not been reduced to
2 writing.’’.

3 (d) GAO STUDY.—

4 (1) STUDY.—Beginning 2 years after the date
5 of enactment of this Act, and each year for a period
6 of 4 years thereafter, the Comptroller General shall
7 conduct a study on the litigation in United States
8 courts during the period beginning 5 years prior to
9 the date of enactment of this Act relating to patent
10 infringement claims involving generic drugs, the
11 number of patent challenges initiated by manufac-
12 turers of generic drugs, and the number of settle-
13 ments of such litigation. The Comptroller General
14 shall transmit to Congress a report of the findings
15 of such a study and an analysis of the effect of the
16 amendments made by subsections (b) and (c) on
17 such litigation, whether such amendments have had
18 an effect on the number and frequency of claims set-
19 tled, and whether such amendments resulted in ear-
20 lier or delayed entry of generic drugs to market, in-
21 cluding whether any harm or benefit to consumers
22 has resulted.

23 (2) DISCLOSURE OF AGREEMENTS.—Notwith-
24 standing any other law, agreements filed under sec-
25 tion 1112 of the Medicare Prescription Drug, Im-

1 shall include information demonstrating
2 that—

3 “(I) the biological product is bio-
4 similar to a reference product based
5 upon data derived from—

6 “(aa) analytical studies that
7 demonstrate that the biological
8 product is highly similar to the
9 reference product notwith-
10 standing minor differences in
11 clinically inactive components;

12 “(bb) animal studies (includ-
13 ing the assessment of toxicity);
14 and

15 “(cc) a clinical study or
16 studies (including the assessment
17 of immunogenicity and phar-
18 macokinetics or
19 pharmacodynamics) that are suf-
20 ficient to demonstrate safety, pu-
21 rity, and potency in 1 or more
22 appropriate conditions of use for
23 which the reference product is li-
24 censed and intended to be used

1 and for which licensure is sought
2 for the biological product;

3 “(II) the biological product and
4 reference product utilize the same
5 mechanism or mechanisms of action
6 for the condition or conditions of use
7 prescribed, recommended, or sug-
8 gested in the proposed labeling, but
9 only to the extent the mechanism or
10 mechanisms of action are known for
11 the reference product;

12 “(III) the condition or conditions
13 of use prescribed, recommended, or
14 suggested in the labeling proposed for
15 the biological product have been pre-
16 viously approved for the reference
17 product;

18 “(IV) the route of administra-
19 tion, the dosage form, and the
20 strength of the biological product are
21 the same as those of the reference
22 product; and

23 “(V) the facility in which the bio-
24 logical product is manufactured, proc-
25 essed, packed, or held meets stand-

1 ards designed to assure that the bio-
2 logical product continues to be safe,
3 pure, and potent.

4 “(ii) DETERMINATION BY SEC-
5 RETARY.—The Secretary may determine,
6 in the Secretary’s discretion, that an ele-
7 ment described in clause (i)(I) is unneces-
8 sary in an application submitted under this
9 subsection.

10 “(iii) ADDITIONAL INFORMATION.—
11 An application submitted under this sub-
12 section—

13 “(I) shall include publicly avail-
14 able information regarding the Sec-
15 retary’s previous determination that
16 the reference product is safe, pure,
17 and potent; and

18 “(II) may include any additional
19 information in support of the applica-
20 tion, including publicly available infor-
21 mation with respect to the reference
22 product or another biological product.

23 “(B) INTERCHANGEABILITY.—An applica-
24 tion (or a supplement to an application) sub-
25 mitted under this subsection may include infor-

1 mation demonstrating that the biological prod-
2 uct meets the standards described in paragraph
3 (4).

4 “(3) EVALUATION BY SECRETARY.—Upon re-
5 view of an application (or a supplement to an appli-
6 cation) submitted under this subsection, the Sec-
7 retary shall license the biological product under this
8 subsection if—

9 “(A) the Secretary determines that the in-
10 formation submitted in the application (or the
11 supplement) is sufficient to show that the bio-
12 logical product—

13 “(i) is biosimilar to the reference
14 product; or

15 “(ii) meets the standards described in
16 paragraph (4), and therefore is inter-
17 changeable with the reference product; and

18 “(B) the applicant (or other appropriate
19 person) consents to the inspection of the facility
20 that is the subject of the application, in accord-
21 ance with subsection (c).

22 “(4) SAFETY STANDARDS FOR DETERMINING
23 INTERCHANGEABILITY.—Upon review of an applica-
24 tion submitted under this subsection or any supple-
25 ment to such application, the Secretary shall deter-

1 mine the biological product to be interchangeable
2 with the reference product if the Secretary deter-
3 mines that the information submitted in the applica-
4 tion (or a supplement to such application) is suffi-
5 cient to show that—

6 “(A) the biological product—

7 “(i) is biosimilar to the reference
8 product; and

9 “(ii) can be expected to produce the
10 same clinical result as the reference prod-
11 uct in any given patient; and

12 “(B) for a biological product that is ad-
13 ministered more than once to an individual, the
14 risk in terms of safety or diminished efficacy of
15 alternating or switching between use of the bio-
16 logical product and the reference product is not
17 greater than the risk of using the reference
18 product without such alternation or switch.

19 “(5) GENERAL RULES.—

20 “(A) ONE REFERENCE PRODUCT PER AP-
21 PLICATION.—A biological product, in an appli-
22 cation submitted under this subsection, may not
23 be evaluated against more than 1 reference
24 product.

1 “(B) REVIEW.—An application submitted
2 under this subsection shall be reviewed by the
3 division within the Food and Drug Administra-
4 tion that is responsible for the review and ap-
5 proval of the application under which the ref-
6 erence product is licensed.

7 “(C) RISK EVALUATION AND MITIGATION
8 STRATEGIES.—The authority of the Secretary
9 with respect to risk evaluation and mitigation
10 strategies under the Federal Food, Drug, and
11 Cosmetic Act shall apply to biological products
12 licensed under this subsection in the same man-
13 ner as such authority applies to biological prod-
14 ucts licensed under subsection (a).

15 “(D) RESTRICTIONS ON BIOLOGICAL PROD-
16 UCTS CONTAINING DANGEROUS INGREDI-
17 ENTS.—If information in an application sub-
18 mitted under this subsection, in a supplement
19 to such an application, or otherwise available to
20 the Secretary shows that a biological product—

21 “(i) is, bears, or contains a select
22 agent or toxin listed in section 73.3 or
23 73.4 of title 42, section 121.3 or 121.4 of
24 title 9, or section 331.3 of title 7, Code of

1 Federal Regulations (or any successor reg-
2 ulations); or

3 “(ii) is, bears, or contains a controlled
4 substance in schedule I or II of section
5 202 of the Controlled Substances Act, as
6 listed in part 1308 of title 21, Code of
7 Federal Regulations (or any successor reg-
8 ulations);

9 the Secretary shall not license the biological
10 product under this subsection unless the Sec-
11 retary determines, after consultation with ap-
12 propriate national security and drug enforce-
13 ment agencies, that there would be no increased
14 risk to the security or health of the public from
15 licensing such biological product under this sub-
16 section.

17 “(6) EXCLUSIVITY FOR FIRST INTERCHANGE-
18 ABLE BIOLOGICAL PRODUCT.—Upon review of an
19 application submitted under this subsection relying
20 on the same reference product for which a prior bio-
21 logical product has received a determination of inter-
22 changeability for any condition of use, the Secretary
23 shall not make a determination under paragraph (4)
24 that the second or subsequent biological product is

1 interchangeable for any condition of use until the
2 earlier of—

3 “(A) 1 year after the first commercial
4 marketing of the first interchangeable bio-
5 similar biological product to be approved as
6 interchangeable for that reference product;

7 “(B) 18 months after—

8 “(i) a final court decision on all pat-
9 ents in suit in an action instituted under
10 subsection (l)(5) against the applicant that
11 submitted the application for the first ap-
12 proved interchangeable biosimilar biological
13 product; or

14 “(ii) the dismissal with or without
15 prejudice of an action instituted under sub-
16 section (l)(5) against the applicant that
17 submitted the application for the first ap-
18 proved interchangeable biosimilar biological
19 product; or

20 “(C)(i) 42 months after approval of the
21 first interchangeable biosimilar biological prod-
22 uct if the applicant that submitted such appli-
23 cation has been sued under subsection (l)(5)
24 and such litigation is still ongoing within such
25 42-month period; or

1 “(ii) 18 months after approval of the first
2 interchangeable biosimilar biological product if
3 the applicant that submitted such application
4 has not been sued under subsection (l)(5).

5 For purposes of this paragraph, the term ‘final court
6 decision’ means a final decision of a court from
7 which no appeal (other than a petition to the United
8 States Supreme Court for a writ of certiorari) has
9 been or can be taken.

10 “(7) EXCLUSIVITY FOR REFERENCE PROD-
11 UCT.—

12 “(A) EFFECTIVE DATE OF BIOSIMILAR AP-
13 PLICATION APPROVAL.—Approval of an applica-
14 tion under this subsection may not be made ef-
15 fective by the Secretary until the date that is
16 12 years after the date on which the reference
17 product was first licensed under subsection (a).

18 “(B) FILING PERIOD.—An application
19 under this subsection may not be submitted to
20 the Secretary until the date that is 4 years
21 after the date on which the reference product
22 was first licensed under subsection (a).

23 “(C) FIRST LICENSURE.—Subparagraphs
24 (A) and (B) shall not apply to a license for or
25 approval of—

1 “(i) a supplement for the biological
2 product that is the reference product; or

3 “(ii) a subsequent application filed by
4 the same sponsor or manufacturer of the
5 biological product that is the reference
6 product (or a licensor, predecessor in inter-
7 est, or other related entity) for—

8 “(I) a change (not including a
9 modification to the structure of the bi-
10 ological product) that results in a new
11 indication, route of administration,
12 dosing schedule, dosage form, delivery
13 system, delivery device, or strength; or

14 “(II) a modification to the struc-
15 ture of the biological product that
16 does not result in a change in safety,
17 purity, or potency.

18 “(8) PEDIATRIC STUDIES.—

19 “(A) EXCLUSIVITY.—If, before or after li-
20 censure of the reference product under sub-
21 section (a) of this section, the Secretary deter-
22 mines that information relating to the use of
23 such product in the pediatric population may
24 produce health benefits in that population, the
25 Secretary makes a written request for pediatric

1 studies (which shall include a timeframe for
2 completing such studies), the applicant or hold-
3 er of the approved application agrees to the re-
4 quest, such studies are completed using appro-
5 priate formulations for each age group for
6 which the study is requested within any such
7 timeframe, and the reports thereof are sub-
8 mitted and accepted in accordance with section
9 505A(d)(3) of the Federal Food, Drug, and
10 Cosmetic Act the period referred to in para-
11 graph (7)(A) of this subsection is deemed to be
12 12 years and 6 months rather than 12 years.

13 “(B) EXCEPTION.—The Secretary shall
14 not extend the period referred to in subpara-
15 graph (A) of this paragraph if the determina-
16 tion under section 505A(d)(3) of the Federal
17 Food, Drug, and Cosmetic Act is made later
18 than 9 months prior to the expiration of such
19 period.

20 “(C) APPLICATION OF CERTAIN PROVI-
21 SIONS.—The provisions of subsections (a), (d),
22 (e), (f), (h), (j), (k), and (l) of section 505A of
23 the Federal Food, Drug, and Cosmetic Act
24 shall apply with respect to the extension of a
25 period under subparagraph (A) of this para-

1 graph to the same extent and in the same man-
2 ner as such provisions apply with respect to the
3 extension of a period under subsection (b) or
4 (c) of section 505A of the Federal Food, Drug,
5 and Cosmetic Act.

6 “(9) GUIDANCE DOCUMENTS.—

7 “(A) IN GENERAL.—The Secretary may,
8 after opportunity for public comment, issue
9 guidance in accordance, except as provided in
10 subparagraph (B)(i), with section 701(h) of the
11 Federal Food, Drug, and Cosmetic Act with re-
12 spect to the licensure of a biological product
13 under this subsection. Any such guidance may
14 be general or specific.

15 “(B) PUBLIC COMMENT.—

16 “(i) IN GENERAL.—The Secretary
17 shall provide the public an opportunity to
18 comment on any proposed guidance issued
19 under subparagraph (A) before issuing
20 final guidance.

21 “(ii) INPUT REGARDING MOST VALU-
22 ABLE GUIDANCE.—The Secretary shall es-
23 tablish a process through which the public
24 may provide the Secretary with input re-
25 garding priorities for issuing guidance.

1 “(C) NO REQUIREMENT FOR APPLICATION
2 CONSIDERATION.—The issuance (or non-
3 issuance) of guidance under subparagraph (A)
4 shall not preclude the review of, or action on,
5 an application submitted under this subsection.

6 “(D) REQUIREMENT FOR PRODUCT CLASS-
7 SPECIFIC GUIDANCE.—If the Secretary issues
8 product class-specific guidance under subpara-
9 graph (A), such guidance shall include a de-
10 scription of—

11 “(i) the criteria that the Secretary will
12 use to determine whether a biological prod-
13 uct is highly similar to a reference product
14 in such product class; and

15 “(ii) the criteria, if available, that the
16 Secretary will use to determine whether a
17 biological product meets the standards de-
18 scribed in paragraph (4).

19 “(E) CERTAIN PRODUCT CLASSES.—

20 “(i) GUIDANCE.—The Secretary may
21 indicate in a guidance document that the
22 science and experience, as of the date of
23 such guidance, with respect to a product or
24 product class (not including any recom-
25 binant protein) does not allow approval of

1 an application for a license as provided
2 under this subsection for such product or
3 product class.

4 “(ii) MODIFICATION OR REVERSAL.—
5 The Secretary may issue a subsequent
6 guidance document under subparagraph
7 (A) to modify or reverse a guidance docu-
8 ment under clause (i).

9 “(iii) NO EFFECT ON ABILITY TO
10 DENY LICENSE.—Clause (i) shall not be
11 construed to require the Secretary to ap-
12 prove a product with respect to which the
13 Secretary has not indicated in a guidance
14 document that the science and experience,
15 as described in clause (i), does not allow
16 approval of such an application.

17 “(10) NAMING.—The Secretary shall ensure
18 that the labeling and packaging of each biological
19 product licensed under this subsection bears a name
20 that uniquely identifies the biological product and
21 distinguishes it from the reference product and any
22 other biological products licensed under this sub-
23 section following evaluation against such reference
24 product.

1 “(l) PATENT NOTICES; RELATIONSHIP TO FINAL AP-
2 PROVAL.—

3 “(1) DEFINITIONS.—For the purposes of this
4 subsection, the term—

5 “(A) ‘biosimilar product’ means the bio-
6 logical product that is the subject of the appli-
7 cation under subsection (k);

8 “(B) ‘relevant patent’ means a patent
9 that—

10 “(i) expires after the date specified in
11 subsection (k)(7)(A) that applies to the
12 reference product; and

13 “(ii) could reasonably be asserted
14 against the applicant due to the unauthor-
15 ized making, use, sale, or offer for sale
16 within the United States, or the importa-
17 tion into the United States of the bio-
18 similar product, or materials used in the
19 manufacture of the biosimilar product, or
20 due to a use of the biosimilar product in
21 a method of treatment that is indicated in
22 the application;

23 “(C) ‘reference product sponsor’ means the
24 holder of an approved application or license for
25 the reference product; and

1 “(D) ‘interested third party’ means a per-
2 son other than the reference product sponsor
3 that owns a relevant patent, or has the right to
4 commence or participate in an action for in-
5 fringement of a relevant patent.

6 “(2) HANDLING OF CONFIDENTIAL INFORMA-
7 TION.—Any entity receiving confidential information
8 pursuant to this subsection shall designate one or
9 more individuals to receive such information. Each
10 individual so designated shall execute an agreement
11 in accordance with regulations promulgated by the
12 Secretary. The regulations shall require each such
13 individual to take reasonable steps to maintain the
14 confidentiality of information received pursuant to
15 this subsection and use the information solely for
16 purposes authorized by this subsection. The obliga-
17 tions imposed on an individual who has received con-
18 fidential information pursuant to this subsection
19 shall continue until the individual returns or de-
20 stroys the confidential information, a court imposes
21 a protective order that governs the use or handling
22 of the confidential information, or the party pro-
23 viding the confidential information agrees to other
24 terms or conditions regarding the handling or use of
25 the confidential information.

1 “(3) PUBLIC NOTICE BY SECRETARY.—Within
2 30 days of acceptance by the Secretary of an appli-
3 cation filed under subsection (k), the Secretary shall
4 publish a notice identifying—

5 “(A) the reference product identified in the
6 application; and

7 “(B) the name and address of an agent
8 designated by the applicant to receive notices
9 pursuant to paragraph (4)(B).

10 “(4) EXCHANGES CONCERNING PATENTS.—

11 “(A) EXCHANGES WITH REFERENCE
12 PRODUCT SPONSOR.—

13 “(i) Within 30 days of the date of ac-
14 ceptance of the application by the Sec-
15 retary, the applicant shall provide the ref-
16 erence product sponsor with a copy of the
17 application and information concerning the
18 biosimilar product and its production. This
19 information shall include a detailed de-
20 scription of the biosimilar product, its
21 method of manufacture, and the materials
22 used in the manufacture of the product.

23 “(ii) Within 60 days of the date of re-
24 ceipt of the information required to be pro-
25 vided under clause (i), the reference prod-

1 uct sponsor shall provide to the applicant
2 a list of relevant patents owned by the ref-
3 erence product sponsor, or in respect of
4 which the reference product sponsor has
5 the right to commence an action of in-
6 fringement or otherwise has an interest in
7 the patent as such patent concerns the bio-
8 similar product.

9 “(iii) If the reference product sponsor
10 is issued or acquires an interest in a rel-
11 evant patent after the date on which the
12 reference product sponsor provides the list
13 required by clause (ii) to the applicant, the
14 reference product sponsor shall identify
15 that patent to the applicant within 30 days
16 of the date of issue of the patent, or the
17 date of acquisition of the interest in the
18 patent, as applicable.

19 “(B) EXCHANGES WITH INTERESTED
20 THIRD PARTIES.—

21 “(i) At any time after the date on
22 which the Secretary publishes a notice for
23 an application under paragraph (3), any
24 interested third party may provide notice
25 to the designated agent of the applicant

1 that the interested third party owns or has
2 rights under 1 or more patents that may
3 be relevant patents. The notice shall iden-
4 tify at least 1 patent and shall designate
5 an individual who has executed an agree-
6 ment in accordance with paragraph (2) to
7 receive confidential information from the
8 applicant.

9 “(ii) Within 30 days of the date of re-
10 ceiving notice pursuant to clause (i), the
11 applicant shall send to the individual des-
12 ignated by the interested third party the
13 information specified in subparagraph
14 (A)(i), unless the applicant and interested
15 third party otherwise agree.

16 “(iii) Within 90 days of the date of
17 receiving information pursuant to clause
18 (ii), the interested third party shall provide
19 to the applicant a list of relevant patents
20 which the interested third party owns, or
21 in respect of which the interested third
22 party has the right to commence or partici-
23 pate in an action for infringement.

24 “(iv) If the interested third party is
25 issued or acquires an interest in a relevant

1 patent after the date on which the inter-
2 ested third party provides the list required
3 by clause (iii), the interested third party
4 shall identify that patent within 30 days of
5 the date of issue of the patent, or the date
6 of acquisition of the interest in the patent,
7 as applicable.

8 “(C) IDENTIFICATION OF BASIS FOR IN-
9 FRINGEMENT.—For any patent identified under
10 clause (ii) or (iii) of subparagraph (A) or under
11 clause (iii) or (iv) of subparagraph (B), the ref-
12 erence product sponsor or the interested third
13 party, as applicable—

14 “(i) shall explain in writing why the
15 sponsor or the interested third party be-
16 lieves the relevant patent would be in-
17 fringed by the making, use, sale, or offer
18 for sale within the United States, or im-
19 portation into the United States, of the
20 biosimilar product or by a use of the bio-
21 similar product in treatment that is indi-
22 cated in the application;

23 “(ii) may specify whether the relevant
24 patent is available for licensing; and

1 “(iii) shall specify the number and
2 date of expiration of the relevant patent.

3 “(D) CERTIFICATION BY APPLICANT CON-
4 CERNING IDENTIFIED RELEVANT PATENTS.—
5 Not later than 45 days after the date on which
6 a patent is identified under clause (ii) or (iii) of
7 subparagraph (A) or under clause (iii) or (iv) of
8 subparagraph (B), the applicant shall send a
9 written statement regarding each identified pat-
10 ent to the party that identified the patent. Such
11 statement shall either—

12 “(i) state that the applicant will not
13 commence marketing of the biosimilar
14 product and has requested the Secretary to
15 not grant final approval of the application
16 before the date of expiration of the noticed
17 patent; or

18 “(ii) provide a detailed written expla-
19 nation setting forth the reasons why the
20 applicant believes—

21 “(I) the making, use, sale, or
22 offer for sale within the United
23 States, or the importation into the
24 United States, of the biosimilar prod-
25 uct, or the use of the biosimilar prod-

1 uct in a treatment indicated in the ap-
2 plication, would not infringe the pat-
3 ent; or

4 “(II) the patent is invalid or un-
5 enforceable.

6 “(5) ACTION FOR INFRINGEMENT INVOLVING
7 REFERENCE PRODUCT SPONSOR.—If an action for
8 infringement concerning a relevant patent identified
9 by the reference product sponsor under clause (ii) or
10 (iii) of paragraph (4)(A), or by an interested third
11 party under clause (iii) or (iv) of paragraph (4)(B),
12 is brought within 60 days of the date of receipt of
13 a statement under paragraph (4)(D)(ii), and the
14 court in which such action has been commenced de-
15 termines the patent is infringed prior to the date ap-
16 plicable under subsection (k)(7)(A) or (k)(8), the
17 Secretary shall make approval of the application ef-
18 fective on the day after the date of expiration of the
19 patent that has been found to be infringed. If more
20 than one such patent is found to be infringed by the
21 court, the approval of the application shall be made
22 effective on the day after the date that the last such
23 patent expires.

24 “(6) NOTIFICATION OF AGREEMENTS.—

25 “(A) REQUIREMENTS.—

1 “(i) AGREEMENT BETWEEN BIO-
2 SIMILAR PRODUCT APPLICANT AND REF-
3 ERENCE PRODUCT SPONSOR.—If a bio-
4 similar product applicant under subsection
5 (k) and the reference product sponsor
6 enter into an agreement described in sub-
7 paragraph (B), the applicant and sponsor
8 shall each file the agreement in accordance
9 with subparagraph (C).

10 “(ii) AGREEMENT BETWEEN BIO-
11 SIMILAR PRODUCT APPLICANTS.—If 2 or
12 more biosimilar product applicants submit
13 an application under subsection (k) for bio-
14 similar products with the same reference
15 product and enter into an agreement de-
16 scribed in subparagraph (B), the appli-
17 cants shall each file the agreement in ac-
18 cordance with subparagraph (C).

19 “(B) SUBJECT MATTER OF AGREEMENT.—
20 An agreement described in this subparagraph—

21 “(i) is an agreement between the bio-
22 similar product applicant under subsection
23 (k) and the reference product sponsor or
24 between 2 or more biosimilar product ap-

1 plicants under subsection (k) regarding the
2 manufacture, marketing, or sale of—

3 “**(I)** the biosimilar product (or
4 biosimilar products) for which an ap-
5 plication was submitted; or

6 “**(II)** the reference product;

7 “(ii) includes any agreement between
8 the biosimilar product applicant under sub-
9 section (k) and the reference product spon-
10 sor or between 2 or more biosimilar prod-
11 uct applicants under subsection (k) that is
12 contingent upon, provides a contingent
13 condition for, or otherwise relates to an
14 agreement described in clause (i); and

15 “**(iii)** excludes any agreement that
16 solely concerns—

17 “**(I)** purchase orders for raw ma-
18 terial supplies;

19 “**(II)** equipment and facility con-
20 tracts;

21 “**(III)** employment or consulting
22 contracts; or

23 “**(IV)** packaging and labeling
24 contracts.

25 “**(C)** FILING.—

1 “(i) IN GENERAL.—The text of an
2 agreement required to be filed by subpara-
3 graph (A) shall be filed with the Assistant
4 Attorney General and the Federal Trade
5 Commission not later than—

6 “(I) 10 business days after the
7 date on which the agreement is exe-
8 cuted; and

9 “(II) prior to the date of the first
10 commercial marketing of, for agree-
11 ments described in subparagraph
12 (A)(i), the biosimilar product that is
13 the subject of the application or, for
14 agreements described in subparagraph
15 (A)(ii), any biosimilar product that is
16 the subject of an application described
17 in such subparagraph.

18 “(ii) IF AGREEMENT NOT REDUCED
19 TO TEXT.—If an agreement required to be
20 filed by subparagraph (A) has not been re-
21 duced to text, the persons required to file
22 the agreement shall each file written de-
23 scriptions of the agreement that are suffi-
24 cient to disclose all the terms and condi-
25 tions of the agreement.

1 “(iii) CERTIFICATION.—The chief ex-
2 ecutive officer or the company official re-
3 sponsible for negotiating any agreement re-
4 quired to be filed by subparagraph (A)
5 shall include in any filing under this para-
6 graph a certification as follows: ‘I declare
7 under penalty of perjury that the following
8 is true and correct: The materials filed
9 with the Federal Trade Commission and
10 the Department of Justice under section
11 351(l)(6) of the Public Health Service Act,
12 with respect to the agreement referenced in
13 this certification: (1) represent the com-
14 plete, final, and exclusive agreement be-
15 tween the parties; (2) include any ancillary
16 agreements that are contingent upon, pro-
17 vide a contingent condition for, or are oth-
18 erwise related to, the referenced agree-
19 ment; and (3) include written descriptions
20 of any oral agreements, representations,
21 commitments, or promises between the
22 parties that are responsive to such section
23 and have not been reduced to writing.’.

24 “(D) DISCLOSURE EXEMPTION.—Any in-
25 formation or documentary material filed with

1 the Assistant Attorney General or the Federal
2 Trade Commission pursuant to this paragraph
3 shall be exempt from disclosure under section
4 552 of title 5, United States Code, and no such
5 information or documentary material may be
6 made public, except as may be relevant to any
7 administrative or judicial action or proceeding.
8 Nothing in this subparagraph prevents disclo-
9 sure of information or documentary material to
10 either body of the Congress or to any duly au-
11 thorized committee or subcommittee of the Con-
12 gress.

13 “(E) ENFORCEMENT.—

14 “(i) CIVIL PENALTY.—Any person
15 that violates a provision of this paragraph
16 shall be liable for a civil penalty of not
17 more than \$11,000 for each day on which
18 the violation occurs. Such penalty may be
19 recovered in a civil action—

20 “(I) brought by the United
21 States; or

22 “(II) brought by the Federal
23 Trade Commission in accordance with
24 the procedures established in section

1 16(a)(1) of the Federal Trade Com-
2 mission Act.

3 “(ii) COMPLIANCE AND EQUITABLE
4 RELIEF.—If any person violates any provi-
5 sion of this paragraph, the United States
6 district court may order compliance, and
7 may grant such other equitable relief as
8 the court in its discretion determines nec-
9 essary or appropriate, upon application of
10 the Assistant Attorney General or the Fed-
11 eral Trade Commission.

12 “(F) RULEMAKING.—The Federal Trade
13 Commission, with the concurrence of the Assist-
14 ant Attorney General and by rule in accordance
15 with section 553 of title 5, United States Code,
16 consistent with the purposes of this para-
17 graph—

18 “(i) may define the terms used in this
19 paragraph;

20 “(ii) may exempt classes of persons or
21 agreements from the requirements of this
22 paragraph; and

23 “(iii) may prescribe such other rules
24 as may be necessary and appropriate to
25 carry out the purposes of this paragraph.

1 “(G) SAVINGS CLAUSE.—Any action taken
2 by the Assistant Attorney General or the Fed-
3 eral Trade Commission, or any failure of the
4 Assistant Attorney General or the Commission
5 to take action, under this paragraph shall not
6 at any time bar any proceeding or any action
7 with respect to any agreement between a bio-
8 similar product applicant under subsection (k)
9 and the reference product sponsor, or any
10 agreement between biosimilar product appli-
11 cants under subsection (k), under any other
12 provision of law, nor shall any filing under this
13 paragraph constitute or create a presumption of
14 any violation of any competition laws.”.

15 (b) DEFINITIONS.—Section 351(i) of the Public
16 Health Service Act (42 U.S.C. 262(i)) is amended—

17 (1) by striking “In this section, the term ‘bio-
18 logical product’ means” and inserting the following:

19 “In this section:

20 “(1) The term ‘biological product’ means”;

21 (2) in paragraph (1), as so designated, by in-
22 serting “protein (except any chemically synthesized
23 polypeptide),” after “allergenic product,”; and

24 (3) by adding at the end the following:

1 “(2) The term ‘biosimilar’ or ‘biosimilarity’, in
2 reference to a biological product that is the subject
3 of an application under subsection (k), means—

4 “(A) that the biological product is highly
5 similar to the reference product notwith-
6 standing minor differences in clinically inactive
7 components; and

8 “(B) there are no clinically meaningful dif-
9 ferences between the biological product and the
10 reference product in terms of the safety, purity,
11 and potency of the product.

12 “(3) The term ‘interchangeable’ or ‘inter-
13 changeability’, in reference to a biological product
14 that is shown to meet the standards described in
15 subsection (k)(4), means that the biological product
16 may be substituted for the reference product without
17 the intervention of the health care provider who pre-
18 scribed the reference product.

19 “(4) The term ‘reference product’ means the
20 single biological product licensed under subsection
21 (a) against which a biological product is evaluated in
22 an application submitted under subsection (k).”.

23 (c) PRODUCTS PREVIOUSLY APPROVED UNDER SEC-
24 TION 505.—

1 (1) REQUIREMENT TO FOLLOW SECTION 351.—
2 Except as provided in paragraph (2), an application
3 for a biological product shall be submitted under
4 section 351 of the Public Health Service Act (42
5 U.S.C. 262) (as amended by this Act).

6 (2) EXCEPTION.—An application for a biological
7 product may be submitted under section 505 of
8 the Federal Food, Drug, and Cosmetic Act (21
9 U.S.C. 355) if—

10 (A) such biological product is in a product
11 class for which a biological product in such
12 product class is the subject of an application
13 approved under such section 505 not later than
14 the date of enactment of this Act; and

15 (B) such application—

16 (i) has been submitted to the Sec-
17 retary of Health and Human Services (re-
18 ferred to in this Act as the “Secretary”)
19 before the date of enactment of this Act;
20 or

21 (ii) is submitted to the Secretary not
22 later than the date that is 10 years after
23 the date of enactment of this Act.

24 (3) LIMITATION.—Notwithstanding paragraph
25 (2), an application for a biological product may not

1 be submitted under section 505 of the Federal Food,
2 Drug, and Cosmetic Act (21 U.S.C. 355) if there is
3 another biological product approved under sub-
4 section (a) of section 351 of the Public Health Serv-
5 ice Act that could be a reference product with re-
6 spect to such application (within the meaning of
7 such section 351) if such application were submitted
8 under subsection (k) of such section 351.

9 (4) DEEMED APPROVED UNDER SECTION 351.—
10 An approved application for a biological product
11 under section 505 of the Federal Food, Drug, and
12 Cosmetic Act (21 U.S.C. 355) shall be deemed to be
13 a license for the biological product under such sec-
14 tion 351 on the date that is 10 years after the date
15 of enactment of this Act.

16 (5) DEFINITIONS.—For purposes of this sub-
17 section, the term “biological product” has the mean-
18 ing given such term under section 351 of the Public
19 Health Service Act (42 U.S.C. 262) (as amended by
20 this Act).

21 **SEC. 2576. FEES RELATING TO BIOSIMILAR BIOLOGICAL**
22 **PRODUCTS.**

23 Subparagraph (B) of section 735(1) of the Federal
24 Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is
25 amended by inserting “, including licensure of a biological

1 product under section 351(k) of such Act” before the pe-
2 riod at the end.

3 **SEC. 2577. AMENDMENTS TO CERTAIN PATENT PROVI-**
4 **SIONS.**

5 (a) Section 271(e)(2) of title 35, United States Code
6 is amended—

7 (1) in subparagraph (A), by striking “or” after
8 “patent,”;

9 (2) in subparagraph (B), by adding “or” after
10 the comma at the end;

11 (3) by inserting the following after subpara-
12 graph (B):

13 “(C) a statement under section
14 351(l)(4)(D)(ii) of the Public Health Service
15 Act,”; and

16 (4) in the matter following subparagraph (C)
17 (as added by paragraph (3)), by inserting before the
18 period the following: “, or if the statement described
19 in subparagraph (C) is provided in connection with
20 an application to obtain a license to engage in the
21 commercial manufacture, use, or sale of a biological
22 product claimed in a patent or the use of which is
23 claimed in a patent before the expiration of such
24 patent”.

1 (b) Section 271(e)(4) of title 35, United States Code,
2 is amended by striking “in paragraph (2)” in both places
3 it appears and inserting “in paragraph (2)(A) or (2)(B)”.

4 **Subtitle D—Community Living**
5 **Assistance Services and Supports**

6 **SEC. 2581. ESTABLISHMENT OF NATIONAL VOLUNTARY IN-**
7 **SURANCE PROGRAM FOR PURCHASING COM-**
8 **MUNITY LIVING ASSISTANCE SERVICES AND**
9 **SUPPORT (CLASS PROGRAM).**

10 (a) ESTABLISHMENT OF CLASS PROGRAM.—The
11 Public Health Service Act (42 U.S.C. 201 et seq.), as
12 amended by section 2301, is amended by adding at the
13 end the following:

14 **“TITLE XXXII—COMMUNITY LIV-**
15 **ING ASSISTANCE SERVICES**
16 **AND SUPPORTS**

17 **“SEC. 3201. PURPOSE.**

18 “The purpose of this title is to establish a national
19 voluntary insurance program for purchasing community
20 living assistance services and supports in order to—

21 “(1) provide individuals with functional limita-
22 tions with tools that will allow them to maintain
23 their personal and financial independence and live in
24 the community through a new financing strategy for
25 community living assistance services and supports;

1 “(2) establish an infrastructure that will help
2 address the Nation’s community living assistance
3 services and supports needs;

4 “(3) alleviate burdens on family caregivers; and

5 “(4) address institutional bias by providing a fi-
6 nancing mechanism that supports personal choice
7 and independence to live in the community.

8 **“SEC. 3202. DEFINITIONS.**

9 “In this title:

10 “(1) **ACTIVE ENROLLEE.**—The term ‘active en-
11 rollee’ means an individual who is enrolled in the
12 **CLASS** program in accordance with section 3204
13 and who has paid any premiums due to maintain
14 such enrollment.

15 “(2) **ACTIVELY EMPLOYED.**—The term ‘actively
16 employed’ means an individual who—

17 “(A) is reporting for work at the individ-
18 ual’s usual place of employment or at another
19 location to which the individual is required to
20 travel because of the individual’s employment
21 (or in the case of an individual who is a mem-
22 ber of the uniformed services, is on active duty
23 and is physically able to perform the duties of
24 the individual’s position); and

1 “(B) is able to perform all the usual and
2 customary duties of the individual’s employment
3 on the individual’s regular work schedule.

4 “(3) ACTIVITIES OF DAILY LIVING.—The term
5 ‘activities of daily living’ has the meaning given the
6 term in section 7702B(c)(2)(B) of the Internal Rev-
7 enue Code of 1986.

8 “(4) CLASS PROGRAM.—The term ‘CLASS
9 program’ means the program established under this
10 title.

11 “(5) ELIGIBILITY ASSESSMENT SYSTEM.—The
12 term ‘Eligibility Assessment System’ means the enti-
13 ty designated by the Secretary under section
14 3205(a)(2)(A)(i).

15 “(6) ELIGIBLE BENEFICIARY.—

16 “(A) IN GENERAL.—The term ‘eligible
17 beneficiary’ means any individual who is an ac-
18 tive enrollee in the CLASS program and, as of
19 the date described in subparagraph (B)—

20 “(i) has paid premiums for enrollment
21 in such program for at least 60 months;

22 “(ii) has earned, for each calendar
23 year that occurs during the first 60
24 months for which the individual has paid
25 premiums for enrollment in the program,

1 at least an amount equal to the amount of
2 wages and self-employment income which
3 an individual must have in order to be
4 credited with a quarter of coverage under
5 section 213(d) of the Social Security Act
6 for that year; and

7 “(iii) has paid premiums for enroll-
8 ment in such program for at least 24 con-
9 secutive months, if a lapse in premium
10 payments of more than 3 months has oc-
11 curred during the period that begins on the
12 date of the individual’s enrollment and
13 ends on the date of such determination.

14 “(B) DATE DESCRIBED.—For purposes of
15 subparagraph (A), the date described in this
16 subparagraph is the date on which the indi-
17 vidual is determined to have a functional limita-
18 tion described in section 3203(a)(1)(C) that is
19 expected to last for a continuous period of more
20 than 90 days.

21 “(C) REGULATIONS.—The Secretary shall
22 promulgate regulations specifying exceptions to
23 the minimum earnings requirements under sub-
24 paragraph (A)(ii) for purposes of being consid-

1 ered an eligible beneficiary for certain popu-
2 lations.

3 “(7) HOSPITAL; NURSING FACILITY; INTER-
4 MEDIATE CARE FACILITY FOR THE MENTALLY RE-
5 TARDED; INSTITUTION FOR MENTAL DISEASES.—
6 The terms ‘hospital’, ‘nursing facility’, ‘intermediate
7 care facility for the mentally retarded’, and ‘institu-
8 tion for mental diseases’ have the meanings given
9 such terms for purposes of Medicaid.

10 “(8) CLASS INDEPENDENCE ADVISORY COUN-
11 CIL.—The term ‘CLASS Independence Advisory
12 Council’ or ‘Council’ means the Advisory Council es-
13 tablished under section 3207 to advise the Secretary.

14 “(9) CLASS INDEPENDENCE BENEFIT PLAN.—
15 The term ‘CLASS Independence Benefit Plan’
16 means the benefit plan developed and designated by
17 the Secretary in accordance with section 3203.

18 “(10) CLASS INDEPENDENCE FUND.—The
19 term ‘CLASS Independence Fund’ or ‘Fund’ means
20 the fund established under section 3206.

21 “(11) MEDICAID.—The term ‘Medicaid’ means
22 the program established under title XIX of the So-
23 cial Security Act.

24 “(12) PROTECTION AND ADVOCACY SYSTEM.—
25 The term ‘Protection and Advocacy System’ means

1 the system for each State established under section
2 143 of the Developmental Disabilities Assistance
3 and Bill of Rights Act of 2000.

4 **“SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.**

5 “(a) PROCESS FOR DEVELOPMENT.—

6 “(1) IN GENERAL.—The Secretary, in consulta-
7 tion with appropriate actuaries and other experts,
8 shall develop at least 3 actuarially sound benefit
9 plans as alternatives for consideration for designa-
10 tion by the Secretary as the CLASS Independence
11 Benefit Plan under which eligible beneficiaries shall
12 receive benefits under this title. Each of the plan al-
13 ternatives developed shall be designed to provide eli-
14 gible beneficiaries with the benefits described in sec-
15 tion 3205 consistent with the following require-
16 ments:

17 “(A) PREMIUMS.—Beginning with the first
18 year of the CLASS program, and for each year
19 thereafter, the Secretary shall establish all pre-
20 miums to be paid by enrollees for the year
21 based on an actuarial analysis of the 75-year
22 costs of the program that ensures solvency
23 throughout such 75-year period.

24 “(B) VESTING PERIOD.—A 5-year vesting
25 period for eligibility for benefits.

1 “(C) BENEFIT TRIGGERS.—A benefit trig-
2 ger for provision of benefits that requires a de-
3 termination that an individual has a functional
4 limitation, as certified by a licensed health care
5 practitioner, described in any of the following
6 clauses that is expected to last for a continuous
7 period of more than 90 days:

8 “(i) The individual is determined to
9 be unable to perform at least the minimum
10 number (which may be 2 or 3) of activities
11 of daily living as are required under the
12 plan for the provision of benefits without
13 substantial assistance (as defined by the
14 Secretary) from another individual.

15 “(ii) The individual requires substan-
16 tial supervision to protect the individual
17 from threats to health and safety due to
18 substantial cognitive impairment.

19 “(iii) The individual has a level of
20 functional limitation similar (as determined
21 under regulations prescribed by the Sec-
22 retary) to the level of functional limitation
23 described in clause (i) or (ii).

24 “(D) CASH BENEFIT.—Payment of a cash
25 benefit that satisfies the following requirements:

1 “(i) MINIMUM REQUIRED AMOUNT.—

2 The benefit amount provides an eligible
3 beneficiary with not less than an average
4 of \$50 per day (as determined based on
5 the reasonably expected distribution of
6 beneficiaries receiving benefits at various
7 benefit levels).

8 “(ii) AMOUNT SCALED TO FUNC-
9 TIONAL ABILITY.—The benefit amount is
10 varied based on a scale of functional abil-
11 ity, with not less than 2, and not more
12 than 6, benefit level amounts.

13 “(iii) DAILY OR WEEKLY.—The ben-
14 efit is paid on a daily or weekly basis.

15 “(iv) NO LIFETIME OR AGGREGATE
16 LIMIT.—The benefit is not subject to any
17 lifetime or aggregate limit.

18 “(2) REVIEW AND RECOMMENDATION BY THE
19 CLASS INDEPENDENCE ADVISORY COUNCIL.—The
20 CLASS Independence Advisory Council shall—

21 “(A) evaluate the alternative benefit plans
22 developed under paragraph (1); and

23 “(B) recommend for designation as the
24 CLASS Independence Benefit Plan for offering
25 to the public the plan that the Council deter-

1 mines best balances price and benefits to meet
2 enrollees' needs in an actuarially sound manner,
3 while optimizing the probability of the long-
4 term sustainability of the CLASS program.

5 “(3) DESIGNATION BY THE SECRETARY.—Not
6 later than October 1, 2012, the Secretary, taking
7 into consideration the recommendation of the
8 CLASS Independence Advisory Council under para-
9 graph (2)(B), shall designate a benefit plan as the
10 CLASS Independence Benefit Plan. The Secretary
11 shall publish such designation, along with details of
12 the plan and the reasons for the selection by the
13 Secretary, in a final rule that allows for a period of
14 public comment.

15 “(b) ADDITIONAL PREMIUM REQUIREMENTS.—

16 “(1) ADJUSTMENT OF PREMIUMS.—

17 “(A) IN GENERAL.—Except as provided in
18 subparagraphs (B), (C), (D), and (E), the
19 amount of the monthly premium determined for
20 an individual upon such individual's enrollment
21 in the CLASS program shall remain the same
22 for as long as the individual is an active en-
23 rollee in the program.

24 “(B) RECALCULATED PREMIUM IF RE-
25 QUIRED FOR PROGRAM SOLVENCY.—

1 “(II) has paid premiums for en-
2 rollment in the program for at least
3 20 years; and

4 “(III) is not actively employed.

5 “(C) RECALCULATED PREMIUM IF RE-
6 ENROLLMENT AFTER MORE THAN A 3-MONTH
7 LAPSE.—

8 “(i) IN GENERAL.—The reenrollment
9 of an individual after a 90-day period dur-
10 ing which the individual failed to pay the
11 monthly premium required to maintain the
12 individual’s enrollment in the CLASS pro-
13 gram shall be treated as an initial enroll-
14 ment for purposes of age-adjusting the
15 premium for enrollment in the program.

16 “(ii) CREDIT FOR PRIOR MONTHS IF
17 REENROLLED WITHIN 5 YEARS.—An indi-
18 vidual who reenrolls in the CLASS pro-
19 gram after such a 90-day period and be-
20 fore the end of the 5-year period that be-
21 gins with the first month for which the in-
22 dividual failed to pay the monthly premium
23 required to maintain the individual’s en-
24 rollment in the program shall be—

1 “(I) credited with any months of
2 paid premiums that accrued prior to
3 the individual’s lapse in enrollment;
4 and

5 “(II) notwithstanding the total
6 amount of any such credited months,
7 required to satisfy section
8 3202(6)(A)(ii) before being eligible to
9 receive benefits.

10 “(D) PENALTY FOR REENROLLMENT
11 AFTER 5-YEAR LAPSE.—In the case of an indi-
12 vidual who reenrolls in the CLASS program
13 after the end of the 5-year period described in
14 subparagraph (C)(ii), the monthly premium re-
15 quired for the individual shall be the age-ad-
16 justed premium that would be applicable to an
17 initially enrolling individual who is the same age
18 as the reenrolling individual, increased by the
19 greater of—

20 “(i) an amount that the Secretary de-
21 termines is actuarially sound for each
22 month that occurs during the period that
23 begins with the first month for which the
24 individual failed to pay the monthly pre-
25 mium required to maintain the individual’s

1 enrollment in the CLASS program and
2 ends with the month preceding the month
3 in which the reenrollment is effective; or

4 “(ii) 1 percent of the applicable age-
5 adjusted premium for each such month oc-
6 ccurring in such period.

7 “(2) ADMINISTRATIVE EXPENSES.—In deter-
8 mining the monthly premiums for the CLASS pro-
9 gram, the Secretary may factor in costs for admin-
10 istering the program, not to exceed—

11 “(A) in the case of the first 5 years in
12 which the program is in effect under this title,
13 an amount equal to 3 percent of all premiums
14 paid during each such year; and

15 “(B) in the case of subsequent years, an
16 amount equal to 5 percent of the total amount
17 of all expenditures (including benefits paid)
18 under this title with respect to that year.

19 “(3) NO UNDERWRITING REQUIREMENTS.—No
20 underwriting (other than on the basis of age in ac-
21 cordance with paragraph (2)) shall be used to—

22 “(A) determine the monthly premium for
23 enrollment in the CLASS program; or

24 “(B) prevent an individual from enrolling
25 in the program.

1 **“SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIRE-**
2 **MENTS.**

3 “(a) AUTOMATIC ENROLLMENT.—

4 “(1) IN GENERAL.—Subject to paragraph (2),
5 the Secretary shall establish procedures under which
6 each individual described in subsection (c) shall be
7 automatically enrolled in the CLASS program by an
8 employer of such individual under rules similar to
9 the rules of sections 401(k)(13) and 414(w) of the
10 Internal Revenue Code of 1986.

11 “(2) ALTERNATIVE ENROLLMENT PROCE-
12 DURES.—The procedures established under para-
13 graph (1) shall provide for an alternative enrollment
14 process for an individual described in subsection (c)
15 in the case of such an individual—

16 “(A) who is self-employed;

17 “(B) who has more than 1 employer;

18 “(C) whose employer does not elect to par-
19 ticipate in the automatic enrollment process es-
20 tablished by the Secretary; or

21 “(D) who is a spouse described in sub-
22 section (c)(2) of who is not subject to automatic
23 enrollment.

24 “(3) ADMINISTRATION.—

25 “(A) IN GENERAL.—The Secretary shall,
26 by regulation, establish procedures to—

1 “(i) ensure that an individual is not
2 automatically enrolled in the CLASS pro-
3 gram by more than 1 employer; and

4 “(ii) allow for an individual’s em-
5 ployer to deduct a premium for a spouse
6 described in subsection (c)(1)(B) who is
7 not subject to automatic enrollment.

8 “(B) FORM.—Enrollment in the CLASS
9 program shall be made in such manner as the
10 Secretary may prescribe in order to ensure ease
11 of administration.

12 “(b) ELECTION TO OPT-OUT.—An individual de-
13 scribed in subsection (c) may elect to waive enrollment in
14 the CLASS program at any time in such form and manner
15 as the Secretary shall prescribe.

16 “(c) INDIVIDUAL DESCRIBED.—For purposes of en-
17 rolling in the CLASS program, an individual described in
18 this paragraph is—

19 “(1) an individual—

20 “(A) who has attained age 18;

21 “(B) who receives wages on which there is
22 imposed a tax under section 3101(a) or 3201(a)
23 of the Internal Revenue Code of 1986;

24 “(C) who is actively employed; and

25 “(D) who is not—

1 “(i) a patient in a hospital or nursing
2 facility, an intermediate care facility for
3 the mentally retarded, or an institution for
4 mental diseases and receiving medical as-
5 sistance under Medicaid; or

6 “(ii) confined in a jail, prison, other
7 penal institution or correctional facility, or
8 by court order pursuant to conviction of a
9 criminal offense or in connection with a
10 verdict or finding described in section
11 202(x)(1)(A)(ii) of the Social Security Act;
12 or

13 “(2) the spouse of an individual described in
14 paragraph (1) and who would be an individual so de-
15 scribed but for subparagraph (B) or (C) of that
16 paragraph.

17 “(d) RULE OF CONSTRUCTION.—Nothing in this title
18 shall be construed as requiring an active enrollee to con-
19 tinue to satisfy subparagraph (B) or (C) of subsection
20 (c)(1) in order to maintain enrollment in the CLASS pro-
21 gram.

22 “(e) PAYMENT.—

23 “(1) PAYROLL DEDUCTION.—An amount equal
24 to the monthly premium for the enrollment in the
25 CLASS program of an individual shall be deducted

1 from the wages of such individual in accordance with
2 such procedures as the Secretary shall establish for
3 employers who elect to deduct and withhold such
4 premiums on behalf of enrolled employees.

5 “(2) ALTERNATIVE PAYMENT MECHANISM.—
6 The Secretary shall establish alternative procedures
7 for the payment of monthly premiums by an indi-
8 vidual enrolled in the CLASS program who does not
9 have an employer who elects to deduct and withhold
10 premiums in accordance with subparagraph (A).

11 “(f) TRANSFER OF PREMIUMS COLLECTED.—

12 “(1) IN GENERAL.—During each calendar year
13 the Secretary of the Treasury shall deposit into the
14 CLASS Independence Fund a total amount equal, in
15 the aggregate, to 100 percent of the premiums col-
16 lected during that year.

17 “(2) TRANSFERS BASED ON ESTIMATES.—The
18 amount deposited pursuant to paragraph (1) shall be
19 transferred in at least monthly payments to the
20 CLASS Independence Fund on the basis of esti-
21 mates by the Secretary and certified to the Sec-
22 retary of the Treasury of the amounts collected in
23 accordance with this section. Proper adjustments
24 shall be made in amounts subsequently transferred

1 to the Fund to the extent prior estimates were in ex-
2 cess of, or were less than, actual amounts collected.

3 “(g) OTHER ENROLLMENT AND DISENROLLMENT
4 OPPORTUNITIES.—The Secretary shall establish proce-
5 dures under which—

6 “(1) an individual who, in the year of the indi-
7 vidual’s initial eligibility to enroll in the CLASS pro-
8 gram, has elected to waive enrollment in the pro-
9 gram, is eligible to elect to enroll in the program, in
10 such form and manner as the Secretary shall estab-
11 lish, only during an open enrollment period estab-
12 lished by the Secretary that is specific to the indi-
13 vidual and that may not occur more frequently than
14 biennially after the date on which the individual first
15 elected to waive enrollment in the program; and

16 “(2) an individual shall only be permitted to
17 disenroll from the program during an annual
18 disenrollment period established by the Secretary
19 and in such form and manner as the Secretary shall
20 establish.

21 **“SEC. 3205. BENEFITS.**

22 “(a) DETERMINATION OF ELIGIBILITY.—

23 “(1) APPLICATION FOR RECEIPT OF BENE-
24 FITS.—The Secretary shall establish procedures
25 under which an active enrollee shall apply for receipt

1 of benefits under the CLASS Independence Benefit
2 Plan.

3 “(2) ELIGIBILITY ASSESSMENTS.—

4 “(A) IN GENERAL.—Not later than Janu-
5 ary 1, 2012, the Secretary shall—

6 “(i) designate an entity (other than a
7 service with which the Commissioner of So-
8 cial Security has entered into an agree-
9 ment, with respect to any State, to make
10 disability determinations for purposes of
11 title II or XVI of the Social Security Act)
12 to serve as an Eligibility Assessment Sys-
13 tem by providing for eligibility assessments
14 of active enrollees who apply for receipt of
15 benefits;

16 “(ii) enter into an agreement with the
17 Protection and Advocacy System for each
18 State to provide advocacy services in ac-
19 cordance with subsection (d); and

20 “(iii) enter into an agreement with
21 public and private entities to provide ad-
22 vice and assistance counseling in accord-
23 ance with subsection (e).

24 “(B) REGULATIONS.—The Secretary shall
25 promulgate regulations to develop an expedited

1 nationally equitable eligibility determination
2 process, as certified by a licensed health care
3 practitioner, an appeals process, and a redeter-
4 mination process, as certified by a licensed
5 health care practitioner, including whether an
6 applicant is eligible for a cash benefit under the
7 program and if so, the amount of the cash ben-
8 efit (in accordance the sliding scale established
9 under the plan).

10 “(C) PRESUMPTIVE ELIGIBILITY FOR CER-
11 TAIN INSTITUTIONALIZED ENROLLEES PLAN-
12 NING TO DISCHARGE.—An active enrollee shall
13 be deemed presumptively eligible if the en-
14 rollee—

15 “(i) has applied for, and attests is eli-
16 gible for, the maximum cash benefit avail-
17 able under the sliding scale established
18 under the CLASS Independence Benefit
19 Plan;

20 “(ii) is a patient in a hospital (but
21 only if the hospitalization is for long-term
22 care), nursing facility, intermediate care
23 facility for the mentally retarded, or an in-
24 stitution for mental diseases; and

1 “(iii) is in the process of, or about to
2 being the process of, planning to discharge
3 from the hospital, facility, or institution, or
4 within 60 days from the date of discharge
5 from the hospital, facility, or institution.

6 “(D) APPEALS.—The Secretary shall es-
7 tablish procedures under which an applicant for
8 benefits under the CLASS Independence Ben-
9 efit Plan shall be guaranteed the right to ap-
10 peal an adverse determination.

11 “(b) BENEFITS.—An eligible beneficiary shall receive
12 the following benefits under the CLASS Independence
13 Benefit Plan:

14 “(1) CASH BENEFIT.—A cash benefit estab-
15 lished by the Secretary in accordance with the re-
16 quirements of section 3203(a)(1)(D) that—

17 “(A) the first year in which beneficiaries
18 receive the benefits under the plan, is not less
19 than the average dollar amount specified in
20 clause (i) of such section; and

21 “(B) for any subsequent year, is not less
22 than the average per day dollar limit applicable
23 under this subparagraph for the preceding year,
24 increased by the percentage increase in the con-

1 sumer price index for all urban consumers
2 (U.S. city average) over the previous year.

3 “(2) ADVOCACY SERVICES.—Advocacy services
4 in accordance with subsection (d).

5 “(3) ADVICE AND ASSISTANCE COUNSELING.—
6 Advice and assistance counseling in accordance with
7 subsection (e).

8 “(4) ADMINISTRATIVE EXPENSES.—Advocacy
9 services and advise and assistance counseling serv-
10 ices under paragraphs (2) and (3) of this subsection
11 shall be included as administrative expenses under
12 section 3203(b)(2).

13 “(c) PAYMENT OF BENEFITS.—

14 “(1) LIFE INDEPENDENCE ACCOUNT.—

15 “(A) IN GENERAL.—The Secretary shall
16 establish procedures for administering the pro-
17 vision of benefits to eligible beneficiaries under
18 the CLASS Independence Benefit Plan, includ-
19 ing the payment of the cash benefit for the ben-
20 eficiary into a Life Independence Account es-
21 tablished by the Secretary on behalf of each eli-
22 gible beneficiary.

23 “(B) USE OF CASH BENEFITS.—Cash ben-
24 efits paid into a Life Independence Account of
25 an eligible beneficiary shall be used to purchase

1 nonmedical services and supports that the bene-
2 ficiary needs to maintain his or her independ-
3 ence at home or in another residential setting
4 of their choice in the community, including (but
5 not limited to) home modifications, assistive
6 technology, accessible transportation, home-
7 maker services, respite care, personal assistance
8 services, home care aides, and nursing support.
9 Nothing in the preceding sentence shall prevent
10 an eligible beneficiary from using cash benefits
11 paid into a Life Independence Account for ob-
12 taining assistance with decisionmaking con-
13 cerning medical care, including the right to ac-
14 cept or refuse medical or surgical treatment
15 and the right to formulate advance directives or
16 other written instructions recognized under
17 State law, such as a living will or durable power
18 of attorney for health care, in the case that an
19 injury or illness causes the individual to be un-
20 able to make health care decisions.

21 “(C) ELECTRONIC MANAGEMENT OF
22 FUNDS.—The Secretary shall establish proce-
23 dures for—

1 “(i) crediting an account established
2 on behalf of a beneficiary with the bene-
3 ficiary’s cash daily benefit;

4 “(ii) allowing the beneficiary to access
5 such account through debit cards; and

6 “(iii) accounting for withdrawals by
7 the beneficiary from such account.

8 “(D) PRIMARY PAYOR RULES FOR BENE-
9 FICIARIES WHO ARE ENROLLED IN MEDICAID.—
10 In the case of an eligible beneficiary who is en-
11 rolled in Medicaid, the following payment rules
12 shall apply:

13 “(i) INSTITUTIONALIZED BENE-
14 FICIARY.—If the beneficiary is a patient in
15 a hospital, nursing facility, intermediate
16 care facility for the mentally retarded, or
17 an institution for mental diseases, the ben-
18 eficiary shall retain an amount equal to 5
19 percent of the beneficiary’s daily or weekly
20 cash benefit (as applicable) (which shall be
21 in addition to the amount of the bene-
22 ficiary’s personal needs allowance provided
23 under Medicaid), and the remainder of
24 such benefit shall be applied toward the fa-
25 cility’s cost of providing the beneficiary’s

1 care, and Medicaid shall provide secondary
2 coverage for such care.

3 “(ii) BENEFICIARIES RECEIVING
4 HOME AND COMMUNITY-BASED SERV-
5 ICES.—

6 “(I) 50 PERCENT OF BENEFIT
7 RETAINED BY BENEFICIARY.—Subject
8 to subclause (II), if a beneficiary is
9 receiving medical assistance under
10 Medicaid for home and community-
11 based services, the beneficiary shall
12 retain an amount equal to 50 percent
13 of the beneficiary’s daily or weekly
14 cash benefit (as applicable), and the
15 remainder of the daily or weekly cash
16 benefit shall be applied toward the
17 cost to the State of providing such as-
18 sistance (and shall not be used to
19 claim Federal matching funds under
20 Medicaid), and Medicaid shall provide
21 secondary coverage for the remainder
22 of any costs incurred in providing
23 such assistance.

24 “(II) REQUIREMENT FOR STATE
25 OFFSET.—A State shall be paid the

1 remainder of a beneficiary's daily or
2 weekly cash benefit under subclause
3 (I) only if the State home and com-
4 munity-based waiver under section
5 1115 of the Social Security Act or
6 subsection (c) or (d) of section 1915
7 of such Act, or the State plan amend-
8 ment under subsection (i) of such sec-
9 tion does not include a waiver of the
10 requirements of section 1902(a)(1) of
11 the Social Security Act (relating to
12 statewideness) or of section
13 1902(a)(10)(B) of such Act (relating
14 to comparability) and the State offers
15 at a minimum case management serv-
16 ices, personal care services, habili-
17 tation services, and respite care under
18 such a waiver or State plan amend-
19 ment.

20 “(III) DEFINITION OF HOME AND
21 COMMUNITY-BASED SERVICES.—In
22 this clause, the term ‘home and com-
23 munity-based services’ means any
24 services which may be offered under a
25 home and community-based waiver

1 authorized for a State under section
2 1115 of the Social Security Act or
3 subsection (c) or (d) of section 1915
4 of such Act or under a State plan
5 amendment under subsection (i) of
6 such section.

7 “(iii) BENEFICIARIES ENROLLED IN
8 PROGRAMS OF ALL-INCLUSIVE CARE FOR
9 THE ELDERLY (PACE).—

10 “(I) IN GENERAL.—Subject to
11 subclause (II), if a beneficiary is re-
12 ceiving medical assistance under Med-
13 icaid for PACE program services
14 under section 1934 of the Social Secu-
15 rity Act, the beneficiary shall retain
16 an amount equal to 50 percent of the
17 beneficiary’s daily or weekly cash ben-
18 efit (as applicable), and the remainder
19 of the daily or weekly cash benefit
20 shall be applied toward the cost to the
21 State of providing such assistance
22 (and shall not be used to claim Fed-
23 eral matching funds under Medicaid),
24 and Medicaid shall provide secondary
25 coverage for the remainder of any

1 costs incurred in providing such as-
2 sistance.

3 “(II) INSTITUTIONALIZED RE-
4 CIPIENTS OF PACE PROGRAM SERV-
5 ICES.—If a beneficiary receiving as-
6 sistance under Medicaid for PACE
7 program services is a patient in a hos-
8 pital, nursing facility, intermediate
9 care facility for the mentally retarded,
10 or an institution for mental diseases,
11 the beneficiary shall be treated as in
12 institutionalized beneficiary under
13 clause (i).

14 “(2) AUTHORIZED REPRESENTATIVES.—

15 “(A) IN GENERAL.—The Secretary shall
16 establish procedures to allow access to a bene-
17 ficiary’s cash benefits by an authorized rep-
18 resentative of the eligible beneficiary on whose
19 behalf such benefits are paid.

20 “(B) QUALITY ASSURANCE AND PROTEC-
21 TION AGAINST FRAUD AND ABUSE.—The proce-
22 dures established under subparagraph (A) shall
23 ensure that authorized representatives of eligi-
24 ble beneficiaries comply with standards of con-
25 duct established by the Secretary, including

1 standards requiring that such representatives
2 provide quality services on behalf of such bene-
3 ficiaries, do not have conflicts of interest, and
4 do not misuse benefits paid on behalf of such
5 beneficiaries or otherwise engage in fraud or
6 abuse.

7 “(3) COMMENCEMENT OF BENEFITS.—Benefits
8 shall be paid to, or on behalf of, an eligible bene-
9 ficiary beginning with the first month in which an
10 application for such benefits is approved.

11 “(4) ROLLOVER OPTION FOR LUMP-SUM PAY-
12 MENT.—An eligible beneficiary may elect to—

13 “(A) defer payment of their daily or weekly
14 benefit and to rollover any such deferred bene-
15 fits from month-to-month, but not from year-to-
16 year; and

17 “(B) receive a lump-sum payment of such
18 deferred benefits in an amount that may not
19 exceed the lesser of—

20 “(i) the total amount of the accrued
21 deferred benefits; or

22 “(ii) the applicable annual benefit.

23 “(5) PERIOD FOR DETERMINATION OF ANNUAL
24 BENEFITS.—

1 “(A) IN GENERAL.—The applicable period
2 for determining with respect to an eligible bene-
3 ficiary the applicable annual benefit and the
4 amount of any accrued deferred benefits is the
5 12-month period that commences with the first
6 month in which the beneficiary began to receive
7 such benefits, and each 12-month period there-
8 after.

9 “(B) INCLUSION OF INCREASED BENE-
10 FITS.—The Secretary shall establish procedures
11 under which cash benefits paid to an eligible
12 beneficiary that increase or decrease as a result
13 of a change in the functional status of the bene-
14 ficiary before the end of a 12-month benefit pe-
15 riod shall be included in the determination of
16 the applicable annual benefit paid to the eligible
17 beneficiary.

18 “(C) RECOUPMENT OF UNPAID, ACCRUED
19 BENEFITS.—

20 “(i) IN GENERAL.—The Secretary, in
21 coordination with the Secretary of the
22 Treasury, shall recoup any accrued bene-
23 fits in the event of—

24 “(I) the death of a beneficiary; or

1 “(II) the failure of a beneficiary
2 to elect under paragraph (4)(B) to re-
3 ceive such benefits as a lump-sum
4 payment before the end of the 12-
5 month period in which such benefits
6 accrued.

7 “(ii) PAYMENT INTO CLASS INDE-
8 PENDENCE FUND.—Any benefits recouped
9 in accordance with clause (i) shall be paid
10 into the CLASS Independence Fund and
11 used in accordance with section 3206.

12 “(6) REQUIREMENT TO RECERTIFY ELIGIBILITY
13 FOR RECEIPT OF BENEFITS.—An eligible beneficiary
14 shall periodically, as determined by the Secretary—

15 “(A) recertify by submission of medical
16 evidence the beneficiary’s continued eligibility
17 for receipt of benefits; and

18 “(B) submit records of expenditures attrib-
19 utable to the aggregate cash benefit received by
20 the beneficiary during the preceding year.

21 “(7) SUPPLEMENT, NOT SUPPLANT OTHER
22 HEALTH CARE BENEFITS.—Subject to the Medicaid
23 payment rules under paragraph (1)(D), benefits re-
24 ceived by an eligible beneficiary shall supplement,
25 but not supplant, other health care benefits for

1 which the beneficiary is eligible under Medicaid or
2 any other Federally funded program that provides
3 health care benefits or assistance.

4 “(d) **ADVOCACY SERVICES.**—An agreement entered
5 into under subsection (a)(2)(A)(ii) shall require the Pro-
6 tection and Advocacy System for the State to—

7 “(1) assign, as needed, an advocacy counselor
8 to each eligible beneficiary that is covered by such
9 agreement and who shall provide an eligible bene-
10 ficiary with—

11 “(A) information regarding how to access
12 the appeals process established for the program;

13 “(B) assistance with respect to the annual
14 recertification and notification required under
15 subsection (c)(6); and

16 “(C) such other assistance with obtaining
17 services as the Secretary, by regulation, shall
18 require; and

19 “(2) ensure that the System and such coun-
20 selors comply with the requirements of subsection
21 (h).

22 “(e) **ADVICE AND ASSISTANCE COUNSELING.**—An
23 agreement entered into under subsection (a)(2)(A)(iii)
24 shall require the entity to assign, as requested by an eligi-
25 ble beneficiary that is covered by such agreement, an ad-

1 vice and assistance counselor who shall provide an eligible
2 beneficiary with information regarding—

3 “(1) accessing and coordinating long-term serv-
4 ices and supports in the most integrated setting;

5 “(2) possible eligibility for other benefits and
6 services;

7 “(3) development of a service and support plan;

8 “(4) information about programs established
9 under the Assistive Technology Act of 1998 and the
10 services offered under such programs;

11 “(5) available assistance with decisionmaking
12 concerning medical care, including the right to ac-
13 cept or refuse medical or surgical treatment and the
14 right to formulate advance directives or other writ-
15 ten instructions recognized under State law, such as
16 a living will or durable power of attorney for health
17 care, in the case that an injury or illness causes the
18 individual to be unable to make health care deci-
19 sions; and

20 “(6) such other services as the Secretary, by
21 regulation, may require.

22 “(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENE-
23 FITS.—Benefits paid to an eligible beneficiary under the
24 CLASS program shall be disregarded for purposes of de-
25 termining or continuing the beneficiary’s eligibility for re-

1 ceipt of benefits under any other Federal, State, or locally
2 funded assistance program, including benefits paid under
3 titles II, XVI, XVIII, XIX, or XXI of the Social Security
4 Act, under the laws administered by the Secretary of Vet-
5 erans Affairs, under low-income housing assistance pro-
6 grams, or under the supplemental nutrition assistance
7 program established under the Food and Nutrition Act of
8 2008.

9 “(g) RULE OF CONSTRUCTION.—Nothing in this title
10 shall be construed as prohibiting benefits paid under the
11 CLASS Independence Benefit Plan from being used to
12 compensate a family caregiver for providing community
13 living assistance services and supports to an eligible bene-
14 ficiary.

15 “(h) PROTECTION AGAINST CONFLICTS OF INTER-
16 EST.—The Secretary shall establish procedures to ensure
17 that the Eligibility Assessment System, the Protection and
18 Advocacy System for a State, advocacy counselors for eli-
19 gible beneficiaries, and any other entities that provide
20 services to active enrollees and eligible beneficiaries under
21 the CLASS program comply with the following:

22 “(1) If the entity provides counseling or plan-
23 ning services, such services are provided in a manner
24 that fosters the best interests of the active enrollee
25 or beneficiary.

1 “(2) The entity has established operating proce-
2 dures that are designed to avoid or minimize con-
3 flicts of interest between the entity and an active en-
4 rollee or beneficiary.

5 “(3) The entity provides information about all
6 services and options available to the active enrollee
7 or beneficiary, to the best of its knowledge, including
8 services available through other entities or providers.

9 “(4) The entity assists the active enrollee or
10 beneficiary to access desired services, regardless of
11 the provider.

12 “(5) The entity reports the number of active
13 enrollees and beneficiaries provided with assistance
14 by age, disability, and whether such enrollees and
15 beneficiaries received services from the entity or an-
16 other entity.

17 “(6) If the entity provides counseling or plan-
18 ning services, the entity ensures that an active en-
19 rollee or beneficiary is informed of any financial in-
20 terest that the entity has in a service provider.

21 “(7) The entity provides an active enrollee or
22 beneficiary with a list of available service providers
23 that can meet the needs of the active enrollee or
24 beneficiary.

1 **“SEC. 3206. CLASS INDEPENDENCE FUND.**

2 “(a) ESTABLISHMENT OF CLASS INDEPENDENCE
3 FUND.—There is established in the Treasury of the
4 United States a trust fund to be known as the ‘CLASS
5 Independence Fund’. The Secretary of the Treasury shall
6 serve as Managing Trustee of such Fund. The Fund shall
7 consist of all amounts derived from payments into the
8 Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and
9 remaining after investment of such amounts under sub-
10 section (b), including additional amounts derived as in-
11 come from such investments. The amounts held in the
12 Fund are appropriated and shall remain available without
13 fiscal year limitation—

14 “(1) to be held for investment on behalf of indi-
15 viduals enrolled in the CLASS program;

16 “(2) to pay the administrative expenses related
17 to the Fund and to investment under subsection (b);
18 and

19 “(3) to pay cash benefits to eligible bene-
20 ficiaries under the CLASS Independence Benefit
21 Plan.

22 “(b) INVESTMENT OF FUND BALANCE.—The Sec-
23 retary of the Treasury shall invest and manage the
24 CLASS Independence Fund in the same manner, and to
25 the same extent, as the Federal Supplementary Medical
26 Insurance Trust Fund may be invested and managed

1 under subsections (c), (d), and (e) of section 1841(d) of
2 the Social Security Act.

3 “(c) BOARD OF TRUSTEES.—

4 “(1) IN GENERAL.—With respect to the CLASS
5 Independence Fund, there is hereby created a body
6 to be known as the Board of Trustees of the CLASS
7 Independence Fund (hereinafter in this section re-
8 ferred to as the ‘Board of Trustees’) composed of
9 the Secretary of the Treasury, the Secretary of
10 Labor, and the Secretary of Health and Human
11 Services, all ex officio, and of two members of the
12 public (both of whom may not be from the same po-
13 litical party), who shall be nominated by the Presi-
14 dent for a term of 4 years and subject to confirma-
15 tion by the Senate. A member of the Board of
16 Trustees serving as a member of the public and
17 nominated and confirmed to fill a vacancy occurring
18 during a term shall be nominated and confirmed
19 only for the remainder of such term. An individual
20 nominated and confirmed as a member of the public
21 may serve in such position after the expiration of
22 such member’s term until the earlier of the time at
23 which the member’s successor takes office or the
24 time at which a report of the Board is first issued
25 under paragraph (2) after the expiration of the

1 member's term. The Secretary of the Treasury shall
2 be the Managing Trustee of the Board of Trustees.
3 The Board of Trustees shall meet not less frequently
4 than once each calendar year. A person serving on
5 the Board of Trustees shall not be considered to be
6 a fiduciary and shall not be personally liable for ac-
7 tions taken in such capacity with respect to the
8 Trust Fund.

9 “(2) DUTIES.—

10 “(A) IN GENERAL.—It shall be the duty of
11 the Board of Trustees to do the following:

12 “(i) Hold the CLASS Independence
13 Fund.

14 “(ii) Report to the Congress not later
15 than the first day of April of each year on
16 the operation and status of the CLASS
17 Independence Fund during the preceding
18 fiscal year and on its expected operation
19 and status during the current fiscal year
20 and the next 2 fiscal years.

21 “(iii) Report immediately to the Con-
22 gress whenever the Board is of the opinion
23 that the amount of the CLASS Independ-
24 ence Fund is not actuarially sound in re-

1 gards to the projections under section
2 3203(b)(1)(B)(i).

3 “(iv) Review the general policies fol-
4 lowed in managing the CLASS Independ-
5 ence Fund, and recommend changes in
6 such policies, including necessary changes
7 in the provisions of law which govern the
8 way in which the CLASS Independence
9 Fund is to be managed.

10 “(B) REPORT.—The report provided for in
11 subparagraph (A)(ii) shall—

12 “(i) include—

13 “(I) a statement of the assets of,
14 and the disbursements made from, the
15 CLASS Independence Fund during
16 the preceding fiscal year;

17 “(II) an estimate of the expected
18 income to, and disbursements to be
19 made from, the CLASS Independence
20 Fund during the current fiscal year
21 and each of the next 2 fiscal years;

22 “(III) a statement of the actu-
23 arial status of the CLASS Independ-
24 ence Fund for the current fiscal year,
25 each of the next 2 fiscal years, and as

1 projected over the 75-year period be-
2 ginning with the current fiscal year;
3 and

4 “(IV) an actuarial opinion certi-
5 fying that the techniques and meth-
6 odologies used are generally accepted
7 within the actuarial profession and
8 that the assumptions and cost esti-
9 mates used are reasonable; and

10 “(ii) be printed as a House document
11 of the session of the Congress to which the
12 report is made.

13 “(C) RECOMMENDATIONS.—If the Board
14 of Trustees determines that enrollment trends
15 and expected future benefit claims on the
16 CLASS Independence Fund are not actuarially
17 sound in regards to the projections under sec-
18 tion 3203(b)(1)(B)(i) and are unlikely to be re-
19 solved with reasonable premium increases or
20 through other means, the Board of Trustees
21 shall include in the report provided for in sub-
22 paragraph (A)(ii) recommendations for such
23 legislative action as the Board of Trustees de-
24 termine to be appropriate, including whether to

1 adjust monthly premiums or impose a tem-
2 porary moratorium on new enrollments.

3 **“SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.**

4 “(a) ESTABLISHMENT.—There is hereby created an
5 Advisory Committee to be known as the ‘CLASS Inde-
6 pendence Advisory Council’.

7 “(b) MEMBERSHIP.—

8 “(1) IN GENERAL.—The CLASS Independence
9 Advisory Council shall be composed of not more
10 than 15 individuals, not otherwise in the employ of
11 the United States—

12 “(A) who shall be appointed by the Presi-
13 dent without regard to the civil service laws and
14 regulations; and

15 “(B) a majority of whom shall be rep-
16 resentatives of individuals who participate or
17 are likely to participate in the CLASS program,
18 and shall include representatives of older and
19 younger workers, individuals with disabilities,
20 family caregivers of individuals who require
21 services and supports to maintain their inde-
22 pendence at home or in another residential set-
23 ting of their choice in the community, individ-
24 uals with expertise in long-term care or dis-
25 ability insurance, actuarial science, economics,

1 and other relevant disciplines, as determined by
2 the Secretary.

3 “(2) TERMS.—

4 “(A) IN GENERAL.—The members of the
5 CLASS Independence Advisory Council shall
6 serve overlapping terms of 3 years (unless ap-
7 pointed to fill a vacancy occurring prior to the
8 expiration of a term, in which case the indi-
9 vidual shall serve for the remainder of the
10 term).

11 “(B) LIMITATION.—A member shall not be
12 eligible to serve for more than 2 consecutive
13 terms.

14 “(3) CHAIR.—The President shall, from time to
15 time, appoint one of the members of the CLASS
16 Independence Advisory Council to serve as the
17 Chair.

18 “(c) DUTIES.—The CLASS Independence Advisory
19 Council shall advise the Secretary on matters of general
20 policy in the administration of the CLASS program estab-
21 lished under this title and in the formulation of regula-
22 tions under this title including with respect to—

23 “(1) the development of the CLASS Independ-
24 ence Benefit Plan under section 3203; and

1 “(2) the determination of monthly premiums
2 under such plan.

3 “(d) APPLICATION OF FACA.—The Federal Advisory
4 Committee Act, other than section 14 of that Act, shall
5 apply to the CLASS Independence Advisory Council.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—

7 “(1) IN GENERAL.—There are authorized to be
8 appropriated to the CLASS Independence Advisory
9 Council to carry out its duties under this section,
10 such sums as may be necessary for fiscal year 2011
11 and for each fiscal year thereafter.

12 “(2) AVAILABILITY.—Any sums appropriated
13 under the authorization contained in this section
14 shall remain available, without fiscal year limitation,
15 until expended.

16 **“SEC. 3208. REGULATIONS; ANNUAL REPORT.**

17 “(a) REGULATIONS.—The Secretary shall promulgate
18 such regulations as are necessary to carry out the CLASS
19 program in accordance with this title. Such regulations
20 shall include provisions to prevent fraud and abuse under
21 the program.

22 “(b) ANNUAL REPORT.—Beginning January 1, 2014,
23 the Secretary shall submit an annual report to Congress
24 on the CLASS program. Each report shall include the fol-
25 lowing:

1 “(1) The total number of enrollees in the pro-
2 gram.

3 “(2) The total number of eligible beneficiaries
4 during the fiscal year.

5 “(3) The total amount of cash benefits provided
6 during the fiscal year.

7 “(4) A description of instances of fraud or
8 abuse identified during the fiscal year.

9 “(5) Recommendations for such administrative
10 or legislative action as the Secretary determines is
11 necessary to improve the program or to prevent the
12 occurrence of fraud or abuse.

13 **“SEC. 3209. INSPECTOR GENERAL’S REPORT.**

14 “The Inspector General of the Department of Health
15 and Human Services shall submit an annual report to the
16 Secretary and Congress relating to the overall progress of
17 the CLASS program and of the existence of waste, fraud,
18 and abuse in the CLASS program. Each such report shall
19 include findings in the following areas:

20 “(1) The eligibility determination process.

21 “(2) The provision of cash benefits.

22 “(3) Quality assurance and protection against
23 waste, fraud, and abuse.

24 “(4) Recouping of unpaid and accrued bene-
25 fits.”.

1 (b) CONFORMING AMENDMENTS TO MEDICAID.—For
2 conforming provisions amending the Medicaid program,
3 see section 1739.

4 **Subtitle E—Miscellaneous**

5 **SEC. 2585. STATES FAILING TO ADHERE TO CERTAIN EM-** 6 **PLOYMENT OBLIGATIONS.**

7 A State is eligible for Federal funds under the provi-
8 sions of the Public Health Service Act (42 U.S.C. 201 et
9 seq.) only if the State—

10 (1) agrees to be subject in its capacity as an
11 employer to each obligation under division A of this
12 Act and the amendments made by such division ap-
13 plicable to persons in their capacity as an employer;
14 and

15 (2) assures that all political subdivisions in the
16 State will do the same.

17 **SEC. 2586. HEALTH CENTERS UNDER PUBLIC HEALTH** 18 **SERVICE ACT; LIABILITY PROTECTIONS FOR** 19 **VOLUNTEER PRACTITIONERS.**

20 (a) IN GENERAL.—Section 224 (42 U.S.C. 233) is
21 amended—

22 (1) in subsection (g)(1)(A)—

23 (A) in the first sentence, by striking “or
24 employee” and inserting “employee, or (subject

1 to subsection (k)(4) volunteer practitioner”;
2 and

3 (B) in the second sentence, by inserting
4 “and subsection (k)(4)” after “subject to para-
5 graph (5)”; and

6 (2) in each of subsections (g), (i), (j), (l), and
7 (m), by striking the term “employee, or contractor”
8 each place such term appears and inserting “em-
9 ployee, volunteer practitioner, or contractor”;

10 (3) in subsection (g)(1)(H), by striking the
11 term “employee, and contractor” each place such
12 term appears and inserting “employee, volunteer
13 practitioner, and contractor”;

14 (4) in subsection (l), by striking the term “em-
15 ployee, or any contractor” and inserting “employee,
16 volunteer practitioner, or contractor”; and

17 (5) in subsections (h)(3) and (k), by striking
18 the term “employees, or contractors” each place
19 such term appears and inserting “employees, volun-
20 teer practitioners, or contractors”.

21 (b) APPLICABILITY; DEFINITION.—Section 224(k)
22 (42 U.S.C. 233(k)) is amended by adding at the end the
23 following paragraph:

24 “(4)(A) Subsections (g) through (m) apply with re-
25 spect to volunteer practitioners beginning with the first

1 fiscal year for which an appropriations Act provides that
2 amounts in the fund under paragraph (2) are available
3 with respect to such practitioners.

4 “(B) For purposes of subsections (g) through (m),
5 the term ‘volunteer practitioner’ means a practitioner who,
6 with respect to an entity described in subsection (g)(4),
7 meets the following conditions:

8 “(i) The practitioner is a licensed physician, a
9 licensed clinical psychologist, or other licensed or
10 certified health care practitioner.

11 “(ii) At the request of such entity, the practi-
12 tioner provides services to patients of the entity, at
13 a site at which the entity operates or at a site des-
14 ignated by the entity. The weekly number of hours
15 of services provided to the patients by the practi-
16 tioner is not a factor with respect to meeting condi-
17 tions under this subparagraph.

18 “(iii) The practitioner does not for the provision
19 of such services receive any compensation from such
20 patients, from the entity, or from third-party payors
21 (including reimbursement under any insurance pol-
22 icy or health plan, or under any Federal or State
23 health benefits program).”.

1 **SEC. 2587. REPORT TO CONGRESS ON THE CURRENT STATE**
2 **OF PARASITIC DISEASES THAT HAVE BEEN**
3 **OVERLOOKED AMONG THE POOREST AMERI-**
4 **CANS.**

5 Not later than 12 months after the date of the enact-
6 ment of this Act, the Secretary of Health and Human
7 Services shall report to Congress on the epidemiology of,
8 impact of, and appropriate funding required to address ne-
9 glected diseases of poverty, including neglected parasitic
10 diseases identified as Chagas disease, cysticercosis,
11 toxocariasis, toxoplasmosis, trichomoniasis, the soil-trans-
12 mitted helminths, and others. The report should provide
13 the information necessary to enhance health policy to ac-
14 curately evaluate and address the threat of these diseases.

15 **SEC. 2588. OFFICE OF WOMEN'S HEALTH.**

16 (a) HEALTH AND HUMAN SERVICES OFFICE ON
17 WOMEN'S HEALTH.—

18 (1) ESTABLISHMENT.—Part A of title II (42
19 U.S.C. 202 et seq.) is amended by adding at the end
20 the following:

21 **“SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON**
22 **WOMEN'S HEALTH.**

23 “(a) ESTABLISHMENT OF OFFICE.—There is estab-
24 lished within the Office of the Secretary, an Office on
25 Women's Health (referred to in this section as the ‘Of-
26 fice’). The Office shall be headed by a Deputy Assistant

1 Secretary for Women’s Health who may report to the Sec-
2 retary.

3 “(b) DUTIES.—The Secretary, acting through the Of-
4 fice, with respect to the health concerns of women, shall—

5 “(1) establish short-range and long-range goals
6 and objectives within the Department of Health and
7 Human Services and, as relevant and appropriate,
8 coordinate with other appropriate offices on activi-
9 ties within the Department that relate to disease
10 prevention, health promotion, service delivery, re-
11 search, and public and health care professional edu-
12 cation, for issues of particular concern to women
13 throughout their lifespan;

14 “(2) provide expert advice and consultation to
15 the Secretary concerning scientific, legal, ethical,
16 and policy issues relating to women’s health;

17 “(3) monitor the Department of Health and
18 Human Services’ offices, agencies, and regional ac-
19 tivities regarding women’s health and identify needs
20 regarding the coordination of activities, including in-
21 tramural and extramural multidisciplinary activities;

22 “(4) establish a Department of Health and
23 Human Services Coordinating Committee on Wom-
24 en’s Health, which shall be chaired by the Deputy
25 Assistant Secretary for Women’s Health and com-

1 posed of senior level representatives from each of the
2 agencies and offices of the Department of Health
3 and Human Services;

4 “(5) establish a National Women’s Health In-
5 formation Center to—

6 “(A) facilitate the exchange of information
7 regarding matters relating to health informa-
8 tion, health promotion, preventive health serv-
9 ices, research advances, and education in the
10 appropriate use of health care;

11 “(B) facilitate access to such information;

12 “(C) assist in the analysis of issues and
13 problems relating to the matters described in
14 this paragraph; and

15 “(D) provide technical assistance with re-
16 spect to the exchange of information (including
17 facilitating the development of materials for
18 such technical assistance);

19 “(6) coordinate efforts to promote women’s
20 health programs and policies with the private sector;
21 and

22 “(7) through publications and any other means
23 appropriate, provide for the exchange of information
24 between the Office and recipients of grants, con-
25 tracts, and agreements under subsection (c), and be-

1 tween the Office and health professionals and the
2 general public.

3 “(c) GRANTS AND CONTRACTS REGARDING DU-
4 TIES.—

5 “(1) AUTHORITY.—In carrying out subsection
6 (b), the Secretary may make grants to, and enter
7 into cooperative agreements, contracts, and inter-
8 agency agreements with, public and private entities,
9 agencies, and organizations.

10 “(2) EVALUATION AND DISSEMINATION.—The
11 Secretary shall directly or through contracts with
12 public and private entities, agencies, and organiza-
13 tions, provide for evaluations of projects carried out
14 with financial assistance provided under paragraph
15 (1) and for the dissemination of information devel-
16 oped as a result of such projects.

17 “(d) REPORTS.—Not later than 1 year after the date
18 of enactment of this section, and every second year there-
19 after, the Secretary shall prepare and submit to the appro-
20 priate committees of Congress a report describing the ac-
21 tivities carried out under this section during the period
22 for which the report is being prepared.”.

23 “(2) TRANSFER OF FUNCTIONS.—There are
24 transferred to the Office on Women’s Health (estab-
25 lished under section 229 of the Public Health Serv-

1 ice Act, as added by this section), all functions exer-
2 cised by the Office on Women's Health of the Public
3 Health Service prior to the date of enactment of this
4 section, including all personnel and compensation
5 authority, all delegation and assignment authority,
6 and all remaining appropriations. All orders, deter-
7 minations, rules, regulations, permits, agreements,
8 grants, contracts, certificates, licenses, registrations,
9 privileges, and other administrative actions that—

10 (A) have been issued, made, granted, or al-
11 lowed to become effective by the President, any
12 Federal agency or official thereof, or by a court
13 of competent jurisdiction, in the performance of
14 functions transferred under this paragraph; and

15 (B) are in effect at the time this section
16 takes effect, or were final before the date of en-
17 actment of this section and are to become effec-
18 tive on or after such date;

19 shall continue in effect according to their terms until
20 modified, terminated, superseded, set aside, or re-
21 voked in accordance with law by the President, the
22 Secretary, or other authorized official, a court of
23 competent jurisdiction, or by operation of law.

24 (b) CENTERS FOR DISEASE CONTROL AND PREVEN-
25 TION OFFICE OF WOMEN'S HEALTH.—Part A of title III

1 (42 U.S.C. 241 et seq.) is amended by adding at the end
2 the following:

3 **“SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVEN-**
4 **TION OFFICE OF WOMEN’S HEALTH.**

5 “(a) ESTABLISHMENT.—There is established within
6 the Office of the Director of the Centers for Disease Con-
7 trol and Prevention, an office to be known as the Office
8 of Women’s Health (referred to in this section as the ‘Of-
9 fice’). The Office shall be headed by a director who shall
10 be appointed by the Director of such Centers.

11 “(b) PURPOSE.—The Director of the Office shall—

12 “(1) report to the Director of the Centers for
13 Disease Control and Prevention on the current level
14 of the Centers’ activity regarding women’s health
15 conditions across, where appropriate, age, biological,
16 and sociocultural contexts, in all aspects of the Cen-
17 ters’ work, including prevention programs, public
18 and professional education, services, and treatment;

19 “(2) establish short-range and long-range goals
20 and objectives within the Centers for women’s health
21 and, as relevant and appropriate, coordinate with
22 other appropriate offices on activities within the
23 Centers that relate to prevention, research, edu-
24 cation and training, service delivery, and policy de-

1 velopment, for issues of particular concern to
2 women;

3 “(3) identify projects in women’s health that
4 should be conducted or supported by the Centers;

5 “(4) consult with health professionals, non-
6 governmental organizations, consumer organizations,
7 women’s health professionals, and other individuals
8 and groups, as appropriate, on the policy of the Cen-
9 ters with regard to women; and

10 “(5) serve as a member of the Department of
11 Health and Human Services Coordinating Com-
12 mittee on Women’s Health (established under sec-
13 tion 229(b)(4)).

14 “(c) DEFINITION.—As used in this section, the term
15 ‘women’s health conditions’, with respect to women of all
16 age, ethnic, and racial groups, means diseases, disorders,
17 and conditions—

18 “(1) unique to, significantly more serious for,
19 or significantly more prevalent in women; and

20 “(2) for which the factors of medical risk or
21 type of medical intervention are different for women,
22 or for which there is reasonable evidence that indi-
23 cates that such factors or types may be different for
24 women.”.

1 (c) OFFICE OF WOMEN’S HEALTH RESEARCH.—Sec-
2 tion 486(a) (42 U.S.C. 287d(a)) is amended by inserting
3 “and who shall report directly to the Director” before the
4 period at the end thereof.

5 (d) SUBSTANCE ABUSE AND MENTAL HEALTH
6 SERVICES ADMINISTRATION.—Section 501(f) (42 U.S.C.
7 290aa(f)) is amended—

8 (1) in paragraph (1), by inserting “who shall
9 report directly to the Administrator” before the pe-
10 riod;

11 (2) by redesignating paragraph (4) as para-
12 graph (5); and

13 (3) by inserting after paragraph (3), the fol-
14 lowing:

15 “(4) OFFICE.—Nothing in this subsection shall
16 be construed to preclude the Secretary from estab-
17 lishing within the Substance Abuse and Mental
18 Health Administration an Office of Women’s
19 Health.”.

20 (e) AGENCY FOR HEALTHCARE RESEARCH AND
21 QUALITY ACTIVITIES REGARDING WOMEN’S HEALTH.—

22 Part C of title IX (42 U.S.C. 299c et seq.) is amended—

23 (1) by redesignating sections 927 and 928 as
24 sections 928 and 929, respectively;

25 (2) by inserting after section 926 the following:

1 **“SEC. 927. ACTIVITIES REGARDING WOMEN’S HEALTH.**

2 “(a) ESTABLISHMENT.—There is established within
3 the Office of the Director, an Office of Women’s Health
4 and Gender-Based Research (referred to in this section
5 as the ‘Office’). The Office shall be headed by a director
6 who shall be appointed by the Director of Healthcare and
7 Research Quality.

8 “(b) PURPOSE.—The official designated under sub-
9 section (a) shall—

10 “(1) report to the Director on the current
11 Agency level of activity regarding women’s health,
12 across, where appropriate, age, biological, and
13 sociocultural contexts, in all aspects of Agency work,
14 including the development of evidence reports and
15 clinical practice protocols and the conduct of re-
16 search into patient outcomes, delivery of health care
17 services, quality of care, and access to health care;

18 “(2) establish short-range and long-range goals
19 and objectives within the Agency for research impor-
20 tant to women’s health and, as relevant and appro-
21 priate, coordinate with other appropriate offices on
22 activities within the Agency that relate to health
23 services and medical effectiveness research, for
24 issues of particular concern to women;

25 “(3) identify projects in women’s health that
26 should be conducted or supported by the Agency;

1 “(4) consult with health professionals, non-
2 governmental organizations, consumer organizations,
3 women’s health professionals, and other individuals
4 and groups, as appropriate, on Agency policy with
5 regard to women; and

6 “(5) serve as a member of the Department of
7 Health and Human Services Coordinating Com-
8 mittee on Women’s Health (established under sec-
9 tion 229(b)(4)).”; and

10 (3) by adding at the end of section 928 (as re-
11 designated by paragraph (1)) the following:

12 “(e) WOMEN’S HEALTH.—For the purpose of car-
13 rying out section 927 regarding women’s health, there are
14 authorized to be appropriated such sums as may be nec-
15 essary for each of fiscal years 2011 through 2015.”.

16 (f) HEALTH RESOURCES AND SERVICES ADMINIS-
17 TRATION OFFICE OF WOMEN’S HEALTH.—Title VII of
18 the Social Security Act (42 U.S.C. 901 et seq.) is amended
19 by adding at the end the following:

20 **“SEC. 713. OFFICE OF WOMEN’S HEALTH.**

21 “(a) ESTABLISHMENT.—The Secretary shall estab-
22 lish within the Office of the Administrator of the Health
23 Resources and Services Administration, an office to be
24 known as the Office of Women’s Health. The Office shall

1 be headed by a director who shall be appointed by the Ad-
2 ministrator.

3 “(b) PURPOSE.—The Director of the Office shall—

4 “(1) report to the Administrator on the current
5 Administration level of activity regarding women’s
6 health across, where appropriate, age, biological, and
7 sociocultural contexts;

8 “(2) establish short-range and long-range goals
9 and objectives within the Health Resources and
10 Services Administration for women’s health and, as
11 relevant and appropriate, coordinate with other ap-
12 propriate offices on activities within the Administra-
13 tion that relate to health care provider training,
14 health service delivery, research, and demonstration
15 projects, for issues of particular concern to women;

16 “(3) identify projects in women’s health that
17 should be conducted or supported by the bureaus of
18 the Administration;

19 “(4) consult with health professionals, non-
20 governmental organizations, consumer organizations,
21 women’s health professionals, and other individuals
22 and groups, as appropriate, on Administration policy
23 with regard to women; and

24 “(5) serve as a member of the Department of
25 Health and Human Services Coordinating Com-

1 mittee on Women’s Health (established under sec-
2 tion 229(b)(4) of the Public Health Service Act).

3 “(c) CONTINUED ADMINISTRATION OF EXISTING
4 PROGRAMS.—The Director of the Office shall assume the
5 authority for the development, implementation, adminis-
6 tration, and evaluation of any projects carried out through
7 the Health Resources and Services Administration relat-
8 ing to women’s health on the date of enactment of this
9 section.

10 “(d) DEFINITIONS.—For purposes of this section:

11 “(1) ADMINISTRATION.—The term ‘Administra-
12 tion’ means the Health Resources and Services Ad-
13 ministration.

14 “(2) ADMINISTRATOR.—The term ‘Adminis-
15 trator’ means the Administrator of the Health Re-
16 sources and Services Administration.

17 “(3) OFFICE.—The term ‘Office’ means the Of-
18 fice of Women’s Health established under this sec-
19 tion in the Administration.”.

20 (g) FOOD AND DRUG ADMINISTRATION OFFICE OF
21 WOMEN’S HEALTH.—Chapter IX of the Federal Food,
22 Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amend-
23 ed by adding at the end the following:

1 **“SEC. 911. OFFICE OF WOMEN’S HEALTH.**

2 “(a) ESTABLISHMENT.—There is established within
3 the Office of the Commissioner, an office to be known as
4 the Office of Women’s Health (referred to in this section
5 as the ‘Office’). The Office shall be headed by a director
6 who shall be appointed by the Commissioner of Food and
7 Drugs.

8 “(b) PURPOSE.—The Director of the Office shall—

9 “(1) report to the Commissioner of Food and
10 Drugs on current Food and Drug Administration
11 (referred to in this section as the ‘Administration’)
12 levels of activity regarding women’s participation in
13 clinical trials and the analysis of data by sex in the
14 testing of drugs, medical devices, and biological
15 products across, where appropriate, age, biological,
16 and sociocultural contexts;

17 “(2) establish short-range and long-range goals
18 and objectives within the Administration for issues
19 of particular concern to women’s health within the
20 jurisdiction of the Administration, including, where
21 relevant and appropriate, adequate inclusion of
22 women and analysis of data by sex in Administration
23 protocols and policies;

24 “(3) provide information to women and health
25 care providers on those areas in which differences
26 between men and women exist;

1 “(4) consult with pharmaceutical, biologics, and
2 device manufacturers, health professionals with ex-
3 pertise in women’s issues, consumer organizations,
4 and women’s health professionals on Administration
5 policy with regard to women;

6 “(5) make annual estimates of funds needed to
7 monitor clinical trials and analysis of data by sex in
8 accordance with needs that are identified; and

9 “(6) serve as a member of the Department of
10 Health and Human Services Coordinating Com-
11 mittee on Women’s Health (established under sec-
12 tion 229(b)(4) of the Public Health Service Act).”.

13 (h) NO NEW REGULATORY AUTHORITY.—Nothing in
14 this section and the amendments made by this section may
15 be construed as establishing regulatory authority or modi-
16 fying any existing regulatory authority.

17 (i) LIMITATION ON TERMINATION.—Notwithstanding
18 any other provision of law, a Federal office of women’s
19 health (including the Office of Research on Women’s
20 Health of the National Institutes of Health) or Federal
21 appointive position with primary responsibility over wom-
22 en’s health issues (including the Associate Administrator
23 for Women’s Services under the Substance Abuse and
24 Mental Health Services Administration) that is in exist-
25 ence on the date of enactment of this section shall not

1 be terminated, reorganized, or have any of its powers or
2 duties transferred unless such termination, reorganization,
3 or transfer is approved by an Act of Congress.

4 (j) **RULE OF CONSTRUCTION.**—Nothing in this sec-
5 tion (or the amendments made by this section) shall be
6 construed to limit the authority of the Secretary of Health
7 and Human Services with respect to women’s health, or
8 with respect to activities carried out through the Depart-
9 ment of Health and Human Services on the date of enact-
10 ment of this section.

11 **SEC. 2589. LONG-TERM CARE AND FAMILY CAREGIVER SUP-**
12 **PORT.**

13 (a) **AMENDMENTS TO THE OLDER AMERICANS ACT**
14 **OF 1965.**—

15 (1) **PROMOTION OF DIRECT CARE WORK-**
16 **FORCE.**—Section 202(b)(1) of the Older Americans
17 Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by
18 inserting before the semicolon the following: “, and,
19 in carrying out the purposes of this paragraph, shall
20 make recommendations to other Federal entities re-
21 garding appropriate and effective means of identi-
22 fying, promoting, and implementing investments in
23 the direct care workforce necessary to meet the
24 growing demand for long-term health services and
25 supports and of assisting States in developing a

1 comprehensive State workforce development plan
2 with respect to such workforce, including assisting
3 efforts to systematically assess, track, and report on
4 workforce adequacy and capacity”.

5 (2) PERSONAL CARE ATTENDANT WORKFORCE
6 ADVISORY PANEL.—Section 202 of such Act (42
7 U.S.C. 3012) is amended by adding at the end the
8 following:

9 “(g)(1) Not later than 90 days after the date of the
10 enactment of this subsection, the Assistant Secretary shall
11 establish a Personal Care Attendant Workforce Advisory
12 Panel to examine and formulate recommendations on—

13 “(A) working conditions and training for work-
14 ers providing long-term services and supports, in-
15 cluding home health aides, certified nurse aides, and
16 personal care attendants; and

17 “(B) other workforce issues related to such
18 workers, including with respect to the adequacy of
19 the number of such workers; the salaries, wages, and
20 benefits of such workers; and access to the services
21 provided by such workers.

22 “(2) The Panel shall include representatives of—

23 “(A) relevant home- and community-based serv-
24 ice providers, health care agencies, and facilities (in-
25 cluding personal or home care agencies, home health

1 care agencies, nursing homes, assisted living facili-
2 ties, and residential care facilities);

3 “(B) the disability community, including indi-
4 viduals with disabilities and family caregivers;

5 “(C) the nursing community;

6 “(D) direct care workers (which may include
7 unions and national organizations);

8 “(E) older individuals, including senior individ-
9 uals and family caregivers;

10 “(F) State and Federal health care entities;
11 and

12 “(G) experts in workforce development and
13 adult learning.

14 “(3) Within one year after the establishment of the
15 Panel, the Panel shall submit a report to the Assistant
16 Secretary and the Congress on workforce issues related
17 to providing long-term services and supports, including in-
18 formation on core competencies for eligible personal or
19 home care aides necessary to successfully provide long-
20 term services and supports to eligible consumers, as well
21 as recommended training curricula and resources.

22 “(4) Within 180 days after receipt by the Assistant
23 Secretary of the report under paragraph (3), the Assistant
24 Secretary shall establish a 3-year demonstration program
25 in 4 States to pilot and evaluate the effectiveness of the

1 competencies articulated by the Panel and the training
2 curricula and training methods recommended by the
3 Panel.

4 “(5) Not later than 1 year after the completion of
5 the demonstration program under paragraph (4), the As-
6 sistant Secretary shall submit to the Congress a report
7 containing the results of the evaluations by the Assistant
8 Secretary pursuant to paragraph (4), together with such
9 recommendations for legislation or administrative action
10 as the Assistant Secretary determines appropriate.”.

11 (b) AUTHORIZATION OF ADDITIONAL APPROPRIA-
12 TIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM
13 UNDER THE OLDER AMERICANS ACT OF 1965.—Section
14 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C.
15 3023(e)(2)) is amended by striking “, \$173,000,000” and
16 all that follows through “2011”, and inserting “and
17 \$250,000,000 for each of fiscal years 2011, 2012, and
18 2013”.

19 **SEC. 2590. WEB SITE ON HEALTH CARE LABOR MARKET**
20 **AND RELATED EDUCATIONAL AND TRAINING**
21 **OPPORTUNITIES.**

22 (a) IN GENERAL.—The Secretary of Labor, in con-
23 sultation with the National Center for Health Workforce
24 Analysis, shall establish and maintain a Web site to serve
25 as a comprehensive source of information, searchable by

1 workforce region, on the health care labor market and re-
2 lated educational and training opportunities.

3 (b) CONTENTS.—The Web site maintained under this
4 section shall include the following:

5 (1) Information on the types of jobs that are
6 currently or are projected to be in high demand in
7 the health care field, including—

8 (A) salary information; and

9 (B) training requirements, such as require-
10 ments for educational credentials, licensure, or
11 certification.

12 (2) Information on training and educational op-
13 portunities within each region for the type of jobs
14 described in paragraph (1), including by—

15 (A) type of provider or program (such as
16 public, private nonprofit, or private for-profit);

17 (B) duration;

18 (C) cost (such as tuition, fees, books, lab-
19 oratory expenses, and other mandatory costs);

20 (D) performance outcomes (such as grad-
21 uation rates, job placement, average salary, job
22 retention, and wage progression);

23 (E) Federal financial aid participation;

24 (F) average graduate loan debt;

25 (G) student loan default rates;

1 (H) average institutional grant aid pro-
2 vided;

3 (I) Federal and State accreditation infor-
4 mation; and

5 (J) other information determined by the
6 Secretary.

7 (3) A mechanism for searching and comparing
8 training and educational options for specific health
9 care occupations to facilitate informed career and
10 education choices.

11 (4) Financial aid information, including with
12 respect to loan forgiveness, loan cancellation, loan
13 repayment, stipends, scholarships, and grants or
14 other assistance authorized by this Act or other Fed-
15 eral or State programs.

16 (c) PUBLIC ACCESSIBILITY.—The Web site main-
17 tained under this section shall—

18 (1) be publicly accessible;

19 (2) be user friendly and convey information in
20 a manner that is easily understandable; and

21 (3) be in English and the second most prevalent
22 language spoken based on the latest Census informa-
23 tion.

1 **SEC. 2591. ONLINE HEALTH WORKFORCE TRAINING PRO-**
2 **GRAMS.**

3 Section 171 of the Workforce Investment Act of 1998
4 (29 U.S.C. 2916) is amended by adding at the end the
5 following:

6 “(f) ONLINE HEALTH WORKFORCE TRAINING PRO-
7 GRAM.—

8 “(1) GRANT PROGRAM.—

9 “(A) IN GENERAL.—The Secretary in con-
10 sultation with the Secretary of Health and
11 Human Services, shall award National Health
12 Workforce Online Training Grants on a com-
13 petitive basis to eligible entities to enable such
14 entities to carry out training for individuals to
15 attain or advance in health care occupations.
16 An entity may leverage such grant with other
17 Federal, State, local, and private resources, in
18 order to expand the participation of businesses,
19 employees, and individuals in such training pro-
20 grams.

21 “(B) ELIGIBILITY.—In order to receive a
22 grant under the program established under this
23 paragraph—

24 “(i) an entity shall be an educational
25 institution, community-based organization,
26 nonprofit organization, workforce invest-

1 ment board, or local or county government;
2 and

3 “(ii) an entity shall provide online
4 workforce training for individuals seeking
5 to attain or advance in health care occupa-
6 tions, including nursing, nursing assist-
7 ants, dentistry, pharmacy, health care
8 management and administration, public
9 health, health information systems anal-
10 ysis, medical assistants, and other health
11 care practitioner and support occupations.

12 “(C) PRIORITY.—Priority in awarding
13 grants under this paragraph shall be given to
14 entities that—

15 “(i) have demonstrated experience in
16 implementing and operating online worker
17 skills training and education programs;

18 “(ii) have demonstrated experience co-
19 ordinating activities, where appropriate,
20 with the workforce investment system; and

21 “(iii) conduct training for occupations
22 with national or local shortages.

23 “(D) DATA COLLECTION.—Grantees under
24 this paragraph shall collect and report informa-
25 tion on—

- 1 “(i) the number of participants;
- 2 “(ii) the services received by the par-
- 3 ticipants;
- 4 “(iii) program completion rates;
- 5 “(iv) factors determined as signifi-
- 6 cantly interfering with program participa-
- 7 tion or completion;
- 8 “(v) the rate of job placement; and
- 9 “(vi) other information as determined
- 10 as needed by the Secretary.

11 “(E) OUTREACH.—Grantees under this

12 paragraph shall conduct outreach activities to

13 disseminate information about their program

14 and results to workforce investment boards,

15 local governments, educational institutions, and

16 other workforce training organizations.

17 “(F) PERFORMANCE LEVELS.—The Sec-

18 retary shall establish indicators of performance

19 that will be used to evaluate the performance of

20 grantees under this paragraph in carrying out

21 the activities described in this paragraph. The

22 Secretary shall negotiate and reach agreement

23 with each grantee regarding the levels of per-

24 formance expected to be achieved by the grant-

25 ee on the indicators of performance.

1 “(G) AUTHORIZATION OF APPROPRIA-
2 TIONS.—There are authorized to be appro-
3 priated to the Secretary to carry out this sub-
4 section \$50,000,000 for fiscal years 2011
5 through 2020.

6 “(2) ONLINE HEALTH PROFESSIONS TRAINING
7 PROGRAM CLEARINGHOUSE.—

8 “(A) DESCRIPTION OF GRANT.—The Sec-
9 retary may award one or more grants to eligible
10 postsecondary educational institutions to pro-
11 vide the services described in this paragraph.

12 “(B) ELIGIBILITY.—To be eligible to re-
13 ceive a grant under this paragraph, a postsec-
14 ondary educational institution shall—

15 “(i) have demonstrated the ability to
16 disseminate research on best practices for
17 implementing workforce investment pro-
18 grams; and

19 “(ii) be a national leader in producing
20 cutting-edge research on technology related
21 to workforce investment systems under
22 subtitle B.

23 “(C) SERVICES.—The postsecondary edu-
24 cational institution that receives a grant under
25 this paragraph shall use such grant—

1 “(i) to provide technical assistance to
2 entities that receive grants under para-
3 graph (1);

4 “(ii) to collect and nationally dissemi-
5 nate the data gathered by entities that re-
6 ceive grants under paragraph (1); and

7 “(iii) to disseminate the best practices
8 identified by the National Health Work-
9 force Online Training Grant Program to
10 other workforce training organizations.

11 “(D) AUTHORIZATION OF APPROPRIA-
12 TIONS.—There are authorized to be appro-
13 priated to the Secretary to carry out this sub-
14 section \$1,000,000 for fiscal years 2011
15 through 2020.”.

16 **SEC. 2592. ACCESS FOR INDIVIDUALS WITH DISABILITIES.**

17 Title V of the Rehabilitation Act of 1973 (29 U.S.C.
18 791 et seq.) is amended by adding at the end of the fol-
19 lowing:

20 **“SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL**
21 **DIAGNOSTIC EQUIPMENT.**

22 “(a) STANDARDS.—Not later than 9 months after the
23 date of enactment of the Affordable Health Care for
24 America Act, the Architectural and Transportation Bar-
25 riers Compliance Board (Access Board) shall issue guide-

1 lines setting forth the minimum technical criteria for new
2 medical diagnostic equipment to be purchased for use in
3 (or in conjunction with) physician's offices, clinics, emer-
4 gency rooms, hospitals, and other medical settings. The
5 guidelines shall ensure that such equipment is accessible
6 to, and usable by, individuals with disabilities, including
7 provisions to ensure independent entry to, use of, and exit
8 from the equipment by such individuals to the maximum
9 extent possible.

10 “(b) MEDICAL DIAGNOSTIC EQUIPMENT COV-
11 ERED.—The guidelines issued under subsection (a) for
12 medical diagnostic equipment shall apply to new purchases
13 of equipment that includes examination tables, examina-
14 tion chairs (including chairs used for eye examinations or
15 procedures, and dental examinations or procedures),
16 weight scales, mammography equipment, x-ray machines,
17 and other equipment commonly used for diagnostic or ex-
18 amination purposes by health professionals.

19 “(c) REGULATIONS.—Not later than 6 months after
20 the date of the issuance of the guidelines under subsection
21 (a), each appropriate Federal agency authorized to pro-
22 mulgate regulations under this Act or under the Ameri-
23 cans with Disabilities Act shall—

24 “(1) prescribe regulations in an accessible for-
25 mat as necessary to carry out the provisions of such

1 Act and section 504 of this Act that include accessi-
2 bility standards that are consistent with the guide-
3 lines issued under subsection (a); and

4 “(2) ensure that health care providers and
5 health care plans covered by the Affordable Health
6 Care for America Act meet the requirements of the
7 Americans with Disabilities Act and section 504, in-
8 cluding provisions ensuring that individuals with dis-
9 abilities receive equal access to all aspects of the
10 health care delivery system.

11 “(d) REVIEW AND AMEND.—The Architectural and
12 Transportation Barriers Compliance Board (Access
13 Board) shall periodically review and, as appropriate,
14 amend the guidelines as prescribed under subsection (a).
15 Not later than 6 months after the date of the issuance
16 of such revised guidelines, revised regulations consistent
17 with such guidelines shall be promulgated in an accessible
18 format by the appropriate Federal agencies described in
19 subsection (e).”.

20 **DIVISION D—INDIAN HEALTH** 21 **CARE IMPROVEMENT**

22 **SEC. 3001. SHORT TITLE; TABLE OF CONTENTS.**

23 (a) SHORT TITLE.—This division may be cited as the
24 “Indian Health Care Improvement Act Amendments of
25 2009”.

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

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

Sec. 3001. Short title; table of contents.

TITLE I—AMENDMENTS TO INDIAN LAWS

- Sec. 3101. Indian Health Care Improvement Act amended.
- Sec. 3102. Soboba sanitation facilities.
- Sec. 3103. Native American Health and Wellness Foundation.
- Sec. 3104. GAO study and report on payments for contract health services.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

- Sec. 3201. Expansion of payments under Medicare, Medicaid, and SCHIP for all covered services furnished by Indian Health Programs.
- Sec. 3202. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid.
- Sec. 3203. Solicitation of proposals for safe harbors under the Social Security Act for facilities of Indian Health Programs and urban Indian organizations.
- Sec. 3204. Annual report on Indians served by Social Security Act health benefit programs.
- Sec. 3205. Development of recommendations to improve interstate coordination of Medicaid and SCHIP coverage of Indian children and other children who are outside of their State of residency because of educational or other needs.

3 **TITLE I—AMENDMENTS TO**
4 **INDIAN LAWS**

5 **SEC. 3101. INDIAN HEALTH CARE IMPROVEMENT AMEND-**
6 **ED.**

7 (a) IN GENERAL.—The Indian Health Care Improve-
8 ment Act (25 U.S.C. 1601 et seq.) is amended to read
9 as follows:

10 **“SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

11 “(a) SHORT TITLE.—This Act may be cited as the
12 ‘Indian Health Care Improvement Act’.

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

- “Sec. 1. Short title; table of contents.
- “Sec. 2. Findings.
- “Sec. 3. Declaration of national Indian health policy.
- “Sec. 4. Definitions.

“TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND
DEVELOPMENT

- “Sec. 101. Purpose.
- “Sec. 102. Health professions recruitment program for Indians.
- “Sec. 103. Health professions preparatory scholarship program for Indians.
- “Sec. 104. Indian health professions scholarships.
- “Sec. 105. American Indians Into Psychology Program.
- “Sec. 106. Scholarship programs for Indian Tribes.
- “Sec. 107. Indian Health Service extern programs.
- “Sec. 108. Continuing education allowances.
- “Sec. 109. Community Health Representative Program.
- “Sec. 110. Indian Health Service Loan Repayment Program.
- “Sec. 111. Scholarship and Loan Repayment Recovery Fund.
- “Sec. 112. Recruitment activities.
- “Sec. 113. Indian recruitment and retention program.
- “Sec. 114. Advanced training and research.
- “Sec. 115. Quentin N. Burdick American Indians Into Nursing Program.
- “Sec. 116. Tribal cultural orientation.
- “Sec. 117. INMED Program.
- “Sec. 118. Health training programs of community colleges.
- “Sec. 119. Retention bonus.
- “Sec. 120. Nursing residency program.
- “Sec. 121. Community Health Aide Program.
- “Sec. 122. Tribal Health Program administration.
- “Sec. 123. Health professional chronic shortage demonstration programs.
- “Sec. 124. National Health Service Corps.
- “Sec. 125. Substance abuse counselor educational curricula demonstration programs.
- “Sec. 126. Behavioral health training and community education programs.
- “Sec. 127. Exemption from payment of certain fees.
- “Sec. 128. Authorization of appropriations.

“TITLE II—HEALTH SERVICES

- “Sec. 201. Indian Health Care Improvement Fund.
- “Sec. 202. Health promotion and disease prevention services.
- “Sec. 203. Diabetes prevention, treatment, and control.
- “Sec. 204. Shared services for long-term care.
- “Sec. 205. Health services research.
- “Sec. 206. Mammography and other cancer screening.
- “Sec. 207. Patient travel costs.
- “Sec. 208. Epidemiology centers.
- “Sec. 209. Comprehensive school health education programs.
- “Sec. 210. Indian youth program.
- “Sec. 211. Prevention, control, and elimination of communicable and infectious diseases.

- “Sec. 212. Other authority for provision of services.
- “Sec. 213. Indian women’s health care.
- “Sec. 214. Environmental and nuclear health hazards.
- “Sec. 215. Arizona as a contract health service delivery area.
- “Sec. 216. North Dakota and South Dakota as contract health service delivery area.
- “Sec. 217. California contract health services program.
- “Sec. 218. California as a contract health service delivery area.
- “Sec. 219. Contract health services for the Trenton Service Area.
- “Sec. 220. Programs operated by Indian Tribes and tribal organizations.
- “Sec. 221. Licensing.
- “Sec. 222. Notification of provision of emergency contract health services.
- “Sec. 223. Prompt action on payment of claims.
- “Sec. 224. Liability for payment.
- “Sec. 225. Office of Indian Men’s Health.
- “Sec. 226. Catastrophic health emergency fund.
- “Sec. 227. Authorization of appropriations.

“TITLE III—FACILITIES

- “Sec. 301. Consultation; construction and renovation of facilities; reports.
- “Sec. 302. Sanitation facilities.
- “Sec. 303. Preference to Indians and Indian firms.
- “Sec. 304. Expenditure of non-Service funds for renovation.
- “Sec. 305. Funding for the construction, expansion, and modernization of small ambulatory care facilities.
- “Sec. 306. Indian health care delivery demonstration project.
- “Sec. 307. Land transfer.
- “Sec. 308. Leases, contracts, and other agreements.
- “Sec. 309. Study on loans, loan guarantees, and loan repayment.
- “Sec. 310. Tribal leasing.
- “Sec. 311. Indian Health Service/tribal facilities joint venture program.
- “Sec. 312. Location of facilities.
- “Sec. 313. Maintenance and improvement of health care facilities.
- “Sec. 314. Tribal management of federally owned quarters.
- “Sec. 315. Applicability of Buy American Act requirement.
- “Sec. 316. Other funding for facilities.
- “Sec. 317. Authorization of appropriations.

“TITLE IV—ACCESS TO HEALTH SERVICES

- “Sec. 401. Treatment of payments under Social Security Act health benefits programs.
- “Sec. 402. Grants to and contracts with the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs.
- “Sec. 403. Reimbursement from certain third parties of costs of health services.
- “Sec. 404. Crediting of reimbursements.
- “Sec. 405. Purchasing health care coverage.
- “Sec. 406. Sharing arrangements with Federal agencies.
- “Sec. 407. Eligible indian veteran services.
- “Sec. 408. Payor of last resort.
- “Sec. 409. Consultation.
- “Sec. 410. State Children’s Health Insurance Program (SCHIP).

- “Sec. 411. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery.
- “Sec. 412. Treatment under Medicaid and SCHIP managed care.
- “Sec. 413. Navajo Nation Medicaid Agency feasibility study.
- “Sec. 414. Exception for excepted benefits.
- “Sec. 415. Authorization of appropriations.

“TITLE V—HEALTH SERVICES FOR URBAN INDIANS

- “Sec. 501. Purpose.
- “Sec. 502. Contracts with, and grants to, urban Indian organizations.
- “Sec. 503. Contracts and grants for the provision of health care and referral services.
- “Sec. 504. Use of Federal Government Facilities and Sources of Supply.
- “Sec. 505. Contracts and grants for the determination of unmet health care needs.
- “Sec. 506. Evaluations; renewals.
- “Sec. 507. Other contract and grant requirements.
- “Sec. 508. Reports and records.
- “Sec. 509. Limitation on contract authority.
- “Sec. 510. Facilities.
- “Sec. 511. Division of Urban Indian Health.
- “Sec. 512. Grants for alcohol and substance abuse-related services.
- “Sec. 513. Treatment of certain demonstration projects.
- “Sec. 514. Urban NIAAA transferred programs.
- “Sec. 515. Conferring with urban Indian organizations.
- “Sec. 516. Urban youth treatment center demonstration.
- “Sec. 517. Grants for diabetes prevention, treatment, and control.
- “Sec. 518. Community health representatives.
- “Sec. 519. Effective date.
- “Sec. 520. Eligibility for services.
- “Sec. 521. Authorization of appropriations.
- “Sec. 522. Health information technology.

“TITLE VI—ORGANIZATIONAL IMPROVEMENTS

- “Sec. 601. Establishment of the Indian Health Service as an agency of the Public Health Service.
- “Sec. 602. Automated management information system.
- “Sec. 603. Authorization of appropriations.

“TITLE VII—BEHAVIORAL HEALTH PROGRAMS

- “Sec. 701. Behavioral health prevention and treatment services.
- “Sec. 702. Memoranda of agreement with the Department of the Interior.
- “Sec. 703. Comprehensive behavioral health prevention and treatment program.
- “Sec. 704. Mental health technician program.
- “Sec. 705. Licensing requirement for mental health care workers.
- “Sec. 706. Indian women treatment programs.
- “Sec. 707. Indian youth program.
- “Sec. 708. Indian youth telemental health demonstration project.
- “Sec. 709. Inpatient and community-based mental health facilities design, construction, and staffing.
- “Sec. 710. Training and community education.
- “Sec. 711. Behavioral health program.

- “Sec. 712. Fetal alcohol disorder programs.
- “Sec. 713. Child sexual abuse and prevention treatment programs.
- “Sec. 714. Domestic and sexual violence prevention and treatment.
- “Sec. 715. Behavioral health research.
- “Sec. 716. Definitions.
- “Sec. 717. Authorization of appropriations.

“TITLE VIII—MISCELLANEOUS

- “Sec. 801. Reports.
- “Sec. 802. Regulations.
- “Sec. 803. Plan of implementation.
- “Sec. 804. Limitation on use of funds appropriated to Indian Health Service.
- “Sec. 805. Eligibility of California Indians.
- “Sec. 806. Health services for ineligible persons.
- “Sec. 807. Reallocation of base resources.
- “Sec. 808. Results of demonstration projects.
- “Sec. 809. Provision of services in Montana.
- “Sec. 810. Moratorium.
- “Sec. 811. Severability provisions.
- “Sec. 812. Use of patient safety organizations.
- “Sec. 813. Confidentiality of medical quality assurance records; qualified immunity for participants.
- “Sec. 814. Claremore Indian Hospital.
- “Sec. 815. Sense of Congress regarding law enforcement and methamphetamine issues in Indian country.
- “Sec. 816. Permitting implementation through contracts with Tribal Health Programs.
- “Sec. 817. Authorization of appropriations; availability.

1 **“SEC. 2. FINDINGS.**

2 “Congress makes the following findings:

3 “(1) Federal health services to maintain and
4 improve the health of the Indians are consonant
5 with and required by the Federal Government’s his-
6 torical and unique legal relationship with, and re-
7 sulting responsibility to, the American Indian people.

8 “(2) A major national goal of the United States
9 is to provide the resources, processes, and structure
10 that will enable Indian tribes and tribal members to
11 obtain the quantity and quality of health care serv-

1 ices and opportunities that will eradicate the health
2 disparities between Indians the general population.

3 “(3) A major national goal of the United States
4 is to provide the quantity and quality of health serv-
5 ices which will permit the health status of Indians
6 to be raised to the highest possible level and to en-
7 courage the maximum participation of Indians in the
8 planning and management of those services.

9 “(4) Federal health services to Indians have re-
10 sulted in a reduction in the prevalence and incidence
11 of preventable illnesses among, and unnecessary and
12 premature deaths of, Indians.

13 “(5) Despite such services, the unmet health
14 needs of the American Indian people are severe and
15 the health status of the Indians is far below that of
16 the general population of the United States.

17 **“SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POL-**
18 **ICY.**

19 “Congress declares that it is the policy of this Nation,
20 in fulfillment of its special trust responsibilities and legal
21 obligations to Indians—

22 “(1) to assure the highest possible health status
23 for Indians and Urban Indians and to provide all re-
24 sources necessary to effect that policy;

1 “(2) to raise the health status of Indians and
2 Urban Indians to at least the levels set forth in the
3 goals contained within the Health People 2010 or
4 successor objectives;

5 “(3) to the greatest extent possible, to allow In-
6 dians to set their own health care priorities and es-
7 tablish goals that reflect their unmet needs;

8 “(4) to increase the proportion of all degrees in
9 the health professions and allied and associated
10 health professions awarded to Indians so that the
11 proportion of Indian health professionals in each
12 Service Area is raised to at least the level of that of
13 the general population;

14 “(5) to require meaningful consultation with In-
15 dian Tribes, Tribal Organizations, and urban Indian
16 organizations to implement this Act and the national
17 policy of Indian self-determination; and

18 “(6) to provide funding for programs and facili-
19 ties operated by Indian Tribes, Tribal Organizations,
20 and Urban Indian Organizations in amounts that
21 are not less than the amounts provided to programs
22 and facilities operated directly by the Service.

23 **“SEC. 4. DEFINITIONS.**

24 “For purposes of this Act:

1 “(1) The term ‘accredited and accessible’ means
2 on or near a reservation and accredited by a na-
3 tional or regional organization with accrediting au-
4 thority.

5 “(2) The term ‘Area Office’ means an adminis-
6 trative entity, including a program office, within the
7 Service through which services and funds are pro-
8 vided to the Service Units within a defined geo-
9 graphic area.

10 “(3) The term ‘Assistant Secretary’ means the
11 Assistant Secretary of Indian Health.

12 “(4)(A) The term ‘behavioral health’ means the
13 blending of substance (including alcohol, drugs,
14 inhalants, and tobacco) abuse and mental health
15 prevention and treatment, for the purpose of pro-
16 viding comprehensive services.

17 “(B) The term ‘behavioral health’ includes the
18 joint development of substance abuse and mental
19 health treatment planning and coordinated case
20 management using a multidisciplinary approach.

21 “(5) The term ‘California Indians’ means those
22 Indians who are eligible for health services of the
23 Service pursuant to section 805.

24 “(6) The term ‘community college’ means—

25 “(A) a tribal college or university, or

1 “(B) a junior or community college.

2 “(7) The term ‘contract health service’ means
3 health services provided at the expense of the Serv-
4 ice or a Tribal Health Program by public or private
5 medical providers or hospitals, other than the Serv-
6 ice Unit or the Tribal Health Program at whose ex-
7 pense the services are provided.

8 “(8) The term ‘Department’ means, unless oth-
9 erwise designated, the Department of Health and
10 Human Services.

11 “(9) The term ‘disease prevention’ means the
12 reduction, limitation, and prevention of disease and
13 its complications and reduction in the consequences
14 of disease, including—

15 “(A) controlling—

16 “(i) the development of diabetes;

17 “(ii) high blood pressure;

18 “(iii) infectious agents;

19 “(iv) injuries;

20 “(v) occupational hazards and disabil-
21 ities;

22 “(vi) sexually transmittable diseases;

23 and

24 “(vii) toxic agents; and

25 “(B) providing—

1 “(i) fluoridation of water; and

2 “(ii) immunizations.

3 “(10) The term ‘health profession’ means
4 allopathic medicine, family medicine, internal medi-
5 cine, pediatrics, geriatric medicine, obstetrics and
6 gynecology, podiatric medicine, nursing, public
7 health nursing, dentistry, psychiatry, osteopathy, op-
8 tometry, pharmacy, psychology, public health, social
9 work, marriage and family therapy, chiropractic
10 medicine, environmental health and engineering, al-
11 lied health professions, naturopathic medicine, and
12 any other health profession.

13 “(11) The term ‘health promotion’ means—

14 “(A) fostering social, economic, environ-
15 mental, and personal factors conducive to
16 health, including raising public awareness about
17 health matters and enabling the people to cope
18 with health problems by increasing their knowl-
19 edge and providing them with valid information;

20 “(B) encouraging adequate and appro-
21 priate diet, exercise, and sleep;

22 “(C) promoting education and work in con-
23 formity with physical and mental capacity;

24 “(D) making available safe water and sani-
25 tary facilities;

- 1 “(E) improving the physical, economic, cul-
2 tural, psychological, and social environment;
3 “(F) promoting culturally competent care;
4 and
5 “(G) providing adequate and appropriate
6 programs, which may include—
7 “(i) abuse prevention (mental and
8 physical);
9 “(ii) community health;
10 “(iii) community safety;
11 “(iv) consumer health education;
12 “(v) diet and nutrition;
13 “(vi) immunization and other preven-
14 tion of communicable diseases, including
15 HIV/AIDS;
16 “(vii) environmental health;
17 “(viii) exercise and physical fitness;
18 “(ix) avoidance of fetal alcohol dis-
19 orders;
20 “(x) first aid and CPR education;
21 “(xi) human growth and development;
22 “(xii) injury prevention and personal
23 safety;
24 “(xiii) behavioral health;

- 1 “(xiv) monitoring of disease indicators
2 between health care provider visits,
3 through appropriate means, including
4 Internet-based health care management
5 systems;
6 “(xv) personal health and wellness
7 practices;
8 “(xvi) personal capacity building;
9 “(xvii) prenatal, pregnancy, and in-
10 fant care;
11 “(xviii) psychological well-being;
12 “(xix) reproductive health and family
13 planning;
14 “(xx) safe and adequate water;
15 “(xxi) healthy work environments;
16 “(xxii) elimination, reduction, and
17 prevention of contaminants that create
18 unhealthy household conditions (including
19 mold and other allergens);
20 “(xxiii) stress control;
21 “(xxiv) substance abuse;
22 “(xxv) sanitary facilities;
23 “(xxvi) sudden infant death syndrome
24 prevention;

1 “(xxvii) tobacco use cessation and re-
2 duction;

3 “(xxviii) violence prevention; and

4 “(xxix) activities to promote achieve-
5 ment of any of the objectives described in
6 section 3(2).

7 “(12) The term ‘Indian’, unless otherwise des-
8 ignated, means any person who is a member of an
9 Indian Tribe or is eligible for health services under
10 section 805, except that, for the purpose of sections
11 102 and 103, the term also means any individual
12 who—

13 “(A)(i) irrespective of whether the indi-
14 vidual lives on or near a reservation, is a mem-
15 ber of a tribe, band, or other organized group
16 of Indians, including those tribes, bands, or
17 groups terminated since 1940 and those recog-
18 nized now or in the future by the State in
19 which they reside; or

20 “(ii) is a descendant, in the first or second
21 degree, of any such member;

22 “(B) is an Eskimo or Aleut or other Alas-
23 ka Native;

24 “(C) is considered by the Secretary of the
25 Interior to be an Indian for any purpose; or

1 “(D) is determined to be an Indian under
2 regulations promulgated by the Secretary.

3 “(13) The term ‘Indian Health Program’
4 means—

5 “(A) any health program administered di-
6 rectly by the Service;

7 “(B) any Tribal Health Program; or

8 “(C) any Indian Tribe or Tribal Organiza-
9 tion to which the Secretary provides funding
10 pursuant to section 23 of the Act of June 25,
11 1910 (25 U.S.C. 47) (commonly known as the
12 ‘Buy Indian Act’).

13 “(14) The term ‘Indian Tribe’ has the meaning
14 given the term in the Indian Self-Determination and
15 Education Assistance Act (25 U.S.C. 450 et seq.).

16 “(15) The term ‘junior or community college’
17 has the meaning given the term by section 312(f) of
18 the Higher Education Act of 1965 (20 U.S.C.
19 1058(f)).

20 “(16) The term ‘reservation’ means any feder-
21 ally recognized Indian Tribe’s reservation, Pueblo, or
22 colony, including former reservations in Oklahoma,
23 Indian allotments, and Alaska Native Regions estab-
24 lished pursuant to the Alaska Native Claims Settle-
25 ment Act (43 U.S.C. 1601 et seq.).

1 “(17) The term ‘Secretary’, unless otherwise
2 designated, means the Secretary of Health and
3 Human Services.

4 “(18) The term ‘Service’ means the Indian
5 Health Service.

6 “(19) The term ‘Service Area’ means the geo-
7 graphical area served by each Area Office.

8 “(20) The term ‘Service Unit’ means an admin-
9 istrative entity of the Service, or a Tribal Health
10 Program through which services are provided, di-
11 rectly or by contract, to eligible Indians within a de-
12 fined geographic area.

13 “(21) The term ‘telehealth’ has the meaning
14 given the term in section 330K(a) of the Public
15 Health Service Act (42 U.S.C. 254e-16(a)).

16 “(22) The term ‘telemedicine’ means a tele-
17 communications link to an end user through the use
18 of eligible equipment that electronically links health
19 professionals or patients and health professionals at
20 separate sites in order to exchange health care infor-
21 mation in audio, video, graphic, or other format for
22 the purpose of providing improved health care serv-
23 ices.

1 “(23) The term ‘tribal college or university’ has
2 the meaning given the term in section 316(b)(3) of
3 the Higher Education Act (20 U.S.C. 1059c(b)(3)).

4 “(24) The term ‘Tribal Health Program’ means
5 an Indian Tribe or Tribal Organization that oper-
6 ates any health program, service, function, activity,
7 or facility funded, in whole or part, by the Service
8 through, or provided for in, a contract or compact
9 with the Service under the Indian Self-Determina-
10 tion and Education Assistance Act (25 U.S.C. 450
11 et seq.).

12 “(25) The term ‘Tribal Organization’ has the
13 meaning given the term in the Indian Self-Deter-
14 mination and Education Assistance Act (25 U.S.C.
15 450 et seq.).

16 “(26) The term ‘Urban Center’ means any com-
17 munity which has a sufficient Urban Indian popu-
18 lation with unmet health needs to warrant assistance
19 under title V of this Act, as determined by the Sec-
20 retary.

21 “(27) The term ‘Urban Indian’ means any indi-
22 vidual who resides in an Urban Center and who
23 meets 1 or more of the following criteria:

24 “(A) Irrespective of whether the individual
25 lives on or near a reservation, the individual is

1 a member of a tribe, band, or other organized
2 group of Indians, including those tribes, bands,
3 or groups terminated since 1940 and those
4 tribes, bands, or groups that are recognized by
5 the States in which they reside, or who is a de-
6 scendant in the first or second degree of any
7 such member.

8 “(B) The individual is an Eskimo, Aleut,
9 or other Alaska Native.

10 “(C) The individual is considered by the
11 Secretary of the Interior to be an Indian for
12 any purpose.

13 “(D) The individual is determined to be an
14 Indian under regulations promulgated by the
15 Secretary.

16 “(28) The term ‘urban Indian organization’
17 means a nonprofit corporate body that (A) is situ-
18 ated in an Urban Center; (B) is governed by an
19 Urban Indian-controlled board of directors; (C) pro-
20 vides for the participation of all interested Indian
21 groups and individuals; and (D) is capable of legally
22 cooperating with other public and private entities for
23 the purpose of performing the activities described in
24 section 503(a).

1 **“TITLE I—INDIAN HEALTH,**
2 **HUMAN RESOURCES, AND DE-**
3 **VELOPMENT**

4 **“SEC. 101. PURPOSE.**

5 “The purpose of this title is to increase, to the max-
6 imum extent feasible, the number of Indians entering the
7 health professions and providing health services, and to
8 assure an optimum supply of health professionals to the
9 Indian Health Programs and urban Indian organizations
10 involved in the provision of health services to Indians.

11 **“SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM**
12 **FOR INDIANS.**

13 “(a) IN GENERAL.—The Secretary, acting through
14 the Service, shall make grants to public or nonprofit pri-
15 vate health or educational entities, Tribal Health Pro-
16 grams, or urban Indian organizations to assist such enti-
17 ties in meeting the costs of—

18 “(1) identifying Indians with a potential for
19 education or training in the health professions and
20 encouraging and assisting them—

21 “(A) to enroll in courses of study in such
22 health professions; or

23 “(B) if they are not qualified to enroll in
24 any such courses of study, to undertake such

1 postsecondary education or training as may be
2 required to qualify them for enrollment;

3 “(2) publicizing existing sources of financial aid
4 available to Indians enrolled in any course of study
5 referred to in paragraph (1) or who are undertaking
6 training necessary to qualify them to enroll in any
7 such course of study; or

8 “(3) establishing other programs which the Sec-
9 retary determines will enhance and facilitate the en-
10 rollment of Indians in, and the subsequent pursuit
11 and completion by them of, courses of study referred
12 to in paragraph (1).

13 “(b) GRANTS.—

14 “(1) APPLICATION.—No grant may be made
15 under this section unless an application has been
16 submitted to, and approved by, the Secretary. Such
17 application shall be in such form, submitted in such
18 manner, and contain such information, as the Sec-
19 retary shall by regulation prescribe pursuant to this
20 Act. The Secretary shall give a preference to appli-
21 cations submitted by Tribal Health Programs or
22 urban Indian organizations.

23 “(2) AMOUNT OF GRANTS; PAYMENT.—The
24 amount of a grant under this section shall be deter-
25 mined by the Secretary. Payments pursuant to this

1 section may be made in advance or by way of reim-
2 bursement, and at such intervals and on such condi-
3 tions as provided for in regulations issued pursuant
4 to this Act. To the extent not otherwise prohibited
5 by law, grants shall be for 3 years, as provided in
6 regulations issued pursuant to this Act.

7 **“SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOL-**
8 **ARSHIP PROGRAM FOR INDIANS.**

9 “(a) SCHOLARSHIPS AUTHORIZED.—The Secretary,
10 acting through the Service, shall provide scholarship
11 grants to Indians who—

12 “(1) have successfully completed their high
13 school education or high school equivalency; and

14 “(2) have demonstrated the potential to suc-
15 cessfully complete courses of study in the health pro-
16 fessions.

17 “(b) PURPOSES.—Scholarship grants provided pursu-
18 ant to this section shall be for the following purposes:

19 “(1) Compensatory preprofessional education of
20 any recipient, such scholarship not to exceed 2 years
21 on a full-time basis (or the part-time equivalent
22 thereof, as determined by the Secretary pursuant to
23 regulations issued under this Act).

24 “(2) Pregraduate education of any recipient
25 leading to a baccalaureate degree in an approved

1 course of study preparatory to a field of study in a
2 health profession, such scholarship not to exceed 4
3 years. An extension of up to 2 years (or the part-
4 time equivalent thereof, as determined by the Sec-
5 retary pursuant to regulations issued pursuant to
6 this Act) may be approved.

7 “(c) OTHER CONDITIONS.—Scholarships under this
8 section—

9 “(1) may cover costs of tuition, books, trans-
10 portation, board, and other necessary related ex-
11 penses of a recipient while attending school;

12 “(2) shall not be denied solely on the basis of
13 the applicant’s scholastic achievement if such appli-
14 cant has been admitted to, or maintained good
15 standing at, an accredited institution; and

16 “(3) shall not be denied solely by reason of such
17 applicant’s eligibility for assistance or benefits under
18 any other Federal program.

19 **“SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.**

20 “(a) IN GENERAL.—

21 “(1) AUTHORITY.—The Secretary, acting
22 through the Service, shall make scholarship grants
23 to Indians who are enrolled full or part time in ac-
24 credited schools pursuing courses of study in the
25 health professions. Such scholarships shall be des-

1 ignated Indian Health Scholarships and shall be
2 made in accordance with section 338A of the Public
3 Health Services Act (42 U.S.C. 254*l*), except as pro-
4 vided in subsection (b) of this section.

5 “(2) DETERMINATIONS BY SECRETARY.—The
6 Secretary, acting through the Service, shall deter-
7 mine—

8 “(A) who shall receive scholarship grants
9 under subsection (a); and

10 “(B) the distribution of the scholarships
11 among health professions on the basis of the
12 relative needs of Indians for additional service
13 in the health professions.

14 “(3) CERTAIN DELEGATION NOT ALLOWED.—
15 The administration of this section shall be a respon-
16 sibility of the Assistant Secretary and shall not be
17 delegated in a contract or compact under the Indian
18 Self-Determination and Education Assistance Act
19 (25 U.S.C. 450 et seq.).

20 “(b) ACTIVE DUTY SERVICE OBLIGATION.—

21 “(1) OBLIGATION MET.—The active duty serv-
22 ice obligation under a written contract with the Sec-
23 retary under this section that an Indian has entered
24 into shall, if that individual is a recipient of an In-
25 dian Health Scholarship, be met in full-time practice

1 equal to 1 year for each school year for which the
2 participant receives a scholarship award under this
3 part, or 2 years, whichever is greater, by service in
4 1 or more of the following:

5 “(A) In an Indian Health Program.

6 “(B) In a program assisted under title V
7 of this Act.

8 “(C) In the private practice of the applica-
9 ble profession if, as determined by the Sec-
10 retary, in accordance with guidelines promul-
11 gated by the Secretary, such practice is situated
12 in a physician or other health professional
13 shortage area and addresses the health care
14 needs of a substantial number of Indians.

15 “(D) In a teaching capacity in a tribal col-
16 lege or university nursing program (or a related
17 health profession program) if, as determined by
18 the Secretary, the health service provided to In-
19 dians would not decrease.

20 “(2) OBLIGATION DEFERRED.—At the request
21 of any individual who has entered into a contract re-
22 ferred to in paragraph (1) and who receives a health
23 professions degree requiring postgraduate training
24 for licensure or to improve clinical skills, the Sec-
25 retary shall defer the active duty service obligation

1 of that individual under that contract, in order that
2 such individual may complete any internship, resi-
3 dency, or other advanced clinical training that is re-
4 quired for the practice of that health profession, for
5 an appropriate period (in years, as determined by
6 the Secretary), subject to the following conditions:

7 “(A) No period of internship, residency, or
8 other advanced clinical training shall be counted
9 as satisfying any period of obligated service
10 under this subsection.

11 “(B) The active duty service obligation of
12 that individual shall commence not later than
13 90 days after the completion of that advanced
14 clinical training (or by a date specified by the
15 Secretary).

16 “(C) The active duty service obligation will
17 be served in the health profession of that indi-
18 vidual in a manner consistent with paragraph
19 (1).

20 “(D) A recipient of a scholarship under
21 this section may, at the election of the recipient,
22 meet the active duty service obligation described
23 in paragraph (1) by service in a program speci-
24 fied under that paragraph that—

1 “(i) is located on the reservation of
2 the Indian Tribe in which the recipient is
3 enrolled; or

4 “(ii) serves the Indian Tribe in which
5 the recipient is enrolled.

6 “(3) PRIORITY WHEN MAKING ASSIGNMENTS.—

7 Subject to paragraph (2), the Secretary, in making
8 assignments of Indian Health Scholarship recipients
9 required to meet the active duty service obligation
10 described in paragraph (1), shall give priority to as-
11 signing individuals to service in those programs
12 specified in paragraph (1) that have a need for
13 health professionals to provide health care services
14 as a result of individuals having breached contracts
15 entered into under this section.

16 “(c) PART-TIME STUDENTS.—In the case of an indi-
17 vidual receiving a scholarship under this section who is
18 enrolled part time in an approved course of study—

19 “(1) such scholarship shall be for a period of
20 years not to exceed the part-time equivalent of 4
21 years, as determined by the Secretary;

22 “(2) the period of obligated service described in
23 subsection (b)(1) shall be equal to the greater of—

24 “(A) the part-time equivalent of 1 year for
25 each year for which the individual was provided

1 a scholarship (as determined by the Secretary);

2 or

3 “(B) 2 years; and

4 “(3) the amount of the monthly stipend speci-
5 fied in section 338A(g)(1)(B) of the Public Health
6 Service Act (42 U.S.C. 254l(g)(1)(B)) shall be re-
7 duced pro rata (as determined by the Secretary)
8 based on the number of hours such student is en-
9 rolled.

10 “(d) BREACH OF CONTRACT.—

11 “(1) SPECIFIED BREACHES.—An individual
12 shall be liable to the United States for the amount
13 which has been paid to the individual, or on behalf
14 of the individual, under a contract entered into with
15 the Secretary under this section on or after the date
16 of enactment of the Indian Health Care Improve-
17 ment Act Amendments of 2009 if that individual—

18 “(A) fails to maintain an acceptable level
19 of academic standing in the educational institu-
20 tion in which he or she is enrolled (such level
21 determined by the educational institution under
22 regulations of the Secretary);

23 “(B) is dismissed from such educational
24 institution for disciplinary reasons;

1 “(C) voluntarily terminates the training in
2 such an educational institution for which he or
3 she is provided a scholarship under such con-
4 tract before the completion of such training; or

5 “(D) fails to accept payment, or instructs
6 the educational institution in which he or she is
7 enrolled not to accept payment, in whole or in
8 part, of a scholarship under such contract, in
9 lieu of any service obligation arising under such
10 contract.

11 “(2) OTHER BREACHES.—If for any reason not
12 specified in paragraph (1) an individual breaches a
13 written contract by failing either to begin such indi-
14 vidual’s service obligation required under such con-
15 tract or to complete such service obligation, the
16 United States shall be entitled to recover from the
17 individual an amount determined in accordance with
18 the formula specified in subsection (l) of section 110
19 in the manner provided for in such subsection.

20 “(3) CANCELLATION UPON DEATH OF RECIPI-
21 ENT.—Upon the death of an individual who receives
22 an Indian Health Scholarship, any outstanding obli-
23 gation of that individual for service or payment that
24 relates to that scholarship shall be canceled.

1 “(4) WAIVERS AND SUSPENSIONS.—The Sec-
2 retary shall provide for the partial or total waiver or
3 suspension of any obligation of service or payment of
4 a recipient of an Indian Health Scholarship if the
5 Secretary determines that—

6 “(A) it is not possible for the recipient to
7 meet that obligation or make that payment;

8 “(B) requiring that recipient to meet that
9 obligation or make that payment would result
10 in extreme hardship to the recipient; or

11 “(C) the enforcement of the requirement to
12 meet the obligation or make the payment would
13 be unconscionable.

14 “(5) EXTREME HARDSHIP.—Notwithstanding
15 any other provision of law, in any case of extreme
16 hardship or for other good cause shown, the Sec-
17 retary may waive, in whole or in part, the right of
18 the United States to recover funds made available
19 under this section.

20 “(6) BANKRUPTCY.—Notwithstanding any
21 other provision of law, with respect to a recipient of
22 an Indian Health Scholarship, no obligation for pay-
23 ment may be released by a discharge in bankruptcy
24 under title 11, United States Code, unless that dis-
25 charge is granted after the expiration of the 5-year

1 period beginning on the initial date on which that
2 payment is due, and only if the bankruptcy court
3 finds that the nondischarge of the obligation would
4 be unconscionable.

5 **“SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
6 **GRAM.**

7 “(a) GRANTS AUTHORIZED.—The Secretary, acting
8 through the Service, shall make grants of not more than
9 \$300,000 to each of 9 colleges and universities for the pur-
10 pose of developing and maintaining Indian psychology ca-
11 reer recruitment programs as a means of encouraging In-
12 dians to enter the behavioral health field. These programs
13 shall be located at various locations throughout the coun-
14 try to maximize their availability to Indian students and
15 new programs shall be established in different locations
16 from time to time.

17 “(b) QUENTIN N. BURDICK PROGRAM GRANT.—The
18 Secretary shall provide a grant authorized under sub-
19 section (a) to develop and maintain a program at the Uni-
20 versity of North Dakota to be known as the ‘Quentin N.
21 Burdick American Indians Into Psychology Program’.
22 Such program shall, to the maximum extent feasible, co-
23 ordinate with the Quentin N. Burdick Indian Health Pro-
24 grams authorized under section 117(b), the Quentin N.
25 Burdick American Indians Into Nursing Program author-

1 ized under section 115(e), and existing university research
2 and communications networks.

3 “(c) REGULATIONS.—The Secretary shall issue regu-
4 lations pursuant to this Act for the competitive awarding
5 of grants provided under this section.

6 “(d) CONDITIONS OF GRANT.—Applicants under this
7 section shall agree to provide a program which, at a min-
8 imum—

9 “(1) provides outreach and recruitment for
10 health professions to Indian communities including
11 elementary, secondary, and accredited and accessible
12 community colleges that will be served by the pro-
13 gram;

14 “(2) incorporates a program advisory board
15 comprised of representatives from the tribes and
16 communities that will be served by the program;

17 “(3) provides summer enrichment programs to
18 expose Indian students to the various fields of psy-
19 chology through research, clinical, and experimental
20 activities;

21 “(4) provides stipends to undergraduate and
22 graduate students to pursue a career in psychology;

23 “(5) develops affiliation agreements with tribal
24 colleges and universities, the Service, university af-
25 filiated programs, and other appropriate accredited

1 and accessible entities to enhance the education of
2 Indian students;

3 “(6) to the maximum extent feasible, uses exist-
4 ing university tutoring, counseling, and student sup-
5 port services; and

6 “(7) to the maximum extent feasible, employs
7 qualified Indians in the program.

8 “(e) ACTIVE DUTY SERVICE REQUIREMENT.—The
9 active duty service obligation prescribed under section
10 338C of the Public Health Service Act (42 U.S.C. 254m)
11 shall be met by each graduate who receives a stipend de-
12 scribed in subsection (d)(4) that is funded under this sec-
13 tion. Such obligation shall be met by service—

14 “(1) in an Indian Health Program;

15 “(2) in a program assisted under title V of this
16 Act; or

17 “(3) in the private practice of psychology if, as
18 determined by the Secretary, in accordance with
19 guidelines promulgated by the Secretary, such prac-
20 tice is situated in a physician or other health profes-
21 sional shortage area and addresses the health care
22 needs of a substantial number of Indians.

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated such sums as may be nec-
25 essary to carry out this section.

1 **“SEC. 106. SCHOLARSHIP PROGRAMS FOR INDIAN TRIBES.**

2 “(a) IN GENERAL.—

3 “(1) GRANTS AUTHORIZED.—The Secretary,
4 acting through the Service, shall make grants to
5 Tribal Health Programs for the purpose of providing
6 scholarships for Indians to serve as health profes-
7 sionals in Indian communities.

8 “(2) AMOUNT.—Amounts available under para-
9 graph (1) for any fiscal year shall not exceed 5 per-
10 cent of the amounts available for each fiscal year for
11 Indian Health Scholarships under section 104.

12 “(3) APPLICATION.—An application for a grant
13 under paragraph (1) shall be in such form and con-
14 tain such agreements, assurances, and information
15 as consistent with this section.

16 “(b) REQUIREMENTS.—

17 “(1) IN GENERAL.—A Tribal Health Program
18 receiving a grant under subsection (a) shall provide
19 scholarships to Indians in accordance with the re-
20 quirements of this section.

21 “(2) COSTS.—With respect to costs of providing
22 any scholarship pursuant to subsection (a)—

23 “(A) 80 percent of the costs of the scholar-
24 ship shall be paid from the funds made avail-
25 able pursuant to subsection (a)(1) provided to
26 the Tribal Health Program; and

1 “(B) 20 percent of such costs may be paid
2 from any other source of funds.

3 “(c) COURSE OF STUDY.—A Tribal Health Program
4 shall provide scholarships under this section only to Indi-
5 ans enrolled or accepted for enrollment in a course of
6 study (approved by the Secretary) in 1 of the health pro-
7 fessions contemplated by this Act.

8 “(d) CONTRACT.—

9 “(1) IN GENERAL.—In providing scholarships
10 under subsection (b), the Secretary and the Tribal
11 Health Program shall enter into a written contract
12 with each recipient of such scholarship.

13 “(2) REQUIREMENTS.—Such contract shall—

14 “(A) obligate such recipient to provide
15 service in an Indian Health Program or urban
16 Indian organization, in the same Service Area
17 where the Tribal Health Program providing the
18 scholarship is located, for—

19 “(i) a number of years for which the
20 scholarship is provided (or the part-time
21 equivalent thereof, as determined by the
22 Secretary), or for a period of 2 years,
23 whichever period is greater; or

1 “(ii) such greater period of time as
2 the recipient and the Tribal Health Pro-
3 gram may agree;

4 “(B) provide that the amount of the schol-
5 arship—

6 “(i) may only be expended for—

7 “(I) tuition expenses, other rea-
8 sonable educational expenses, and rea-
9 sonable living expenses incurred in at-
10 tendance at the educational institu-
11 tion; and

12 “(II) payment to the recipient of
13 a monthly stipend of not more than
14 the amount authorized by section
15 338(g)(1)(B) of the Public Health
16 Service Act (42 U.S.C.
17 254m(g)(1)(B)), with such amount to
18 be reduced pro rata (as determined by
19 the Secretary) based on the number of
20 hours such student is enrolled, and
21 not to exceed, for any year of attend-
22 ance for which the scholarship is pro-
23 vided, the total amount required for
24 the year for the purposes authorized
25 in this clause; and

1 “(ii) may not exceed, for any year of
2 attendance for which the scholarship is
3 provided, the total amount required for the
4 year for the purposes authorized in clause
5 (i);

6 “(C) require the recipient of such scholar-
7 ship to maintain an acceptable level of academic
8 standing as determined by the educational insti-
9 tution in accordance with regulations issued
10 pursuant to this Act; and

11 “(D) require the recipient of such scholar-
12 ship to meet the educational and licensure re-
13 quirements appropriate to each health profes-
14 sion.

15 “(3) SERVICE IN OTHER SERVICE AREAS.—The
16 contract may allow the recipient to serve in another
17 Service Area, provided the Tribal Health Program
18 and Secretary approve and services are not dimin-
19 ished to Indians in the Service Area where the Trib-
20 al Health Program providing the scholarship is lo-
21 cated.

22 “(e) BREACH OF CONTRACT.—

23 “(1) SPECIFIC BREACHES.—An individual who
24 has entered into a written contract with the Sec-
25 retary and a Tribal Health Program under sub-

1 section (d) shall be liable to the United States for
2 the Federal share of the amount which has been
3 paid to him or her, or on his or her behalf, under
4 the contract if that individual—

5 “(A) fails to maintain an acceptable level
6 of academic standing in the educational institu-
7 tion in which he or she is enrolled (such level
8 as determined by the educational institution
9 under regulations of the Secretary);

10 “(B) is dismissed from such educational
11 institution for disciplinary reasons;

12 “(C) voluntarily terminates the training in
13 such an educational institution for which he or
14 she is provided a scholarship under such con-
15 tract before the completion of such training; or

16 “(D) fails to accept payment, or instructs
17 the educational institution in which he or she is
18 enrolled not to accept payment, in whole or in
19 part, of a scholarship under such contract, in
20 lieu of any service obligation arising under such
21 contract.

22 “(2) OTHER BREACHES.—If for any reason not
23 specified in paragraph (1), an individual breaches a
24 written contract by failing to either begin such indi-
25 vidual’s service obligation required under such con-

1 tract or to complete such service obligation, the
2 United States shall be entitled to recover from the
3 individual an amount determined in accordance with
4 the formula specified in subsection (l) of section 110
5 in the manner provided for in such subsection.

6 “(3) CANCELLATION UPON DEATH OF RECIPI-
7 ENT.—Upon the death of an individual who receives
8 an Indian Health Scholarship, any outstanding obli-
9 gation of that individual for service or payment that
10 relates to that scholarship shall be canceled.

11 “(4) INFORMATION.—The Secretary may carry
12 out this subsection on the basis of information re-
13 ceived from Tribal Health Programs involved or on
14 the basis of information collected through such other
15 means as the Secretary deems appropriate.

16 “(f) RELATION TO SOCIAL SECURITY ACT.—The re-
17 cipient of a scholarship under this section shall agree, in
18 providing health care pursuant to the requirements here-
19 in—

20 “(1) not to discriminate against an individual
21 seeking care on the basis of the ability of the indi-
22 vidual to pay for such care or on the basis that pay-
23 ment for such care will be made pursuant to a pro-
24 gram established in title XVIII of the Social Secu-

1 rity Act or pursuant to the programs established in
2 title XIX or title XXI of such Act; and

3 “(2) to accept assignment under section
4 1842(b)(3)(B)(ii) of the Social Security Act for all
5 services for which payment may be made under part
6 B of title XVIII of such Act, and to enter into an
7 appropriate agreement with the State agency that
8 administers the State plan for medical assistance
9 under title XIX, or the State child health plan under
10 title XXI, of such Act to provide service to individ-
11 uals entitled to medical assistance or child health as-
12 sistance, respectively, under the plan.

13 “(g) CONTINUANCE OF FUNDING.—The Secretary
14 shall make payments under this section to a Tribal Health
15 Program for any fiscal year subsequent to the first fiscal
16 year of such payments unless the Secretary determines
17 that, for the immediately preceding fiscal year, the Tribal
18 Health Program has not complied with the requirements
19 of this section.

20 **“SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.**

21 “(a) EMPLOYMENT PREFERENCE.—Any individual
22 who receives a scholarship pursuant to section 104 or 106
23 shall be given preference for employment in the Service,
24 or may be employed by a Tribal Health Program or an
25 urban Indian organization, or other agencies of the De-

1 partment as available, during any nonacademic period of
2 the year.

3 “(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE
4 OBLIGATION.—Periods of employment pursuant to this
5 subsection shall not be counted in determining fulfillment
6 of the service obligation incurred as a condition of the
7 scholarship.

8 “(c) TIMING; LENGTH OF EMPLOYMENT.—Any indi-
9 vidual enrolled in a program, including a high school pro-
10 gram, authorized under section 102(a) may be employed
11 by the Service or by a Tribal Health Program or an urban
12 Indian organization during any nonacademic period of the
13 year. Any such employment shall not exceed 120 days dur-
14 ing any calendar year.

15 “(d) NONAPPLICABILITY OF COMPETITIVE PER-
16 SONNEL SYSTEM.—Any employment pursuant to this sec-
17 tion shall be made without regard to any competitive per-
18 sonnel system or agency personnel limitation and to a po-
19 sition which will enable the individual so employed to re-
20 ceive practical experience in the health profession in which
21 he or she is engaged in study. Any individual so employed
22 shall receive payment for his or her services comparable
23 to the salary he or she would receive if he or she were
24 employed in the competitive system. Any individual so em-

1 ployed shall not be counted against any employment ceil-
2 ing affecting the Service or the Department.

3 **“SEC. 108. CONTINUING EDUCATION ALLOWANCES.**

4 “In order to encourage scholarship and stipend re-
5 cipients under sections 104, 105, 106, and 115 and health
6 professionals, including community health representatives
7 and emergency medical technicians, to join or continue in
8 an Indian Health Program and to provide their services
9 in the rural and remote areas where a significant portion
10 of Indians reside, the Secretary, acting through the Serv-
11 ice, may—

12 “(1) provide programs or allowances to transi-
13 tion into an Indian Health Program, including li-
14 censing, board or certification examination assist-
15 ance, and technical assistance in fulfilling service ob-
16 ligations under sections 104, 105, 106, and 115; and

17 “(2) provide programs or allowances to health
18 professionals employed in an Indian Health Program
19 to enable them for a period of time each year pre-
20 scribed by regulation of the Secretary to take leave
21 of their duty stations for professional consultation,
22 management, leadership, and refresher training
23 courses.

1 **“SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PRO-**
2 **GRAM.**

3 “(a) IN GENERAL.—Under the authority of the Act
4 of November 2, 1921 (25 U.S.C. 13) (commonly known
5 as the ‘Snyder Act’), the Secretary, acting through the
6 Service, shall maintain a Community Health Representa-
7 tive Program under which Indian Health Programs—

8 “(1) provide for the training of Indians as com-
9 munity health representatives; and

10 “(2) use such community health representatives
11 in the provision of health care, health promotion,
12 and disease prevention services to Indian commu-
13 nities.

14 “(b) DUTIES.—The Community Health Representa-
15 tive Program of the Service, shall—

16 “(1) provide a high standard of training for
17 community health representatives to ensure that the
18 community health representatives provide quality
19 health care, health promotion, and disease preven-
20 tion services to the Indian communities served by
21 the Program;

22 “(2) in order to provide such training, develop
23 and maintain a curriculum that—

24 “(A) combines education in the theory of
25 health care with supervised practical experience
26 in the provision of health care; and

1 “(B) provides instruction and practical ex-
2 perience in health promotion and disease pre-
3 vention activities, with appropriate consider-
4 ation given to lifestyle factors that have an im-
5 pact on Indian health status, such as alco-
6 holism, family dysfunction, and poverty;

7 “(3) maintain a system which identifies the
8 needs of community health representatives for con-
9 tinuing education in health care, health promotion,
10 and disease prevention and develop programs that
11 meet the needs for continuing education;

12 “(4) maintain a system that provides close su-
13 pervision of Community Health Representatives;

14 “(5) maintain a system under which the work
15 of Community Health Representatives is reviewed
16 and evaluated; and

17 “(6) promote traditional health care practices
18 of the Indian Tribes served consistent with the Serv-
19 ice standards for the provision of health care, health
20 promotion, and disease prevention.

21 **“SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT**
22 **PROGRAM.**

23 “(a) ESTABLISHMENT.—The Secretary, acting
24 through the Service, shall establish and administer a pro-
25 gram to be known as the Service Loan Repayment Pro-

1 gram (hereinafter referred to as the ‘Loan Repayment
2 Program’) in order to ensure an adequate supply of
3 trained health professionals necessary to maintain accredi-
4 tation of, and provide health care services to Indians
5 through, Indian Health Programs and urban Indian orga-
6 nizations.

7 “(b) ELIGIBLE INDIVIDUALS.—To be eligible to par-
8 ticipate in the Loan Repayment Program, an individual
9 must—

10 “(1)(A) be enrolled—

11 “(i) in a course of study or program in an
12 accredited educational institution (as deter-
13 mined by the Secretary under section
14 338B(b)(1)(c)(i) of the Public Health Service
15 Act (42 U.S.C. 254l–1(b)(1)(c)(i))) and be
16 scheduled to complete such course of study in
17 the same year such individual applies to partici-
18 pate in such program; or

19 “(ii) in an approved graduate training pro-
20 gram in a health profession; or

21 “(B) have—

22 “(i) a degree in a health profession; and

23 “(ii) a license to practice a health profes-
24 sion;

1 “(2)(A) be eligible for, or hold, an appointment
2 as a commissioned officer in the Regular or Reserve
3 Corps of the Public Health Service;

4 “(B) meet the professional standards for civil
5 service employment in the Service; or

6 “(C) be employed in an Indian Health Program
7 or urban Indian organization without a service obli-
8 gation; and

9 “(3) submit to the Secretary an application for
10 a contract described in subsection (e).

11 “(c) APPLICATION.—

12 “(1) INFORMATION TO BE INCLUDED WITH
13 FORMS.—In disseminating application forms and
14 contract forms to individuals desiring to participate
15 in the Loan Repayment Program, the Secretary
16 shall include with such forms a fair summary of the
17 rights and liabilities of an individual whose applica-
18 tion is approved (and whose contract is accepted) by
19 the Secretary, including in the summary a clear ex-
20 planation of the damages to which the United States
21 is entitled under subsection (l) in the case of the in-
22 dividual’s breach of contract. The Secretary shall
23 provide such individuals with sufficient information
24 regarding the advantages and disadvantages of serv-
25 ice as a commissioned officer in the Regular or Re-

1 serve Corps of the Public Health Service or a civil-
2 ian employee of the Service to enable the individual
3 to make a decision on an informed basis.

4 “(2) CLEAR LANGUAGE.—The application form,
5 contract form, and all other information furnished
6 by the Secretary under this section shall be written
7 in a manner calculated to be understood by the aver-
8 age individual applying to participate in the Loan
9 Repayment Program.

10 “(3) TIMELY AVAILABILITY OF FORMS.—The
11 Secretary shall make such application forms, con-
12 tract forms, and other information available to indi-
13 viduals desiring to participate in the Loan Repay-
14 ment Program on a date sufficiently early to ensure
15 that such individuals have adequate time to carefully
16 review and evaluate such forms and information.

17 “(d) PRIORITIES.—

18 “(1) LIST.—Consistent with subsection (j), the
19 Secretary shall annually—

20 “(A) identify the positions in each Indian
21 Health Program or urban Indian organization
22 for which there is a need or a vacancy; and

23 “(B) rank those positions in order of pri-
24 ority.

1 “(2) APPROVALS.—Consistent with the priority
2 determined under paragraph (1), the Secretary, in
3 determining which applications under the Loan Re-
4 payment Program to approve (and which contracts
5 to accept), shall—

6 “(A) give first priority to applications
7 made by individual Indians; and

8 “(B) after making determinations on all
9 applications submitted by individual Indians as
10 required under subparagraph (A), give priority
11 to—

12 “(i) individuals recruited through the
13 efforts of an Indian Health Program or
14 urban Indian organization; and

15 “(ii) other individuals based on the
16 priority rankings under paragraph (1).

17 “(e) RECIPIENT CONTRACTS.—

18 “(1) CONTRACT REQUIRED.—An individual be-
19 comes a participant in the Loan Repayment Pro-
20 gram only upon the Secretary and the individual en-
21 tering into a written contract described in paragraph
22 (2).

23 “(2) CONTENTS OF CONTRACT.—The written
24 contract referred to in this section between the Sec-
25 retary and an individual shall contain—

1 “(A) an agreement under which—

2 “(i) subject to subparagraph (C), the
3 Secretary agrees—

4 “(I) to pay loans on behalf of the
5 individual in accordance with the pro-
6 visions of this section; and

7 “(II) to accept (subject to the
8 availability of appropriated funds for
9 carrying out this section) the indi-
10 vidual into the Service or place the in-
11 dividual with a Tribal Health Pro-
12 gram or urban Indian organization as
13 provided in clause (ii)(III); and

14 “(ii) subject to subparagraph (C), the
15 individual agrees—

16 “(I) to accept loan payments on
17 behalf of the individual;

18 “(II) in the case of an individual
19 described in subsection (b)(1)—

20 “(aa) to maintain enrollment
21 in a course of study or training
22 described in subsection (b)(1)(A)
23 until the individual completes the
24 course of study or training; and

1 “(bb) while enrolled in such
2 course of study or training, to
3 maintain an acceptable level of
4 academic standing (as deter-
5 mined under regulations of the
6 Secretary by the educational in-
7 stitution offering such course of
8 study or training); and

9 “(III) to serve for a time period
10 (in this section referred to as the ‘pe-
11 riod of obligated service’) equal to 2
12 years or such longer period as the in-
13 dividual may agree to serve in the
14 full-time clinical practice of such indi-
15 vidual’s profession in an Indian
16 Health Program or urban Indian or-
17 ganization to which the individual
18 may be assigned by the Secretary;

19 “(B) a provision permitting the Secretary
20 to extend for such longer additional periods, as
21 the individual may agree to, the period of obli-
22 gated service agreed to by the individual under
23 subparagraph (A)(ii)(III);

24 “(C) a provision that any financial obliga-
25 tion of the United States arising out of a con-

1 tract entered into under this section and any
2 obligation of the individual which is conditioned
3 thereon is contingent upon funds being appro-
4 priated for loan repayments under this section;

5 “(D) a statement of the damages to which
6 the United States is entitled under subsection
7 (k) for the individual’s breach of the contract;
8 and

9 “(E) such other statements of the rights
10 and liabilities of the Secretary and of the indi-
11 vidual, not inconsistent with this section.

12 “(f) DEADLINE FOR DECISION ON APPLICATION.—
13 The Secretary shall provide written notice to an individual
14 within 21 days on—

15 “(1) the Secretary’s approving, under sub-
16 section (e)(1), of the individual’s participation in the
17 Loan Repayment Program, including extensions re-
18 sulting in an aggregate period of obligated service in
19 excess of 4 years; or

20 “(2) the Secretary’s disapproving an individ-
21 ual’s participation in such Program.

22 “(g) PAYMENTS.—

23 “(1) IN GENERAL.—A loan repayment provided
24 for an individual under a written contract under the
25 Loan Repayment Program shall consist of payment,

1 in accordance with paragraph (2), on behalf of the
2 individual of the principal, interest, and related ex-
3 penses on government and commercial loans received
4 by the individual regarding the undergraduate or
5 graduate education of the individual (or both), which
6 loans were made for—

7 “(A) tuition expenses;

8 “(B) all other reasonable educational ex-
9 penses, including fees, books, and laboratory ex-
10 penses, incurred by the individual; and

11 “(C) reasonable living expenses as deter-
12 mined by the Secretary.

13 “(2) AMOUNT.—For each year of obligated
14 service that an individual contracts to serve under
15 subsection (e), the Secretary may pay up to \$35,000
16 or an amount equal to the amount specified in sec-
17 tion 338B(g)(2)(A) of the Public Health Service
18 Act, whichever is more, on behalf of the individual
19 for loans described in paragraph (1). In making a
20 determination of the amount to pay for a year of
21 such service by an individual, the Secretary shall
22 consider the extent to which each such determina-
23 tion—

24 “(A) affects the ability of the Secretary to
25 maximize the number of contracts that can be

1 provided under the Loan Repayment Program
2 from the amounts appropriated for such con-
3 tracts;

4 “(B) provides an incentive to serve in In-
5 dian Health Programs and urban Indian orga-
6 nizations with the greatest shortages of health
7 professionals; and

8 “(C) provides an incentive with respect to
9 the health professional involved remaining in an
10 Indian Health Program or urban Indian organi-
11 zation with such a health professional shortage,
12 and continuing to provide primary health serv-
13 ices, after the completion of the period of obli-
14 gated service under the Loan Repayment Pro-
15 gram.

16 “(3) TIMING.—Any arrangement made by the
17 Secretary for the making of loan repayments in ac-
18 cordance with this subsection shall provide that any
19 repayments for a year of obligated service shall be
20 made no later than the end of the fiscal year in
21 which the individual completes such year of service.

22 “(4) REIMBURSEMENTS FOR TAX LIABILITY.—
23 For the purpose of providing reimbursements for tax
24 liability resulting from a payment under paragraph
25 (2) on behalf of an individual, the Secretary—

1 “(A) in addition to such payments, may
2 make payments to the individual in an amount
3 equal to not less than 20 percent and not more
4 than 39 percent of the total amount of loan re-
5 payments made for the taxable year involved;
6 and

7 “(B) may make such additional payments
8 as the Secretary determines to be appropriate
9 with respect to such purpose.

10 “(5) PAYMENT SCHEDULE.—The Secretary
11 may enter into an agreement with the holder of any
12 loan for which payments are made under the Loan
13 Repayment Program to establish a schedule for the
14 making of such payments.

15 “(h) EMPLOYMENT CEILING.—Notwithstanding any
16 other provision of law, individuals who have entered into
17 written contracts with the Secretary under this section
18 shall not be counted against any employment ceiling af-
19 fecting the Department while those individuals are under-
20 going academic training.

21 “(i) RECRUITMENT.—The Secretary shall conduct re-
22 cruiting programs for the Loan Repayment Program and
23 other manpower programs of the Service at educational
24 institutions training health professionals or specialists
25 identified in subsection (a).

1 “(j) APPLICABILITY OF LAW.—Section 214 of the
2 Public Health Service Act (42 U.S.C. 215) shall not apply
3 to individuals during their period of obligated service
4 under the Loan Repayment Program.

5 “(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary,
6 in assigning individuals to serve in Indian Health Pro-
7 grams or urban Indian organizations pursuant to con-
8 tracts entered into under this section, shall—

9 “(1) ensure that the staffing needs of Tribal
10 Health Programs and urban Indian organizations
11 receive consideration on an equal basis with pro-
12 grams that are administered directly by the Service;
13 and

14 “(2) give priority to assigning individuals to In-
15 dian Health Programs and urban Indian organiza-
16 tions that have a need for health professionals to
17 provide health care services as a result of individuals
18 having breached contracts entered into under this
19 section.

20 “(l) BREACH OF CONTRACT.—

21 “(1) SPECIFIC BREACHES.—An individual who
22 has entered into a written contract with the Sec-
23 retary under this section and has not received a
24 waiver under subsection (m) shall be liable, in lieu
25 of any service obligation arising under such contract,

1 to the United States for the amount which has been
2 paid on such individual's behalf under the contract
3 if that individual—

4 “(A) is enrolled in the final year of a
5 course of study and—

6 “(i) fails to maintain an acceptable
7 level of academic standing in the edu-
8 cational institution in which he or she is
9 enrolled (such level determined by the edu-
10 cational institution under regulations of
11 the Secretary);

12 “(ii) voluntarily terminates such en-
13 rollment; or

14 “(iii) is dismissed from such edu-
15 cational institution before completion of
16 such course of study; or

17 “(B) is enrolled in a graduate training pro-
18 gram and fails to complete such training pro-
19 gram.

20 “(2) OTHER BREACHES; FORMULA FOR
21 AMOUNT OWED.—If, for any reason not specified in
22 paragraph (1), an individual breaches his or her
23 written contract under this section by failing either
24 to begin, or complete, such individual's period of ob-
25 ligated service in accordance with subsection (e)(2),

1 the United States shall be entitled to recover from
2 such individual an amount to be determined in ac-
3 cordance with the following formula: $A=3Z(t-s/t)$
4 in which—

5 “(A) ‘A’ is the amount the United States
6 is entitled to recover;

7 “(B) ‘Z’ is the sum of the amounts paid
8 under this section to, or on behalf of, the indi-
9 vidual and the interest on such amounts which
10 would be payable if, at the time the amounts
11 were paid, they were loans bearing interest at
12 the maximum legal prevailing rate, as deter-
13 mined by the Secretary of the Treasury;

14 “(C) ‘t’ is the total number of months in
15 the individual’s period of obligated service; and

16 “(D) ‘s’ is the number of months of such
17 period served by such individual in accordance
18 with this section.

19 “(3) TIME PERIOD FOR REPAYMENT.—Any
20 amount of damages which the United States is enti-
21 tled to recover under this subsection shall be paid to
22 the United States within the 1-year period beginning
23 on the date of the breach or such longer period be-
24 ginning on such date as shall be specified by the
25 Secretary.

1 “(4) DEDUCTIONS IN MEDICARE PAYMENTS.—
2 Amounts not paid within such period shall be sub-
3 ject to collection through deductions in Medicare
4 payments pursuant to section 1892 of the Social Se-
5 curity Act.

6 “(5) RECOVERY OF DELINQUENCY.—

7 “(A) IN GENERAL.—If damages described
8 in paragraph (4) are delinquent for 3 months,
9 the Secretary shall, for the purpose of recov-
10 ering such damages—

11 “(i) use collection agencies contracted
12 with by the Administrator of General Serv-
13 ices; or

14 “(ii) enter into contracts for the re-
15 covery of such damages with collection
16 agencies selected by the Secretary.

17 “(B) REPORT.—Each contract for recov-
18 ering damages pursuant to this subsection shall
19 provide that the contractor will, not less than
20 once each 6 months, submit to the Secretary a
21 status report on the success of the contractor in
22 collecting such damages. Section 3718 of title
23 31, United States Code, shall apply to any such
24 contract to the extent not inconsistent with this
25 subsection.

1 “(m) WAIVER OR SUSPENSION OF OBLIGATION.—

2 “(1) IN GENERAL.—The Secretary shall by reg-
3 ulation provide for the partial or total waiver or sus-
4 pension of any obligation of service or payment by
5 an individual under the Loan Repayment Program
6 whenever compliance by the individual is impossible
7 or would involve extreme hardship to the individual
8 and if enforcement of such obligation with respect to
9 any individual would be unconscionable.

10 “(2) CANCELED UPON DEATH.—Any obligation
11 of an individual under the Loan Repayment Pro-
12 gram for service or payment of damages shall be
13 canceled upon the death of the individual.

14 “(3) HARDSHIP WAIVER.—The Secretary may
15 waive, in whole or in part, the rights of the United
16 States to recover amounts under this section in any
17 case of extreme hardship or other good cause shown,
18 as determined by the Secretary.

19 “(4) BANKRUPTCY.—Any obligation of an indi-
20 vidual under the Loan Repayment Program for pay-
21 ment of damages may be released by a discharge in
22 bankruptcy under title 11 of the United States Code
23 only if such discharge is granted after the expiration
24 of the 5-year period beginning on the first date that
25 payment of such damages is required, and only if

1 the bankruptcy court finds that nondischarge of the
2 obligation would be unconscionable.

3 “(n) REPORT.—The Secretary shall submit to the
4 President, for inclusion in the report required to be sub-
5 mitted to Congress under section 801, a report concerning
6 the previous fiscal year which sets forth by Service Area
7 the following:

8 “(1) A list of the health professional positions
9 maintained by Indian Health Programs and urban
10 Indian organizations for which recruitment or reten-
11 tion is difficult.

12 “(2) The number of Loan Repayment Program
13 applications filed with respect to each type of health
14 profession.

15 “(3) The number of contracts described in sub-
16 section (e) that are entered into with respect to each
17 health profession.

18 “(4) The amount of loan payments made under
19 this section, in total and by health profession.

20 “(5) The number of scholarships that are pro-
21 vided under sections 104 and 106 with respect to
22 each health profession.

23 “(6) The amount of scholarship grants provided
24 under sections 104 and 106, in total and by health
25 profession.

1 “(1) BY SECRETARY.—Amounts in the LRRF
2 may be expended by the Secretary, acting through
3 the Service, to make payments to an Indian Health
4 Program—

5 “(A) to which a scholarship recipient under
6 section 104 and 106 or a loan repayment pro-
7 gram participant under section 110 has been
8 assigned to meet the obligated service require-
9 ments pursuant to such sections; and

10 “(B) that has a need for a health profes-
11 sional to provide health care services as a result
12 of such recipient or participant having breached
13 the contract entered into under section 104,
14 106, or 110.

15 “(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal
16 Health Program receiving payments pursuant to
17 paragraph (1) may expend the payments to provide
18 scholarships or recruit and employ, directly or by
19 contract, health professionals to provide health care
20 services.

21 “(c) INVESTMENT OF FUNDS.—The Secretary of the
22 Treasury shall invest such amounts of the LRRF as the
23 Secretary of Health and Human Services determines are
24 not required to meet current withdrawals from the LRRF.
25 Such investments may be made only in interest bearing

1 obligations of the United States. For such purpose, such
2 obligations may be acquired on original issue at the issue
3 price, or by purchase of outstanding obligations at the
4 market price.

5 “(d) SALE OF OBLIGATIONS.—Any obligation ac-
6 quired by the LRRF may be sold by the Secretary of the
7 Treasury at the market price.

8 **“SEC. 112. RECRUITMENT ACTIVITIES.**

9 “(a) REIMBURSEMENT FOR TRAVEL.—The Sec-
10 retary, acting through the Service, may reimburse health
11 professionals seeking positions with Indian Health Pro-
12 grams or urban Indian organizations, including individ-
13 uals considering entering into a contract under section
14 110 and their spouses, for actual and reasonable expenses
15 incurred in traveling to and from their places of residence
16 to an area in which they may be assigned for the purpose
17 of evaluating such area with respect to such assignment.

18 “(b) RECRUITMENT PERSONNEL.—The Secretary,
19 acting through the Service, shall assign 1 individual in
20 each Area Office to be responsible on a full-time basis for
21 recruitment activities.

22 **“SEC. 113. INDIAN RECRUITMENT AND RETENTION PRO-**
23 **GRAM.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Service, shall fund, on a competitive basis, innovative

1 demonstration projects for a period not to exceed 3 years
2 to enable Indian Health Programs and urban Indian orga-
3 nizations to recruit, place, and retain health professionals
4 to meet their staffing needs.

5 “(b) ELIGIBLE ENTITIES; APPLICATION.—Any In-
6 dian Health Program or Urban Indian organization may
7 submit an application for funding of a project pursuant
8 to this section.

9 **“SEC. 114. ADVANCED TRAINING AND RESEARCH.**

10 “(a) DEMONSTRATION PROGRAM.—The Secretary,
11 acting through the Service, shall establish a demonstration
12 project to enable health professionals who have worked in
13 an Indian Health Program or urban Indian organization
14 for a substantial period of time to pursue advanced train-
15 ing or research areas of study for which the Secretary de-
16 termines a need exists.

17 “(b) SERVICE OBLIGATION.—An individual who par-
18 ticipates in a program under subsection (a), where the
19 educational costs are borne by the Service, shall incur an
20 obligation to serve in an Indian Health Program or urban
21 Indian organization for a period of obligated service equal
22 to at least the period of time during which the individual
23 participates in such program. In the event that the indi-
24 vidual fails to complete such obligated service, the indi-
25 vidual shall be liable to the United States for the period

1 of service remaining. In such event, with respect to indi-
2 viduals entering the program after the date of enactment
3 of the Indian Health Care Improvement Act Amendments
4 of 2009, the United States shall be entitled to recover
5 from such individual an amount to be determined in ac-
6 cordance with the formula specified in subsection (l) of
7 section 110 in the manner provided for in such subsection.

8 “(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—
9 Health professionals from Tribal Health Programs and
10 urban Indian organizations shall be given an equal oppor-
11 tunity to participate in the program under subsection (a).

12 **“SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO**
13 **NURSING PROGRAM.**

14 “(a) GRANTS AUTHORIZED.—For the purpose of in-
15 creasing the number of nurses, nurse midwives, and nurse
16 practitioners who deliver health care services to Indians,
17 the Secretary, acting through the Service, shall provide
18 grants to the following:

19 “(1) Public or private schools of nursing.

20 “(2) Tribal colleges or universities.

21 “(3) Nurse midwife programs and advanced
22 practice nurse programs that are provided by any
23 tribal college or university accredited nursing pro-
24 gram, or in the absence of such, any other public or
25 private institutions.

1 “(b) USE OF GRANTS.—Grants provided under sub-
2 section (a) may be used for 1 or more of the following:

3 “(1) To recruit individuals for programs which
4 train individuals to be nurses, nurse midwives, or
5 advanced practice nurses.

6 “(2) To provide scholarships to Indians enrolled
7 in such programs that may pay the tuition charged
8 for such program and other expenses incurred in
9 connection with such program, including books, fees,
10 room and board, and stipends for living expenses.

11 “(3) To provide a program that encourages
12 nurses, nurse midwives, and advanced practice
13 nurses to provide, or continue to provide, health care
14 services to Indians.

15 “(4) To provide a program that increases the
16 skills of, and provides continuing education to,
17 nurses, nurse midwives, and advanced practice
18 nurses.

19 “(5) To provide any program that is designed
20 to achieve the purpose described in subsection (a).

21 “(c) APPLICATIONS.—Each application for a grant
22 under subsection (a) shall include such information as the
23 Secretary may require to establish the connection between
24 the program of the applicant and a health care facility
25 that primarily serves Indians.

1 “(d) PREFERENCES FOR GRANT RECIPIENTS.—In
2 providing grants under subsection (a), the Secretary shall
3 extend a preference to the following:

4 “(1) Programs that provide a preference to In-
5 dians.

6 “(2) Programs that train nurse midwives or ad-
7 vanced practice nurses.

8 “(3) Programs that are interdisciplinary.

9 “(4) Programs that are conducted in coopera-
10 tion with a program for gifted and talented Indian
11 students.

12 “(5) Programs conducted by tribal colleges and
13 universities.

14 “(e) QUENTIN N. BURDICK PROGRAM GRANT.—The
15 Secretary shall provide 1 of the grants authorized under
16 subsection (a) to establish and maintain a program at the
17 University of North Dakota to be known as the ‘Quentin
18 N. Burdick American Indians Into Nursing Program’.
19 Such program shall, to the maximum extent feasible, co-
20 ordinate with the Quentin N. Burdick Indian Health Pro-
21 grams established under section 117(b) and the Quentin
22 N. Burdick American Indians Into Psychology Program
23 established under section 105(b).

24 “(f) ACTIVE DUTY SERVICE OBLIGATION.—The ac-
25 tive duty service obligation prescribed under section 338C

1 of the Public Health Service Act (42 U.S.C. 254m) shall
2 be met by each individual who receives training or assist-
3 ance described in paragraph (1) or (2) of subsection (b)
4 that is funded by a grant provided under subsection (a).

5 Such obligation shall be met by service—

6 “(1) in the Service;

7 “(2) in a program of an Indian Tribe or Tribal
8 Organization conducted under the Indian Self-Deter-
9 mination and Education Assistance Act (25 U.S.C.
10 450 et seq.) (including programs under agreements
11 with the Bureau of Indian Affairs);

12 “(3) in a program assisted under title V of this
13 Act;

14 “(4) in the private practice of nursing if, as de-
15 termined by the Secretary, in accordance with guide-
16 lines promulgated by the Secretary, such practice is
17 situated in a physician or other health shortage area
18 and addresses the health care needs of a substantial
19 number of Indians; or

20 “(5) in a teaching capacity in a tribal college or
21 university nursing program (or a related health pro-
22 fession program) if, as determined by the Secretary,
23 health services provided to Indians would not de-
24 crease.

1 **“SEC. 116. TRIBAL CULTURAL ORIENTATION.**

2 “(a) CULTURAL EDUCATION OF EMPLOYEES.—The
3 Secretary, acting through the Service, shall require that
4 appropriate employees of the Service who serve Indian
5 Tribes in each Service Area receive educational instruction
6 in the history and culture of such Indian Tribes and their
7 relationship to the Service.

8 “(b) PROGRAM.—In carrying out subsection (a), the
9 Secretary shall establish a program which shall, to the ex-
10 tent feasible—

11 “(1) be developed in consultation with the af-
12 fected Indian Tribes, Tribal Organizations, and
13 urban Indian organizations;

14 “(2) be carried out through tribal colleges or
15 universities;

16 “(3) include instruction in American Indian
17 studies; and

18 “(4) describe the use and place of traditional
19 health care practices of the Indian Tribes in the
20 Service Area.

21 **“SEC. 117. INMED PROGRAM.**

22 “(a) GRANTS AUTHORIZED.—The Secretary, acting
23 through the Service, is authorized to provide grants to col-
24 leges and universities for the purpose of maintaining and
25 expanding the Indian health careers recruitment program
26 known as the ‘Indians Into Medicine Program’ (herein-

1 after in this section referred to as ‘INMED’) as a means
2 of encouraging Indians to enter the health professions.

3 “(b) QUENTIN N. BURDICK GRANT.—The Secretary
4 shall provide 1 of the grants authorized under subsection
5 (a) to maintain the INMED program at the University
6 of North Dakota, to be known as the ‘Quentin N. Burdick
7 Indian Health Programs’, unless the Secretary makes a
8 determination, based upon program reviews, that the pro-
9 gram is not meeting the purposes of this section. Such
10 program shall, to the maximum extent feasible, coordinate
11 with the Quentin N. Burdick American Indians Into Psy-
12 chology Program established under section 105(b) and the
13 Quentin N. Burdick American Indians Into Nursing Pro-
14 gram established under section 115.

15 “(c) REGULATIONS.—The Secretary, pursuant to this
16 Act, shall develop regulations to govern grants pursuant
17 to this section.

18 “(d) REQUIREMENTS.—Applicants for grants pro-
19 vided under this section shall agree to provide a program
20 which—

21 “(1) provides outreach and recruitment for
22 health professions to Indian communities including
23 elementary and secondary schools and community
24 colleges located on reservations which will be served
25 by the program;

1 “(2) incorporates a program advisory board
2 comprised of representatives from the Indian Tribes
3 and Indian communities which will be served by the
4 program;

5 “(3) provides summer preparatory programs for
6 Indian students who need enrichment in the subjects
7 of math and science in order to pursue training in
8 the health professions;

9 “(4) provides tutoring, counseling, and support
10 to students who are enrolled in a health career pro-
11 gram of study at the respective college or university;
12 and

13 “(5) to the maximum extent feasible, employs
14 qualified Indians in the program.

15 **“SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY**
16 **COLLEGES.**

17 “(a) GRANTS TO ESTABLISH PROGRAMS.—

18 “(1) IN GENERAL.—The Secretary, acting
19 through the Service, shall award grants to accredited
20 and accessible community colleges for the purpose of
21 assisting such community colleges in the establish-
22 ment of programs which provide education in a
23 health profession leading to a degree or diploma in
24 a health profession for individuals who desire to

1 practice such profession on or near a reservation or
2 in an Indian Health Program.

3 “(2) AMOUNT OF GRANTS.—The amount of any
4 grant awarded to a community college under para-
5 graph (1) for the first year in which such a grant
6 is provided to the community college shall not exceed
7 \$250,000.

8 “(b) GRANTS FOR MAINTENANCE AND RECRUIT-
9 ING.—

10 “(1) IN GENERAL.—The Secretary, acting
11 through the Service, shall award grants to accredited
12 and accessible community colleges that have estab-
13 lished a program described in subsection (a)(1) for
14 the purpose of maintaining the program and recruit-
15 ing students for the program.

16 “(2) REQUIREMENTS.—Grants may only be
17 made under this section to a community college
18 which—

19 “(A) is accredited;

20 “(B) has a relationship with a hospital fa-
21 cility, Service facility, or hospital that could
22 provide training of nurses or health profes-
23 sionals;

1 “(C) has entered into an agreement with
2 an accredited college or university medical
3 school, the terms of which—

4 “(i) provide a program that enhances
5 the transition and recruitment of students
6 into advanced baccalaureate or graduate
7 programs that train health professionals;
8 and

9 “(ii) stipulate certifications necessary
10 to approve internship and field placement
11 opportunities at Indian Health Programs;

12 “(D) has a qualified staff which has the
13 appropriate certifications;

14 “(E) is capable of obtaining State or re-
15 gional accreditation of the program described in
16 subsection (a)(1); and

17 “(F) agrees to provide for Indian pref-
18 erence for applicants for programs under this
19 section.

20 “(c) TECHNICAL ASSISTANCE.—The Secretary shall
21 encourage community colleges described in subsection
22 (b)(2) to establish and maintain programs described in
23 subsection (a)(1) by—

24 “(1) entering into agreements with such col-
25 leges for the provision of qualified personnel of the

1 Service to teach courses of study in such programs;
2 and

3 “(2) providing technical assistance and support
4 to such colleges.

5 “(d) ADVANCED TRAINING.—

6 “(1) REQUIRED.—Any program receiving as-
7 sistance under this section that is conducted with re-
8 spect to a health profession shall also offer courses
9 of study which provide advanced training for any
10 health professional who—

11 “(A) has already received a degree or di-
12 ploma in such health profession; and

13 “(B) provides clinical services on or near a
14 reservation or for an Indian Health Program.

15 “(2) MAY BE OFFERED AT ALTERNATE SITE.—

16 Such courses of study may be offered in conjunction
17 with the college or university with which the commu-
18 nity college has entered into the agreement required
19 under subsection (b)(2)(C).

20 “(e) PRIORITY.—Where the requirements of sub-
21 section (b) are met, grant award priority shall be provided
22 to tribal colleges and universities in Service Areas where
23 they exist.

1 **“SEC. 119. RETENTION BONUS.**

2 “(a) BONUS AUTHORIZED.—The Secretary may pay
3 a retention bonus to any health professional employed by,
4 or assigned to, and serving in, an Indian Health Program
5 or urban Indian organization either as a civilian employee
6 or as a commissioned officer in the Regular or Reserve
7 Corps of the Public Health Service who—

8 “(1) is assigned to, and serving in, a position
9 for which recruitment or retention of personnel is
10 difficult;

11 “(2) the Secretary determines is needed by In-
12 dian Health Programs and urban Indian organiza-
13 tions;

14 “(3) has—

15 “(A) completed 2 years of employment
16 with an Indian Health Program or urban In-
17 dian organization; or

18 “(B) completed any service obligations in-
19 curred as a requirement of—

20 “(i) any Federal scholarship program;

21 or

22 “(ii) any Federal education loan re-
23 payment program; and

24 “(4) enters into an agreement with an Indian
25 Health Program or urban Indian organization for

1 continued employment for a period of not less than
2 1 year.

3 “(b) RATES.—The Secretary may establish rates for
4 the retention bonus which shall provide for a higher an-
5 nual rate for multiyear agreements than for single year
6 agreements referred to in subsection (a)(4), but in no
7 event shall the annual rate be more than \$25,000 per
8 annum.

9 “(c) DEFAULT OF RETENTION AGREEMENT.—Any
10 health professional failing to complete the agreed upon
11 term of service, except where such failure is through no
12 fault of the individual, shall be obligated to refund to the
13 Government the full amount of the retention bonus for the
14 period covered by the agreement, plus interest as deter-
15 mined by the Secretary in accordance with section
16 110(l)(2)(B).

17 “(d) OTHER RETENTION BONUS.—The Secretary
18 may pay a retention bonus to any health professional em-
19 ployed by a Tribal Health Program if such health profes-
20 sional is serving in a position which the Secretary deter-
21 mines is—

22 “(1) a position for which recruitment or reten-
23 tion is difficult; and

24 “(2) necessary for providing health care services
25 to Indians.

1 **“SEC. 120. NURSING RESIDENCY PROGRAM.**

2 “(a) ESTABLISHMENT OF PROGRAM.—The Sec-
3 retary, acting through the Service, shall establish a pro-
4 gram to enable Indians who are licensed practical nurses,
5 licensed vocational nurses, and registered nurses who are
6 working in an Indian Health Program or urban Indian
7 organization, and have done so for a period of not less
8 than 1 year, to pursue advanced training. Such program
9 shall include a combination of education and work study
10 in an Indian Health Program or urban Indian organiza-
11 tion leading to an associate or bachelor’s degree (in the
12 case of a licensed practical nurse or licensed vocational
13 nurse), a bachelor’s degree (in the case of a registered
14 nurse), or advanced degrees or certifications in nursing
15 and public health.

16 “(b) SERVICE OBLIGATION.—An individual who par-
17 ticipates in a program under subsection (a), where the
18 educational costs are paid by the Service, shall incur an
19 obligation to serve in an Indian Health Program or urban
20 Indian organization for a period of obligated service equal
21 to 1 year for every year that nonprofessional employee (li-
22 censed practical nurses, licensed vocational nurses, nurs-
23 ing assistants, and various health care technicians), or 2
24 years for every year that professional nurse (associate de-
25 gree and bachelor-prepared registered nurses), partici-
26 pates in such program. In the event that the individual

1 fails to complete such obligated service, the United States
2 shall be entitled to recover from such individual an amount
3 determined in accordance with the formula specified sub-
4 section (d)(1) of Section 104 for individuals failing to
5 graduate from their degree program and subsection (l) of
6 Section 110 for individuals failing to start or complete the
7 obligated service.

8 **“SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.**

9 “(a) GENERAL PURPOSES OF PROGRAM.—Under the
10 authority of the Act of November 2, 1921 (25 U.S.C. 13)
11 (commonly known as the ‘Snyder Act’), the Secretary, act-
12 ing through the Service, shall develop and operate a Com-
13 munity Health Aide Program in Alaska under which the
14 Service—

15 “(1) provides for the training of Alaska Natives
16 as health aides or community health practitioners;

17 “(2) uses such aides or practitioners in the pro-
18 vision of health care, health promotion, and disease
19 prevention services to Alaska Natives living in vil-
20 lages in rural Alaska; and

21 “(3) provides for the establishment of tele-
22 conferencing capacity in health clinics located in or
23 near such villages for use by community health aides
24 or community health practitioners.

1 “(b) SPECIFIC PROGRAM REQUIREMENTS.—The Sec-
2 retary, acting through the Community Health Aide Pro-
3 gram of the Service, shall—

4 “(1) using trainers accredited by the Program,
5 provide a high standard of training to community
6 health aides and community health practitioners to
7 ensure that such aides and practitioners provide
8 quality health care, health promotion, and disease
9 prevention services to the villages served by the Pro-
10 gram;

11 “(2) in order to provide such training, develop
12 a curriculum that—

13 “(A) combines education in the theory of
14 health care with supervised practical experience
15 in the provision of health care;

16 “(B) provides instruction and practical ex-
17 perience in the provision of acute care, emer-
18 gency care, health promotion, disease preven-
19 tion, and the efficient and effective manage-
20 ment of clinic pharmacies, supplies, equipment,
21 and facilities; and

22 “(C) promotes the achievement of the
23 health status objectives specified in section
24 3(2);

1 “(3) establish and maintain a Community
2 Health Aide Certification Board to certify as com-
3 munity health aides or community health practi-
4 tioners individuals who have successfully completed
5 the training described in paragraph (1) or can dem-
6 onstrate equivalent experience;

7 “(4) develop and maintain a system which iden-
8 tifies the needs of community health aides and com-
9 munity health practitioners for continuing education
10 in the provision of health care, including the areas
11 described in paragraph (2)(B), and develop pro-
12 grams that meet the needs for such continuing edu-
13 cation;

14 “(5) develop and maintain a system that pro-
15 vides close supervision of community health aides
16 and community health practitioners;

17 “(6) develop a system under which the work of
18 community health aides and community health prac-
19 titioners is reviewed and evaluated to assure the pro-
20 vision of quality health care, health promotion, and
21 disease prevention services; and

22 “(7) ensure that pulpal therapy (not including
23 pulpotomies on deciduous teeth) or extraction of
24 adult teeth can be performed by a dental health aide
25 therapist only after consultation with a licensed den-

1 tist who determines that the procedure is a medical
2 emergency that cannot be resolved with palliative
3 treatment, and further that dental health aide thera-
4 pists are strictly prohibited from performing all
5 other oral or jaw surgeries, provided that uncompli-
6 cated extractions shall not be considered oral sur-
7 gery under this section.

8 “(c) PROGRAM REVIEW.—

9 “(1) NEUTRAL PANEL.—

10 “(A) ESTABLISHMENT.—The Secretary,
11 acting through the Service, shall establish a
12 neutral panel to carry out the study under
13 paragraph (2).

14 “(B) MEMBERSHIP.—Members of the neu-
15 tral panel shall be appointed by the Secretary
16 from among clinicians, economists, community
17 practitioners, oral epidemiologists, and Alaska
18 Natives.

19 “(2) STUDY.—

20 “(A) IN GENERAL.—The neutral panel es-
21 tablished under paragraph (1) shall conduct a
22 study of the dental health aide therapist serv-
23 ices provided by the Community Health Aide
24 Program under this section to ensure that the

1 quality of care provided through those services
2 is adequate and appropriate.

3 “(B) PARAMETERS OF STUDY.—The Sec-
4 retary, in consultation with interested parties,
5 including professional dental organizations,
6 shall develop the parameters of the study.

7 “(C) INCLUSIONS.—The study shall in-
8 clude a determination by the neutral panel with
9 respect to—

10 “(i) the ability of the dental health
11 aide therapist services under this section to
12 address the dental care needs of Alaska
13 Natives;

14 “(ii) the quality of care provided
15 through those services, including any train-
16 ing, improvement, or additional oversight
17 required to improve the quality of care;
18 and

19 “(iii) whether safer and less costly al-
20 ternatives to the dental health aide thera-
21 pist services exist.

22 “(D) CONSULTATION.—In carrying out the
23 study under this paragraph, the neutral panel
24 shall consult with Alaska Tribal Organizations

1 with respect to the adequacy and accuracy of
2 the study.

3 “(3) REPORT.—The neutral panel shall submit
4 to the Secretary, the Committee on Indian Affairs of
5 the Senate, and the Committee on Natural Re-
6 sources of the House of Representatives a report de-
7 scribing the results of the study under paragraph
8 (2), including a description of—

9 “(A) any determination of the neutral
10 panel under paragraph (2)(C); and

11 “(B) any comments received from an Alas-
12 ka Tribal Organization under paragraph
13 (2)(D).

14 “(d) NATIONALIZATION OF PROGRAM.—

15 “(1) IN GENERAL.—Except as provided in para-
16 graph (2), the Secretary, acting through the Service,
17 may establish a national Community Health Aide
18 Program in accordance with the program under this
19 section, as the Secretary determines to be appro-
20 priate.

21 “(2) EXCEPTION.—The national Community
22 Health Aide Program under paragraph (1) shall not
23 include dental health aide therapist services.

24 “(3) REQUIREMENT.—In establishing a na-
25 tional program under paragraph (1), the Secretary

1 shall not reduce the amount of funds provided for
2 the Community Health Aide Program described in
3 subsections (a) and (b).

4 **“SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.**

5 “The Secretary shall, by contract or otherwise, pro-
6 vide training for individuals in the administration and
7 planning of Tribal Health Programs, with priority to Indi-
8 ans.

9 **“SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE**
10 **DEMONSTRATION PROGRAMS.**

11 “(a) DEMONSTRATION PROGRAMS AUTHORIZED.—
12 The Secretary, acting through the Service, may fund dem-
13 onstration programs for Tribal Health Programs to ad-
14 dress the chronic shortages of health professionals.

15 “(b) PURPOSES OF PROGRAMS.—The purposes of
16 demonstration programs funded under subsection (a) shall
17 be—

18 “(1) to provide direct clinical and practical ex-
19 perience at a Service Unit to health profession stu-
20 dents and residents from medical schools;

21 “(2) to improve the quality of health care for
22 Indians by assuring access to qualified health care
23 professionals; and

24 “(3) to provide academic and scholarly opportu-
25 nities for health professionals serving Indians by

1 identifying all academic and scholarly resources of
2 the region.

3 “(c) ADVISORY BOARD.—The demonstration pro-
4 grams established pursuant to subsection (a) shall incor-
5 porate a program advisory board composed of representa-
6 tives from the Indian Tribes and Indian communities in
7 the area which will be served by the program.

8 **“SEC. 124. NATIONAL HEALTH SERVICE CORPS.**

9 “(a) NO REDUCTION IN SERVICES.—The Secretary
10 shall not—

11 “(1) remove a member of the National Health
12 Service Corps from an Indian Health Program or
13 urban Indian organization; or

14 “(2) withdraw funding used to support such
15 member, unless the Secretary, acting through the
16 Service, has ensured that the Indians receiving serv-
17 ices from such member will experience no reduction
18 in services.

19 “(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—
20 At the request of an Indian Health Program, the services
21 of a member of the National Health Service Corps as-
22 signed to an Indian Health Program may be limited to
23 the persons who are eligible for services from such Pro-
24 gram.

1 **“SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL**
2 **CURRICULA DEMONSTRATION PROGRAMS.**

3 “(a) **CONTRACTS AND GRANTS.**—The Secretary, act-
4 ing through the Service, may enter into contracts with,
5 or make grants to, accredited tribal colleges and univer-
6 sities and eligible accredited and accessible community col-
7 leges to establish demonstration programs to develop edu-
8 cational curricula for substance abuse counseling.

9 “(b) **USE OF FUNDS.**—Funds provided under this
10 section shall be used only for developing and providing
11 educational curriculum for substance abuse counseling (in-
12 cluding paying salaries for instructors). Such curricula
13 may be provided through satellite campus programs.

14 “(c) **TIME PERIOD OF ASSISTANCE; RENEWAL.**—A
15 contract entered into or a grant provided under this sec-
16 tion shall be for a period of 3 years. Such contract or
17 grant may be renewed for an additional 2-year period
18 upon the approval of the Secretary.

19 “(d) **CRITERIA FOR REVIEW AND APPROVAL OF AP-**
20 **PLICATIONS.**—Not later than 180 days after the date of
21 enactment of the Indian Health Care Improvement Act
22 Amendments of 2009, the Secretary, after consultation
23 with Indian Tribes and administrators of tribal colleges
24 and universities and eligible accredited and accessible com-
25 munity colleges, shall develop and issue criteria for the
26 review and approval of applications for funding (including

1 applications for renewals of funding) under this section.
2 Such criteria shall ensure that demonstration programs
3 established under this section promote the development of
4 the capacity of such entities to educate substance abuse
5 counselors.

6 “(e) ASSISTANCE.—The Secretary shall provide such
7 technical and other assistance as may be necessary to en-
8 able grant recipients to comply with the provisions of this
9 section.

10 “(f) REPORT.—Each fiscal year, the Secretary shall
11 submit to the President, for inclusion in the report which
12 is required to be submitted under section 801 for that fis-
13 cal year, a report on the findings and conclusions derived
14 from the demonstration programs conducted under this
15 section during that fiscal year.

16 “(g) DEFINITION.—For the purposes of this section,
17 the term ‘educational curriculum’ means 1 or more of the
18 following:

19 “(1) Classroom education.

20 “(2) Clinical work experience.

21 “(3) Continuing education workshops.

22 **“SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMU-**
23 **NITY EDUCATION PROGRAMS.**

24 “(a) STUDY; LIST.—The Secretary, acting through
25 the Service, and the Secretary of the Interior, in consulta-

1 tion with Indian Tribes and Tribal Organizations, shall
2 conduct a study and compile a list of the types of staff
3 positions specified in subsection (b) whose qualifications
4 include, or should include, training in the identification,
5 prevention, education, referral, or treatment of mental ill-
6 ness, or dysfunctional and self-destructive behavior.

7 “(b) POSITIONS.—The positions referred to in sub-
8 section (a) are—

9 “(1) staff positions within the Bureau of Indian
10 Affairs, including existing positions, in the fields
11 of—

12 “(A) elementary and secondary education;

13 “(B) social services and family and child
14 welfare;

15 “(C) law enforcement and judicial services;

16 and

17 “(D) alcohol and substance abuse;

18 “(2) staff positions within the Service; and

19 “(3) staff positions similar to those identified in
20 paragraphs (1) and (2) established and maintained
21 by Indian Tribes, Tribal Organizations (without re-
22 gard to the funding source), and urban Indian orga-
23 nizations.

24 “(c) TRAINING CRITERIA.—

1 “(1) IN GENERAL.—The appropriate Secretary
2 shall provide training criteria appropriate to each
3 type of position identified in subsection (b)(1) and
4 (b)(2) and ensure that appropriate training has
5 been, or shall be provided to any individual in any
6 such position. With respect to any such individual in
7 a position identified pursuant to subsection (b)(3),
8 the respective Secretaries shall provide appropriate
9 training to, or provide funds to, an Indian Tribe,
10 Tribal Organization, or urban Indian organization
11 for training of appropriate individuals. In the case of
12 positions funded under a contract or compact under
13 the Indian Self-Determination and Education Assist-
14 ance Act (25 U.S.C. 450 et seq.), the appropriate
15 Secretary shall ensure that such training costs are
16 included in the contract or compact, as the Sec-
17 retary determines necessary.

18 “(2) POSITION SPECIFIC TRAINING CRITERIA.—
19 Position specific training criteria shall be culturally
20 relevant to Indians and Indian Tribes and shall en-
21 sure that appropriate information regarding tradi-
22 tional health care practices is provided.

23 “(d) COMMUNITY EDUCATION ON MENTAL ILL-
24 NESS.—The Service shall develop and implement, on re-
25 quest of an Indian Tribe, Tribal Organization, or urban

1 Indian organization, or assist the Indian Tribe, Tribal Or-
2 ganization, or urban Indian organization to develop and
3 implement, a program of community education on mental
4 illness. In carrying out this subsection, the Service shall,
5 upon request of an Indian Tribe, Tribal Organization, or
6 urban Indian organization, provide technical assistance to
7 the Indian Tribe, Tribal Organization, or urban Indian or-
8 ganization to obtain and develop community educational
9 materials on the identification, prevention, referral, and
10 treatment of mental illness and dysfunctional and self-de-
11 structive behavior.

12 “(e) PLAN.—Not later than 90 days after the date
13 of enactment of the Indian Health Care Improvement Act
14 Amendments of 2009, the Secretary shall develop a plan
15 under which the Service will increase the health care staff
16 providing behavioral health services by at least 500 posi-
17 tions within 5 years after the date of enactment of this
18 section, with at least 200 of such positions devoted to
19 child, adolescent, and family services. The plan developed
20 under this subsection shall be implemented under the Act
21 of November 2, 1921 (25 U.S.C. 13) (commonly known
22 as the ‘Snyder Act’).

23 **“SEC. 127. EXEMPTION FROM PAYMENT OF CERTAIN FEES.**

24 “Employees of a Tribal Health Program or an Urban
25 Indian Organization shall be exempt from payment of li-

1 censing, registration, and other fees imposed by a Federal
2 agency to the same extent that Commissioned Corps Offi-
3 cers or other employees of the Indian Health Service are
4 exempt from such fees.

5 **“SEC. 128. AUTHORIZATION OF APPROPRIATIONS.**

6 “There are authorized to be appropriated such sums
7 as may be necessary to carry out this title.

8 **“TITLE II—HEALTH SERVICES**

9 **“SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.**

10 “(a) USE OF FUNDS.—The Secretary, acting through
11 the Service, is authorized to expend funds, directly or
12 under the authority of the Indian Self-Determination and
13 Education Assistance Act (25 U.S.C. 450 et seq.), which
14 are appropriated under the authority of this section, for
15 the purposes of—

16 “(1) eliminating the deficiencies in health sta-
17 tus and health resources of all Indian Tribes;

18 “(2) eliminating backlogs in the provision of
19 health care services to Indians;

20 “(3) meeting the health needs of Indians in an
21 efficient and equitable manner, including the use of
22 telehealth and telemedicine when appropriate;

23 “(4) eliminating inequities in funding for both
24 direct care and contract health service programs;
25 and

1 “(5) augmenting the ability of the Service to
2 meet the following health service responsibilities with
3 respect to those Indian Tribes with the highest levels
4 of health status deficiencies and resource defi-
5 ciencies:

6 “(A) Clinical care, including inpatient care,
7 outpatient care (including audiology, clinical
8 eye, and vision care), primary care, secondary
9 and tertiary care, and long-term care.

10 “(B) Preventive health, including mam-
11 mography and other cancer screening in accord-
12 ance with section 207.

13 “(C) Dental care.

14 “(D) Mental health, including community
15 mental health services, inpatient mental health
16 services, dormitory mental health services,
17 therapeutic and residential treatment centers,
18 and training of traditional health care practi-
19 tioners.

20 “(E) Emergency medical services.

21 “(F) Treatment and control of, and reha-
22 bilitative care related to, alcoholism and drug
23 abuse (including fetal alcohol syndrome) among
24 Indians.

1 “(G) Injury prevention programs, includ-
2 ing data collection and evaluation, demonstra-
3 tion projects, training, and capacity building.

4 “(H) Home health care.

5 “(I) Community health representatives.

6 “(J) Maintenance and improvement.

7 “(b) NO OFFSET OR LIMITATION.—Any funds appro-
8 priated under the authority of this section shall not be
9 used to offset or limit any other appropriations made to
10 the Service under this Act or the Act of November 2, 1921
11 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’),
12 or any other provision of law.

13 “(c) ALLOCATION; USE.—

14 “(1) IN GENERAL.—Funds appropriated under
15 the authority of this section shall be allocated to
16 Service Units, Indian Tribes, or Tribal Organiza-
17 tions. The funds allocated to each Indian Tribe,
18 Tribal Organization, or Service Unit under this
19 paragraph shall be used by the Indian Tribe, Tribal
20 Organization, or Service Unit under this paragraph
21 to improve the health status and reduce the resource
22 deficiency of each Indian Tribe served by such Serv-
23 ice Unit, Indian Tribe, or Tribal Organization.

24 “(2) APPORTIONMENT OF ALLOCATED
25 FUNDS.—The apportionment of funds allocated to a

1 Service Unit, Indian Tribe, or Tribal Organization
2 under paragraph (1) among the health service re-
3 sponsibilities described in subsection (a)(5) shall be
4 determined by the Service in consultation with, and
5 with the active participation of, the affected Indian
6 Tribes and Tribal Organizations.

7 “(d) PROVISIONS RELATING TO HEALTH STATUS
8 AND RESOURCE DEFICIENCIES.—For the purposes of this
9 section, the following definitions apply:

10 “(1) DEFINITION.—The term ‘health status
11 and resource deficiency’ means the extent to
12 which—

13 “(A) the health status objectives set forth
14 in section 3(2) are not being achieved; and

15 “(B) the Indian Tribe or Tribal Organiza-
16 tion does not have available to it the health re-
17 sources it needs, taking into account the actual
18 cost of providing health care services given local
19 geographic, climatic, rural, or other cir-
20 cumstances.

21 “(2) AVAILABLE RESOURCES.—The health re-
22 sources available to an Indian Tribe or Tribal Orga-
23 nization include health resources provided by the
24 Service as well as health resources used by the In-
25 dian Tribe or Tribal Organization, including services

1 and financing systems provided by any Federal pro-
2 grams, private insurance, and programs of State or
3 local governments.

4 “(3) PROCESS FOR REVIEW OF DETERMINA-
5 TIONS.—The Secretary shall establish procedures
6 which allow any Indian Tribe or Tribal Organization
7 to petition the Secretary for a review of any deter-
8 mination of the extent of the health status and re-
9 source deficiency of such Indian Tribe or Tribal Or-
10 ganization.

11 “(e) ELIGIBILITY FOR FUNDS.—Tribal Health Pro-
12 grams shall be eligible for funds appropriated under the
13 authority of this section on an equal basis with programs
14 that are administered directly by the Service.

15 “(f) REPORT.—By no later than the date that is 3
16 years after the date of enactment of the Indian Health
17 Care Improvement Act Amendments of 2009, the Sec-
18 retary shall submit to Congress the current health status
19 and resource deficiency report of the Service for each
20 Service Unit, including newly recognized or acknowledged
21 Indian Tribes. Such report shall set out—

22 “(1) the methodology then in use by the Service
23 for determining Tribal health status and resource
24 deficiencies, as well as the most recent application of
25 that methodology;

1 “(2) the extent of the health status and re-
2 source deficiency of each Indian Tribe served by the
3 Service or a Tribal Health Program;

4 “(3) the amount of funds necessary to eliminate
5 the health status and resource deficiencies of all In-
6 dian Tribes served by the Service or a Tribal Health
7 Program; and

8 “(4) an estimate of—

9 “(A) the amount of health service funds
10 appropriated under the authority of this Act, or
11 any other Act, including the amount of any
12 funds transferred to the Service for the pre-
13 ceding fiscal year which is allocated to each
14 Service Unit, Indian Tribe, or Tribal Organiza-
15 tion;

16 “(B) the number of Indians eligible for
17 health services in each Service Unit or Indian
18 Tribe or Tribal Organization; and

19 “(C) the number of Indians using the
20 Service resources made available to each Service
21 Unit, Indian Tribe or Tribal Organization, and,
22 to the extent available, information on the wait-
23 ing lists and number of Indians turned away for
24 services due to lack of resources.

1 and disease prevention services to Indians to achieve the
2 health status objectives set forth in section 3(2).

3 “(c) EVALUATION.—The Secretary, after obtaining
4 input from the affected Tribal Health Programs, shall
5 submit to the President for inclusion in the report which
6 is required to be submitted to Congress under section 801
7 an evaluation of—

8 “(1) the health promotion and disease preven-
9 tion needs of Indians;

10 “(2) the health promotion and disease preven-
11 tion activities which would best meet such needs;

12 “(3) the internal capacity of the Service and
13 Tribal Health Programs to meet such needs; and

14 “(4) the resources which would be required to
15 enable the Service and Tribal Health Programs to
16 undertake the health promotion and disease preven-
17 tion activities necessary to meet such needs.

18 **“SEC. 203. DIABETES PREVENTION, TREATMENT, AND CON-**

19 **TROL.**

20 “(a) DETERMINATIONS REGARDING DIABETES.—
21 The Secretary, acting through the Service, and in con-
22 sultation with Indian Tribes and Tribal Organizations,
23 shall determine—

1 “(1) by Indian Tribe and by Service Unit, the
2 incidence of, and the types of complications resulting
3 from, diabetes among Indians; and

4 “(2) based on the determinations made pursu-
5 ant to paragraph (1), the measures (including pa-
6 tient education and effective ongoing monitoring of
7 disease indicators) each Service Unit should take to
8 reduce the incidence of, and prevent, treat, and con-
9 trol the complications resulting from, diabetes
10 among Indian Tribes within that Service Unit.

11 “(b) DIABETES SCREENING.—To the extent medi-
12 cally indicated and with informed consent, the Secretary
13 shall screen each Indian who receives services from the
14 Service for diabetes and for conditions which indicate a
15 high risk that the individual will become diabetic and es-
16 tablish a cost-effective approach to ensure ongoing moni-
17 toring of disease indicators. Such screening and moni-
18 toring may be conducted by a Tribal Health Program and
19 may be conducted through appropriate Internet-based
20 health care management programs.

21 “(c) DIABETES PROJECTS.—The Secretary shall con-
22 tinue to maintain each model diabetes project in existence
23 on the date of enactment of the Indian Health Care Im-
24 provement Act Amendments of 2009.

1 “(d) DIALYSIS PROGRAMS.—The Secretary is author-
2 ized to provide, through the Service, Indian Tribes, and
3 Tribal Organizations, dialysis programs, including the
4 purchase of dialysis equipment and the provision of nec-
5 essary staffing.

6 “(e) OTHER DUTIES OF THE SECRETARY.—

7 “(1) IN GENERAL.—The Secretary shall, to the
8 extent funding is available—

9 “(A) in each Area Office, consult with In-
10 dian Tribes and Tribal Organizations regarding
11 programs for the prevention, treatment, and
12 control of diabetes;

13 “(B) establish in each Area Office a reg-
14 istry of patients with diabetes to track the inci-
15 dence of diabetes and the complications from
16 diabetes in that area; and

17 “(C) ensure that data collected in each
18 Area Office regarding diabetes and related com-
19 plications among Indians are disseminated to
20 all other Area Offices, subject to applicable pa-
21 tient privacy laws.

22 “(2) DIABETES CONTROL OFFICERS.—

23 “(A) IN GENERAL.—The Secretary may es-
24 tablish and maintain in each Area Office a posi-
25 tion of diabetes control officer to coordinate and

1 manage any activity of that Area Office relating
2 to the prevention, treatment, or control of dia-
3 betes to assist the Secretary in carrying out a
4 program under this section or section 330C of
5 the Public Health Service Act (42 U.S.C. 254c-
6 3).

7 “(B) CERTAIN ACTIVITIES.—Any activity
8 carried out by a diabetes control officer under
9 subparagraph (A) that is the subject of a con-
10 tract or compact under the Indian Self-Deter-
11 mination and Education Assistance Act (25
12 U.S.C. 450 et seq.), and any funds made avail-
13 able to carry out such an activity, shall not be
14 divisible for purposes of that Act.

15 **“SEC. 204. SHARED SERVICES FOR LONG-TERM CARE.**

16 “(a) LONG-TERM CARE.—Notwithstanding any other
17 provision of law, the Secretary, acting through the Service,
18 is authorized to provide directly, or enter into contracts
19 or compacts under the Indian Self-Determination and
20 Education Assistance Act (25 U.S.C. 450 et seq.) with
21 Indian Tribes or Tribal Organizations for, the delivery of
22 long-term care (including health care services associated
23 with long-term care) provided in a facility to Indians. Such
24 agreements shall provide for the sharing of staff or other
25 services between the Service or a Tribal Health Program

1 and a long-term care or related facility owned and oper-
2 ated (directly or through a contract or compact under the
3 Indian Self-Determination and Education Assistance Act
4 (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal
5 Organization.

6 “(b) CONTENTS OF AGREEMENTS.—An agreement
7 entered into pursuant to subsection (a)—

8 “(1) may, at the request of the Indian Tribe or
9 Tribal Organization, delegate to such Indian Tribe
10 or Tribal Organization such powers of supervision
11 and control over Service employees as the Secretary
12 deems necessary to carry out the purposes of this
13 section;

14 “(2) shall provide that expenses (including sala-
15 ries) relating to services that are shared between the
16 Service and the Tribal Health Program be allocated
17 proportionately between the Service and the Indian
18 Tribe or Tribal Organization; and

19 “(3) may authorize such Indian Tribe or Tribal
20 Organization to construct, renovate, or expand a
21 long-term care or other similar facility (including the
22 construction of a facility attached to a Service facil-
23 ity).

24 “(c) MINIMUM REQUIREMENT.—Any nursing facility
25 provided for under this section shall meet the require-

1 ments for nursing facilities under section 1919 of the So-
2 cial Security Act.

3 “(d) OTHER ASSISTANCE.—The Secretary shall pro-
4 vide such technical and other assistance as may be nec-
5 essary to enable applicants to comply with the provisions
6 of this section.

7 “(e) USE OF EXISTING OR UNDERUSED FACILI-
8 TIES.—The Secretary shall encourage the use of existing
9 facilities that are underused or allow the use of swing beds
10 for long-term or similar care.

11 **“SEC. 205. HEALTH SERVICES RESEARCH.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Service, shall make funding available for research to
14 further the performance of the health service responsibil-
15 ities of Indian Health Programs.

16 “(b) COORDINATION OF RESOURCES AND ACTIVI-
17 TIES.—The Secretary shall also, to the maximum extent
18 practicable, coordinate departmental research resources
19 and activities to address relevant Indian Health Program
20 research needs.

21 “(c) AVAILABILITY.—Tribal Health Programs shall
22 be given an equal opportunity to compete for, and receive,
23 research funds under this section.

24 “(d) USE OF FUNDS.—This funding may be used for
25 both clinical and nonclinical research.

1 “(e) EVALUATION AND DISSEMINATION.—The Sec-
2 retary shall periodically—

3 “(1) evaluate the impact of research conducted
4 under this section; and

5 “(2) disseminate to Tribal Health Programs in-
6 formation regarding that research as the Secretary
7 determines to be appropriate.

8 **“SEC. 206. MAMMOGRAPHY AND OTHER CANCER SCREEN-**
9 **ING.**

10 “The Secretary, acting through the Service, shall pro-
11 vide for screening as follows:

12 “(1) Screening mammography (as defined in
13 section 1861(jj) of the Social Security Act) for In-
14 dian women at a frequency appropriate to such
15 women under accepted and appropriate national
16 standards, and under such terms and conditions as
17 are consistent with standards established by the Sec-
18 retary to ensure the safety and accuracy of screen-
19 ing mammography under part B of title XVIII of
20 such Act.

21 “(2) Other cancer screening that receives an A
22 or B rating as recommended by the United States
23 Preventive Services Task Force established under
24 section 915(a)(1) of the Public Health Service Act
25 (42 U.S.C. 299b–4(a)(1)). The Secretary shall en-

1 sure that screening provided for under this para-
2 graph complies with the recommendations of the
3 Task Force with respect to—

4 “(A) frequency;

5 “(B) the population to be served;

6 “(C) the procedure or technology to be
7 used;

8 “(D) evidence of effectiveness; and

9 “(E) other matters that the Secretary de-
10 termines appropriate.

11 **“SEC. 207. PATIENT TRAVEL COSTS.**

12 “(a) DEFINITION OF QUALIFIED ESCORT.—In this
13 section, the term ‘qualified escort’ means—

14 “(1) an adult escort (including a parent, guard-
15 ian, or other family member) who is required be-
16 cause of the physical or mental condition, or age, of
17 the applicable patient;

18 “(2) a health professional for the purpose of
19 providing necessary medical care during travel by
20 the applicable patient; or

21 “(3) other escorts, as the Secretary or applica-
22 ble Indian Health Program determines to be appro-
23 priate.

24 “(b) PROVISION OF FUNDS.—The Secretary, acting
25 through the Service, is authorized to provide funds for the

1 following patient travel costs, including qualified escorts,
2 associated with receiving health care services provided (ei-
3 ther through direct or contract care or through a contract
4 or compact under the Indian Self-Determination and Edu-
5 cation Assistance Act (25 U.S.C. 450 et seq.)) under this
6 Act—

7 “(1) emergency air transportation and non-
8 emergency air transportation where ground trans-
9 portation is infeasible;

10 “(2) transportation by private vehicle (where no
11 other means of transportation is available), specially
12 equipped vehicle, and ambulance; and

13 “(3) transportation by such other means as
14 may be available and required when air or motor ve-
15 hicle transportation is not available.

16 **“SEC. 208. EPIDEMIOLOGY CENTERS.**

17 “(a) ESTABLISHMENT OF CENTERS.—The Secretary
18 shall establish an epidemiology center in each Service Area
19 to carry out the functions described in subsection (b). Any
20 new center established after the date of enactment of the
21 Indian Health Care Improvement Act Amendments of
22 2008 may be operated under a grant authorized by sub-
23 section (d), but funding under such a grant shall not be
24 divisible.

1 “(b) FUNCTIONS OF CENTERS.—In consultation with
2 and upon the request of Indian Tribes, Tribal Organiza-
3 tions, and Urban Indian communities, each Service Area
4 epidemiology center established under this section shall,
5 with respect to such Service Area—

6 “(1) collect data relating to, and monitor
7 progress made toward meeting, each of the health
8 status objectives of the Service, the Indian Tribes,
9 Tribal Organizations, and Urban Indian commu-
10 nities in the Service Area;

11 “(2) evaluate existing delivery systems, data
12 systems, and other systems that impact the improve-
13 ment of Indian health;

14 “(3) assist Indian Tribes, Tribal Organizations,
15 and Urban Indian Organizations in identifying their
16 highest priority health status objectives and the
17 services needed to achieve such objectives, based on
18 epidemiological data;

19 “(4) make recommendations for the targeting
20 of services needed by the populations served;

21 “(5) make recommendations to improve health
22 care delivery systems for Indians and Urban Indi-
23 ans;

24 “(6) provide requested technical assistance to
25 Indian Tribes, Tribal Organizations, and Urban In-

1 dian Organizations in the development of local
2 health service priorities and incidence and prevalence
3 rates of disease and other illness in the community;
4 and

5 “(7) provide disease surveillance and assist In-
6 dian Tribes, Tribal Organizations, and Urban Indian
7 communities to promote public health.

8 “(c) TECHNICAL ASSISTANCE.—The Director of the
9 Centers for Disease Control and Prevention shall provide
10 technical assistance to the centers in carrying out the re-
11 quirements of this section.

12 “(d) GRANTS FOR STUDIES.—

13 “(1) IN GENERAL.—The Secretary may make
14 grants to Indian Tribes, Tribal Organizations, In-
15 dian organizations, and eligible intertribal consortia
16 to conduct epidemiological studies of Indian commu-
17 nities.

18 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
19 intertribal consortium or Indian organization is eligi-
20 ble to receive a grant under this subsection if—

21 “(A) the intertribal consortium is incor-
22 porated for the primary purpose of improving
23 Indian health; and

24 “(B) the intertribal consortium is rep-
25 resentative of the Indian Tribes or urban In-

1 dian communities in which the intertribal con-
2 sortium is located.

3 “(3) APPLICATIONS.—An application for a
4 grant under this subsection shall be submitted in
5 such manner and at such time as the Secretary shall
6 prescribe.

7 “(4) REQUIREMENTS.—An applicant for a
8 grant under this subsection shall—

9 “(A) demonstrate the technical, adminis-
10 trative, and financial expertise necessary to
11 carry out the functions described in paragraph
12 (5);

13 “(B) consult and cooperate with providers
14 of related health and social services in order to
15 avoid duplication of existing services; and

16 “(C) demonstrate cooperation from Indian
17 Tribes or Urban Indian Organizations in the
18 area to be served.

19 “(5) USE OF FUNDS.—A grant awarded under
20 paragraph (1) may be used—

21 “(A) to carry out the functions described
22 in subsection (b);

23 “(B) to provide information to and consult
24 with tribal leaders, urban Indian community

1 leaders, and related health staff on health care
2 and health service management issues; and

3 “(C) in collaboration with Indian Tribes,
4 Tribal Organizations, and urban Indian com-
5 munities, to provide the Service with informa-
6 tion regarding ways to improve the health sta-
7 tus of Indians.

8 “(e) ACCESS TO INFORMATION.—

9 “(1) An epidemiology center operated by a
10 grantee pursuant to a grant awarded under sub-
11 section (d) shall be treated as a public health au-
12 thority for purposes of the Health Insurance Port-
13 ability and Accountability Act of 1996, as such enti-
14 ties are defined in part 164.501 of title 45, Code of
15 Federal Regulations.

16 “(2) The Secretary shall grant to such epidemi-
17 ology center access to use of the data, data sets,
18 monitoring systems, delivery systems, and other pro-
19 tected health information in the possession of the
20 Secretary.

21 “(3) The activities of such an epidemiology cen-
22 ter shall be for the purposes of research and for pre-
23 venting and controlling disease, injury, or disability
24 for purposes of the Health Insurance Portability and
25 Accountability Act of 1996 (Public Law 104–191;

1 110 Stat. 2033), as such activities are described in
2 part 164.512 of title 45, Code of Federal Regula-
3 tions (or a successor regulation).

4 “(f) FUNDS NOT DIVISIBLE.—An epidemiology cen-
5 ter established under this section shall be subject to the
6 provisions of the Indian Self-Determination and Edu-
7 cation Assistance Act (25 U.S.C. 450 et seq.), but the
8 funds for such center shall not be divisible.

9 **“SEC. 209. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
10 **PROGRAMS.**

11 “(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—
12 In addition to carrying out any other program for health
13 promotion or disease prevention, the Secretary, acting
14 through the Service, is authorized to award grants to In-
15 dian Tribes and Tribal Organizations to develop com-
16 prehensive school health education programs for children
17 from pre-school through grade 12 in schools for the benefit
18 of Indian children.

19 “(b) USE OF GRANT FUNDS.—A grant awarded
20 under this section may be used for purposes which may
21 include, but are not limited to, the following:

22 “(1) Developing health education materials both
23 for regular school programs and afterschool pro-
24 grams.

1 “(2) Training teachers in comprehensive school
2 health education materials.

3 “(3) Integrating school-based, community-
4 based, and other public and private health promotion
5 efforts.

6 “(4) Encouraging healthy, tobacco-free school
7 environments.

8 “(5) Coordinating school-based health programs
9 with existing services and programs available in the
10 community.

11 “(6) Developing school programs on nutrition
12 education, personal health, oral health, and fitness.

13 “(7) Developing behavioral health wellness pro-
14 grams.

15 “(8) Developing chronic disease prevention pro-
16 grams.

17 “(9) Developing substance abuse prevention
18 programs.

19 “(10) Developing injury prevention and safety
20 education programs.

21 “(11) Developing activities for the prevention
22 and control of communicable diseases.

23 “(12) Developing community and environmental
24 health education programs that include traditional
25 health care practitioners.

1 “(13) Violence prevention.

2 “(14) Such other health issues as are appro-
3 priate.

4 “(c) TECHNICAL ASSISTANCE.—Upon request, the
5 Secretary, acting through the Service, shall provide tech-
6 nical assistance to Indian Tribes and Tribal Organizations
7 in the development of comprehensive health education
8 plans and the dissemination of comprehensive health edu-
9 cation materials and information on existing health pro-
10 grams and resources.

11 “(d) CRITERIA FOR REVIEW AND APPROVAL OF AP-
12 PLICATIONS.—The Secretary, acting through the Service,
13 and in consultation with Indian Tribes and Tribal Organi-
14 zations, shall establish criteria for the review and approval
15 of applications for grants awarded under this section.

16 “(e) DEVELOPMENT OF PROGRAM FOR BIA-FUNDED
17 SCHOOLS.—

18 “(1) IN GENERAL.—The Secretary of the Inte-
19 rior, acting through the Bureau of Indian Affairs
20 and in cooperation with the Secretary, acting
21 through the Service, shall develop a comprehensive
22 school health education program for children from
23 preschool through grade 12 in schools for which sup-
24 port is provided by the Bureau of Indian Affairs.

1 “(2) REQUIREMENTS FOR PROGRAMS.—Such
2 programs shall include—

3 “(A) school programs on nutrition edu-
4 cation, personal health, oral health, and fitness;

5 “(B) behavioral health wellness programs;

6 “(C) chronic disease prevention programs;

7 “(D) substance abuse prevention pro-
8 grams;

9 “(E) injury prevention and safety edu-
10 cation programs; and

11 “(F) activities for the prevention and con-
12 trol of communicable diseases.

13 “(3) DUTIES OF THE SECRETARY.—The Sec-
14 retary of the Interior shall—

15 “(A) provide training to teachers in com-
16 prehensive school health education materials;

17 “(B) ensure the integration and coordina-
18 tion of school-based programs with existing
19 services and health programs available in the
20 community; and

21 “(C) encourage healthy, tobacco-free school
22 environments.

23 **“SEC. 210. INDIAN YOUTH PROGRAM.**

24 “(a) PROGRAM AUTHORIZED.—The Secretary, acting
25 through the Service, is authorized to establish and admin-

1 ister a program to provide grants to Indian Tribes, Tribal
2 Organizations, and urban Indian organizations for innova-
3 tive mental and physical disease prevention and health
4 promotion and treatment programs for Indian and urban
5 Indian preadolescent and adolescent youths.

6 “(b) USE OF FUNDS.—

7 “(1) ALLOWABLE USES.—Funds made available
8 under this section may be used to—

9 “(A) develop prevention and treatment
10 programs for Indian youth which promote men-
11 tal and physical health and incorporate cultural
12 values, community and family involvement, and
13 traditional health care practitioners; and

14 “(B) develop and provide community train-
15 ing and education.

16 “(2) PROHIBITED USE.—Funds made available
17 under this section may not be used to provide serv-
18 ices described in section 707(c).

19 “(c) DUTIES OF THE SECRETARY.—The Secretary
20 shall—

21 “(1) disseminate to Indian Tribes, Tribal Orga-
22 nizations, and urban Indian organizations informa-
23 tion regarding models for the delivery of comprehen-
24 sive health care services to Indian and urban Indian
25 adolescents;

1 “(2) encourage the implementation of such
2 models; and

3 “(3) at the request of an Indian Tribe, Tribal
4 Organization, or urban Indian organization, provide
5 technical assistance in the implementation of such
6 models.

7 “(d) CRITERIA FOR REVIEW AND APPROVAL OF AP-
8 PPLICATIONS.—The Secretary, in consultation with Indian
9 Tribes, Tribal Organizations, and urban Indian organiza-
10 tions, shall establish criteria for the review and approval
11 of applications or proposals under this section.

12 **“SEC. 211. PREVENTION, CONTROL, AND ELIMINATION OF**
13 **COMMUNICABLE AND INFECTIOUS DISEASES.**

14 “(a) GRANTS AUTHORIZED.—The Secretary, acting
15 through the Service, and after consultation with the Cen-
16 ters for Disease Control and Prevention, may make grants
17 available to Indian Tribes, Tribal Organizations, and
18 urban Indian organizations for the following:

19 “(1) Projects for the prevention, control, and
20 elimination of communicable and infectious diseases,
21 including tuberculosis, hepatitis, HIV, respiratory
22 syncytial virus, hanta virus, sexually transmitted dis-
23 eases, and H. Pylori.

1 “(2) Public information and education pro-
2 grams for the prevention, control, and elimination of
3 communicable and infectious diseases.

4 “(3) Education, training, and clinical skills im-
5 provement activities in the prevention, control, and
6 elimination of communicable and infectious diseases
7 for health professionals, including allied health pro-
8 fessionals.

9 “(4) Demonstration projects for the screening,
10 treatment, and prevention of hepatitis C virus
11 (HCV).

12 “(b) APPLICATION REQUIRED.—The Secretary may
13 provide funding under subsection (a) only if an application
14 or proposal for funding is submitted to the Secretary.

15 “(c) COORDINATION WITH HEALTH AGENCIES.—In-
16 dian Tribes, Tribal Organizations, and urban Indian orga-
17 nizations receiving funding under this section are encour-
18 aged to coordinate their activities with the Centers for
19 Disease Control and Prevention and State and local health
20 agencies.

21 “(d) TECHNICAL ASSISTANCE; REPORT.—In carrying
22 out this section, the Secretary—

23 “(1) may, at the request of an Indian Tribe,
24 Tribal Organization, or urban Indian organization,
25 provide technical assistance; and

1 “(2) shall prepare and submit a report to Con-
2 gress biennially on the use of funds under this sec-
3 tion and on the progress made toward the preven-
4 tion, control, and elimination of communicable and
5 infectious diseases among Indians and Urban Indi-
6 ans.

7 **“SEC. 212. OTHER AUTHORITY FOR PROVISION OF SERV-**
8 **ICES.**

9 “(a) FUNDING AUTHORIZED.—The Secretary may
10 provide funding under this Act to meet the objectives set
11 forth in section 3 of this Act through health care-related
12 services and programs of the Service, Indian Tribes, and
13 Tribal Organizations not otherwise described in this Act
14 for the following services:

15 “(1) Hospice care.

16 “(2) Assisted living services.

17 “(3) Long-term care services.

18 “(4) Home- and community-based services.

19 “(b) ELIGIBILITY.—The following individuals shall be
20 eligible to receive long-term care under this section:

21 “(1) Individuals who are unable to perform a
22 certain number of activities of daily living without
23 assistance.

24 “(2) Individuals with a mental impairment,
25 such as dementia, Alzheimer’s disease, or another

1 disabling mental illness, who may be able to perform
2 activities of daily living under supervision.

3 “(3) Such other individuals as an applicable In-
4 dian Health Program determines to be appropriate.

5 “(c) DEFINITIONS.—For the purposes of this section,
6 the following definitions shall apply:

7 “(1) The term ‘assisted living services’ means
8 any service provided by an assisted living facility (as
9 defined in section 232(b) of the National Housing
10 Act (12 U.S.C. 1715w(b))), except that such an as-
11 sisted living facility—

12 “(A) shall not be required to obtain a li-
13 cense; but

14 “(B) shall meet all applicable standards
15 for licensure.

16 “(2) The term ‘home- and community-based
17 services’ means 1 or more of the services specified
18 in paragraphs (1) through (9) of section 1929(a) of
19 the Social Security Act (42 U.S.C. 1396t(a))
20 (whether provided by the Service or by an Indian
21 Tribe or Tribal Organization pursuant to the Indian
22 Self-Determination and Education Assistance Act
23 (25 U.S.C. 450 et seq.)) that are or will be provided
24 in accordance with applicable standards.

1 “(3) The term ‘hospice care’ means the items
2 and services specified in subparagraphs (A) through
3 (H) of section 1861(dd)(1) of the Social Security
4 Act (42 U.S.C. 1395x(dd)(1)), and such other serv-
5 ices which an Indian Tribe or Tribal Organization
6 determines are necessary and appropriate to provide
7 in furtherance of this care.

8 “(4) The term ‘long-term care services’ has the
9 meaning given the term ‘qualified long-term care
10 services’ in section 7702B(c) of the Internal Rev-
11 enue Code of 1986.

12 “(d) AUTHORIZATION OF CONVENIENT CARE SERV-
13 ICES.—The Secretary, acting through the Service, Indian
14 Tribes, and Tribal Organizations, may also provide fund-
15 ing under this Act to meet the objectives set forth in sec-
16 tion 3 of this Act for convenient care services programs
17 pursuant to section 306(c)(2)(A).

18 **“SEC. 213. INDIAN WOMEN’S HEALTH CARE.**

19 “The Secretary, acting through the Service and In-
20 dian Tribes, Tribal Organizations, and Urban Indian Or-
21 ganizations, shall monitor and improve the quality of
22 health care for Indian women of all ages through the plan-
23 ning and delivery of programs administered by the Service,
24 in order to improve and enhance the treatment models of
25 care for Indian women.

1 **“SEC. 214. ENVIRONMENTAL AND NUCLEAR HEALTH HAZ-**
2 **ARDS.**

3 “(a) STUDIES AND MONITORING.—The Secretary
4 and the Service shall conduct, in conjunction with other
5 appropriate Federal agencies and in consultation with con-
6 cerned Indian Tribes and Tribal Organizations, studies
7 and ongoing monitoring programs to determine trends in
8 the health hazards to Indian miners and to Indians on
9 or near reservations and Indian communities as a result
10 of environmental hazards which may result in chronic or
11 life threatening health problems, such as nuclear resource
12 development, petroleum contamination, and contamination
13 of water source and of the food chain. Such studies shall
14 include—

15 “(1) an evaluation of the nature and extent of
16 health problems caused by environmental hazards
17 currently exhibited among Indians and the causes of
18 such health problems;

19 “(2) an analysis of the potential effect of ongo-
20 ing and future environmental resource development
21 on or near reservations and Indian communities, in-
22 cluding the cumulative effect over time on health;

23 “(3) an evaluation of the types and nature of
24 activities, practices, and conditions causing or affect-
25 ing such health problems, including uranium mining
26 and milling, uranium mine tailing deposits, nuclear

1 power plant operation and construction, and nuclear
2 waste disposal; oil and gas production or transpor-
3 tation on or near reservations or Indian commu-
4 nities; and other development that could affect the
5 health of Indians and their water supply and food
6 chain;

7 “(4) a summary of any findings and rec-
8 ommendations provided in Federal and State stud-
9 ies, reports, investigations, and inspections during
10 the 5 years prior to the date of enactment of the In-
11 dian Health Care Improvement Act Amendments of
12 2009 that directly or indirectly relate to the activi-
13 ties, practices, and conditions affecting the health or
14 safety of such Indians; and

15 “(5) the efforts that have been made by Federal
16 and State agencies and resource and economic devel-
17 opment companies to effectively carry out an edu-
18 cation program for such Indians regarding the
19 health and safety hazards of such development.

20 “(b) HEALTH CARE PLANS.—Upon completion of
21 such studies, the Secretary and the Service shall take into
22 account the results of such studies and develop health care
23 plans to address the health problems studied under sub-
24 section (a). The plans shall include—

1 “(1) methods for diagnosing and treating Indi-
2 ans currently exhibiting such health problems;

3 “(2) preventive care and testing for Indians
4 who may be exposed to such health hazards, includ-
5 ing the monitoring of the health of individuals who
6 have or may have been exposed to excessive amounts
7 of radiation or affected by other activities that have
8 had or could have a serious impact upon the health
9 of such individuals; and

10 “(3) a program of education for Indians who,
11 by reason of their work or geographic proximity to
12 such nuclear or other development activities, may ex-
13 perience health problems.

14 “(c) SUBMISSION OF REPORT AND PLAN TO CON-
15 GRESS.—The Secretary and the Service shall submit to
16 Congress the study prepared under subsection (a) no later
17 than 18 months after the date of enactment of the Indian
18 Health Care Improvement Act Amendments of 2009. The
19 health care plan prepared under subsection (b) shall be
20 submitted in a report no later than 1 year after the study
21 prepared under subsection (a) is submitted to Congress.
22 Such report shall include recommended activities for the
23 implementation of the plan, as well as an evaluation of
24 any activities previously undertaken by the Service to ad-
25 dress such health problems.

1 “(d) INTERGOVERNMENTAL TASK FORCE.—

2 “(1) ESTABLISHMENT; MEMBERS.—There is es-
3 tablished an Intergovernmental Task Force to be
4 composed of the following individuals (or their des-
5 ignees):

6 “(A) The Secretary of Energy.

7 “(B) The Secretary of the Environmental
8 Protection Agency.

9 “(C) The Director of the Bureau of Mines.

10 “(D) The Assistant Secretary for Occupa-
11 tional Safety and Health.

12 “(E) The Secretary of the Interior.

13 “(F) The Secretary of Health and Human
14 Services.

15 “(G) The Director of the Indian Health
16 Service.

17 “(2) DUTIES.—The Task Force shall—

18 “(A) identify existing and potential oper-
19 ations related to nuclear resource development
20 or other environmental hazards that affect or
21 may affect the health of Indians on or near a
22 reservation or in an Indian community; and

23 “(B) enter into activities to correct exist-
24 ing health hazards and ensure that current and
25 future health problems resulting from nuclear

1 resource or other development activities are
2 minimized or reduced.

3 “(3) CHAIRMAN; MEETINGS.—The Secretary of
4 Health and Human Services shall be the Chairman
5 of the Task Force. The Task Force shall meet at
6 least twice each year.

7 “(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—
8 In the case of any Indian who—

9 “(1) as a result of employment in or near a
10 uranium mine or mill or near any other environ-
11 mental hazard, suffers from a work-related illness or
12 condition;

13 “(2) is eligible to receive diagnosis and treat-
14 ment services from an Indian Health Program; and

15 “(3) by reason of such Indian’s employment, is
16 entitled to medical care at the expense of such mine
17 or mill operator or entity responsible for the environ-
18 mental hazard, the Indian Health Program shall, at
19 the request of such Indian, render appropriate med-
20 ical care to such Indian for such illness or condition
21 and may be reimbursed for any medical care so ren-
22 dered to which such Indian is entitled at the expense
23 of such operator or entity from such operator or en-
24 tity. Nothing in this subsection shall affect the
25 rights of such Indian to recover damages other than

1 such amounts paid to the Indian Health Program
2 from the employer for providing medical care for
3 such illness or condition.

4 **“SEC. 215. ARIZONA AS A CONTRACT HEALTH SERVICE DE-**
5 **LIVERY AREA.**

6 “(a) IN GENERAL.—For fiscal years beginning with
7 the fiscal year ending September 30, 1983, and ending
8 with the fiscal year ending September 30, 2025, the State
9 of Arizona shall be designated as a contract health service
10 delivery area by the Service for the purpose of providing
11 contract health care services to members of federally rec-
12 ognized Indian Tribes of Arizona.

13 “(b) MAINTENANCE OF SERVICES.—The Service
14 shall not curtail any health care services provided to Indi-
15 ans residing on reservations in the State of Arizona if such
16 curtailment is due to the provision of contract services in
17 such State pursuant to the designation of such State as
18 a contract health service delivery area pursuant to sub-
19 section (a).

20 **“SEC. 216. NORTH DAKOTA AND SOUTH DAKOTA AS CON-**
21 **TRACT HEALTH SERVICE DELIVERY AREA.**

22 “(a) IN GENERAL.—Beginning in fiscal year 2003,
23 the States of North Dakota and South Dakota shall be
24 designated as a contract health service delivery area by
25 the Service for the purpose of providing contract health

1 care services to members of federally recognized Indian
2 Tribes of North Dakota and South Dakota.

3 “(b) LIMITATION.—The Service shall not curtail any
4 health care services provided to Indians residing on any
5 reservation, or in any county that has a common boundary
6 with any reservation, in the State of North Dakota or
7 South Dakota if such curtailment is due to the provision
8 of contract services in such States pursuant to the des-
9 ignation of such States as a contract health service deliv-
10 ery area pursuant to subsection (a).

11 **“SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PRO-**
12 **GRAM.**

13 “(a) FUNDING AUTHORIZED.—The Secretary is au-
14 thorized to fund a program using the California Rural In-
15 dian Health Board (hereafter in this section referred to
16 as the ‘CRIHB’) as a contract care intermediary to im-
17 prove the accessibility of health services to California Indi-
18 ans.

19 “(b) REIMBURSEMENT CONTRACT.—The Secretary
20 shall enter into an agreement with the CRIHB to reim-
21 burse the CRIHB for costs (including reasonable adminis-
22 trative costs) incurred pursuant to this section, in pro-
23 viding medical treatment under contract to California In-
24 dians described in section 805(a) throughout the Cali-

1 fornia contract health services delivery area described in
2 section 219 with respect to high cost contract care cases.

3 “(c) ADMINISTRATIVE EXPENSES.—Not more than 5
4 percent of the amounts provided to the CRIHB under this
5 section for any fiscal year may be for reimbursement for
6 administrative expenses incurred by the CRIHB during
7 such fiscal year.

8 “(d) LIMITATION ON PAYMENT.—No payment may
9 be made for treatment provided hereunder to the extent
10 payment may be made for such treatment under the In-
11 dian Catastrophic Health Emergency Fund described in
12 section 202 or from amounts appropriated or otherwise
13 made available to the California contract health service de-
14 livery area for a fiscal year.

15 “(e) ADVISORY BOARD.—There is established an ad-
16 visory board which shall advise the CRIHB in carrying
17 out this section. The advisory board shall be composed of
18 representatives, selected by the CRIHB, from not less
19 than 8 Tribal Health Programs serving California Indians
20 covered under this section at least 1/2 of whom of whom
21 are not affiliated with the CRIHB.

22 **“SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE**
23 **DELIVERY AREA.**

24 “The State of California, excluding the counties of
25 Alameda, Contra Costa, Los Angeles, Marin, Orange, Sac-

1 ramento, San Francisco, San Mateo, Santa Clara, Kern,
2 Merced, Monterey, Napa, San Benito, San Joaquin, San
3 Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ven-
4 tura, shall be designated as a contract health service deliv-
5 ery area by the Service for the purpose of providing con-
6 tract health services to California Indians. However, any
7 of the counties listed herein may only be included in the
8 contract health services delivery area if funding is specifi-
9 cally provided by the Service for such services in those
10 counties.

11 **“SEC. 219. CONTRACT HEALTH SERVICES FOR THE TREN-**
12 **TON SERVICE AREA.**

13 “(a) **AUTHORIZATION FOR SERVICES.**—The Sec-
14 retary, acting through the Service, is directed to provide
15 contract health services to members of the Turtle Moun-
16 tain Band of Chippewa Indians that reside in the Trenton
17 Service Area of Divide, McKenzie, and Williams counties
18 in the State of North Dakota and the adjoining counties
19 of Richland, Roosevelt, and Sheridan in the State of Mon-
20 tana.

21 “(b) **NO EXPANSION OF ELIGIBILITY.**—Nothing in
22 this section may be construed as expanding the eligibility
23 of members of the Turtle Mountain Band of Chippewa In-
24 dians for health services provided by the Service beyond

1 the scope of eligibility for such health services that applied
2 on May 1, 1986.

3 **“SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND**
4 **TRIBAL ORGANIZATIONS.**

5 “The Service shall provide funds for health care pro-
6 grams, functions, services, activities, information tech-
7 nology, and facilities operated by Tribal Health Programs
8 on the same basis as such funds are provided to programs,
9 functions, services, activities, information technology, and
10 facilities operated directly by the Service.

11 **“SEC. 221. LICENSING.**

12 “Licensed health care professionals employed by a
13 Tribal Health Program shall, if licensed in any State, be
14 exempt from the licensing requirements of the State in
15 which the Tribal Health Program performs the services
16 described in its contract or compact under the Indian Self-
17 Determination and Education Assistance Act (25 U.S.C.
18 450 et seq.) while performing such services.

19 **“SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY**
20 **CONTRACT HEALTH SERVICES.**

21 “With respect to an elderly Indian or an Indian with
22 a disability receiving emergency medical care or services
23 from a non-Service provider or in a non-Service facility
24 under the authority of this Act, the time limitation (as

1 a condition of payment) for notifying the Service of such
2 treatment or admission shall be 30 days.

3 **“SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.**

4 “(a) DEADLINE FOR RESPONSE.—The Service shall
5 respond to a notification of a claim by a provider of a
6 contract care service with either an individual purchase
7 order or a denial of the claim within 5 working days after
8 the receipt of such notification.

9 “(b) EFFECT OF UNTIMELY RESPONSE.—If the
10 Service fails to respond to a notification of a claim in ac-
11 cordance with subsection (a), the Service shall accept as
12 valid the claim submitted by the provider of a contract
13 care service.

14 “(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—
15 The Service shall pay a valid contract care service claim
16 within 30 days after the completion of the claim.

17 **“SEC. 224. LIABILITY FOR PAYMENT.**

18 “(a) NO PATIENT LIABILITY.—A patient who re-
19 ceives contract health care services that are authorized by
20 the Service shall not be liable for the payment of any
21 charges or costs associated with the provision of such serv-
22 ices.

23 “(b) NOTIFICATION.—The Secretary shall notify a
24 contract care provider and any patient who receives con-
25 tract health care services authorized by the Service that

1 such patient is not liable for the payment of any charges
2 or costs associated with the provision of such services not
3 later than 5 business days after receipt of a notification
4 of a claim by a provider of contract care services.

5 “(c) NO RECOURSE.—Following receipt of the notice
6 provided under subsection (b), or, if a claim has been
7 deemed accepted under section 224(b), the provider shall
8 have no further recourse against the patient who received
9 the services.

10 **“SEC. 225. OFFICE OF INDIAN MEN’S HEALTH.**

11 “(a) ESTABLISHMENT.—The Secretary may establish
12 within the Service an office to be known as the ‘Office
13 of Indian Men’s Health’ (referred to in this section as the
14 ‘Office’).

15 “(b) DIRECTOR.—

16 “(1) IN GENERAL.—The Office shall be headed
17 by a director, to be appointed by the Secretary.

18 “(2) DUTIES.—The director shall coordinate
19 and promote the status of the health of Indian men
20 in the United States.

21 “(c) REPORT.—Not later than 2 years after the date
22 of enactment of the Indian Health Care Improvement Act
23 Amendments of 2009, the Secretary, acting through the
24 director of the Office, shall submit to Congress a report
25 describing—

1 “(1) any activity carried out by the director as
2 of the date on which the report is prepared; and

3 “(2) any finding of the director with respect to
4 the health of Indian men.

5 **“SEC. 226. CATASTROPHIC HEALTH EMERGENCY FUND.**

6 “(a) ESTABLISHMENT.—There is established an In-
7 dian Catastrophic Health Emergency Fund (hereafter in
8 this section referred to as the ‘CHEF’) consisting of—

9 “(1) the amounts deposited under subsection
10 (f); and

11 “(2) the amounts appropriated to CHEF’ under
12 this section.

13 “(b) ADMINISTRATION.—CHEF’ shall be adminis-
14 tered by the Secretary, acting through the headquarters
15 of the Service, solely for the purpose of meeting the ex-
16 traordinary medical costs associated with the treatment of
17 victims of disasters or catastrophic illnesses who are with-
18 in the responsibility of the Service.

19 “(c) CONDITIONS ON USE OF FUND.—No part of
20 CHEF’ or its administration shall be subject to contract
21 or grant under any law, including the Indian Self-Deter-
22 mination and Education Assistance Act (25 U.S.C. 450
23 et seq.), nor shall CHEF’ funds be allocated, apportioned,
24 or delegated on an Area Office, Service Unit, or other
25 similar basis.

1 “(d) REGULATIONS.—The Secretary shall promul-
2 gate regulations consistent with the provisions of this sec-
3 tion to—

4 “(1) establish a definition of disasters and cata-
5 strophic illnesses for which the cost of the treatment
6 provided under contract would qualify for payment
7 from CHEF;

8 “(2) provide that a Service Unit shall not be el-
9 igible for reimbursement for the cost of treatment
10 from CHEF until its cost of treating any victim of
11 such catastrophic illness or disaster has reached a
12 certain threshold cost which the Secretary shall es-
13 tablish at—

14 “(A) the 2000 level of \$19,000; and

15 “(B) for any subsequent year, not less
16 than the threshold cost of the previous year in-
17 creased by the percentage increase in the med-
18 ical care expenditure category of the consumer
19 price index for all urban consumers (United
20 States city average) for the 12-month period
21 ending with December of the previous year;

22 “(3) establish a procedure for the reimburse-
23 ment of the portion of the costs that exceeds such
24 threshold cost incurred by—

25 “(A) Service Units; or

1 “(B) whenever otherwise authorized by the
2 Service, non-Service facilities or providers;

3 “(4) establish a procedure for payment from
4 CHEF in cases in which the exigencies of the med-
5 ical circumstances warrant treatment prior to the
6 authorization of such treatment by the Service; and

7 “(5) establish a procedure that will ensure that
8 no payment shall be made from CHEF to any pro-
9 vider of treatment to the extent that such provider
10 is eligible to receive payment for the treatment from
11 any other Federal, State, local, or private source of
12 reimbursement for which the patient is eligible.

13 “(e) NO OFFSET OR LIMITATION.—Amounts appro-
14 priated to CHEF under this section shall not be used to
15 offset or limit appropriations made to the Service under
16 the authority of the Act of November 2, 1921 (25 U.S.C.
17 13) (commonly known as the ‘Snyder Act’), or any other
18 law.

19 “(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There
20 shall be deposited into CHEF all reimbursements to which
21 the Service is entitled from any Federal, State, local, or
22 private source (including third party insurance) by reason
23 of treatment rendered to any victim of a disaster or cata-
24 strophic illness the cost of which was paid from CHEF.

1 **“SEC. 227. AUTHORIZATION OF APPROPRIATIONS.**

2 “There are authorized to be appropriated such sums
3 as may be necessary to carry out this title.

4 **“TITLE III—FACILITIES**

5 **“SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVA-**
6 **TION OF FACILITIES; REPORTS.**

7 “(a) PREREQUISITES FOR EXPENDITURE OF
8 FUNDS.—Prior to the expenditure of, or the making of
9 any binding commitment to expend, any funds appro-
10 priated for the planning, design, construction, or renova-
11 tion of facilities pursuant to the Act of November 2, 1921
12 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’),
13 the Secretary, acting through the Service, shall—

14 “(1) consult with any Indian Tribe that would
15 be significantly affected by such expenditure for the
16 purpose of determining and, whenever practicable,
17 honoring tribal preferences concerning size, location,
18 type, and other characteristics of any facility on
19 which such expenditure is to be made; and

20 “(2) ensure, whenever practicable and applica-
21 ble, that such facility meets the construction stand-
22 ards of any accrediting body recognized by the Sec-
23 retary for the purposes of the Medicare, Medicaid,
24 and SCHIP programs under titles XVIII, XIX, and
25 XXI of the Social Security Act by not later than 1

1 year after the date on which the construction or ren-
2 ovation of such facility is completed.

3 “(b) CLOSURES.—

4 “(1) EVALUATION REQUIRED.—Notwith-
5 standing any other provision of law, no facility oper-
6 ated by the Service may be closed if the Secretary
7 has not submitted to Congress, not less than 1 year
8 and not more than 2 years before the date of the
9 proposed closure, an evaluation, completed not more
10 than 2 years before such submission, of the impact
11 of the proposed closure that specifies, in addition to
12 other considerations—

13 “(A) the accessibility of alternative health
14 care resources for the population served by such
15 facility;

16 “(B) the cost-effectiveness of such closure;

17 “(C) the quality of health care to be pro-
18 vided to the population served by such facility
19 after such closure;

20 “(D) the availability of contract health
21 care funds to maintain existing levels of service;

22 “(E) the views of the Indian Tribes served
23 by such facility concerning such closure;

24 “(F) the level of use of such facility by all
25 eligible Indians; and

1 “(G) the distance between such facility and
2 the nearest operating Service hospital.

3 “(2) EXCEPTION FOR CERTAIN TEMPORARY
4 CLOSURES.—Paragraph (1) shall not apply to any
5 temporary closure of a facility or any portion of a
6 facility if such closure is necessary for medical, envi-
7 ronmental, or construction safety reasons.

8 “(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

9 “(1) IN GENERAL.—

10 “(A) PRIORITY SYSTEM.—The Secretary,
11 acting through the Service, shall maintain a
12 health care facility priority system, which—

13 “(i) shall be developed in consultation
14 with Indian Tribes and Tribal Organiza-
15 tions;

16 “(ii) shall give Indian Tribes’ needs
17 the highest priority;

18 “(iii)(I) may include the lists required
19 in paragraph (2)(B)(ii); and

20 “(II) shall include the methodology re-
21 quired in paragraph (2)(B)(v); and

22 “(III) may include such other facili-
23 ties, and such renovation or expansion
24 needs of any health care facility, as the

1 Service, Indian Tribes, and Tribal Organi-
2 zations may identify; and

3 “(iv) shall provide an opportunity for
4 the nomination of planning, design, and
5 construction projects by the Service, In-
6 dian Tribes, and Tribal Organizations for
7 consideration under the priority system at
8 least once every 3 years, or more fre-
9 quently as the Secretary determines to be
10 appropriate.

11 “(B) NEEDS OF FACILITIES UNDER
12 ISDEAA AGREEMENTS.—The Secretary shall en-
13 sure that the planning, design, construction,
14 renovation, and expansion needs of Service and
15 non-Service facilities operated under contracts
16 or compacts in accordance with the Indian Self-
17 Determination and Education Assistance Act
18 (25 U.S.C. 450 et seq.) are fully and equitably
19 integrated into the health care facility priority
20 system.

21 “(C) CRITERIA FOR EVALUATING
22 NEEDS.—For purposes of this subsection, the
23 Secretary, in evaluating the needs of facilities
24 operated under a contract or compact under the
25 Indian Self-Determination and Education As-

1 sistance Act (25 U.S.C. 450 et seq.), shall use
2 the criteria used by the Secretary in evaluating
3 the needs of facilities operated directly by the
4 Service.

5 “(D) PRIORITY OF CERTAIN PROJECTS
6 PROTECTED.—The priority of any project estab-
7 lished under the construction priority system in
8 effect on the date of enactment of the Indian
9 Health Care Improvement Act Amendments of
10 2009 shall not be affected by any change in the
11 construction priority system taking place after
12 that date if the project—

13 “(i) was identified in the fiscal year
14 2008 Service budget justification as—

15 “(I) 1 of the 10 top-priority inpa-
16 tient projects;

17 “(II) 1 of the 10 top-priority out-
18 patient projects;

19 “(III) 1 of the 10 top-priority
20 staff quarters developments; or

21 “(IV) 1 of the 10 top-priority
22 Youth Regional Treatment Centers;

23 “(ii) had completed both Phase I and
24 Phase II of the construction priority sys-

1 tem in effect on the date of enactment of
2 such Act; or

3 “(iii) is not included in clause (i) or
4 (ii) and is selected, as determined by the
5 Secretary—

6 “(I) on the initiative of the Sec-
7 retary; or

8 “(II) pursuant to a request of an
9 Indian Tribe or Tribal Organization.

10 “(2) REPORT; CONTENTS.—

11 “(A) INITIAL COMPREHENSIVE REPORT.—

12 “(i) DEFINITIONS.—In this subpara-
13 graph:

14 “(I) FACILITIES APPROPRIATION
15 ADVISORY BOARD.—The term ‘Facili-
16 ties Appropriation Advisory Board’
17 means the advisory board, comprised
18 of 12 members representing Indian
19 tribes and 2 members representing
20 the Service, established at the discre-
21 tion of the Assistant Secretary—

22 “(aa) to provide advice and
23 recommendations for policies and
24 procedures of the programs fund-

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1 ed pursuant to facilities appro-
2 priations; and

3 “(bb) to address other facili-
4 ties issues.

5 “(II) FACILITIES NEEDS ASSESS-
6 MENT WORKGROUP.—The term ‘Fa-
7 cilities Needs Assessment Workgroup’
8 means the workgroup established at
9 the discretion of the Assistant Sec-
10 retary—

11 “(aa) to review the health
12 care facilities construction pri-
13 ority system; and

14 “(bb) to make recommenda-
15 tions to the Facilities Appropria-
16 tion Advisory Board for revising
17 the priority system.

18 “(ii) INITIAL REPORT.—

19 “(I) IN GENERAL.—Not later
20 than 1 year after the date of enact-
21 ment of the Indian Health Care Im-
22 provement Act Amendments of 2009,
23 the Secretary shall submit to the
24 Committee on Indian Affairs of the
25 Senate and the Committee on Natural

1 Resources of the House of Represent-
2 atives a report that describes the com-
3 prehensive, national, ranked list of all
4 health care facilities needs for the
5 Service, Indian Tribes, and Tribal Or-
6 ganizations (including inpatient health
7 care facilities, outpatient health care
8 facilities, specialized health care facili-
9 ties (such as for long-term care and
10 alcohol and drug abuse treatment),
11 wellness centers, staff quarters and
12 hostels associated with health care fa-
13 cilities, and the renovation and expan-
14 sion needs, if any, of such facilities)
15 developed by the Service, Indian
16 Tribes, and Tribal Organizations for
17 the Facilities Needs Assessment
18 Workgroup and the Facilities Appro-
19 priation Advisory Board.

20 “(II) INCLUSIONS.—The initial
21 report shall include—

22 “(aa) the methodology and
23 criteria used by the Service in de-
24 termining the needs and estab-

1 lishing the ranking of the facili-
2 ties needs; and

3 “ (bb) such other information
4 as the Secretary determines to be
5 appropriate.

6 “ (iii) UPDATES OF REPORT.—Begin-
7 ning in calendar year 2011, the Secretary
8 shall—

9 “ (I) update the report under
10 clause (ii) not less frequently than
11 once every 5 years; and

12 “ (II) include the updated report
13 in the appropriate annual report
14 under subparagraph (B) for submis-
15 sion to Congress under section 801.

16 “ (B) ANNUAL REPORTS.—The Secretary
17 shall submit to the President, for inclusion in
18 the report required to be transmitted to Con-
19 gress under section 801, a report which sets
20 forth the following:

21 “ (i) A description of the health care
22 facility priority system of the Service es-
23 tablished under paragraph (1).

24 “ (ii) Health care facilities lists, which
25 may include—

1 “(I) the 10 top-priority inpatient
2 health care facilities;

3 “(II) the 10 top-priority out-
4 patient health care facilities;

5 “(III) the 10 top-priority special-
6 ized health care facilities (such as
7 long-term care and alcohol and drug
8 abuse treatment);

9 “(IV) the 10 top-priority staff
10 quarters developments associated with
11 health care facilities; and

12 “(V) the 10 top-priority hostels
13 associated with health care facilities.

14 “(iii) The justification for such order
15 of priority.

16 “(iv) The projected cost of such
17 projects.

18 “(v) The methodology adopted by the
19 Service in establishing priorities under its
20 health care facility priority system.

21 “(3) REQUIREMENTS FOR PREPARATION OF RE-
22 PORTS.—In preparing the report required under
23 paragraph (2), the Secretary shall—

24 “(A) consult with and obtain information
25 on all health care facilities needs from Indian

1 Tribes, Tribal Organizations, and urban Indian
2 organizations; and

3 “(B) review the total unmet needs of all
4 Indian Tribes, Tribal Organizations, and urban
5 Indian organizations for health care facilities
6 (including hostels and staff quarters), including
7 needs for renovation and expansion of existing
8 facilities.

9 “(d) REVIEW OF METHODOLOGY USED FOR HEALTH
10 FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

11 “(1) IN GENERAL.—Not later than 1 year after
12 the establishment of the priority system under sub-
13 section (c)(1)(A), the Comptroller General of the
14 United States shall prepare and finalize a report re-
15 viewing the methodologies applied, and the processes
16 followed, by the Service in making each assessment
17 of needs for the list under subsection (c)(2)(A)(ii)
18 and developing the priority system under subsection
19 (c)(1), including a review of—

20 “(A) the recommendations of the Facilities
21 Appropriation Advisory Board and the Facili-
22 ties Needs Assessment Workgroup (as those
23 terms are defined in subsection (c)(2)(A)(i));
24 and

1 “(B) the relevant criteria used in ranking
2 or prioritizing facilities other than hospitals or
3 clinics.

4 “(2) SUBMISSION TO CONGRESS.—The Comp-
5 troller General of the United States shall submit the
6 report under paragraph (1) to—

7 “(A) the Committees on Indian Affairs and
8 Appropriations of the Senate;

9 “(B) the Committees on Natural Re-
10 sources and Appropriations of the House of
11 Representatives; and

12 “(C) the Secretary.

13 “(e) FUNDING CONDITION.—All funds appropriated
14 under the Act of November 2, 1921 (25 U.S.C. 13) (com-
15 monly known as the ‘Snyder Act’), for the planning, de-
16 sign, construction, or renovation of health facilities for the
17 benefit of 1 or more Indian Tribes shall be subject to the
18 provisions of the Indian Self-Determination and Edu-
19 cation Assistance Act (25 U.S.C. 450 et seq.).

20 “(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—
21 The Secretary shall consult and cooperate with Indian
22 Tribes, Tribal Organizations, and urban Indian organiza-
23 tions in developing innovative approaches to address all
24 or part of the total unmet need for construction of health

1 facilities, including those provided for in other sections of
2 this title and other approaches.

3 **“SEC. 302. SANITATION FACILITIES.**

4 “(a) FINDINGS.—Congress finds the following:

5 “(1) The provision of sanitation facilities is pri-
6 marily a health consideration and function.

7 “(2) Indian people suffer an inordinately high
8 incidence of disease, injury, and illness directly at-
9 tributable to the absence or inadequacy of sanitation
10 facilities.

11 “(3) The long-term cost to the United States of
12 treating and curing such disease, injury, and illness
13 is substantially greater than the short-term cost of
14 providing sanitation facilities and other preventive
15 health measures.

16 “(4) Many Indian homes and Indian commu-
17 nities still lack sanitation facilities.

18 “(5) It is in the interest of the United States,
19 and it is the policy of the United States, that all In-
20 dian communities and Indian homes, new and exist-
21 ing, be provided with sanitation facilities.

22 “(b) FACILITIES AND SERVICES.—In furtherance of
23 the findings made in subsection (a), Congress reaffirms
24 the primary responsibility and authority of the Service to
25 provide the necessary sanitation facilities and services as

1 provided in section 7 of the Act of August 5, 1954 (42
2 U.S.C. 2004a). Under such authority, the Secretary, act-
3 ing through the Service, is authorized to provide the fol-
4 lowing:

5 “(1) Financial and technical assistance to In-
6 dian Tribes, Tribal Organizations, and Indian com-
7 munities in the establishment, training, and equip-
8 ping of utility organizations to operate and maintain
9 sanitation facilities, including the provision of exist-
10 ing plans, standard details, and specifications avail-
11 able in the Department, to be used at the option of
12 the Indian Tribe, Tribal Organization, or Indian
13 community.

14 “(2) Ongoing technical assistance and training
15 to Indian Tribes, Tribal Organizations, and Indian
16 communities in the management of utility organiza-
17 tions which operate and maintain sanitation facili-
18 ties.

19 “(3) Priority funding for operation and mainte-
20 nance assistance for, and emergency repairs to, sani-
21 tation facilities operated by an Indian Tribe, Tribal
22 Organization or Indian community when necessary
23 to avoid an imminent health threat or to protect the
24 investment in sanitation facilities and the investment

1 in the health benefits gained through the provision
2 of sanitation facilities.

3 “(c) FUNDING.—Notwithstanding any other provi-
4 sion of law—

5 “(1) the Secretary of Housing and Urban De-
6 velopment is authorized to transfer funds appro-
7 priated under the Native American Housing Assist-
8 ance and Self-Determination Act of 1996 (25 U.S.C.
9 4101 et seq.) to the Secretary of Health and Human
10 Services;

11 “(2) the Secretary of Health and Human Serv-
12 ices is authorized to accept and use such funds for
13 the purpose of providing sanitation facilities and
14 services for Indians under section 7 of the Act of
15 August 5, 1954 (42 U.S.C. 2004a);

16 “(3) unless specifically authorized when funds
17 are appropriated, the Secretary shall not use funds
18 appropriated under section 7 of the Act of August
19 5, 1954 (42 U.S.C. 2004a), to provide sanitation fa-
20 cilities to new homes constructed using funds pro-
21 vided by the Department of Housing and Urban De-
22 velopment;

23 “(4) the Secretary of Health and Human Serv-
24 ices is authorized to accept from any source, includ-
25 ing Federal and State agencies, funds for the pur-

1 pose of providing sanitation facilities and services
2 and place these funds into contracts or compacts
3 under the Indian Self-Determination and Education
4 Assistance Act (25 U.S.C. 450 et seq.);

5 “(5) except as otherwise prohibited by this sec-
6 tion, the Secretary may use funds appropriated
7 under the authority of section 7 of the Act of Au-
8 gust 5, 1954 (42 U.S.C. 2004a), to fund up to 100
9 percent of the amount of an Indian Tribe’s loan ob-
10 tained under any Federal program for new projects
11 to construct eligible sanitation facilities to serve In-
12 dian homes;

13 “(6) except as otherwise prohibited by this sec-
14 tion, the Secretary may use funds appropriated
15 under the authority of section 7 of the Act of Au-
16 gust 5, 1954 (42 U.S.C. 2004a), to meet matching
17 or cost participation requirements under other Fed-
18 eral and non-Federal programs for new projects to
19 construct eligible sanitation facilities;

20 “(7) all Federal agencies are authorized to
21 transfer to the Secretary funds identified, granted,
22 loaned, or appropriated whereby the Department’s
23 applicable policies, rules, and regulations shall apply
24 in the implementation of such projects;

1 “(8) the Secretary of Health and Human Serv-
2 ices shall enter into interagency agreements with
3 Federal and State agencies for the purpose of pro-
4 viding financial assistance for sanitation facilities
5 and services under this Act;

6 “(9) the Secretary of Health and Human Serv-
7 ices shall, by regulation, establish standards applica-
8 ble to the planning, design, and construction of sani-
9 tation facilities funded under this Act; and

10 “(10) the Secretary of Health and Human
11 Services is authorized to accept payments for goods
12 and services furnished by the Service from appro-
13 priate public authorities, nonprofit organizations or
14 agencies, or Indian Tribes, as contributions by that
15 authority, organization, agency, or tribe to agree-
16 ments made under section 7 of the Act of August 5,
17 1954 (42 U.S.C. 2004a), and such payments shall
18 be credited to the same or subsequent appropriation
19 account as funds appropriated under the authority
20 of section 7 of the Act of August 5, 1954 (42 U.S.C.
21 2004a).

22 “(d) CERTAIN CAPABILITIES NOT PREREQUISITE.—
23 The financial and technical capability of an Indian Tribe,
24 Tribal Organization, or Indian community to safely oper-
25 ate, manage, and maintain a sanitation facility shall not

1 be a prerequisite to the provision or construction of sanita-
2 tion facilities by the Secretary.

3 “(e) FINANCIAL ASSISTANCE.—The Secretary is au-
4 thorized to provide financial assistance to Indian Tribes,
5 Tribal Organizations, and Indian communities in an
6 amount equal to the Federal share of the costs of oper-
7 ating, managing, and maintaining the facilities provided
8 under the plan described in subsection (h)(1)(F).

9 “(f) OPERATION, MANAGEMENT, AND MAINTENANCE
10 OF FACILITIES.—The Indian Tribe has the primary re-
11 sponsibility to establish, collect, and use reasonable user
12 fees, or otherwise set aside funding, for the purpose of
13 operating, managing, and maintaining sanitation facilities.
14 If a sanitation facility serving a community that is oper-
15 ated by an Indian Tribe or Tribal Organization is threat-
16 ened with imminent failure and such operator lacks capac-
17 ity to maintain the integrity or the health benefits of the
18 sanitation facility, then the Secretary is authorized to as-
19 sist the Indian Tribe, Tribal Organization, or Indian com-
20 munity in the resolution of the problem on a short-term
21 basis through cooperation with the emergency coordinator
22 or by providing operation, management, and maintenance
23 service.

24 “(g) ISDEAA PROGRAM FUNDED ON EQUAL
25 BASIS.—Tribal Health Programs shall be eligible (on an

1 equal basis with programs that are administered directly
2 by the Service) for—

3 “(1) any funds appropriated pursuant to this
4 section; and

5 “(2) any funds appropriated for the purpose of
6 providing sanitation facilities.

7 “(h) REPORT.—

8 “(1) REQUIRED; CONTENTS.—The Secretary, in
9 consultation with the Secretary of Housing and
10 Urban Development, Indian Tribes, Tribal Organiza-
11 tions, and tribally designated housing entities (as de-
12 fined in section 4 of the Native American Housing
13 Assistance and Self-Determination Act of 1996 (25
14 U.S.C. 4103)) shall submit to the President, for in-
15 clusion in the report required to be transmitted to
16 Congress under section 801, a report which sets
17 forth—

18 “(A) the current Indian sanitation facility
19 priority system of the Service;

20 “(B) the methodology for determining
21 sanitation deficiencies and needs;

22 “(C) the criteria on which the deficiencies
23 and needs will be evaluated;

24 “(D) the level of initial and final sanitation
25 deficiency for each type of sanitation facility for

1 each project of each Indian Tribe or Indian
2 community;

3 “(E) the amount and most effective use of
4 funds, derived from whatever source, necessary
5 to accommodate the sanitation facilities needs
6 of new homes assisted with funds under the
7 Native American Housing Assistance and Self-
8 Determination Act (25 U.S.C. 4101 et seq.),
9 and to reduce the identified sanitation defi-
10 ciency levels of all Indian Tribes and Indian
11 communities to level I sanitation deficiency as
12 defined in paragraph (3)(A); and

13 “(F) a 10-year plan to provide sanitation
14 facilities to serve existing Indian homes and In-
15 dian communities and new and renovated In-
16 dian homes.

17 “(2) UNIFORM METHODOLOGY.—The method-
18 ology used by the Secretary in determining, pre-
19 paring cost estimates for, and reporting sanitation
20 deficiencies for purposes of paragraph (1) shall be
21 applied uniformly to all Indian Tribes and Indian
22 communities.

23 “(3) SANITATION DEFICIENCY LEVELS.—For
24 purposes of this subsection, the sanitation deficiency
25 levels for an individual, Indian Tribe, or Indian com-

1 munity sanitation facility to serve Indian homes are
2 determined as follows:

3 “(A) A level I deficiency exists if a sanita-
4 tion facility serving an individual, Indian Tribe,
5 or Indian community—

6 “(i) complies with all applicable water
7 supply, pollution control, and solid waste
8 disposal laws; and

9 “(ii) deficiencies relate to routine re-
10 placement, repair, or maintenance needs.

11 “(B) A level II deficiency exists if a sanita-
12 tion facility serving an individual, Indian Tribe,
13 or Indian community substantially or recently
14 complied with all applicable water supply, pollu-
15 tion control, and solid waste laws and any defi-
16 ciencies relate to—

17 “(i) small or minor capital improve-
18 ments needed to bring the facility back
19 into compliance;

20 “(ii) capital improvements that are
21 necessary to enlarge or improve the facili-
22 ties in order to meet the current needs for
23 domestic sanitation facilities; or

24 “(iii) the lack of equipment or train-
25 ing by an Indian Tribe, Tribal Organiza-

1 tion, or an Indian community to properly
2 operate and maintain the sanitation facili-
3 ties.

4 “(C) A level III deficiency exists if a sani-
5 tation facility serving an individual, Indian
6 Tribe or Indian community meets 1 or more of
7 the following conditions—

8 “(i) water or sewer service in the
9 home is provided by a haul system with
10 holding tanks and interior plumbing;

11 “(ii) major significant interruptions to
12 water supply or sewage disposal occur fre-
13 quently, requiring major capital improve-
14 ments to correct the deficiencies; or

15 “(iii) there is no access to or no ap-
16 proved or permitted solid waste facility
17 available.

18 “(D) A level IV deficiency exists—

19 “(i) if a sanitation facility for an indi-
20 vidual home, an Indian Tribe, or an Indian
21 community exists but—

22 “(I) lacks—

23 “(aa) a safe water supply
24 system; or

1 “(bb) a waste disposal sys-
2 tem;

3 “(II) contains no piped water or
4 sewer facilities; or

5 “(III) has become inoperable due
6 to a major component failure; or

7 “(ii) if only a washeteria or central fa-
8 cility exists in the community.

9 “(E) A level V deficiency exists in the ab-
10 sence of a sanitation facility, where individual
11 homes do not have access to safe drinking
12 water or adequate wastewater (including sew-
13 age) disposal.

14 “(i) DEFINITIONS.—For purposes of this section, the
15 following terms apply:

16 “(1) INDIAN COMMUNITY.—The term ‘Indian
17 community’ means a geographic area, a significant
18 proportion of whose inhabitants are Indians and
19 which is served by or capable of being served by a
20 facility described in this section.

21 “(2) SANITATION FACILITIES.—The terms
22 ‘sanitation facility’ and ‘sanitation facilities’ mean
23 safe and adequate water supply systems, sanitary
24 sewage disposal systems, and sanitary solid waste

1 systems (and all related equipment and support in-
2 frastructure).

3 **“SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.**

4 “(a) BUY INDIAN ACT.—The Secretary, acting
5 through the Service, may use the negotiating authority of
6 section 23 of the Act of June 25, 1910 (25 U.S.C. 47,
7 commonly known as the ‘Buy Indian Act’), to give pref-
8 erence to any Indian or any enterprise, partnership, cor-
9 poration, or other type of business organization owned and
10 controlled by an Indian or Indians including former or
11 currently federally recognized Indian Tribes in the State
12 of New York (hereinafter referred to as an ‘Indian firm’)
13 in the construction and renovation of Service facilities pur-
14 suant to section 301 and in the construction of sanitation
15 facilities pursuant to section 302. Such preference may be
16 accorded by the Secretary unless the Secretary finds, pur-
17 suant to regulations, that the project or function to be
18 contracted for will not be satisfactory or such project or
19 function cannot be properly completed or maintained
20 under the proposed contract. The Secretary, in arriving
21 at such a finding, shall consider whether the Indian or
22 Indian firm will be deficient with respect to—

23 “(1) ownership and control by Indians;

24 “(2) equipment;

25 “(3) bookkeeping and accounting procedures;

1 “(4) substantive knowledge of the project or
2 function to be contracted for;

3 “(5) adequately trained personnel; or

4 “(6) other necessary components of contract
5 performance.

6 “(b) PAY RATES.—For the purposes of implementing
7 the provisions of this title, the Secretary shall assure that
8 the rates of pay for personnel engaged in the construction
9 or renovation of facilities constructed or renovated in
10 whole or in part by funds made available pursuant to this
11 title are not less than the prevailing local wage rates for
12 similar work as determined in accordance with the Act of
13 March 3, 1931 (40 U.S.C. 276a–276a-5, known as the
14 Davis-Bacon Act).

15 “(c) LABOR STANDARDS.—For the purposes of im-
16 plementing the provisions of this title, contracts for the
17 construction or renovation of health care facilities, staff
18 quarters, and sanitation facilities, and related support in-
19 frastructure, funded in whole or in part with funds made
20 available pursuant to this title, shall contain a provision
21 requiring compliance with subchapter IV of chapter 31 of
22 title 40, United States Code (commonly known as the
23 ‘Davis-Bacon Act’).

1 **“SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR**
2 **RENOVATION.**

3 “(a) IN GENERAL.—Notwithstanding any other pro-
4 vision of law, if the requirements of subsection (c) are met,
5 the Secretary, acting through the Service, is authorized
6 to accept any major expansion, renovation, or moderniza-
7 tion by any Indian Tribe or Tribal Organization of any
8 Service facility or of any other Indian health facility oper-
9 ated pursuant to a contract or compact under the Indian
10 Self-Determination and Education Assistance Act (25
11 U.S.C. 450 et seq.), including—

12 “(1) any plans or designs for such expansion,
13 renovation, or modernization; and

14 “(2) any expansion, renovation, or moderniza-
15 tion for which funds appropriated under any Federal
16 law were lawfully expended.

17 “(b) PRIORITY LIST.—

18 “(1) IN GENERAL.—The Secretary shall main-
19 tain a separate priority list to address the needs for
20 increased operating expenses, personnel, or equip-
21 ment for such facilities. The methodology for estab-
22 lishing priorities shall be developed through regula-
23 tions. The list of priority facilities will be revised an-
24 nually in consultation with Indian Tribes and Tribal
25 Organizations.

1 “(2) REPORT.—The Secretary shall submit to
2 the President, for inclusion in the report required to
3 be transmitted to Congress under section 801, the
4 priority list maintained pursuant to paragraph (1).

5 “(c) REQUIREMENTS.—The requirements of this sub-
6 section are met with respect to any expansion, renovation,
7 or modernization if—

8 “(1) the Indian Tribe or Tribal Organization—

9 “(A) provides notice to the Secretary of its
10 intent to expand, renovate, or modernize; and

11 “(B) applies to the Secretary to be placed
12 on a separate priority list to address the needs
13 of such new facilities for increased operating ex-
14 penses, personnel, or equipment; and

15 “(2) the expansion, renovation, or moderniza-
16 tion—

17 “(A) is approved by the appropriate area
18 director of the Service for Federal facilities; and

19 “(B) is administered by the Indian Tribe
20 or Tribal Organization in accordance with any
21 applicable regulations prescribed by the Sec-
22 retary with respect to construction or renova-
23 tion of Service facilities.

24 “(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—

25 In addition to the requirements under subsection (c), for

1 any expansion, the Indian Tribe or Tribal Organization
2 shall provide to the Secretary additional information pur-
3 suant to regulations, including additional staffing, equip-
4 ment, and other costs associated with the expansion.

5 “(e) CLOSURE OR CONVERSION OF FACILITIES.—If
6 any Service facility which has been expanded, renovated,
7 or modernized by an Indian Tribe or Tribal Organization
8 under this section ceases to be used as a Service facility
9 during the 20-year period beginning on the date such ex-
10 pansion, renovation, or modernization is completed, such
11 Indian Tribe or Tribal Organization shall be entitled to
12 recover from the United States an amount which bears
13 the same ratio to the value of such facility at the time
14 of such cessation as the value of such expansion, renova-
15 tion, or modernization (less the total amount of any funds
16 provided specifically for such facility under any Federal
17 program that were expended for such expansion, renova-
18 tion, or modernization) bore to the value of such facility
19 at the time of the completion of such expansion, renova-
20 tion, or modernization.

21 **“SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION,**
22 **AND MODERNIZATION OF SMALL AMBULA-**
23 **TORY CARE FACILITIES.**

24 “(a) GRANTS.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Service, shall make grants to Indian
3 Tribes and Tribal Organizations for the construc-
4 tion, expansion, or modernization of facilities for the
5 provision of ambulatory care services to eligible Indi-
6 ans (and noneligible persons pursuant to subsections
7 (b)(2) and (c)(1)(C)). A grant made under this sec-
8 tion may cover up to 100 percent of the costs of
9 such construction, expansion, or modernization. For
10 the purposes of this section, the term ‘construction’
11 includes the replacement of an existing facility.

12 “(2) GRANT AGREEMENT REQUIRED.—A grant
13 under paragraph (1) may only be made available to
14 a Tribal Health Program operating an Indian health
15 facility (other than a facility owned or constructed
16 by the Service, including a facility originally owned
17 or constructed by the Service and transferred to an
18 Indian Tribe or Tribal Organization).

19 “(b) USE OF GRANT FUNDS.—

20 “(1) ALLOWABLE USES.—A grant awarded
21 under this section may be used for the construction,
22 expansion, or modernization (including the planning
23 and design of such construction, expansion, or mod-
24 ernization) of an ambulatory care facility—

25 “(A) located apart from a hospital;

1 “(B) not funded under section 301 or sec-
2 tion 306; and

3 “(C) which, upon completion of such con-
4 struction or modernization will—

5 “(i) have a total capacity appropriate
6 to its projected service population;

7 “(ii) provide annually no fewer than
8 150 patient visits by eligible Indians and
9 other users who are eligible for services in
10 such facility in accordance with section
11 806(e)(2); and

12 “(iii) provide ambulatory care in a
13 Service Area (specified in the contract or
14 compact under the Indian Self-Determina-
15 tion and Education Assistance Act (25
16 U.S.C. 450 et seq.)) with a population of
17 no fewer than 1,500 eligible Indians and
18 other users who are eligible for services in
19 such facility in accordance with section
20 806(e)(2).

21 “(2) ADDITIONAL ALLOWABLE USE.—The Sec-
22 retary may also reserve a portion of the funding pro-
23 vided under this section and use those reserved
24 funds to reduce an outstanding debt incurred by In-
25 dian Tribes or Tribal Organizations for the con-

1 construction, expansion, or modernization of an ambula-
2 tory care facility that meets the requirements under
3 paragraph (1). The provisions of this section shall
4 apply, except that such applications for funding
5 under this paragraph shall be considered separately
6 from applications for funding under paragraph (1).

7 “(3) USE ONLY FOR CERTAIN PORTION OF
8 COSTS.—A grant provided under this section may be
9 used only for the cost of that portion of a construc-
10 tion, expansion, or modernization project that bene-
11 fits the Service population identified above in sub-
12 section (b)(1)(C) (ii) and (iii). The requirements of
13 clauses (ii) and (iii) of paragraph (1)(C) shall not
14 apply to an Indian Tribe or Tribal Organization ap-
15 plying for a grant under this section for a health
16 care facility located or to be constructed on an is-
17 land or when such facility is not located on a road
18 system providing direct access to an inpatient hos-
19 pital where care is available to the Service popu-
20 lation.

21 “(c) GRANTS.—

22 “(1) APPLICATION.—No grant may be made
23 under this section unless an application or proposal
24 for the grant has been approved by the Secretary in
25 accordance with applicable regulations and has set

1 forth reasonable assurance by the applicant that, at
2 all times after the construction, expansion, or mod-
3 ernization of a facility carried out using a grant re-
4 ceived under this section—

5 “(A) adequate financial support will be
6 available for the provision of services at such
7 facility;

8 “(B) such facility will be available to eligi-
9 ble Indians without regard to ability to pay or
10 source of payment; and

11 “(C) such facility will, as feasible without
12 diminishing the quality or quantity of services
13 provided to eligible Indians, serve noneligible
14 persons on a cost basis.

15 “(2) PRIORITY.—In awarding grants under this
16 section, the Secretary shall give priority to Indian
17 Tribes and Tribal Organizations that demonstrate—

18 “(A) a need for increased ambulatory care
19 services; and

20 “(B) insufficient capacity to deliver such
21 services.

22 “(3) PEER REVIEW PANELS.—The Secretary
23 may provide for the establishment of peer review
24 panels, as necessary, to review and evaluate applica-
25 tions and proposals and to advise the Secretary re-

1 and Education Assistance Act (25 U.S.C. 450 et seq.) for
2 the purpose of carrying out a health care delivery dem-
3 onstration project to test alternative means of delivering
4 health care and services to Indians through facilities.

5 “(b) USE OF FUNDS.—The Secretary, in approving
6 projects pursuant to this section, may authorize such con-
7 tracts for the construction and renovation of hospitals,
8 health centers, health stations, and other facilities to de-
9 liver health care services and is authorized to—

10 “(1) waive any leasing prohibition;

11 “(2) permit carryover of funds appropriated for
12 the provision of health care services;

13 “(3) permit the use of other available funds;

14 “(4) permit the use of funds or property do-
15 nated from any source for project purposes;

16 “(5) provide for the reversion of donated real or
17 personal property to the donor; and

18 “(6) permit the use of Service funds to match
19 other funds, including Federal funds.

20 “(c) REGULATIONS.—The Secretary shall develop
21 and promulgate regulations, not later than 1 year after
22 the date of enactment of the Indian Health Care Improve-
23 ment Act Amendments of 2009, for the review and ap-
24 proval of applications submitted under this section.

1 “(d) CRITERIA.—The Secretary may approve projects
2 that meet the following criteria:

3 “(1) There is a need for a new facility or pro-
4 gram or the reorientation of an existing facility or
5 program.

6 “(2) A significant number of Indians, including
7 those with low health status, will be served by the
8 project.

9 “(3) The project has the potential to deliver
10 services in an efficient and effective manner.

11 “(4) The project is economically viable.

12 “(5) The Indian Tribe or Tribal Organization
13 has the administrative and financial capability to ad-
14 minister the project.

15 “(6) The project is integrated with providers of
16 related health and social services and is coordinated
17 with, and avoids duplication of, existing services.

18 “(e) PEER REVIEW PANELS.—The Secretary may
19 provide for the establishment of peer review panels, as nec-
20 essary, to review and evaluate applications using the cri-
21 teria developed pursuant to subsection (d).

22 “(f) PRIORITY.—The Secretary shall give priority to
23 applications for demonstration projects in each of the fol-
24 lowing Service Units to the extent that such applications

1 are timely filed and meet the criteria specified in sub-
2 section (d):

3 “(1) Cass Lake, Minnesota.

4 “(2) Mescalero, New Mexico.

5 “(3) Owyhee, Nevada.

6 “(4) Schurz, Nevada.

7 “(5) Ft. Yuma, California.

8 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
9 provide such technical and other assistance as may be nec-
10 essary to enable applicants to comply with the provisions
11 of this section.

12 “(h) SERVICE TO INELIGIBLE PERSONS.—Subject to
13 section 806, the authority to provide services to persons
14 otherwise ineligible for the health care benefits of the
15 Service and the authority to extend hospital privileges in
16 Service facilities to non-Service health practitioners as
17 provided in section 806 may be included, subject to the
18 terms of such section, in any demonstration project ap-
19 proved pursuant to this section.

20 “(i) EQUITABLE TREATMENT.—For purposes of sub-
21 section (d)(1), the Secretary shall, in evaluating facilities
22 operated under any contract or compact under the Indian
23 Self-Determination and Education Assistance Act (25
24 U.S.C. 450 et seq.), use the same criteria that the Sec-

1 retary uses in evaluating facilities operated directly by the
2 Service.

3 “(j) **EQUITABLE INTEGRATION OF FACILITIES.**—The
4 Secretary shall ensure that the planning, design, construc-
5 tion, renovation, and expansion needs of Service and non-
6 Service facilities which are the subject of a contract or
7 compact under the Indian Self-Determination and Edu-
8 cation Assistance Act (25 U.S.C. 450 et seq.) for health
9 services are fully and equitably integrated into the imple-
10 mentation of the health care delivery demonstration
11 projects under this section.

12 **“SEC. 307. LAND TRANSFER.**

13 “Notwithstanding any other provision of law, the Bu-
14 reau of Indian Affairs and all other agencies and depart-
15 ments of the United States are authorized to transfer, at
16 no cost, land and improvements to the Service for the pro-
17 vision of health care services. The Secretary is authorized
18 to accept such land and improvements for such purposes.

19 **“SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.**

20 “The Secretary, acting through the Service, may
21 enter into leases, contracts, and other agreements with In-
22 dian Tribes and Tribal Organizations which hold (1) title
23 to, (2) a leasehold interest in, or (3) a beneficial interest
24 in (when title is held by the United States in trust for
25 the benefit of an Indian Tribe) facilities used or to be used

1 for the administration and delivery of health services by
2 an Indian Health Program. Such leases, contracts, or
3 agreements may include provisions for construction or ren-
4 ovation and provide for compensation to the Indian Tribe
5 or Tribal Organization of rental and other costs consistent
6 with section 105(l) of the Indian Self-Determination and
7 Education Assistance Act (25 U.S.C. 450j(l)) and regula-
8 tions thereunder.

9 **“SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND**
10 **LOAN REPAYMENT.**

11 “(a) IN GENERAL.—The Secretary, in consultation
12 with the Secretary of the Treasury, Indian Tribes, and
13 Tribal Organizations, shall carry out a study to determine
14 the feasibility of establishing a loan fund to provide to In-
15 dian Tribes and Tribal Organizations direct loans or guar-
16 antees for loans for the construction of health care facili-
17 ties, including—

18 “(1) inpatient facilities;

19 “(2) outpatient facilities;

20 “(3) staff quarters;

21 “(4) hostels; and

22 “(5) specialized care facilities, such as behav-
23 ioral health and elder care facilities.

24 “(b) DETERMINATIONS.—In carrying out the study
25 under subsection (a), the Secretary shall determine—

1 “(1) the maximum principal amount of a loan
2 or loan guarantee that should be offered to a recipi-
3 ent from the loan fund;

4 “(2) the percentage of eligible costs, not to ex-
5 ceed 100 percent, that may be covered by a loan or
6 loan guarantee from the loan fund (including costs
7 relating to planning, design, financing, site land de-
8 velopment, construction, rehabilitation, renovation,
9 conversion, improvements, medical equipment and
10 furnishings, and other facility-related costs and cap-
11 ital purchase (but excluding staffing));

12 “(3) the cumulative total of the principal of di-
13 rect loans and loan guarantees, respectively, that
14 may be outstanding at any 1 time;

15 “(4) the maximum term of a loan or loan guar-
16 antee that may be made for a facility from the loan
17 fund;

18 “(5) the maximum percentage of funds from
19 the loan fund that should be allocated for payment
20 of costs associated with planning and applying for a
21 loan or loan guarantee;

22 “(6) whether acceptance by the Secretary of an
23 assignment of the revenue of an Indian Tribe or
24 Tribal Organization as security for any direct loan

1 or loan guarantee from the loan fund would be ap-
2 propriate;

3 “(7) whether, in the planning and design of
4 health facilities under this section, users eligible
5 under section 806(c) may be included in any projec-
6 tion of patient population;

7 “(8) whether funds of the Service provided
8 through loans or loan guarantees from the loan fund
9 should be eligible for use in matching other Federal
10 funds under other programs;

11 “(9) the appropriateness of, and best methods
12 for, coordinating the loan fund with the health care
13 priority system of the Service under section 301; and

14 “(10) any legislative or regulatory changes re-
15 quired to implement recommendations of the Sec-
16 retary based on results of the study.

17 “(c) REPORT.—Not later than September 30, 2010,
18 the Secretary shall submit to the Committee on Indian Af-
19 fairs of the Senate and the Committee on Natural Re-
20 sources and the Committee on Energy and Commerce of
21 the House of Representatives a report that describes—

22 “(1) the manner of consultation made as re-
23 quired by subsection (a); and

1 “(2) the results of the study, including any rec-
2 ommendations of the Secretary based on results of
3 the study.

4 **“SEC. 310. TRIBAL LEASING.**

5 “A Tribal Health Program may lease permanent
6 structures for the purpose of providing health care services
7 without obtaining advance approval in appropriation Acts.

8 **“SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES**
9 **JOINT VENTURE PROGRAM.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Service, shall make arrangements with Indian Tribes
12 and Tribal Organizations to establish joint venture dem-
13 onstration projects under which an Indian Tribe or Tribal
14 Organization shall expend tribal, private, or other avail-
15 able funds, for the acquisition or construction of a health
16 facility for a minimum of 10 years, under a no-cost lease,
17 in exchange for agreement by the Service to provide the
18 equipment, supplies, and staffing for the operation and
19 maintenance of such a health facility. An Indian Tribe or
20 Tribal Organization may use tribal funds, private sector,
21 or other available resources, including loan guarantees, to
22 fulfill its commitment under a joint venture entered into
23 under this subsection. An Indian Tribe or Tribal Organi-
24 zation shall be eligible to establish a joint venture project
25 if, when it submits a letter of intent, it—

1 “(1) has begun but not completed the process
2 of acquisition or construction of a health facility to
3 be used in the joint venture project;

4 “(2) has not begun the process of acquisition or
5 construction of a health facility for use in the joint
6 venture project; or

7 “(3) in its application for a joint venture agree-
8 ment, agrees—

9 “(A) to construct a facility for the joint
10 venture which complies with the size and space
11 criteria established by the Service; or

12 “(B) if the facility it proposes for the joint
13 venture is already in existence or under con-
14 struction, that only the portion of such facility
15 which complies with the size and space criteria
16 of the Service will be eligible for the joint ven-
17 ture agreement.

18 “(b) REQUIREMENTS.—The Secretary shall make
19 such an arrangement with an Indian Tribe or Tribal Orga-
20 nization only if—

21 “(1) the Secretary first determines that the In-
22 dian Tribe or Tribal Organization has the adminis-
23 trative and financial capabilities necessary to com-
24 plete the timely acquisition or construction of the
25 relevant health facility; and

1 “(2) the Indian Tribe or Tribal Organization
2 meets the need criteria determined using the criteria
3 developed under the health care facility priority sys-
4 tem under section 301, unless the Secretary deter-
5 mines, pursuant to regulations, that other criteria
6 will result in a more cost-effective and efficient
7 method of facilitating and completing construction of
8 health care facilities.

9 “(c) CONTINUED OPERATION.—The Secretary shall
10 negotiate an agreement with the Indian Tribe or Tribal
11 Organization regarding the continued operation of the fa-
12 cility at the end of the initial 10 year no-cost lease period.

13 “(d) BREACH OF AGREEMENT.—An Indian Tribe or
14 Tribal Organization that has entered into a written agree-
15 ment with the Secretary under this section, and that
16 breaches or terminates without cause such agreement,
17 shall be liable to the United States for the amount that
18 has been paid to the Indian Tribe or Tribal Organization,
19 or paid to a third party on the Indian Tribe’s or Tribal
20 Organization’s behalf, under the agreement. The Sec-
21 retary has the right to recover tangible property (including
22 supplies) and equipment, less depreciation, and any funds
23 expended for operations and maintenance under this sec-
24 tion. The preceding sentence does not apply to any funds

1 expended for the delivery of health care services, per-
2 sonnel, or staffing.

3 “(e) RECOVERY FOR NONUSE.—An Indian Tribe or
4 Tribal Organization that has entered into a written agree-
5 ment with the Secretary under this subsection shall be en-
6 titled to recover from the United States an amount that
7 is proportional to the value of such facility if, at any time
8 within the 10-year term of the agreement, the Service
9 ceases to use the facility or otherwise breaches the agree-
10 ment.

11 “(f) DEFINITION.—For the purposes of this section,
12 the term ‘health facility’ or ‘health facilities’ includes
13 quarters needed to provide housing for staff of the rel-
14 evant Tribal Health Program.

15 **“SEC. 312. LOCATION OF FACILITIES.**

16 “(a) IN GENERAL.—In all matters involving the reor-
17 ganization or development of Service facilities or in the
18 establishment of related employment projects to address
19 unemployment conditions in economically depressed areas,
20 the Bureau of Indian Affairs and the Service shall give
21 priority to locating such facilities and projects on Indian
22 lands, or lands in Alaska owned by any Alaska Native vil-
23 lage, or village or regional corporation under the Alaska
24 Native Claims Settlement Act (43 U.S.C. 1601 et seq.),
25 or any land allotted to any Alaska Native, if requested

1 by the Indian owner and the Indian Tribe with jurisdiction
2 over such lands or other lands owned or leased by the In-
3 dian Tribe or Tribal Organization. Top priority shall be
4 given to Indian land owned by 1 or more Indian Tribes.

5 “(b) DEFINITION.—For purposes of this section, the
6 term ‘Indian lands’ means—

7 “(1) all lands within the exterior boundaries of
8 any reservation; and

9 “(2) any lands title to which is held in trust by
10 the United States for the benefit of any Indian
11 Tribe or individual Indian or held by any Indian
12 Tribe or individual Indian subject to restriction by
13 the United States against alienation.

14 **“SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH**
15 **CARE FACILITIES.**

16 “(a) REPORT.—The Secretary shall submit to the
17 President, for inclusion in the report required to be trans-
18 mitted to Congress under section 801, a report which iden-
19 tifies the backlog of maintenance and repair work required
20 at both Service and tribal health care facilities, including
21 new health care facilities expected to be in operation in
22 the next fiscal year. The report shall also identify the need
23 for renovation and expansion of existing facilities to sup-
24 port the growth of health care programs.

1 “(b) MAINTENANCE OF NEWLY CONSTRUCTED
2 SPACE.—The Secretary, acting through the Service, is au-
3 thorized to expend maintenance and improvement funds
4 to support maintenance of newly constructed space only
5 if such space falls within the approved supportable space
6 allocation for the Indian Tribe or Tribal Organization.
7 Supportable space allocation shall be defined through the
8 health care facility priority system under section 301(c).

9 “(c) REPLACEMENT FACILITIES.—In addition to
10 using maintenance and improvement funds for renovation,
11 modernization, and expansion of facilities, an Indian Tribe
12 or Tribal Organization may use maintenance and improve-
13 ment funds for construction of a replacement facility if
14 the costs of renovation of such facility would exceed a
15 maximum renovation cost threshold. The Secretary shall
16 consult with Indian Tribes and Tribal Organizations in de-
17 termining the maximum renovation cost threshold.

18 **“SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED**
19 **QUARTERS.**

20 “(a) RENTAL RATES.—

21 “(1) ESTABLISHMENT.—Notwithstanding any
22 other provision of law, a Tribal Health Program
23 which operates a hospital or other health facility and
24 the federally owned quarters associated therewith
25 pursuant to a contract or compact under the Indian

1 Self-Determination and Education Assistance Act
2 (25 U.S.C. 450 et seq.) shall have the authority to
3 establish the rental rates charged to the occupants
4 of such quarters by providing notice to the Secretary
5 of its election to exercise such authority.

6 “(2) OBJECTIVES.—In establishing rental rates
7 pursuant to authority of this subsection, a Tribal
8 Health Program shall endeavor to achieve the fol-
9 lowing objectives:

10 “(A) To base such rental rates on the rea-
11 sonable value of the quarters to the occupants
12 thereof.

13 “(B) To generate sufficient funds to pru-
14 dently provide for the operation and mainte-
15 nance of the quarters, and subject to the discre-
16 tion of the Tribal Health Program, to supply
17 reserve funds for capital repairs and replace-
18 ment of the quarters.

19 “(3) EQUITABLE FUNDING.—Any quarters
20 whose rental rates are established by a Tribal
21 Health Program pursuant to this subsection shall
22 remain eligible for quarters improvement and repair
23 funds to the same extent as all federally owned
24 quarters used to house personnel in Services-sup-
25 ported programs.

1 “(4) NOTICE OF RATE CHANGE.—A Tribal
2 Health Program which exercises the authority pro-
3 vided under this subsection shall provide occupants
4 with no less than 60 days notice of any change in
5 rental rates.

6 “(b) DIRECT COLLECTION OF RENT.—

7 “(1) IN GENERAL.—Notwithstanding any other
8 provision of law, and subject to paragraph (2), a
9 Tribal Health Program shall have the authority to
10 collect rents directly from Federal employees who oc-
11 cupy such quarters in accordance with the following:

12 “(A) The Tribal Health Program shall no-
13 tify the Secretary and the subject Federal em-
14 ployees of its election to exercise its authority
15 to collect rents directly from such Federal em-
16 ployees.

17 “(B) Upon receipt of a notice described in
18 subparagraph (A), the Federal employees shall
19 pay rents for occupancy of such quarters di-
20 rectly to the Tribal Health Program and the
21 Secretary shall have no further authority to col-
22 lect rents from such employees through payroll
23 deduction or otherwise.

24 “(C) Such rent payments shall be retained
25 by the Tribal Health Program and shall not be

1 made payable to or otherwise be deposited with
2 the United States.

3 “(D) Such rent payments shall be depos-
4 ited into a separate account which shall be used
5 by the Tribal Health Program for the mainte-
6 nance (including capital repairs and replace-
7 ment) and operation of the quarters and facili-
8 ties as the Tribal Health Program shall deter-
9 mine.

10 “(2) RETROCESSION OF AUTHORITY.—If a
11 Tribal Health Program which has made an election
12 under paragraph (1) requests retrocession of its au-
13 thority to directly collect rents from Federal employ-
14 ees occupying federally owned quarters, such ret-
15 rocession shall become effective on the earlier of—

16 “(A) the first day of the month that begins
17 no less than 180 days after the Tribal Health
18 Program notifies the Secretary of its desire to
19 retrocede; or

20 “(B) such other date as may be mutually
21 agreed by the Secretary and the Tribal Health
22 Program.

23 “(c) RATES IN ALASKA.—To the extent that a Tribal
24 Health Program, pursuant to authority granted in sub-
25 section (a), establishes rental rates for federally owned

1 quarters provided to a Federal employee in Alaska, such
2 rents may be based on the cost of comparable private rent-
3 al housing in the nearest established community with a
4 year-round population of 1,500 or more individuals.

5 **“SEC. 315. APPLICABILITY OF BUY AMERICAN ACT RE-**
6 **QUIREMENT.**

7 “(a) **APPLICABILITY.**—The Secretary shall ensure
8 that the requirements of the Buy American Act apply to
9 all procurements made with funds provided pursuant to
10 section 317. Indian Tribes and Tribal Organizations shall
11 be exempt from these requirements.

12 “(b) **EFFECT OF VIOLATION.**—If it has been finally
13 determined by a court or Federal agency that any person
14 intentionally affixed a label bearing a ‘Made in America’
15 inscription or any inscription with the same meaning, to
16 any product sold in or shipped to the United States that
17 is not made in the United States, such person shall be
18 ineligible to receive any contract or subcontract made with
19 funds provided pursuant to section 317, pursuant to the
20 debarment, suspension, and ineligibility procedures de-
21 scribed in sections 9.400 through 9.409 of title 48, Code
22 of Federal Regulations.

23 “(c) **DEFINITIONS.**—For purposes of this section, the
24 term ‘Buy American Act’ means title III of the Act enti-
25 tled ‘An Act making appropriations for the Treasury and

1 Post Office Departments for the fiscal year ending June
2 30, 1934, and for other purposes', approved March 3,
3 1933 (41 U.S.C. 10a et seq.).

4 **“SEC. 316. OTHER FUNDING FOR FACILITIES.**

5 “(a) AUTHORITY TO ACCEPT FUNDS.—The Sec-
6 retary is authorized to accept from any source, including
7 Federal and State agencies, funds that are available for
8 the construction of health care facilities and use such
9 funds to plan, design, and construct health care facilities
10 for Indians and to place such funds into a contract or com-
11 pact under the Indian Self-Determination and Education
12 Assistance Act (25 U.S.C. 450 et seq.). Receipt of such
13 funds shall have no effect on the priorities established pur-
14 suant to section 301.

15 “(b) INTERAGENCY AGREEMENTS.—The Secretary is
16 authorized to enter into interagency agreements with
17 other Federal agencies or State agencies and other entities
18 and to accept funds from such Federal or State agencies
19 or other sources to provide for the planning, design, and
20 construction of health care facilities to be administered by
21 Indian Health Programs in order to carry out the pur-
22 poses of this Act and the purposes for which the funds
23 were appropriated or for which the funds were otherwise
24 provided.

1 “(c) TRANSFERRED FUNDS.—Any Federal agency to
2 which funds for the construction of health care facilities
3 are appropriated is authorized to transfer such funds to
4 the Secretary for the construction of health care facilities
5 to carry out the purposes of this Act as well as the pur-
6 poses for which such funds are appropriated to such other
7 Federal agency.

8 “(d) ESTABLISHMENT OF STANDARDS.—The Sec-
9 retary, through the Service, shall establish standards by
10 regulation for the planning, design, and construction of
11 health care facilities serving Indians under this Act.

12 **“SEC. 317. AUTHORIZATION OF APPROPRIATIONS.**

13 “There are authorized to be appropriated such sums
14 as may be necessary to carry out this title.

15 **“TITLE IV—ACCESS TO HEALTH**
16 **SERVICES**

17 **“SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SE-**
18 **CURITY ACT HEALTH BENEFITS PROGRAMS.**

19 “(a) DISREGARD OF MEDICARE, MEDICAID, AND
20 SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—
21 Any payments received by an Indian Health Program or
22 by an urban Indian organization under title XVIII, XIX,
23 or XXI of the Social Security Act for services provided
24 to Indians eligible for benefits under such respective titles

1 shall not be considered in determining appropriations for
2 the provision of health care and services to Indians.

3 “(b) NONPREFERENTIAL TREATMENT.—Nothing in
4 this Act authorizes the Secretary to provide services to an
5 Indian with coverage under title XVIII, XIX, or XXI of
6 the Social Security Act in preference to an Indian without
7 such coverage.

8 “(c) USE OF FUNDS.—

9 “(1) SPECIAL FUND.—

10 “(A) 100 PERCENT PASS-THROUGH OF
11 PAYMENTS DUE TO FACILITIES.—Notwith-
12 standing any other provision of law, but subject
13 to paragraph (2), payments to which a facility
14 of the Service is entitled by reason of a provi-
15 sion of title XVIII or XIX of the Social Secu-
16 rity Act shall be placed in a special fund to be
17 held by the Secretary. In making payments
18 from such fund, the Secretary shall ensure that
19 each Service Unit of the Service receives 100
20 percent of the amount to which the facilities of
21 the Service, for which such Service Unit makes
22 collections, are entitled by reason of a provision
23 of either such title.

24 “(B) USE OF FUNDS.—Amounts received
25 by a facility of the Service under subparagraph

1 (A) by reason of a provision of title XVIII or
2 XIX of the Social Security Act shall first be
3 used (to such extent or in such amounts as are
4 provided in appropriation Acts) for the purpose
5 of making any improvements in the programs
6 of the Service operated by or through such fa-
7 cility which may be necessary to achieve or
8 maintain compliance with the applicable condi-
9 tions and requirements of such respective title.
10 Any amounts so received that are in excess of
11 the amount necessary to achieve or maintain
12 such conditions and requirements shall, subject
13 to consultation with the Indian Tribes being
14 served by the Service Unit, be used for increas-
15 ing the facility's capacity to provide, or improv-
16 ing the quality or accessibility of, services.

17 “(2) DIRECT PAYMENT OPTION.—Paragraph
18 (1) shall not apply to a Tribal Health Program upon
19 the election of such Program under subsection (d) to
20 receive payments directly. No payment may be made
21 out of the special fund described in such paragraph
22 with respect to reimbursement made for services
23 provided by such Program during the period of such
24 election.

25 “(d) DIRECT BILLING.—

1 “(1) IN GENERAL.—Subject to complying with
2 the requirements of paragraph (2), a Tribal Health
3 Program may elect to directly bill for, and receive
4 payment for, health care items and services provided
5 by such Program for which payment is made under
6 title XVIII, XIX, or XXI of the Social Security Act.

7 “(2) DIRECT REIMBURSEMENT.—

8 “(A) USE OF FUNDS.—Each Tribal Health
9 Program making the election described in para-
10 graph (1) with respect to a program under title
11 XVIII, XIX, or XXI of the Social Security Act
12 shall be reimbursed directly by that program
13 for items and services furnished without regard
14 to subsection (c)(1), but all amounts so reim-
15 bursed shall be used by the Tribal Health Pro-
16 gram for the same purposes with respect to
17 such Program for which payment under sub-
18 paragraph (A) of subsection (c)(1) to a facility
19 of the Service may be used pursuant to sub-
20 paragraph (B) of such subsection with respect
21 to the Service.

22 “(B) AUDITS.—The amounts paid to a
23 Tribal Health Program making the election de-
24 scribed in paragraph (1) with respect to a pro-
25 gram under title XVIII, XIX, or XXI of the So-

1 cial Security Act shall be subject to all auditing
2 requirements applicable to the program under
3 such title, as well as all auditing requirements
4 applicable to programs administered by an In-
5 dian Health Program. Nothing in the preceding
6 sentence shall be construed as limiting the ap-
7 plication of auditing requirements applicable to
8 amounts paid under title XVIII, XIX, or XXI
9 of the Social Security Act.

10 “(C) IDENTIFICATION OF SOURCE OF PAY-
11 MENTS.—Any Tribal Health Program that re-
12 ceives reimbursements or payments under title
13 XVIII, XIX, or XXI of the Social Security Act
14 shall provide to the Service a list of each pro-
15 vider enrollment number (or other identifier)
16 under which such Program receives such reim-
17 bursements or payments.

18 “(3) EXAMINATION AND IMPLEMENTATION OF
19 CHANGES.—

20 “(A) IN GENERAL.—The Secretary, acting
21 through the Service and with the assistance of
22 the Administrator of the Centers for Medicare
23 & Medicaid Services, shall examine on an ongo-
24 ing basis and implement any administrative
25 changes that may be necessary to facilitate di-

1 rect billing and reimbursement under the pro-
2 gram established under this subsection, includ-
3 ing any agreements with States that may be
4 necessary to provide for direct billing under a
5 program under title XIX or XXI of the Social
6 Security Act.

7 “(B) COORDINATION OF INFORMATION.—
8 The Service shall provide the Administrator of
9 the Centers for Medicare & Medicaid Services
10 with copies of the lists submitted to the Service
11 under paragraph (2)(C), enrollment data re-
12 garding patients served by the Service (and by
13 Tribal Health Programs, to the extent such
14 data is available to the Service), and such other
15 information as the Administrator may require
16 for purposes of administering title XVIII, XIX,
17 or XXI of the Social Security Act.

18 “(4) WITHDRAWAL FROM PROGRAM.—A Tribal
19 Health Program that bills directly under the pro-
20 gram established under this subsection may with-
21 draw from participation in the same manner and
22 under the same conditions that an Indian Tribe or
23 Tribal Organization may retrocede a contracted pro-
24 gram to the Secretary under the authority of the In-
25 dian Self-Determination and Education Assistance

1 Act (25 U.S.C. 450 et seq.). All cost accounting and
2 billing authority under the program established
3 under this subsection shall be returned to the Sec-
4 retary upon the Secretary's acceptance of the with-
5 drawal of participation in this program.

6 “(5) TERMINATION FOR FAILURE TO COMPLY
7 WITH REQUIREMENTS.—The Secretary may termi-
8 nate the participation of a Tribal Health Program or
9 in the direct billing program established under this
10 subsection if the Secretary determines that the Pro-
11 gram has failed to comply with the requirements of
12 paragraph (2). The Secretary shall provide a Tribal
13 Health Program with notice of a determination that
14 the Program has failed to comply with any such re-
15 quirement and a reasonable opportunity to correct
16 such noncompliance prior to terminating the Pro-
17 gram's participation in the direct billing program es-
18 tablished under this subsection.

19 “(e) RELATED PROVISIONS UNDER THE SOCIAL SE-
20 CURITY ACT.—For provisions related to subsections (c)
21 and (d), see sections 1880, 1911, and 2107(e)(1)(D) of
22 the Social Security Act.

1 **“SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERV-**
2 **ICE, INDIAN TRIBES, TRIBAL ORGANIZA-**
3 **TIONS, AND URBAN INDIAN ORGANIZATIONS**
4 **TO FACILITATE OUTREACH, ENROLLMENT,**
5 **AND COVERAGE OF INDIANS UNDER SOCIAL**
6 **SECURITY ACT HEALTH BENEFIT PROGRAMS.**

7 “(a) INDIAN TRIBES AND TRIBAL ORGANIZA-
8 TIONS.—The Secretary, acting through the Service, shall
9 make grants to or enter into contracts with Indian Tribes
10 and Tribal Organizations to assist such Tribes and Tribal
11 Organizations in establishing and administering programs
12 on or near reservations, trust lands, and Alaska Native
13 Villages, including programs to provide outreach and en-
14 rollment through video, electronic delivery methods, or
15 telecommunication devices that allow real-time or time-de-
16 layed communication between individual Indians and the
17 benefit program, to assist individual Indians—

18 “(1) to enroll for benefits under a program es-
19 tablished under title XVIII, XIX, or XXI of the So-
20 cial Security Act; and

21 “(2) with respect to such programs for which
22 the charging of premiums and cost sharing is not
23 prohibited under such programs, to pay premiums or
24 cost sharing for coverage for such benefits, which
25 may be based on financial need (as determined by
26 the Indian Tribe or Tribes or Tribal Organizations

1 being served based on a schedule of income levels de-
2 veloped or implemented by such Tribe, Tribes, or
3 Tribal Organizations).

4 “(b) CONDITIONS.—The Secretary, acting through
5 the Service, shall place conditions as deemed necessary to
6 effect the purpose of this section in any grant or contract
7 which the Secretary makes with any Indian Tribe or Trib-
8 al Organization pursuant to this section. Such conditions
9 shall include requirements that the Indian Tribe or Tribal
10 Organization successfully undertake—

11 “(1) to determine the population of Indians eli-
12 gible for the benefits described in subsection (a);

13 “(2) to educate Indians with respect to the ben-
14 efits available under the respective programs;

15 “(3) to provide transportation for such indi-
16 vidual Indians to the appropriate offices for enroll-
17 ment or applications for such benefits; and

18 “(4) to develop and implement methods of im-
19 proving the participation of Indians in receiving ben-
20 efits under such programs.

21 “(c) APPLICATION TO URBAN INDIAN ORGANIZA-
22 TIONS.—

23 “(1) IN GENERAL.—The provisions of sub-
24 section (a) shall apply with respect to grants and
25 other funding to urban Indian organizations with re-

1 spect to populations served by such organizations in
2 the same manner they apply to grants and contracts
3 with Indian Tribes and Tribal Organizations with
4 respect to programs on or near reservations.

5 “(2) REQUIREMENTS.—The Secretary shall in-
6 clude in the grants or contracts made or provided
7 under paragraph (1) requirements that are—

8 “(A) consistent with the requirements im-
9 posed by the Secretary under subsection (b);

10 “(B) appropriate to urban Indian organi-
11 zations and urban Indians; and

12 “(C) necessary to effect the purposes of
13 this section.

14 “(d) FACILITATING COOPERATION IN ENROLLMENT
15 AND RETENTION.—The Secretary, acting through the
16 Centers for Medicare & Medicaid Services, shall consult
17 with States, the Service, Indian Tribes, Tribal Organi-
18 zations, and urban Indian organizations to develop and dis-
19 seminate best practices with respect to facilitating agree-
20 ments between the States and Indian Tribes, Tribal Orga-
21 nizations, and urban Indian organizations relating to en-
22 rollment and retention of Indians in programs established
23 under titles XVIII, XIX, and XXI of the Social Security
24 Act.

1 “(e) AGREEMENTS TO IMPROVE ENROLLMENT OF
2 INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENE-
3 FITS PROGRAMS.—For provisions relating to agreements
4 between the Secretary and the Service, Indian Tribes,
5 Tribal Organizations, and urban Indian organizations for
6 the collection, preparation, and submission of applications
7 by Indians for assistance under the Medicaid and chil-
8 dren’s health insurance programs established under titles
9 XIX and XXI of the Social Security Act, and benefits
10 under the Medicare program established under title XVIII
11 of such Act, see subsections (a) and (b) of section 1139
12 of the Social Security Act.

13 “(f) DEFINITIONS.—In this section:

14 “(1) PREMIUM.—The term ‘premium’ includes
15 any enrollment fee or similar charge.

16 “(2) COST SHARING.—The term ‘cost sharing’
17 includes any deduction, deductible, copayment, coin-
18 surance, or similar charge.

19 “(3) BENEFITS.—The term ‘benefits’ means,
20 with respect to—

21 “(A) title XVIII of the Social Security Act,
22 benefits under such title;

23 “(B) title XIX of such Act, medical assist-
24 ance under such title; and

1 “(C) title XXI of such Act, assistance
2 under such title.

3 **“SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
4 **TIES OF COSTS OF HEALTH SERVICES.**

5 “(a) RIGHT OF RECOVERY.—Except as provided in
6 subsection (f), the United States, an Indian Tribe, or
7 Tribal Organization shall have the right to recover from
8 an insurance company, health maintenance organization,
9 employee benefit plan, third-party tortfeasor, or any other
10 responsible or liable third party (including a political sub-
11 division or local governmental entity of a State) the rea-
12 sonable charges incurred by the Secretary, an Indian
13 Tribe, or Tribal Organization, or, if higher, the highest
14 amount the third party would pay for care and services
15 furnished by providers other than governmental entities,
16 in providing health services through the Service, an Indian
17 Tribe, or Tribal Organization to any individual to the
18 same extent that such individual, or any nongovernmental
19 provider of such services, would be eligible to receive dam-
20 ages, reimbursement, or indemnification for such charges
21 if—

22 “(1) such services had been provided by a non-
23 governmental provider; and

1 “(2) such individual had been required to pay
2 such charges or expenses and did pay such charges
3 or expenses.

4 “(b) LIMITATIONS ON RECOVERIES FROM STATES.—
5 Subsection (a) shall provide a right of recovery against
6 any State, only if the injury, illness, or disability for which
7 health services were provided is covered under—

8 “(1) workers’ compensation laws; or

9 “(2) a no-fault automobile accident insurance
10 plan or program.

11 “(c) NONAPPLICATION OF OTHER LAWS.—No law of
12 any State, or of any political subdivision of a State and
13 no provision of any contract, insurance or health mainte-
14 nance organization policy, employee benefit plan, self-in-
15 surance plan, managed care plan, or other health care plan
16 or program entered into or renewed after the date of the
17 enactment of the Indian Health Care Amendments of
18 1988, shall prevent or hinder the right of recovery of the
19 United States, an Indian Tribe, or Tribal Organization
20 under subsection (a).

21 “(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—
22 No action taken by the United States, an Indian Tribe,
23 or Tribal Organization to enforce the right of recovery
24 provided under this section shall operate to deny to the

1 injured person the recovery for that portion of the person's
2 damage not covered hereunder.

3 “(e) ENFORCEMENT.—

4 “(1) IN GENERAL.—The United States, an In-
5 dian Tribe, or Tribal Organization may enforce the
6 right of recovery provided under subsection (a) by—

7 “(A) intervening or joining in any civil ac-
8 tion or proceeding brought—

9 “(i) by the individual for whom health
10 services were provided by the Secretary, an
11 Indian Tribe, or Tribal Organization; or

12 “(ii) by any representative or heirs of
13 such individual, or

14 “(B) instituting a civil action, including a
15 civil action for injunctive relief and other relief
16 and including, with respect to a political sub-
17 division or local governmental entity of a State,
18 such an action against an official thereof.

19 “(2) NOTICE.—All reasonable efforts shall be
20 made to provide notice of action instituted under
21 paragraph (1)(B) to the individual to whom health
22 services were provided, either before or during the
23 pendency of such action.

24 “(3) RECOVERY FROM TORTFEASORS.—

1 “(A) IN GENERAL.—In any case in which
2 an Indian Tribe or Tribal Organization that is
3 authorized or required under a compact or con-
4 tract issued pursuant to the Indian Self-Deter-
5 mination and Education Assistance Act (25
6 U.S.C. 450 et seq.) to furnish or pay for health
7 services to a person who is injured or suffers a
8 disease on or after the date of enactment of the
9 Indian Health Care Improvement Act Amend-
10 ments of 2009 under circumstances that estab-
11 lish grounds for a claim of liability against the
12 tortfeasor with respect to the injury or disease,
13 the Indian Tribe or Tribal Organization shall
14 have a right to recover from the tortfeasor (or
15 an insurer of the tortfeasor) the reasonable
16 value of the health services so furnished, paid
17 for, or to be paid for, in accordance with the
18 Federal Medical Care Recovery Act (42 U.S.C.
19 2651 et seq.), to the same extent and under the
20 same circumstances as the United States may
21 recover under that Act.

22 “(B) TREATMENT.—The right of an In-
23 dian Tribe or Tribal Organization to recover
24 under subparagraph (A) shall be independent of
25 the rights of the injured or diseased person

1 served by the Indian Tribe or Tribal Organiza-
2 tion.

3 “(f) LIMITATION.—Absent specific written authoriza-
4 tion by the governing body of an Indian Tribe for the pe-
5 riod of such authorization (which may not be for a period
6 of more than 1 year and which may be revoked at any
7 time upon written notice by the governing body to the
8 Service), the United States shall not have a right of recov-
9 ery under this section if the injury, illness, or disability
10 for which health services were provided is covered under
11 a self-insurance plan funded by an Indian Tribe, Tribal
12 Organization, or urban Indian organization. Where such
13 authorization is provided, the Service may receive and ex-
14 pend such amounts for the provision of additional health
15 services consistent with such authorization.

16 “(g) COSTS AND ATTORNEYS’ FEES.—In any action
17 brought to enforce the provisions of this section, a pre-
18 vailing plaintiff shall be awarded its reasonable attorneys’
19 fees and costs of litigation.

20 “(h) NONAPPLICATION OF CLAIMS FILING REQUIRE-
21 MENTS.—An insurance company, health maintenance or-
22 ganization, self-insurance plan, managed care plan, or
23 other health care plan or program (under the Social Secu-
24 rity Act or otherwise) may not deny a claim for benefits
25 submitted by the Service or by an Indian Tribe or Tribal

1 Organization based on the format in which the claim is
2 submitted if such format complies with the format re-
3 quired for submission of claims under title XVIII of the
4 Social Security Act or recognized under section 1175 of
5 such Act.

6 “(i) APPLICATION TO URBAN INDIAN ORGANIZA-
7 TIONS.—The previous provisions of this section shall apply
8 to urban Indian organizations with respect to populations
9 served by such Organizations in the same manner they
10 apply to Indian Tribes and Tribal Organizations with re-
11 spect to populations served by such Indian Tribes and
12 Tribal Organizations.

13 “(j) STATUTE OF LIMITATIONS.—The provisions of
14 section 2415 of title 28, United States Code, shall apply
15 to all actions commenced under this section, and the ref-
16 erences therein to the United States are deemed to include
17 Indian Tribes, Tribal Organizations, and urban Indian or-
18 ganizations.

19 “(k) SAVINGS.—Nothing in this section shall be con-
20 strued to limit any right of recovery available to the
21 United States, an Indian Tribe, or Tribal Organization
22 under the provisions of any applicable, Federal, State, or
23 Tribal law, including medical lien laws.

1 **“SEC. 404. CREDITING OF REIMBURSEMENTS.**

2 “(a) RETENTION OF AMOUNTS FOR USE BY PRO-
3 GRAM.—Except as provided in section 202(f) (relating to
4 the Catastrophic Health Emergency Fund) and section
5 806 (relating to health services for ineligible persons), all
6 reimbursements received or recovered, including under
7 section 806, by reason of the provision of health services
8 by the Service, by an Indian Tribe or Tribal Organization,
9 or by an urban Indian organization, shall be credited to
10 the Service, such Indian Tribe or Tribal Organization, or
11 such urban Indian organization, respectively, and may be
12 used as provided in section 401. In the case of such a
13 service provided by or through a Service Unit, such
14 amounts shall be credited to such unit and used for such
15 purposes.

16 “(b) NO OFFSET OF AMOUNTS.—The Service may
17 not offset or limit any amount obligated to any Service
18 Unit or entity receiving funding from the Service because
19 of the receipt of reimbursements under subsection (a).

20 **“SEC. 405. PURCHASING HEALTH CARE COVERAGE.**

21 “(a) PURCHASING COVERAGE.—

22 “(1) IN GENERAL.—Insofar as amounts are
23 made available under law (including a provision of
24 the Social Security Act, the Indian Self-Determina-
25 tion and Education Assistance Act (25 U.S.C. 450
26 et seq.), or other law, other than under section 402)

1 to Indian Tribes, Tribal Organizations, and urban
2 Indian organizations for health benefits for Service
3 beneficiaries, Indian Tribes, Tribal Organizations,
4 and urban Indian organizations may use such
5 amounts to purchase health benefits coverage that
6 qualifies as creditable coverage under section
7 2701(e)(1) of the Public Health Service Act for such
8 beneficiaries, including, subject to paragraph (2),
9 through—

10 “(A) a tribally owned and operated health
11 care plan;

12 “(B) a State or locally authorized or li-
13 censed health care plan;

14 “(C) a health insurance provider or man-
15 aged care organization; or

16 “(D) a self-insured plan.

17 “(2) EXCEPTION.—The coverage provided
18 under paragraph (1) may not include coverage con-
19 sisting of—

20 “(A) benefits provided under a health flexi-
21 ble spending arrangement (as defined in section
22 106(c)(2) of the Internal Revenue Code of
23 1986); or

24 “(B) a high deductible health plan (as de-
25 fined in section 223(c)(2) of such Code), with-

1 out regard to whether the plan is purchased in
2 conjunction with a health savings account (as
3 defined under section 223(d) of such Code).

4 “(3) PERMITTING PURCHASE OF COVERAGE
5 BASED ON FINANCIAL NEED.—The purchase of cov-
6 erage by an Indian Tribe, Tribal Organization, or
7 urban Indian organization under this subsection may
8 be based on the financial needs of beneficiaries (as
9 determined by the Indian Tribe or Tribes being
10 served based on a schedule of income levels devel-
11 oped or implemented by such Indian Tribe or
12 Tribes).

13 “(b) EXPENSES FOR SELF-INSURED PLAN.—In the
14 case of a self-insured plan under subsection (a)(4), the
15 amounts may be used for expenses of operating the plan,
16 including administration and insurance to limit the finan-
17 cial risks to the entity offering the plan.

18 “(c) CONSTRUCTION.—Nothing in this section shall
19 be construed as affecting the use of any amounts not re-
20 ferred to in subsection (a).

21 **“SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGEN-**
22 **CIES.**

23 “(a) AUTHORITY.—

24 “(1) IN GENERAL.—The Secretary may enter
25 into (or expand) arrangements for the sharing of

1 medical facilities and services between the Service,
2 Indian Tribes, and Tribal Organizations and the De-
3 partment of Veterans Affairs and the Department of
4 Defense.

5 “(2) CONSULTATION BY SECRETARY RE-
6 QUIRED.—The Secretary may not finalize any ar-
7 rangement between the Service and a Department
8 described in paragraph (1) without first consulting
9 with the Indian Tribes which will be significantly af-
10 fected by the arrangement.

11 “(b) LIMITATIONS.—The Secretary shall not take
12 any action under this section or under subchapter IV of
13 chapter 81 of title 38, United States Code, which would
14 impair—

15 “(1) the priority access of any Indian to health
16 care services provided through the Service and the
17 eligibility of any Indian to receive health services
18 through the Service;

19 “(2) the quality of health care services provided
20 to any Indian through the Service;

21 “(3) the priority access of any veteran to health
22 care services provided by the Department of Vet-
23 erans Affairs;

1 “(4) the quality of health care services provided
2 by the Department of Veterans Affairs or the De-
3 partment of Defense; or

4 “(5) the eligibility of any Indian who is a vet-
5 eran to receive health services through the Depart-
6 ment of Veterans Affairs.

7 “(c) REIMBURSEMENT.—The Service, Indian Tribe,
8 or Tribal Organization shall be reimbursed by the Depart-
9 ment of Veterans Affairs or the Department of Defense
10 (as the case may be) where services are provided through
11 the Service, an Indian Tribe, or a Tribal Organization to
12 beneficiaries eligible for services from either such Depart-
13 ment, notwithstanding any other provision of law.

14 “(d) CONSTRUCTION.—Nothing in this section may
15 be construed as creating any right of a non-Indian veteran
16 to obtain health services from the Service.

17 **“SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.**

18 “(a) FINDINGS; PURPOSE.—

19 “(1) FINDINGS.—Congress finds that—

20 “(A) collaborations between the Secretary
21 and the Secretary of Veterans Affairs regarding
22 the treatment of Indian veterans at facilities of
23 the Service should be encouraged to the max-
24 imum extent practicable; and

1 “(B) increased enrollment for services of
2 the Department of Veterans Affairs by veterans
3 who are members of Indian tribes should be en-
4 couraged to the maximum extent practicable.

5 “(2) PURPOSE.—The purpose of this section is
6 to reaffirm the goals stated in the document entitled
7 ‘Memorandum of Understanding Between the VA/
8 Veterans Health Administration And HHS/Indian
9 Health Service’ and dated February 25, 2003 (relat-
10 ing to cooperation and resource sharing between the
11 Veterans Health Administration and Service).

12 “(b) DEFINITIONS.—In this section:

13 “(1) ELIGIBLE INDIAN VETERAN.—The term
14 ‘eligible Indian veteran’ means an Indian or Alaska
15 Native veteran who receives any medical service that
16 is—

17 “(A) authorized under the laws adminis-
18 tered by the Secretary of Veterans Affairs; and

19 “(B) administered at a facility of the Serv-
20 ice (including a facility operated by an Indian
21 tribe or tribal organization through a contract
22 or compact with the Service under the Indian
23 Self-Determination and Education Assistance
24 Act (25 U.S.C. 450 et seq.)) pursuant to a local
25 memorandum of understanding.

1 “(2) LOCAL MEMORANDUM OF UNDER-
2 STANDING.—The term ‘local memorandum of under-
3 standing’ means a memorandum of understanding
4 between the Secretary (or a designee, including the
5 director of any Area Office of the Service) and the
6 Secretary of Veterans Affairs (or a designee) to im-
7 plement the document entitled ‘Memorandum of Un-
8 derstanding Between the VA/Veterans Health Ad-
9 ministration And HHS/Indian Health Service’ and
10 dated February 25, 2003 (relating to cooperation
11 and resource sharing between the Veterans Health
12 Administration and Indian Health Service).

13 “(c) ELIGIBLE INDIAN VETERANS’ EXPENSES.—

14 “(1) IN GENERAL.—Notwithstanding any other
15 provision of law, the Secretary shall provide for vet-
16 eran-related expenses incurred by eligible Indian vet-
17 erans as described in subsection (b)(1)(B).

18 “(2) METHOD OF PAYMENT.—The Secretary
19 shall establish such guidelines as the Secretary de-
20 termines to be appropriate regarding the method of
21 payments to the Secretary of Veterans Affairs under
22 paragraph (1).

23 “(d) TRIBAL APPROVAL OF MEMORANDA.—In nego-
24 tiating a local memorandum of understanding with the
25 Secretary of Veterans Affairs regarding the provision of

1 services to eligible Indian veterans, the Secretary shall
2 consult with each Indian tribe that would be affected by
3 the local memorandum of understanding.

4 “(e) FUNDING.—

5 “(1) TREATMENT.—Expenses incurred by the
6 Secretary in carrying out subsection (c)(1) shall not
7 be considered to be Contract Health Service ex-
8 penses.

9 “(2) USE OF FUNDS.—Of funds made available
10 to the Secretary in appropriations Acts for the Serv-
11 ice (excluding funds made available for facilities,
12 Contract Health Services, or contract support costs),
13 the Secretary shall use such sums as are necessary
14 to carry out this section.

15 **“SEC. 408. PAYOR OF LAST RESORT.**

16 “Indian Health Programs and health care programs
17 operated by Urban Indian Organizations shall be the
18 payor of last resort for services provided to persons eligible
19 for services from Indian Health Programs and Urban In-
20 dian Organizations, notwithstanding any Federal, State,
21 or local law to the contrary.

22 **“SEC. 409. CONSULTATION.**

23 “For provisions related to consultation with rep-
24 resentatives of Indian Health Programs and urban Indian
25 organizations with respect to the health care programs es-

1 tablished under titles XVIII, XIX, and XXI of the Social
2 Security Act, see section 1139(d) of the Social Security
3 Act (42 U.S.C. 1320b–9(d)).

4 **“SEC. 410. STATE CHILDREN’S HEALTH INSURANCE PRO-**
5 **GRAM (SCHIP).**

6 “For provisions relating to—

7 “(1) outreach to families of Indian children
8 likely to be eligible for child health assistance under
9 the State children’s health insurance program estab-
10 lished under title XXI of the Social Security Act, see
11 sections 2105(c)(2)(C) and 1139(a) of such Act (42
12 U.S.C. 1397ee(c)(2), 1320b–9); and

13 “(2) ensuring that child health assistance is
14 provided under such program to targeted low-income
15 children who are Indians and that payments are
16 made under such program to Indian Health Pro-
17 grams and urban Indian organizations operating in
18 the State that provide such assistance, see sections
19 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42
20 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).

1 **“SEC. 411. PREMIUM AND COST SHARING PROTECTIONS**
2 **AND ELIGIBILITY DETERMINATIONS UNDER**
3 **MEDICAID AND SCHIP AND PROTECTION OF**
4 **CERTAIN INDIAN PROPERTY FROM MEDICAID**
5 **ESTATE RECOVERY.**

6 “For provisions relating to—

7 “(1) premiums or cost sharing protections for
8 Indians furnished items or services directly by In-
9 dian Health Programs or through referral under the
10 contract health service under the Medicaid program
11 established under title XIX of the Social Security
12 Act, see sections 1916(j) and 1916A(a)(1) of the So-
13 cial Security Act (42 U.S.C. 1396o(j), 1396o-
14 1(a)(1));

15 “(2) rules regarding the treatment of certain
16 property for purposes of determining eligibility
17 under such programs, see sections 1902(e)(13) and
18 2107(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(13),
19 1397gg(e)(1)(B)); and

20 “(3) the protection of certain property from es-
21 tate recovery provisions under the Medicaid pro-
22 gram, see section 1917(b)(3)(B) of such Act (42
23 U.S.C. 1396p(b)(3)(B)).

1 **“SEC. 412. TREATMENT UNDER MEDICAID AND SCHIP MAN-**
2 **AGED CARE.**

3 “For provisions relating to the treatment of Indians
4 enrolled in a managed care entity under the Medicaid pro-
5 gram under title XIX of the Social Security Act and In-
6 dian Health Programs and urban Indian organizations
7 that are providers of items or services to such Indian en-
8 rollees, see sections 1932(h) and 2107(e)(1)(H) of the So-
9 cial Security Act (42 U.S.C. 1396u–2(h),
10 1397gg(e)(1)(H)).

11 **“SEC. 413. NAVAJO NATION MEDICAID AGENCY FEASI-**
12 **BILITY STUDY.**

13 “(a) STUDY.—The Secretary shall conduct a study
14 to determine the feasibility of treating the Navajo Nation
15 as a State for the purposes of title XIX of the Social Secu-
16 rity Act, to provide services to Indians living within the
17 boundaries of the Navajo Nation through an entity estab-
18 lished having the same authority and performing the same
19 functions as single-State Medicaid agencies responsible for
20 the administration of the State plan under title XIX of
21 the Social Security Act.

22 “(b) CONSIDERATIONS.—In conducting the study,
23 the Secretary shall consider the feasibility of—

24 “(1) assigning and paying all expenditures for
25 the provision of services and related administration
26 funds, under title XIX of the Social Security Act, to

1 Indians living within the boundaries of the Navajo
2 Nation that are currently paid to or would otherwise
3 be paid to the State of Arizona, New Mexico, or
4 Utah;

5 “(2) providing assistance to the Navajo Nation
6 in the development and implementation of such enti-
7 ty for the administration, eligibility, payment, and
8 delivery of medical assistance under title XIX of the
9 Social Security Act;

10 “(3) providing an appropriate level of matching
11 funds for Federal medical assistance with respect to
12 amounts such entity expends for medical assistance
13 for services and related administrative costs; and

14 “(4) authorizing the Secretary, at the option of
15 the Navajo Nation, to treat the Navajo Nation as a
16 State for the purposes of title XIX of the Social Se-
17 curity Act (relating to the State children’s health in-
18 surance program) under terms equivalent to those
19 described in paragraphs (2) through (4).

20 “(c) REPORT.—Not later than 3 years after the date
21 of enactment of the Indian Health Care Improvement Act
22 Amendments of 2009, the Secretary shall submit to the
23 Committee on Indian Affairs and Committee on Finance
24 of the Senate and the Committee on Natural Resources

1 and Committee on Energy and Commerce of the House
2 of Representatives a report that includes—

3 “(1) the results of the study under this section;

4 “(2) a summary of any consultation that oc-
5 curred between the Secretary and the Navajo Na-
6 tion, other Indian Tribes, the States of Arizona,
7 New Mexico, and Utah, counties which include Nav-
8 ajo Lands, and other interested parties, in con-
9 ducting this study;

10 “(3) projected costs or savings associated with
11 establishment of such entity, and any estimated im-
12 pact on services provided as described in this section
13 in relation to probable costs or savings; and

14 “(4) legislative actions that would be required
15 to authorize the establishment of such entity if such
16 entity is determined by the Secretary to be feasible.

17 **“SEC. 414. EXCEPTION FOR EXCEPTED BENEFITS.**

18 “The previous provisions of this title shall not apply
19 to the provision of excepted benefits described in para-
20 graph (1)(A) or (3) of section 2791(c) of the Public
21 Health Service Act (42 U.S.C. 300gg–91(c)).

22 **“SEC. 415. AUTHORIZATION OF APPROPRIATIONS.**

23 “There are authorized to be appropriated such sums
24 as may be necessary to carry out this title.

1 **“TITLE V—HEALTH SERVICES**
2 **FOR URBAN INDIANS**

3 **“SEC. 501. PURPOSE.**

4 “The purpose of this title is to establish and maintain
5 programs in Urban Centers to make health services more
6 accessible and available to Urban Indians.

7 **“SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN IN-**
8 **DIAN ORGANIZATIONS.**

9 “Under authority of the Act of November 2, 1921
10 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’),
11 the Secretary, acting through the Service, shall enter into
12 contracts with, or make grants to, urban Indian organiza-
13 tions to assist such organizations in the establishment and
14 administration, within Urban Centers, of programs which
15 meet the requirements set forth in this title. Subject to
16 section 506, the Secretary, acting through the Service,
17 shall include such conditions as the Secretary considers
18 necessary to effect the purpose of this title in any contract
19 into which the Secretary enters with, or in any grant the
20 Secretary makes to, any urban Indian organization pursu-
21 ant to this title.

22 **“SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION**
23 **OF HEALTH CARE AND REFERRAL SERVICES.**

24 “(a) REQUIREMENTS FOR GRANTS AND CON-
25 TRACTS.—Under authority of the Act of November 2,

1 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder
2 Act’), the Secretary, acting through the Service, shall
3 enter into contracts with, and make grants to, urban In-
4 dian organizations for the provision of health care and re-
5 ferral services for Urban Indians. Any such contract or
6 grant shall include requirements that the urban Indian or-
7 ganization successfully undertake to—

8 “(1) estimate the population of Urban Indians
9 residing in the Urban Center or centers that the or-
10 ganization proposes to serve who are or could be re-
11 cipients of health care or referral services;

12 “(2) estimate the current health status of
13 Urban Indians residing in such Urban Center or
14 centers;

15 “(3) estimate the current health care needs of
16 Urban Indians residing in such Urban Center or
17 centers;

18 “(4) provide basic health education, including
19 health promotion and disease prevention education,
20 to Urban Indians;

21 “(5) make recommendations to the Secretary
22 and Federal, State, local, and other resource agen-
23 cies on methods of improving health service pro-
24 grams to meet the needs of Urban Indians; and

1 “(6) where necessary, provide, or enter into
2 contracts for the provision of, health care services
3 for Urban Indians.

4 “(b) CRITERIA.—The Secretary, acting through the
5 Service, shall, by regulation, prescribe the criteria for se-
6 lecting urban Indian organizations to enter into contracts
7 or receive grants under this section. Such criteria shall,
8 among other factors, include—

9 “(1) the extent of unmet health care needs of
10 Urban Indians in the Urban Center or centers in-
11 volved;

12 “(2) the size of the urban Indian population in
13 the Urban Center or centers involved;

14 “(3) the extent, if any, to which the activities
15 set forth in subsection (a) would duplicate any
16 project funded under this title, or under any current
17 public health service project funded in a manner
18 other than pursuant to this title;

19 “(4) the capability of an urban Indian organiza-
20 tion to perform the activities set forth in subsection
21 (a) and to enter into a contract with the Secretary
22 or to meet the requirements for receiving a grant
23 under this section;

1 “(5) the satisfactory performance and success-
2 ful completion by an urban Indian organization of
3 other contracts with the Secretary under this title;

4 “(6) the appropriateness and likely effectiveness
5 of conducting the activities set forth in subsection
6 (a) in an Urban Center or centers; and

7 “(7) the extent of existing or likely future par-
8 ticipation in the activities set forth in subsection (a)
9 by appropriate health and health-related Federal,
10 State, local, and other agencies.

11 “(c) ACCESS TO HEALTH PROMOTION AND DISEASE
12 PREVENTION PROGRAMS.—The Secretary, acting through
13 the Service, shall facilitate access to or provide health pro-
14 motion and disease prevention services for Urban Indians
15 through grants made to urban Indian organizations ad-
16 ministering contracts entered into or receiving grants
17 under subsection (a).

18 “(d) IMMUNIZATION SERVICES.—

19 “(1) ACCESS OR SERVICES PROVIDED.—The
20 Secretary, acting through the Service, shall facilitate
21 access to, or provide, immunization services for
22 Urban Indians through grants made to urban Indian
23 organizations administering contracts entered into or
24 receiving grants under this section.

1 “(2) DEFINITION.—For purposes of this sub-
2 section, the term ‘immunization services’ means
3 services to provide without charge immunizations
4 against vaccine-preventable diseases.

5 “(e) BEHAVIORAL HEALTH SERVICES.—

6 “(1) ACCESS OR SERVICES PROVIDED.—The
7 Secretary, acting through the Service, shall facilitate
8 access to, or provide, behavioral health services for
9 Urban Indians through grants made to urban Indian
10 organizations administering contracts entered into or
11 receiving grants under subsection (a).

12 “(2) ASSESSMENT REQUIRED.—Except as pro-
13 vided by paragraph (3)(A), a grant may not be made
14 under this subsection to an urban Indian organiza-
15 tion until that organization has prepared, and the
16 Service has approved, an assessment of the fol-
17 lowing:

18 “(A) The behavioral health needs of the
19 urban Indian population concerned.

20 “(B) The behavioral health services and
21 other related resources available to that popu-
22 lation.

23 “(C) The barriers to obtaining those serv-
24 ices and resources.

1 “(D) The needs that are unmet by such
2 services and resources.

3 “(3) PURPOSES OF GRANTS.—Grants may be
4 made under this subsection for the following:

5 “(A) To prepare assessments required
6 under paragraph (2).

7 “(B) To provide outreach, educational, and
8 referral services to Urban Indians regarding the
9 availability of direct behavioral health services,
10 to educate Urban Indians about behavioral
11 health issues and services, and effect coordina-
12 tion with existing behavioral health providers in
13 order to improve services to Urban Indians.

14 “(C) To provide outpatient behavioral
15 health services to Urban Indians, including the
16 identification and assessment of illness, thera-
17 peutic treatments, case management, support
18 groups, family treatment, and other treatment.

19 “(D) To develop innovative behavioral
20 health service delivery models which incorporate
21 Indian cultural support systems and resources.

22 “(f) PREVENTION OF CHILD ABUSE.—

23 “(1) ACCESS OR SERVICES PROVIDED.—The
24 Secretary, acting through the Service, shall facilitate
25 access to or provide services for Urban Indians

1 through grants to urban Indian organizations ad-
2 ministering contracts entered into or receiving
3 grants under subsection (a) to prevent and treat
4 child abuse (including sexual abuse) among Urban
5 Indians.

6 “(2) EVALUATION REQUIRED.—Except as pro-
7 vided by paragraph (3)(A), a grant may not be made
8 under this subsection to an urban Indian organiza-
9 tion until that organization has prepared, and the
10 Service has approved, an assessment that documents
11 the prevalence of child abuse in the urban Indian
12 population concerned and specifies the services and
13 programs (which may not duplicate existing services
14 and programs) for which the grant is requested.

15 “(3) PURPOSES OF GRANTS.—Grants may be
16 made under this subsection for the following:

17 “(A) To prepare assessments required
18 under paragraph (2).

19 “(B) For the development of prevention,
20 training, and education programs for Urban In-
21 dians, including child education, parent edu-
22 cation, provider training on identification and
23 intervention, education on reporting require-
24 ments, prevention campaigns, and establishing

1 service networks of all those involved in Indian
2 child protection.

3 “(C) To provide direct outpatient treat-
4 ment services (including individual treatment,
5 family treatment, group therapy, and support
6 groups) to Urban Indians who are child victims
7 of abuse (including sexual abuse) or adult sur-
8 vivors of child sexual abuse, to the families of
9 such child victims, and to urban Indian per-
10 petrators of child abuse (including sexual
11 abuse).

12 “(4) CONSIDERATIONS WHEN MAKING
13 GRANTS.—In making grants to carry out this sub-
14 section, the Secretary shall take into consideration—

15 “(A) the support for the urban Indian or-
16 ganization demonstrated by the child protection
17 authorities in the area, including committees or
18 other services funded under the Indian Child
19 Welfare Act of 1978 (25 U.S.C. 1901 et seq.),
20 if any;

21 “(B) the capability and expertise dem-
22 onstrated by the urban Indian organization to
23 address the complex problem of child sexual
24 abuse in the community; and

1 “(C) the assessment required under para-
2 graph (2).

3 “(g) OTHER GRANTS.—The Secretary, acting
4 through the Service, may enter into a contract with or
5 make grants to an urban Indian organization that pro-
6 vides or arranges for the provision of health care services
7 (through satellite facilities, provider networks, or other-
8 wise) to Urban Indians in more than 1 Urban Center.

9 **“SEC. 504. USE OF FEDERAL GOVERNMENT FACILITIES AND**
10 **SOURCES OF SUPPLY.**

11 “(a) IN GENERAL.—The Secretary may permit an
12 urban Indian organization that has entered into a contract
13 or received a grant pursuant to this title, in carrying out
14 such contract or grant, to use existing facilities and all
15 equipment therein or pertaining thereto and other per-
16 sonal property owned by the Federal Government within
17 the Secretary’s jurisdiction under such terms and condi-
18 tions as may be agreed upon for their use and mainte-
19 nance.

20 “(b) DONATIONS.—Subject to subsection (d), the
21 Secretary may donate to an urban Indian organization
22 that has entered into a contract or received a grant pursu-
23 ant to this title any personal or real property determined
24 to be excess to the needs of the Indian Health Service or

1 the General Services Administration for the purposes of
2 carrying out the contract or grant.

3 “(c) ACQUISITION OF PROPERTY.—The Secretary
4 may acquire excess or surplus government personal or real
5 property for donation, subject to subsection (d) to an
6 urban Indian organization that has entered into a contract
7 or received a grant pursuant to this title if the Secretary
8 determines that the property is appropriate for use by the
9 urban Indian organization for a purpose for which a con-
10 tract or grant is authorized under this title.

11 “(d) PRIORITY.—In the event that the Secretary re-
12 ceives a request for a specific item of personal or real
13 property described in subsections (b) or (c) from an urban
14 Indian organization and from an Indian Tribe or Tribal
15 Organization, the Secretary shall give priority to the re-
16 quest for donation to the Indian Tribe or Tribal Organiza-
17 tion if the Secretary receives the request from the Indian
18 Tribe or Tribal Organization before the date the Secretary
19 transfers title to the property or, if earlier, the date the
20 Secretary transfers the property physically, to the urban
21 Indian organization.

22 “(e) EXECUTIVE AGENCY STATUS.—For purposes of
23 section 201(a) of the Federal Property and Administrative
24 Services Act of 1949 (40 U.S.C. 481(a)) (relating to Fed-
25 eral sources of supply), an urban Indian organization that

1 has entered into a contract or received a grant pursuant
2 to this title may be deemed to be an executive agency when
3 carrying out such contract or grant.

4 **“SEC. 505. CONTRACTS AND GRANTS FOR THE DETERMINA-**
5 **TION OF UNMET HEALTH CARE NEEDS.**

6 “(a) GRANTS AND CONTRACTS AUTHORIZED.—
7 Under authority of the Act of November 2, 1921 (25
8 U.S.C. 13) (commonly known as the ‘Snyder Act’), the
9 Secretary, acting through the Service, may enter into con-
10 tracts with or make grants to urban Indian organizations
11 situated in Urban Centers for which contracts have not
12 been entered into or grants have not been made under sec-
13 tion 503.

14 “(b) PURPOSE.—The purpose of a contract or grant
15 made under this section shall be the determination of the
16 matters described in subsection (c)(1) in order to assist
17 the Secretary in assessing the health status and health
18 care needs of Urban Indians in the Urban Center involved
19 and determining whether the Secretary should enter into
20 a contract or make a grant under section 503 with respect
21 to the urban Indian organization which the Secretary has
22 entered into a contract with, or made a grant to, under
23 this section.

1 “(c) GRANT AND CONTRACT REQUIREMENTS.—Any
2 contract entered into, or grant made, by the Secretary
3 under this section shall include requirements that—

4 “(1) the urban Indian organization successfully
5 undertakes to—

6 “(A) document the health care status and
7 unmet health care needs of urban Indians in
8 the Urban Center involved; and

9 “(B) with respect to urban Indians in the
10 Urban Center involved, determine the matters
11 described in paragraphs (2), (3), (4), and (7) of
12 section 503(b); and

13 “(2) the urban Indian organization complete
14 performance of the contract, or carry out the re-
15 quirements of the grant, within 1 year after the date
16 on which the Secretary and such organization enter
17 into such contract, or within 1 year after such orga-
18 nization receives such grant, whichever is applicable.

19 “(d) NO RENEWALS.—The Secretary may not renew
20 any contract entered into or grant made under this sec-
21 tion.

22 **“SEC. 506. EVALUATIONS; RENEWALS.**

23 “(a) PROCEDURES FOR EVALUATIONS.—The Sec-
24 retary, acting through the Service, shall develop proce-
25 dures to evaluate compliance with grant requirements and

1 compliance with and performance of contracts entered into
2 by urban Indian organizations under this title. Such pro-
3 cedures shall include provisions for carrying out the re-
4 quirements of this section.

5 “(b) EVALUATIONS.—The Secretary, acting through
6 the Service, shall evaluate the compliance of each Urban
7 Indian Organization which has entered into a contract or
8 received a grant under section 503 with the terms of such
9 contract or grant. For purposes of this evaluation, the
10 Secretary shall—

11 “(1) acting through the Service, conduct an an-
12 nual onsite evaluation of the organization; or

13 “(2) accept in lieu of such onsite evaluation evi-
14 dence of the organization’s provisional or full accred-
15 itation by a private independent entity recognized by
16 the Secretary for purposes of conducting quality re-
17 views of providers participating in the Medicare pro-
18 gram under title XVIII of the Social Security Act.

19 “(c) NONCOMPLIANCE; UNSATISFACTORY PERFORM-
20 ANCE.—If, as a result of the evaluations conducted under
21 this section, the Secretary determines that an urban In-
22 dian organization has not complied with the requirements
23 of a grant or complied with or satisfactorily performed a
24 contract under section 503, the Secretary shall, prior to
25 renewing such contract or grant, attempt to resolve with

1 the organization the areas of noncompliance or unsatisfac-
2 tory performance and modify the contract or grant to pre-
3 vent future occurrences of noncompliance or unsatisfac-
4 tory performance. If the Secretary determines that the
5 noncompliance or unsatisfactory performance cannot be
6 resolved and prevented in the future, the Secretary shall
7 not renew the contract or grant with the organization and
8 is authorized to enter into a contract or make a grant
9 under section 503 with another urban Indian organization
10 which is situated in the same Urban Center as the urban
11 Indian organization whose contract or grant is not re-
12 newed under this section.

13 “(d) CONSIDERATIONS FOR RENEWALS.—In deter-
14 mining whether to renew a contract or grant with an
15 urban Indian organization under section 503 which has
16 completed performance of a contract or grant under sec-
17 tion 504, the Secretary shall review the records of the
18 urban Indian organization, the reports submitted under
19 section 507, and shall consider the results of the onsite
20 evaluations or accreditations under subsection (b).

21 **“SEC. 507. OTHER CONTRACT AND GRANT REQUIREMENTS.**

22 “(a) PROCUREMENT.—Contracts with urban Indian
23 organizations entered into pursuant to this title shall be
24 in accordance with all Federal contracting laws and regu-
25 lations relating to procurement except that in the discre-

1 tion of the Secretary, such contracts may be negotiated
2 without advertising and need not conform to the provisions
3 of sections 1304 and 3131 through 3133 of title 40,
4 United States Code.

5 “(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—

6 “(1) IN GENERAL.—Payments under any con-
7 tracts or grants pursuant to this title, notwith-
8 standing any term or condition of such contract or
9 grant—

10 “(A) may be made in a single advance pay-
11 ment by the Secretary to the urban Indian or-
12 ganization by no later than the end of the first
13 30 days of the funding period with respect to
14 which the payments apply, unless the Secretary
15 determines through an evaluation under section
16 505 that the organization is not capable of ad-
17 ministering such a single advance payment; and

18 “(B) if any portion thereof is unexpended
19 by the urban Indian organization during the
20 funding period with respect to which the pay-
21 ments initially apply, shall be carried forward
22 for expenditure with respect to allowable or re-
23 imburseable costs incurred by the organization
24 during 1 or more subsequent funding periods
25 without additional justification or documenta-

1 tion by the organization as a condition of car-
2 rying forward the availability for expenditure of
3 such funds.

4 “(2) SEMIANNUAL AND QUARTERLY PAYMENTS
5 AND REIMBURSEMENTS.—If the Secretary deter-
6 mines under paragraph (1)(A) that an urban Indian
7 organization is not capable of administering an en-
8 tire single advance payment, on request of the urban
9 Indian organization, the payments may be made—

10 “(A) in semiannual or quarterly payments
11 by not later than 30 days after the date on
12 which the funding period with respect to which
13 the payments apply begins; or

14 “(B) by way of reimbursement.

15 “(c) REVISION OR AMENDMENT OF CONTRACTS.—
16 Notwithstanding any provision of law to the contrary, the
17 Secretary may, at the request and consent of an urban
18 Indian organization, revise or amend any contract entered
19 into by the Secretary with such organization under this
20 title as necessary to carry out the purposes of this title.

21 “(d) FAIR AND UNIFORM SERVICES AND ASSIST-
22 ANCE.—Contracts with or grants to urban Indian organi-
23 zations and regulations adopted pursuant to this title shall
24 include provisions to assure the fair and uniform provision

1 to urban Indians of services and assistance under such
2 contracts or grants by such organizations.

3 **“SEC. 508. REPORTS AND RECORDS.**

4 “(a) REPORTS.—

5 “(1) IN GENERAL.—For each fiscal year during
6 which an urban Indian organization receives or ex-
7 pends funds pursuant to a contract entered into or
8 a grant received pursuant to this title, such urban
9 Indian organization shall submit to the Secretary
10 not more frequently than every 6 months, a report
11 that includes the following:

12 “(A) In the case of a contract or grant
13 under section 503, recommendations pursuant
14 to section 503(a)(5).

15 “(B) Information on activities conducted
16 by the organization pursuant to the contract or
17 grant.

18 “(C) An accounting of the amounts and
19 purpose for which Federal funds were ex-
20 pended.

21 “(D) A minimum set of data, using uni-
22 formly defined elements, as specified by the
23 Secretary after consultation with urban Indian
24 organizations.

25 “(2) HEALTH STATUS AND SERVICES.—

1 “(A) IN GENERAL.—Not later than 18
2 months after the date of enactment of the In-
3 dian Health Care Improvement Act Amend-
4 ments of 2009, the Secretary, acting through
5 the Service, shall submit to Congress a report
6 evaluating—

7 “(i) the health status of urban Indi-
8 ans;

9 “(ii) the services provided to Indians
10 pursuant to this title; and

11 “(iii) areas of unmet needs in the de-
12 livery of health services to urban Indians.

13 “(B) CONSULTATION AND CONTRACTS.—
14 In preparing the report under paragraph (1),
15 the Secretary—

16 “(i) shall consult with urban Indian
17 organizations; and

18 “(ii) may enter into a contract with a
19 national organization representing urban
20 Indian organizations to conduct any aspect
21 of the report.

22 “(b) AUDIT.—The reports and records of the urban
23 Indian organization with respect to a contract or grant
24 under this title shall be subject to audit by the Secretary
25 and the Comptroller General of the United States.

1 “(c) COSTS OF AUDITS.—The Secretary shall allow
2 as a cost of any contract or grant entered into or awarded
3 under section 502 or 503 the cost of an annual inde-
4 pendent financial audit conducted by—

5 “(1) a certified public accountant; or

6 “(2) a certified public accounting firm qualified
7 to conduct Federal compliance audits.

8 **“SEC. 509. LIMITATION ON CONTRACT AUTHORITY.**

9 “The authority of the Secretary to enter into con-
10 tracts or to award grants under this title shall be to the
11 extent, and in an amount, provided for in appropriation
12 Acts.

13 **“SEC. 510. FACILITIES.**

14 “(a) GRANTS.—The Secretary, acting through the
15 Service, may make grants to contractors or grant recipi-
16 ents under this title for the lease, purchase, renovation,
17 construction, or expansion of facilities, including leased fa-
18 cilities, in order to assist such contractors or grant recipi-
19 ents in complying with applicable licensure or certification
20 requirements.

21 “(b) LOAN FUND STUDY.—The Secretary, acting
22 through the Service, may carry out a study to determine
23 the feasibility of establishing a loan fund to provide to
24 urban Indian organizations direct loans or guarantees for
25 loans for the construction of health care facilities in a

1 manner consistent with section 309, including by submit-
2 ting a report in accordance with subsection (c) of that sec-
3 tion.

4 **“SEC. 511. DIVISION OF URBAN INDIAN HEALTH.**

5 “There is established within the Service a Division
6 of Urban Indian Health, which shall be responsible for—

7 “(1) carrying out the provisions of this title;

8 “(2) providing central oversight of the pro-
9 grams and services authorized under this title; and

10 “(3) providing technical assistance to urban In-
11 dian organizations.

12 **“SEC. 512. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-**
13 **RELATED SERVICES.**

14 “(a) GRANTS AUTHORIZED.—The Secretary, acting
15 through the Service, may make grants for the provision
16 of health-related services in prevention of, treatment of,
17 rehabilitation of, or school- and community-based edu-
18 cation regarding, alcohol and substance abuse in Urban
19 Centers to those urban Indian organizations with which
20 the Secretary has entered into a contract under this title
21 or under section 201.

22 “(b) GOALS.—Each grant made pursuant to sub-
23 section (a) shall set forth the goals to be accomplished
24 pursuant to the grant. The goals shall be specific to each
25 grant as agreed to between the Secretary and the grantee.

1 “(c) CRITERIA.—The Secretary shall establish cri-
2 teria for the grants made under subsection (a), including
3 criteria relating to the following:

4 “(1) The size of the urban Indian population.

5 “(2) Capability of the organization to ade-
6 quately perform the activities required under the
7 grant.

8 “(3) Satisfactory performance standards for the
9 organization in meeting the goals set forth in such
10 grant. The standards shall be negotiated and agreed
11 to between the Secretary and the grantee on a
12 grant-by-grant basis.

13 “(4) Identification of the need for services.

14 “(d) ALLOCATION OF GRANTS.—The Secretary shall
15 develop a methodology for allocating grants made pursu-
16 ant to this section based on the criteria established pursu-
17 ant to subsection (c).

18 “(e) GRANTS SUBJECT TO CRITERIA.—Any grant re-
19 ceived by an urban Indian organization under this Act for
20 substance abuse prevention, treatment, and rehabilitation
21 shall be subject to the criteria set forth in subsection (c).

1 **“SEC. 513. TREATMENT OF CERTAIN DEMONSTRATION**
2 **PROJECTS.**

3 “Notwithstanding any other provision of law, the
4 Tulsa Clinic and Oklahoma City Clinic demonstration
5 projects shall—

6 “(1) be permanent programs within the Serv-
7 ice’s direct care program;

8 “(2) continue to be treated as Service Units
9 and Operating Units in the allocation of resources
10 and coordination of care; and

11 “(3) continue to meet the requirements and
12 definitions of an urban Indian organization in this
13 Act, and shall not be subject to the provisions of the
14 Indian Self-Determination and Education Assistance
15 Act (25 U.S.C. 450 et seq.).

16 **“SEC. 514. URBAN NIAAA TRANSFERRED PROGRAMS.**

17 “(a) GRANTS AND CONTRACTS.—The Secretary,
18 through the Division of Urban Indian Health, shall make
19 grants or enter into contracts with urban Indian organiza-
20 tions, to take effect not later than September 30, 2010,
21 for the administration of urban Indian alcohol programs
22 that were originally established under the National Insti-
23 tute on Alcoholism and Alcohol Abuse (hereafter in this
24 section referred to as ‘NIAAA’) and transferred to the
25 Service.

1 “(b) USE OF FUNDS.—Grants provided or contracts
2 entered into under this section shall be used to provide
3 support for the continuation of alcohol prevention and
4 treatment services for urban Indian populations and such
5 other objectives as are agreed upon between the Service
6 and a recipient of a grant or contract under this section.

7 “(c) ELIGIBILITY.—Urban Indian organizations that
8 operate Indian alcohol programs originally funded under
9 the NIAAA and subsequently transferred to the Service
10 are eligible for grants or contracts under this section.

11 “(d) REPORT.—The Secretary shall evaluate and re-
12 port to Congress on the activities of programs funded
13 under this section not less than every 5 years.

14 **“SEC. 515. CONFERRING WITH URBAN INDIAN ORGANIZA-**
15 **TIONS.**

16 “(a) IN GENERAL.—The Secretary shall ensure that
17 the Service confers or conferences, to the greatest extent
18 practicable, with Urban Indian Organizations.

19 “(b) DEFINITION OF CONFER; CONFERENCE.—In
20 this section, the terms ‘confer’ and ‘conference’ mean an
21 open and free exchange of information and opinions
22 that—

23 “(1) leads to mutual understanding and com-
24 prehension; and

1 “(2) emphasizes trust, respect, and shared re-
2 sponsibility.

3 **“SEC. 516. URBAN YOUTH TREATMENT CENTER DEM-**
4 **ONSTRATION.**

5 “(a) CONSTRUCTION AND OPERATION.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Service, through grant or contract, shall
8 fund the construction and operation of at least 1
9 residential treatment center in each Service Area
10 that meets the eligibility requirements set forth in
11 subsection (b) to demonstrate the provision of alco-
12 hol and substance abuse treatment services to Urban
13 Indian youth in a culturally competent residential
14 setting.

15 “(2) TREATMENT.—Each residential treatment
16 center described in paragraph (1) shall be in addi-
17 tion to any facilities constructed under section
18 707(b).

19 “(b) ELIGIBILITY REQUIREMENTS.—To be eligible to
20 obtain a facility under subsection (a)(1), a Service Area
21 shall meet the following requirements:

22 “(1) There is an Urban Indian Organization in
23 the Service Area.

1 “(2) There reside in the Service Area Urban In-
2 dian youth with need for alcohol and substance
3 abuse treatment services in a residential setting.

4 “(3) There is a significant shortage of cul-
5 turally competent residential treatment services for
6 Urban Indian youth in the Service Area.

7 **“SEC. 517. GRANTS FOR DIABETES PREVENTION, TREAT-**
8 **MENT, AND CONTROL.**

9 “(a) GRANTS AUTHORIZED.—The Secretary may
10 make grants to those urban Indian organizations that
11 have entered into a contract or have received a grant
12 under this title for the provision of services for the preven-
13 tion and treatment of, and control of the complications
14 resulting from, diabetes among urban Indians.

15 “(b) GOALS.—Each grant made pursuant to sub-
16 section (a) shall set forth the goals to be accomplished
17 under the grant. The goals shall be specific to each grant
18 as agreed to between the Secretary and the grantee.

19 “(c) ESTABLISHMENT OF CRITERIA.—The Secretary
20 shall establish criteria for the grants made under sub-
21 section (a) relating to—

22 “(1) the size and location of the urban Indian
23 population to be served;

24 “(2) the need for prevention of and treatment
25 of, and control of the complications resulting from,

1 diabetes among the urban Indian population to be
2 served;

3 “(3) performance standards for the organiza-
4 tion in meeting the goals set forth in such grant
5 that are negotiated and agreed to by the Secretary
6 and the grantee;

7 “(4) the capability of the organization to ade-
8 quately perform the activities required under the
9 grant; and

10 “(5) the willingness of the organization to col-
11 laborate with the registry, if any, established by the
12 Secretary under section 203(e)(1)(B) in the Area
13 Office of the Service in which the organization is lo-
14 cated.

15 “(d) FUNDS SUBJECT TO CRITERIA.—Any funds re-
16 ceived by an urban Indian organization under this Act for
17 the prevention, treatment, and control of diabetes among
18 urban Indians shall be subject to the criteria developed
19 by the Secretary under subsection (c).

20 **“SEC. 518. COMMUNITY HEALTH REPRESENTATIVES.**

21 “The Secretary, acting through the Service, may
22 enter into contracts with, and make grants to, urban In-
23 dian organizations for the employment of Indians trained
24 as health service providers through the Community Health
25 Representatives Program under section 109 in the provi-

1 sion of health care, health promotion, and disease preven-
2 tion services to urban Indians.

3 **“SEC. 519. EFFECTIVE DATE.**

4 “The amendments made by the Indian Health Care
5 Improvement Act Amendments of 2009 to this title shall
6 take effect beginning on the date of enactment of that Act,
7 regardless of whether the Secretary has promulgated regu-
8 lations implementing such amendments.

9 **“SEC. 520. ELIGIBILITY FOR SERVICES.**

10 “Urban Indians shall be eligible for, and the ultimate
11 beneficiaries of, health care or referral services provided
12 pursuant to this title.

13 **“SEC. 521. AUTHORIZATION OF APPROPRIATIONS.**

14 “(a) IN GENERAL.—There are authorized to be ap-
15 propriated such sums as may be necessary to carry out
16 this title.

17 “(b) URBAN INDIAN ORGANIZATIONS.—The Sec-
18 retary, acting through the Service, is authorized to estab-
19 lish programs, including programs for the awarding of
20 grants, for urban Indian organizations that are identical
21 to any programs established pursuant to section 126 (be-
22 havioral health training), section 209 (school health edu-
23 cation), section 211 (prevention of communicable dis-
24 eases), section 701 (behavioral health prevention and

1 treatment services), and section 707(g) (multidrug abuse
2 program).

3 **“SEC. 522. HEALTH INFORMATION TECHNOLOGY.**

4 “The Secretary, acting through the Service, may
5 make grants to urban Indian organizations under this title
6 for the development, adoption, and implementation of
7 health information technology (as defined in section
8 3000(5) of the American Recovery and Reinvestment Act),
9 telemedicine services development, and related infrastruc-
10 ture.

11 **“TITLE VI—ORGANIZATIONAL**
12 **IMPROVEMENTS**

13 **“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
14 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
15 **SERVICE.**

16 “(a) ESTABLISHMENT.—

17 “(1) IN GENERAL.—In order to more effectively
18 and efficiently carry out the responsibilities, authori-
19 ties, and functions of the United States to provide
20 health care services to Indians and Indian Tribes, as
21 are or may be hereafter provided by Federal statute
22 or treaties, there is established within the Public
23 Health Service of the Department the Indian Health
24 Service.

1 “(2) ASSISTANT SECRETARY OF INDIAN
2 HEALTH.—The Service shall be administered by an
3 Assistant Secretary of Indian Health, who shall be
4 appointed by the President, by and with the advice
5 and consent of the Senate. The Assistant Secretary
6 shall report to the Secretary. Effective with respect
7 to an individual appointed by the President, by and
8 with the advice and consent of the Senate, after
9 January 1, 2010, the term of service of the Assist-
10 ant Secretary shall be 4 years. An Assistant Sec-
11 retary may serve more than 1 term.

12 “(3) INCUMBENT.—The individual serving in
13 the position of Director of the Service on the day be-
14 fore the date of enactment of the Indian Health
15 Care Improvement Act Amendments of 2009 shall
16 serve as Assistant Secretary.

17 “(4) ADVOCACY AND CONSULTATION.—The po-
18 sition of Assistant Secretary is established to, in a
19 manner consistent with the government-to-govern-
20 ment relationship between the United States and In-
21 dian Tribes—

22 “(A) facilitate advocacy for the develop-
23 ment of appropriate Indian health policy; and

24 “(B) promote consultation on matters re-
25 lating to Indian health.

1 “(b) AGENCY.—The Service shall be an agency within
2 the Public Health Service of the Department, and shall
3 not be an office, component, or unit of any other agency
4 of the Department.

5 “(c) DUTIES.—The Assistant Secretary shall—

6 “(1) perform all functions that were, on the day
7 before the date of enactment of the Indian Health
8 Care Improvement Act Amendments of 2009, car-
9 ried out by or under the direction of the individual
10 serving as Director of the Service on that day;

11 “(2) perform all functions of the Secretary re-
12 lating to the maintenance and operation of hospital
13 and health facilities for Indians and the planning
14 for, and provision and utilization of, health services
15 for Indians;

16 “(3) administer all health programs under
17 which health care is provided to Indians based upon
18 their status as Indians which are administered by
19 the Secretary, including programs under—

20 “(A) this Act;

21 “(B) the Act of November 2, 1921 (25
22 U.S.C. 13);

23 “(C) the Act of August 5, 1954 (42 U.S.C.
24 2001 et seq.);

1 “(D) the Act of August 16, 1957 (42
2 U.S.C. 2005 et seq.); and

3 “(E) the Indian Self-Determination and
4 Education Assistance Act (25 U.S.C. 450 et
5 seq.);

6 “(4) administer all scholarship and loan func-
7 tions carried out under title I;

8 “(5) report directly to the Secretary concerning
9 all policy- and budget-related matters affecting In-
10 dian health;

11 “(6) collaborate with the Assistant Secretary
12 for Health concerning appropriate matters of Indian
13 health that affect the agencies of the Public Health
14 Service;

15 “(7) advise each Assistant Secretary of the De-
16 partment concerning matters of Indian health with
17 respect to which that Assistant Secretary has au-
18 thority and responsibility;

19 “(8) advise the heads of other agencies and pro-
20 grams of the Department concerning matters of In-
21 dian health with respect to which those heads have
22 authority and responsibility;

23 “(9) coordinate the activities of the Department
24 concerning matters of Indian health; and

1 “(10) perform such other functions as the Sec-
2 retary may designate.

3 “(d) AUTHORITY.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Assistant Secretary, shall have the au-
6 thority—

7 “(A) except to the extent provided for in
8 paragraph (2), to appoint and compensate em-
9 ployees for the Service in accordance with title
10 5, United States Code;

11 “(B) to enter into contracts for the pro-
12 curement of goods and services to carry out the
13 functions of the Service; and

14 “(C) to manage, expend, and obligate all
15 funds appropriated for the Service.

16 “(2) PERSONNEL ACTIONS.—Notwithstanding
17 any other provision of law, the provisions of section
18 12 of the Act of June 18, 1934 (48 Stat. 986; 25
19 U.S.C. 472), shall apply to all personnel actions
20 taken with respect to new positions created within
21 the Service as a result of its establishment under
22 subsection (a).

23 “(e) REFERENCES.—Any reference to the Director of
24 the Indian Health Service in any other Federal law, Exec-
25 utive order, rule, regulation, or delegation of authority, or

1 in any document of or relating to the Director of the In-
2 dian Health Service, shall be deemed to refer to the Assist-
3 ant Secretary.

4 **“SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYS-**
5 **TEM.**

6 “(a) ESTABLISHMENT.—

7 “(1) IN GENERAL.—The Secretary shall estab-
8 lish an automated management information system
9 for the Service.

10 “(2) REQUIREMENTS OF SYSTEM.—The infor-
11 mation system established under paragraph (1) shall
12 include—

13 “(A) a financial management system;

14 “(B) a patient care information system for
15 each area served by the Service;

16 “(C) privacy protections consistent with
17 the regulations promulgated under section
18 264(c) of the Health Insurance Portability and
19 Accountability Act of 1996 or, to the extent
20 consistent with such regulations, other Federal
21 rules applicable to privacy of automated man-
22 agement information systems of a Federal
23 agency;

24 “(D) a services-based cost accounting com-
25 ponent that provides estimates of the costs as-

1 sociated with the provision of specific medical
2 treatments or services in each Area office of the
3 Service;

4 “(E) an interface mechanism for patient
5 billing and accounts receivable system; and

6 “(F) a training component.

7 “(b) PROVISION OF SYSTEMS TO TRIBES AND ORGA-
8 NIZATIONS.—The Secretary shall provide each Tribal
9 Health Program automated management information sys-
10 tems which—

11 “(1) meet the management information needs
12 of such Tribal Health Program with respect to the
13 treatment by the Tribal Health Program of patients
14 of the Service; and

15 “(2) meet the management information needs
16 of the Service.

17 “(c) ACCESS TO RECORDS.—The Service shall pro-
18 vide access of patients to their medical or health records
19 which are held by, or on behalf of, the Service in accord-
20 ance with the regulations promulgated under section
21 264(c) of the Health Insurance Portability and Account-
22 ability Act of 1996 or, to the extent consistent with such
23 regulations, other Federal rules applicable to access to
24 health care records.

1 “(d) AUTHORITY TO ENHANCE INFORMATION TECH-
2 NOLOGY.—The Secretary, acting through the Assistant
3 Secretary, shall have the authority to enter into contracts,
4 agreements, or joint ventures with other Federal agencies,
5 States, private and nonprofit organizations, for the pur-
6 pose of enhancing information technology in Indian
7 Health Programs and facilities.

8 **“SEC. 603. AUTHORIZATION OF APPROPRIATIONS.**

9 “There is authorized to be appropriated such sums
10 as may be necessary to carry out this title.

11 **“TITLE VII—BEHAVIORAL**
12 **HEALTH PROGRAMS**

13 **“SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREAT-**
14 **MENT SERVICES.**

15 “(a) PURPOSES.—The purposes of this section are as
16 follows:

17 “(1) To authorize and direct the Secretary, act-
18 ing through the Service, to develop a comprehensive
19 behavioral health prevention and treatment program
20 which emphasizes collaboration among alcohol and
21 substance abuse, social services, and mental health
22 programs.

23 “(2) To provide information, direction, and
24 guidance relating to mental illness and dysfunction
25 and self-destructive behavior, including child abuse

1 and family violence, to those Federal, tribal, State,
2 and local agencies responsible for programs in In-
3 dian communities in areas of health care, education,
4 social services, child and family welfare, alcohol and
5 substance abuse, law enforcement, and judicial serv-
6 ices.

7 “(3) To assist Indian Tribes to identify services
8 and resources available to address mental illness and
9 dysfunctional and self-destructive behavior.

10 “(4) To provide authority and opportunities for
11 Indian Tribes and Tribal Organizations to develop,
12 implement, and coordinate with community-based
13 programs which include identification, prevention,
14 education, referral, and treatment services, including
15 through multidisciplinary resource teams.

16 “(5) To ensure that Indians, as citizens of the
17 United States and of the States in which they re-
18 side, have the same access to behavioral health serv-
19 ices to which all citizens have access.

20 “(6) To modify or supplement existing pro-
21 grams and authorities in the areas identified in
22 paragraph (2).

23 “(b) PLANS.—

24 “(1) DEVELOPMENT.—The Secretary, acting
25 through the Service, shall encourage Indian Tribes

1 and Tribal Organizations to develop tribal plans,
2 and urban Indian organizations to develop local
3 plans, and for all such groups to participate in de-
4 veloping areawide plans for Indian Behavioral
5 Health Services. The plans shall include, to the ex-
6 tent feasible, the following components:

7 “(A) An assessment of the scope of alcohol
8 or other substance abuse, mental illness, and
9 dysfunctional and self-destructive behavior, in-
10 cluding suicide, child abuse, and family vio-
11 lence, among Indians, including—

12 “(i) the number of Indians served who
13 are directly or indirectly affected by such
14 illness or behavior; or

15 “(ii) an estimate of the financial and
16 human cost attributable to such illness or
17 behavior.

18 “(B) An assessment of the existing and
19 additional resources necessary for the preven-
20 tion and treatment of such illness and behavior,
21 including an assessment of the progress toward
22 achieving the availability of the full continuum
23 of care described in subsection (c).

24 “(C) An estimate of the additional funding
25 needed by the Service, Indian Tribes, Tribal

1 Organizations, and urban Indian organizations
2 to meet their responsibilities under the plans.

3 “(2) NATIONAL CLEARINGHOUSE.—The Sec-
4 retary, acting through the Service, shall coordinate
5 with existing national clearinghouses and informa-
6 tion centers to include at the clearinghouses and
7 centers plans and reports on the outcomes of such
8 plans developed by Indian Tribes, Tribal Organiza-
9 tions, urban Indian organizations, and Service Areas
10 relating to behavioral health. The Secretary shall en-
11 sure access to these plans and outcomes by any In-
12 dian Tribe, Tribal Organization, urban Indian orga-
13 nization, or the Service.

14 “(3) TECHNICAL ASSISTANCE.—The Secretary
15 shall provide technical assistance to Indian Tribes,
16 Tribal Organizations, and urban Indian organiza-
17 tions in preparation of plans under this section and
18 in developing standards of care that may be used
19 and adopted locally.

20 “(c) PROGRAMS.—The Secretary, acting through the
21 Service, shall provide, to the extent feasible and if funding
22 is available, programs including the following:

23 “(1) COMPREHENSIVE CARE.—A comprehensive
24 continuum of behavioral health care which pro-
25 vides—

1 “(A) community-based prevention, inter-
2 vention, outpatient, and behavioral health
3 aftercare;

4 “(B) detoxification (social and medical);

5 “(C) acute hospitalization;

6 “(D) intensive outpatient/day treatment;

7 “(E) residential treatment;

8 “(F) transitional living for those needing a
9 temporary, stable living environment that is
10 supportive of treatment and recovery goals;

11 “(G) emergency shelter;

12 “(H) intensive case management; and

13 “(I) diagnostic services.

14 “(2) CHILD CARE.—Behavioral health services
15 for Indians from birth through age 17, including—

16 “(A) preschool and school age fetal alcohol
17 disorder services, including assessment and be-
18 havioral intervention;

19 “(B) mental health and substance abuse
20 services (emotional, organic, alcohol, drug, in-
21 halant, and tobacco);

22 “(C) identification and treatment of co-oc-
23 curring disorders and comorbidity;

24 “(D) prevention of alcohol, drug, inhalant,
25 and tobacco use;

1 “(E) early intervention, treatment, and
2 aftercare;

3 “(F) promotion of healthy approaches to
4 risk and safety issues; and

5 “(G) identification and treatment of ne-
6 glect and physical, mental, and sexual abuse.

7 “(3) ADULT CARE.—Behavioral health services
8 for Indians from age 18 through 55, including—

9 “(A) early intervention, treatment, and
10 aftercare;

11 “(B) mental health and substance abuse
12 services (emotional, alcohol, drug, inhalant, and
13 tobacco), including sex specific services;

14 “(C) identification and treatment of co-oc-
15 curring disorders (dual diagnosis) and comor-
16 bidity;

17 “(D) promotion of healthy approaches for
18 risk-related behavior;

19 “(E) treatment services for women at risk
20 of giving birth to a child with a fetal alcohol
21 disorder; and

22 “(F) sex specific treatment for sexual as-
23 sault and domestic violence.

24 “(4) FAMILY CARE.—Behavioral health services
25 for families, including—

1 “(A) early intervention, treatment, and
2 aftercare for affected families;

3 “(B) treatment for sexual assault and do-
4 mestic violence; and

5 “(C) promotion of healthy approaches re-
6 lating to parenting, domestic violence, and other
7 abuse issues.

8 “(5) ELDER CARE.—Behavioral health services
9 for Indians 56 years of age and older, including—

10 “(A) early intervention, treatment, and
11 aftercare;

12 “(B) mental health and substance abuse
13 services (emotional, alcohol, drug, inhalant, and
14 tobacco), including sex specific services;

15 “(C) identification and treatment of co-oc-
16 curring disorders (dual diagnosis) and comor-
17 bidity;

18 “(D) promotion of healthy approaches to
19 managing conditions related to aging;

20 “(E) sex specific treatment for sexual as-
21 sault, domestic violence, neglect, physical and
22 mental abuse and exploitation; and

23 “(F) identification and treatment of de-
24 mentias regardless of cause.

25 “(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

1 “(1) ESTABLISHMENT.—The governing body of
2 any Indian Tribe, Tribal Organization, or urban In-
3 dian organization may adopt a resolution for the es-
4 tablishment of a community behavioral health plan
5 providing for the identification and coordination of
6 available resources and programs to identify, pre-
7 vent, or treat substance abuse, mental illness, or
8 dysfunctional and self-destructive behavior, including
9 child abuse and family violence, among its members
10 or its service population. This plan should include
11 behavioral health services, social services, intensive
12 outpatient services, and continuing aftercare.

13 “(2) TECHNICAL ASSISTANCE.—At the request
14 of an Indian Tribe, Tribal Organization, or urban
15 Indian organization, the Bureau of Indian Affairs
16 and the Service shall cooperate with and provide
17 technical assistance to the Indian Tribe, Tribal Or-
18 ganization, or urban Indian organization in the de-
19 velopment and implementation of such plan.

20 “(3) FUNDING.—The Secretary, acting through
21 the Service, may make funding available to Indian
22 Tribes and Tribal Organizations which adopt a reso-
23 lution pursuant to paragraph (1) to obtain technical
24 assistance for the development of a community be-

1 update any existing memoranda of agreement, as required
2 by section 4205 of the Indian Alcohol and Substance
3 Abuse Prevention and Treatment Act of 1986 (25 U.S.C.
4 2411) under which the Secretaries address the following:

5 “(1) The scope and nature of mental illness and
6 dysfunctional and self-destructive behavior, including
7 child abuse and family violence, among Indians.

8 “(2) The existing Federal, tribal, State, local,
9 and private services, resources, and programs avail-
10 able to provide behavioral health services for Indi-
11 ans.

12 “(3) The unmet need for additional services, re-
13 sources, and programs necessary to meet the needs
14 identified pursuant to paragraph (1).

15 “(4)(A) The right of Indians, as citizens of the
16 United States and of the States in which they re-
17 side, to have access to behavioral health services to
18 which all citizens have access.

19 “(B) The right of Indians to participate in, and
20 receive the benefit of, such services.

21 “(C) The actions necessary to protect the exer-
22 cise of such right.

23 “(5) The responsibilities of the Bureau of In-
24 dian Affairs and the Service, including mental illness
25 identification, prevention, education, referral, and

1 treatment services (including services through multi-
2 disciplinary resource teams), at the central, area,
3 and agency and Service Unit, Service Area, and
4 headquarters levels to address the problems identi-
5 fied in paragraph (1).

6 “(6) A strategy for the comprehensive coordina-
7 tion of the behavioral health services provided by the
8 Bureau of Indian Affairs and the Service to meet
9 the problems identified pursuant to paragraph (1),
10 including—

11 “(A) the coordination of alcohol and sub-
12 stance abuse programs of the Service, the Bu-
13 reau of Indian Affairs, and Indian Tribes and
14 Tribal Organizations (developed under the In-
15 dian Alcohol and Substance Abuse Prevention
16 and Treatment Act of 1986 (25 U.S.C. 2401 et
17 seq.)) with behavioral health initiatives pursu-
18 ant to this Act, particularly with respect to the
19 referral and treatment of dually diagnosed indi-
20 viduals requiring behavioral health and sub-
21 stance abuse treatment; and

22 “(B) ensuring that the Bureau of Indian
23 Affairs and Service programs and services (in-
24 cluding multidisciplinary resource teams) ad-
25 dressing child abuse and family violence are co-

1 ordinated with such non-Federal programs and
2 services.

3 “(7) Directing appropriate officials of the Bu-
4 reau of Indian Affairs and the Service, particularly
5 at the agency and Service Unit levels, to cooperate
6 fully with tribal requests made pursuant to commu-
7 nity behavioral health plans adopted under section
8 701(c) and section 4206 of the Indian Alcohol and
9 Substance Abuse Prevention and Treatment Act of
10 1986 (25 U.S.C. 2412).

11 “(8) Providing for an annual review of such
12 agreement by the Secretaries which shall be provided
13 to Congress and Indian Tribes and Tribal Organiza-
14 tions.

15 “(b) SPECIFIC PROVISIONS REQUIRED.—The memo-
16 randa of agreement updated or entered into pursuant to
17 subsection (a) shall include specific provisions pursuant to
18 which the Service shall assume responsibility for—

19 “(1) the determination of the scope of the prob-
20 lem of alcohol and substance abuse among Indians,
21 including the number of Indians within the jurisdic-
22 tion of the Service who are directly or indirectly af-
23 fected by alcohol and substance abuse and the finan-
24 cial and human cost;

1 “(2) an assessment of the existing and needed
2 resources necessary for the prevention of alcohol and
3 substance abuse and the treatment of Indians af-
4 fected by alcohol and substance abuse; and

5 “(3) an estimate of the funding necessary to
6 adequately support a program of prevention of alco-
7 hol and substance abuse and treatment of Indians
8 affected by alcohol and substance abuse.

9 “(c) PUBLICATION.—Each memorandum of agree-
10 ment entered into or renewed (and amendments or modi-
11 fications thereto) under subsection (a) shall be published
12 in the Federal Register. At the same time as publication
13 in the Federal Register, the Secretary shall provide a copy
14 of such memoranda, amendment, or modification to each
15 Indian Tribe, Tribal Organization, and urban Indian orga-
16 nization.

17 **“SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PRE-**
18 **VENTION AND TREATMENT PROGRAM.**

19 “(a) ESTABLISHMENT.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Service, shall provide a program of com-
22 prehensive behavioral health, prevention, treatment,
23 and aftercare, including Systems of Care, which
24 shall include—

1 “(A) prevention, through educational inter-
2 vention, in Indian communities;

3 “(B) acute detoxification, psychiatric hos-
4 pitalization, residential, and intensive outpatient
5 treatment;

6 “(C) community-based rehabilitation and
7 aftercare;

8 “(D) community education and involve-
9 ment, including extensive training of health
10 care, educational, and community-based per-
11 sonnel;

12 “(E) specialized residential treatment pro-
13 grams for high-risk populations, including preg-
14 nant and postpartum women and their children;
15 and

16 “(F) diagnostic services.

17 “(2) TARGET POPULATIONS.—The target popu-
18 lation of such programs shall be members of Indian
19 Tribes. Efforts to train and educate key members of
20 the Indian community shall also target employees of
21 health, education, judicial, law enforcement, legal,
22 and social service programs.

23 “(b) CONTRACT HEALTH SERVICES.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Service, may enter into contracts with

1 public or private providers of behavioral health treat-
2 ment services for the purpose of carrying out the
3 program required under subsection (a).

4 “(2) PROVISION OF ASSISTANCE.—In carrying
5 out this subsection, the Secretary shall provide as-
6 sistance to Indian Tribes and Tribal Organizations
7 to develop criteria for the certification of behavioral
8 health service providers and accreditation of service
9 facilities which meet minimum standards for such
10 services and facilities.

11 **“SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.**

12 “(a) IN GENERAL.—Under the authority of the Act
13 of November 2, 1921 (25 U.S.C. 13) (commonly known
14 as the ‘Snyder Act’), the Secretary shall establish and
15 maintain a mental health technician program within the
16 Service which—

17 “(1) provides for the training of Indians as
18 mental health technicians; and

19 “(2) employs such technicians in the provision
20 of community-based mental health care that includes
21 identification, prevention, education, referral, and
22 treatment services.

23 “(b) PARAPROFESSIONAL TRAINING.—In carrying
24 out subsection (a), the Secretary, acting through the Serv-
25 ice, shall provide high-standard paraprofessional training

1 in mental health care necessary to provide quality care to
2 the Indian communities to be served. Such training shall
3 be based upon a curriculum developed or approved by the
4 Secretary which combines education in the theory of men-
5 tal health care with supervised practical experience in the
6 provision of such care.

7 “(c) SUPERVISION AND EVALUATION OF TECHNI-
8 CIANS.—The Secretary, acting through the Service, shall
9 supervise and evaluate the mental health technicians in
10 the training program.

11 “(d) TRADITIONAL HEALTH CARE PRACTICES.—The
12 Secretary, acting through the Service, shall ensure that
13 the program established pursuant to this subsection in-
14 volves the use and promotion of the traditional health care
15 practices of the Indian Tribes to be served.

16 **“SEC. 705. LICENSING REQUIREMENT FOR MENTAL**
17 **HEALTH CARE WORKERS.**

18 “(a) IN GENERAL.—Subject to the provisions of sec-
19 tion 221, and except as provided in subsection (b), any
20 individual employed as a psychologist, social worker, or
21 marriage and family therapist for the purpose of providing
22 mental health care services to Indians in a clinical setting
23 under this Act is required to be licensed as a psychologist,
24 social worker, or marriage and family therapist, respec-
25 tively.

1 “(b) TRAINEES.—An individual may be employed as
2 a trainee in psychology, social work, or marriage and fam-
3 ily therapy to provide mental health care services de-
4 scribed in subsection (a) if such individual—

5 “(1) works under the direct supervision of a li-
6 censed psychologist, social worker, or marriage and
7 family therapist, respectively;

8 “(2) is enrolled in or has completed at least 2
9 years of course work at a post-secondary, accredited
10 education program for psychology, social work, mar-
11 riage and family therapy, or counseling; and

12 “(3) meets such other training, supervision, and
13 quality review requirements as the Secretary may es-
14 tablish.

15 **“SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.**

16 “(a) GRANTS.—The Secretary, consistent with sec-
17 tion 701, may make grants to Indian Tribes, Tribal Orga-
18 nizations, and urban Indian organizations to develop and
19 implement a comprehensive behavioral health program of
20 prevention, intervention, treatment, and relapse preven-
21 tion services that specifically addresses the cultural, his-
22 torical, social, and child care needs of Indian women, re-
23 gardless of age.

24 “(b) USE OF GRANT FUNDS.—A grant made pursu-
25 ant to this section may be used to—

1 “(1) develop and provide community training,
2 education, and prevention programs for Indian
3 women relating to behavioral health issues, including
4 fetal alcohol disorders;

5 “(2) identify and provide psychological services,
6 counseling, advocacy, support, and relapse preven-
7 tion to Indian women and their families; and

8 “(3) develop prevention and intervention models
9 for Indian women which incorporate traditional
10 health care practices, cultural values, and commu-
11 nity and family involvement.

12 “(c) CRITERIA.—The Secretary, in consultation with
13 Indian Tribes and Tribal Organizations, shall establish
14 criteria for the review and approval of applications and
15 proposals for funding under this section.

16 “(d) ALLOCATION OF FUNDS FOR URBAN INDIAN
17 ORGANIZATIONS.—Twenty percent of the funds appro-
18 priated pursuant to this section shall be used to make
19 grants to urban Indian organizations.

20 **“SEC. 707. INDIAN YOUTH PROGRAM.**

21 “(a) DETOXIFICATION AND REHABILITATION.—The
22 Secretary, acting through the Service, consistent with sec-
23 tion 701, shall develop and implement a program for acute
24 detoxification and treatment for Indian youths, including
25 behavioral health services. The program shall include re-

1 gional treatment centers designed to include detoxification
2 and rehabilitation for both sexes on a referral basis and
3 programs developed and implemented by Indian Tribes or
4 Tribal Organizations at the local level under the Indian
5 Self-Determination and Education Assistance Act (25
6 U.S.C. 450 et seq.). Regional centers shall be integrated
7 with the intake and rehabilitation programs based in the
8 referring Indian community.

9 “(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT
10 CENTERS OR FACILITIES.—

11 “(1) ESTABLISHMENT.—

12 “(A) IN GENERAL.—The Secretary, acting
13 through the Service, shall construct, renovate,
14 or, as necessary, purchase, and appropriately
15 staff and operate, at least 1 youth regional
16 treatment center or treatment network in each
17 area under the jurisdiction of an Area Office.

18 “(B) AREA OFFICE IN CALIFORNIA.—For
19 the purposes of this subsection, the Area Office
20 in California shall be considered to be 2 Area
21 Offices, 1 office whose jurisdiction shall be con-
22 sidered to encompass the northern area of the
23 State of California, and 1 office whose jurisdic-
24 tion shall be considered to encompass the re-
25 mainder of the State of California for the pur-

1 pose of implementing California treatment net-
2 works.

3 “(2) FUNDING.—For the purpose of staffing
4 and operating such centers or facilities, funding
5 shall be pursuant to the Act of November 2, 1921
6 (25 U.S.C. 13).

7 “(3) LOCATION.—A youth treatment center
8 constructed or purchased under this subsection shall
9 be constructed or purchased at a location within the
10 area described in paragraph (1) agreed upon (by ap-
11 propriate tribal resolution) by a majority of the In-
12 dian Tribes to be served by such center.

13 “(4) SPECIFIC PROVISION OF FUNDS.—

14 “(A) IN GENERAL.—Notwithstanding any
15 other provision of this title, the Secretary may,
16 from amounts authorized to be appropriated for
17 the purposes of carrying out this section, make
18 funds available to—

19 “(i) the Tanana Chiefs Conference,
20 Incorporated, for the purpose of leasing,
21 constructing, renovating, operating, and
22 maintaining a residential youth treatment
23 facility in Fairbanks, Alaska; and

24 “(ii) the Southeast Alaska Regional
25 Health Corporation to staff and operate a

1 residential youth treatment facility without
2 regard to the proviso set forth in section
3 4(l) of the Indian Self-Determination and
4 Education Assistance Act (25 U.S.C.
5 450b(l)).

6 “(B) PROVISION OF SERVICES TO ELIGI-
7 BLE YOUTHS.—Until additional residential
8 youth treatment facilities are established in
9 Alaska pursuant to this section, the facilities
10 specified in subparagraph (A) shall make every
11 effort to provide services to all eligible Indian
12 youths residing in Alaska.

13 “(c) INTERMEDIATE ADOLESCENT BEHAVIORAL
14 HEALTH SERVICES.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Service, may provide intermediate be-
17 havioral health services, which may incorporate Sys-
18 tems of Care, to Indian children and adolescents, in-
19 cluding—

20 “(A) pretreatment assistance;

21 “(B) inpatient, outpatient, and aftercare
22 services;

23 “(C) emergency care;

24 “(D) suicide prevention and crisis interven-
25 tion; and

1 “(E) prevention and treatment of mental
2 illness and dysfunctional and self-destructive
3 behavior, including child abuse and family vio-
4 lence.

5 “(2) USE OF FUNDS.—Funds provided under
6 this subsection may be used—

7 “(A) to construct or renovate an existing
8 health facility to provide intermediate behav-
9 ioral health services;

10 “(B) to hire behavioral health profes-
11 sionals;

12 “(C) to staff, operate, and maintain an in-
13 termediate mental health facility, group home,
14 sober housing, transitional housing or similar
15 facilities, or youth shelter where intermediate
16 behavioral health services are being provided;

17 “(D) to make renovations and hire appro-
18 priate staff to convert existing hospital beds
19 into adolescent psychiatric units; and

20 “(E) for intensive home- and community-
21 based services.

22 “(3) CRITERIA.—The Secretary, acting through
23 the Service, shall, in consultation with Indian Tribes
24 and Tribal Organizations, establish criteria for the

1 review and approval of applications or proposals for
2 funding made available pursuant to this subsection.

3 “(d) FEDERALLY OWNED STRUCTURES.—

4 “(1) IN GENERAL.—The Secretary, in consulta-
5 tion with Indian Tribes and Tribal Organizations,
6 shall—

7 “(A) identify and use, where appropriate,
8 federally owned structures suitable for local res-
9 idential or regional behavioral health treatment
10 for Indian youths; and

11 “(B) establish guidelines for determining
12 the suitability of any such federally owned
13 structure to be used for local residential or re-
14 gional behavioral health treatment for Indian
15 youths.

16 “(2) TERMS AND CONDITIONS FOR USE OF
17 STRUCTURE.—Any structure described in paragraph
18 (1) may be used under such terms and conditions as
19 may be agreed upon by the Secretary and the agency
20 having responsibility for the structure and any In-
21 dian Tribe or Tribal Organization operating the pro-
22 gram.

23 “(e) REHABILITATION AND AFTERCARE SERVICES.—

24 “(1) IN GENERAL.—The Secretary, Indian
25 Tribes, or Tribal Organizations, in cooperation with

1 the Secretary of the Interior, shall develop and im-
2 plement within each Service Unit, community-based
3 rehabilitation and follow-up services for Indian
4 youths who are having significant behavioral health
5 problems, and require long-term treatment, commu-
6 nity reintegration, and monitoring to support the In-
7 dian youths after their return to their home commu-
8 nity.

9 “(2) ADMINISTRATION.—Services under para-
10 graph (1) shall be provided by trained staff within
11 the community who can assist the Indian youths in
12 their continuing development of self-image, positive
13 problem-solving skills, and nonalcohol or substance
14 abusing behaviors. Such staff may include alcohol
15 and substance abuse counselors, mental health pro-
16 fessionals, and other health professionals and para-
17 professionals, including community health represent-
18 atives.

19 “(f) INCLUSION OF FAMILY IN YOUTH TREATMENT
20 PROGRAM.—In providing the treatment and other services
21 to Indian youths authorized by this section, the Secretary,
22 acting through the Service, shall provide for the inclusion
23 of family members of such youths in the treatment pro-
24 grams or other services as may be appropriate. Not less
25 than 10 percent of the funds appropriated for the pur-

1 poses of carrying out subsection (e) shall be used for out-
2 patient care of adult family members related to the treat-
3 ment of an Indian youth under that subsection.

4 “(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
5 acting through the Service, shall provide, consistent with
6 section 701, programs and services to prevent and treat
7 the abuse of multiple forms of substances, including alco-
8 hol, drugs, inhalants, and tobacco, among Indian youths
9 residing in Indian communities, on or near reservations,
10 and in urban areas and provide appropriate mental health
11 services to address the incidence of mental illness among
12 such youths.

13 “(h) INDIAN YOUTH MENTAL HEALTH.—The Sec-
14 retary, acting through the Service, shall collect data for
15 the report under section 801 with respect to—

16 “(1) the number of Indian youth who are being
17 provided mental health services through the Service
18 and Tribal Health Programs;

19 “(2) a description of, and costs associated with,
20 the mental health services provided for Indian youth
21 through the Service and Tribal Health Programs;

22 “(3) the number of youth referred to the Serv-
23 ice or Tribal Health Programs for mental health
24 services;

1 “(4) the development of culturally relevant edu-
2 cational materials on suicide; and

3 “(5) data collection and reporting.

4 “(b) DEFINITIONS.—For the purpose of this section,
5 the following definitions shall apply:

6 “(1) DEMONSTRATION PROJECT.—The term
7 ‘demonstration project’ means the Indian youth tele-
8 mental health demonstration project authorized
9 under subsection (c).

10 “(2) TELEMENTAL HEALTH.—The term ‘tele-
11 mental health’ means the use of electronic informa-
12 tion and telecommunications technologies to support
13 long distance mental health care, patient and profes-
14 sional-related education, public health, and health
15 administration.

16 “(c) AUTHORIZATION.—

17 “(1) IN GENERAL.—The Secretary is authorized
18 to award grants under the demonstration project for
19 the provision of telemental health services to Indian
20 youth who—

21 “(A) have expressed suicidal ideas;

22 “(B) have attempted suicide; or

23 “(C) have mental health conditions that in-
24 crease or could increase the risk of suicide.

1 “(2) ELIGIBILITY FOR GRANTS.—Such grants
2 shall be awarded to Indian Tribes and Tribal Orga-
3 nizations that operate 1 or more facilities—

4 “(A) located in Alaska and part of the
5 Alaska Federal Health Care Access Network;

6 “(B) reporting active clinical telehealth ca-
7 pabilities; or

8 “(C) offering school-based telemental
9 health services relating to psychiatry to Indian
10 youth.

11 “(3) GRANT PERIOD.—The Secretary shall
12 award grants under this section for a period of up
13 to 4 years.

14 “(4) AWARDING OF GRANTS.—Not more than 5
15 grants shall be provided under paragraph (1), with
16 priority consideration given to Indian Tribes and
17 Tribal Organizations that—

18 “(A) serve a particular community or geo-
19 graphic area where there is a demonstrated
20 need to address Indian youth suicide;

21 “(B) enter in to collaborative partnerships
22 with Indian Health Service or Tribal Health
23 Programs or facilities to provide services under
24 this demonstration project;

1 “(C) serve an isolated community or geo-
2 graphic area which has limited or no access to
3 behavioral health services; or

4 “(D) operate a detention facility at which
5 Indian youth are detained.

6 “(d) USE OF FUNDS.—

7 “(1) IN GENERAL.—An Indian Tribe or Tribal
8 Organization shall use a grant received under sub-
9 section (c) for the following purposes:

10 “(A) To provide telemental health services
11 to Indian youth, including the provision of—

12 “(i) psychotherapy;

13 “(ii) psychiatric assessments and di-
14 agnostic interviews, therapies for mental
15 health conditions predisposing to suicide,
16 and treatment; and

17 “(iii) alcohol and substance abuse
18 treatment.

19 “(B) To provide clinician-interactive med-
20 ical advice, guidance and training, assistance in
21 diagnosis and interpretation, crisis counseling
22 and intervention, and related assistance to
23 Service, tribal, or urban clinicians and health
24 services providers working with youth being
25 served under this demonstration project.

1 “(C) To assist, educate and train commu-
2 nity leaders, health education professionals and
3 paraprofessionals, tribal outreach workers, and
4 family members who work with the youth re-
5 ceiving telemental health services under this
6 demonstration project, including with identifica-
7 tion of suicidal tendencies, crisis intervention
8 and suicide prevention, emergency skill develop-
9 ment, and building and expanding networks
10 among these individuals and with State and
11 local health services providers.

12 “(D) To develop and distribute culturally
13 appropriate community educational materials
14 on—

15 “(i) suicide prevention;

16 “(ii) suicide education;

17 “(iii) suicide screening;

18 “(iv) suicide intervention; and

19 “(v) ways to mobilize communities
20 with respect to the identification of risk
21 factors for suicide.

22 “(E) For data collection and reporting re-
23 lated to Indian youth suicide prevention efforts.

24 “(2) TRADITIONAL HEALTH CARE PRAC-
25 TICES.—In carrying out the purposes described in

1 paragraph (1), an Indian Tribe or Tribal Organiza-
2 tion may use and promote the traditional health care
3 practices of the Indian Tribes of the youth to be
4 served.

5 “(e) APPLICATIONS.—To be eligible to receive a grant
6 under subsection (c), an Indian Tribe or Tribal Organiza-
7 tion shall prepare and submit to the Secretary an applica-
8 tion, at such time, in such manner, and containing such
9 information as the Secretary may require, including—

10 “(1) a description of the project that the Indian
11 Tribe or Tribal Organization will carry out using the
12 funds provided under the grant;

13 “(2) a description of the manner in which the
14 project funded under the grant would—

15 “(A) meet the telemental health care needs
16 of the Indian youth population to be served by
17 the project; or

18 “(B) improve the access of the Indian
19 youth population to be served to suicide preven-
20 tion and treatment services;

21 “(3) evidence of support for the project from
22 the local community to be served by the project;

23 “(4) a description of how the families and lead-
24 ership of the communities or populations to be

1 served by the project would be involved in the devel-
2 opment and ongoing operations of the project;

3 “(5) a plan to involve the tribal community of
4 the youth who are provided services by the project
5 in planning and evaluating the mental health care
6 and suicide prevention efforts provided, in order to
7 ensure the integration of community, clinical, envi-
8 ronmental, and cultural components of the treat-
9 ment; and

10 “(6) a plan for sustaining the project after Fed-
11 eral assistance for the demonstration project has ter-
12 minated.

13 “(f) COLLABORATION; REPORTING TO NATIONAL
14 CLEARINGHOUSE.—

15 “(1) COLLABORATION.—The Secretary, acting
16 through the Service, shall encourage Indian Tribes
17 and Tribal Organizations receiving grants under this
18 section to collaborate to enable comparisons about
19 best practices across projects.

20 “(2) REPORTING TO NATIONAL CLEARING-
21 HOUSE.—The Secretary, acting through the Service,
22 shall also encourage Indian Tribes and Tribal Orga-
23 nizations receiving grants under this section to sub-
24 mit relevant, declassified project information to the
25 national clearinghouse authorized under section

1 701(b)(2) in order to better facilitate program per-
2 formance and improve suicide prevention, interven-
3 tion, and treatment services.

4 “(g) ANNUAL REPORT.—Each grant recipient shall
5 submit to the Secretary an annual report that—

6 “(1) describes the number of telemental health
7 services provided; and

8 “(2) includes any other information that the
9 Secretary may require.

10 “(h) REPORT TO CONGRESS.—Not later than 270
11 days after the termination of the demonstration project,
12 the Secretary shall submit to the Committee on Indian Af-
13 fairs of the Senate and the Committee on Natural Re-
14 sources and Committee on Energy and Commerce of the
15 House of Representatives a final report, based on the an-
16 nual reports provided by grant recipients under subsection
17 (h), that—

18 “(1) describes the results of the projects funded
19 by grants awarded under this section, including any
20 data available which indicates the number of at-
21 tempted suicides;

22 “(2) evaluates the impact of the telemental
23 health services funded by the grants in reducing the
24 number of completed suicides among Indian youth;

1 “(3) evaluates whether the demonstration
2 project should be—

3 “(A) expanded to provide more than 5
4 grants; and

5 “(B) designated a permanent program;
6 and

7 “(4) evaluates the benefits of expanding the
8 demonstration project to include urban Indian orga-
9 nizations.

10 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is
11 authorized to be appropriated such sums as may be nec-
12 essary to carry out this section.

13 **“SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL**
14 **HEALTH FACILITIES DESIGN, CONSTRUC-**
15 **TION, AND STAFFING.**

16 “Not later than 1 year after the date of enactment
17 of the Indian Health Care Improvement Act Amendments
18 of 2009, the Secretary, acting through the Service, may
19 provide, in each area of the Service, not less than 1 inpa-
20 tient mental health care facility, or the equivalent, for In-
21 dians with behavioral health problems. For the purposes
22 of this subsection, California shall be considered to be 2
23 Area Offices, 1 office whose location shall be considered
24 to encompass the northern area of the State of California
25 and 1 office whose jurisdiction shall be considered to en-

1 compass the remainder of the State of California. The Sec-
2 retary shall consider the possible conversion of existing,
3 underused Service hospital beds into psychiatric units to
4 meet such need.

5 **“SEC. 710. TRAINING AND COMMUNITY EDUCATION.**

6 “(a) PROGRAM.—The Secretary, in cooperation with
7 the Secretary of the Interior, shall develop and implement
8 or assist Indian Tribes and Tribal Organizations to de-
9 velop and implement, within each Service Unit or tribal
10 program, a program of community education and involve-
11 ment which shall be designed to provide concise and timely
12 information to the community leadership of each tribal
13 community. Such program shall include education about
14 behavioral health issues to political leaders, Tribal judges,
15 law enforcement personnel, members of tribal health and
16 education boards, health care providers including tradi-
17 tional practitioners, and other critical members of each
18 tribal community. Such program may also include commu-
19 nity-based training to develop local capacity and tribal
20 community provider training for prevention, intervention,
21 treatment, and aftercare.

22 “(b) INSTRUCTION.—The Secretary, acting through
23 the Service, shall provide instruction in the area of behav-
24 ioral health issues, including instruction in crisis interven-
25 tion and family relations in the context of alcohol and sub-

1 stance abuse, child sexual abuse, youth alcohol and sub-
2 stance abuse, and the causes and effects of fetal alcohol
3 disorders to appropriate employees of the Bureau of In-
4 dian Affairs and the Service, and to personnel in schools
5 or programs operated under any contract with the Bureau
6 of Indian Affairs or the Service, including supervisors of
7 emergency shelters and halfway houses described in sec-
8 tion 4213 of the Indian Alcohol and Substance Abuse Pre-
9 vention and Treatment Act of 1986 (25 U.S.C. 2433).

10 “(c) TRAINING MODELS.—In carrying out the edu-
11 cation and training programs required by this section, the
12 Secretary, in consultation with Indian Tribes, Tribal Or-
13 ganizations, Indian behavioral health experts, and Indian
14 alcohol and substance abuse prevention experts, shall de-
15 velop and provide community-based training models. Such
16 models shall address—

17 “(1) the elevated risk of alcohol and behavioral
18 health problems faced by children of alcoholics;

19 “(2) the cultural, spiritual, and
20 multigenerational aspects of behavioral health prob-
21 lem prevention and recovery; and

22 “(3) community-based and multidisciplinary
23 strategies, including Systems of Care, for preventing
24 and treating behavioral health problems.

1 **“SEC. 711. BEHAVIORAL HEALTH PROGRAM.**

2 “(a) INNOVATIVE PROGRAMS.—The Secretary, acting
3 through the Service, consistent with section 701, may
4 plan, develop, implement, and carry out programs to de-
5 liver innovative community-based behavioral health serv-
6 ices to Indians.

7 “(b) AWARDS; CRITERIA.—The Secretary may award
8 a grant for a project under subsection (a) to an Indian
9 Tribe or Tribal Organization and may consider the fol-
10 lowing criteria:

11 “(1) The project will address significant unmet
12 behavioral health needs among Indians.

13 “(2) The project will serve a significant number
14 of Indians.

15 “(3) The project has the potential to deliver
16 services in an efficient and effective manner.

17 “(4) The Indian Tribe or Tribal Organization
18 has the administrative and financial capability to ad-
19 minister the project.

20 “(5) The project may deliver services in a man-
21 ner consistent with traditional health care practices.

22 “(6) The project is coordinated with, and avoids
23 duplication of, existing services.

24 “(c) EQUITABLE TREATMENT.—For purposes of this
25 subsection, the Secretary shall, in evaluating project appli-
26 cations or proposals, use the same criteria that the Sec-

1 retary uses in evaluating any other application or proposal
2 for such funding.

3 **“SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.**

4 “(a) PROGRAMS.—

5 “(1) ESTABLISHMENT.—The Secretary, con-
6 sistent with section 701 and acting through the
7 Service, is authorized to establish and operate fetal
8 alcohol disorder programs as provided in this section
9 for the purposes of meeting the health status objec-
10 tives specified in section 3.

11 “(2) USE OF FUNDS.—

12 “(A) IN GENERAL.—Funding provided
13 pursuant to this section shall be used for the
14 following:

15 “(i) To develop and provide for Indi-
16 ans community and in-school training, edu-
17 cation, and prevention programs relating
18 to fetal alcohol disorders.

19 “(ii) To identify and provide behav-
20 ioral health treatment to high-risk Indian
21 women and high-risk women pregnant with
22 an Indian’s child.

23 “(iii) To identify and provide appro-
24 priate psychological services, educational
25 and vocational support, counseling, advo-

1 cacy, and information to fetal alcohol dis-
2 order affected Indians and their families or
3 caretakers.

4 “(iv) To develop and implement coun-
5 seling and support programs in schools for
6 fetal alcohol disorder affected Indian chil-
7 dren.

8 “(v) To develop prevention and inter-
9 vention models which incorporate practi-
10 tioners of traditional health care practices,
11 cultural values, and community involve-
12 ment.

13 “(vi) To develop, print, and dissemi-
14 nate education and prevention materials on
15 fetal alcohol disorder.

16 “(vii) To develop and implement, in
17 consultation with Indian Tribes, Tribal Or-
18 ganizations, and urban Indian organiza-
19 tions, culturally sensitive assessment and
20 diagnostic tools including dysmorphology
21 clinics and multidisciplinary fetal alcohol
22 disorder clinics for use in Indian commu-
23 nities and Urban Centers.

24 “(B) ADDITIONAL USES.—In addition to
25 any purpose under subparagraph (A), funding

1 provided pursuant to this section may be used
2 for 1 or more of the following:

3 “(i) Early childhood intervention
4 projects from birth on to mitigate the ef-
5 fects of fetal alcohol disorder among Indi-
6 ans.

7 “(ii) Community-based support serv-
8 ices for Indians and women pregnant with
9 Indian children.

10 “(iii) Community-based housing for
11 adult Indians with fetal alcohol disorder.

12 “(3) CRITERIA FOR APPLICATIONS.—The Sec-
13 retary shall establish criteria for the review and ap-
14 proval of applications for funding under this section.

15 “(b) SERVICES.—The Secretary, acting through the
16 Service, shall—

17 “(1) develop and provide services for the pre-
18 vention, intervention, treatment, and aftercare for
19 those affected by fetal alcohol disorder in Indian
20 communities; and

21 “(2) provide supportive services, including serv-
22 ices to meet the special educational, vocational,
23 school-to-work transition, and independent living
24 needs of adolescent and adult Indians with fetal al-
25cohol disorder.

1 “(c) TASK FORCE.—The Secretary shall establish a
2 task force to be known as the Fetal Alcohol Disorder Task
3 Force to advise the Secretary in carrying out subsection
4 (b). Such task force shall be composed of representatives
5 from the following:

6 “(1) The National Institute on Drug Abuse.

7 “(2) The National Institute on Alcohol and Al-
8 coholism.

9 “(3) The Office of Substance Abuse Prevention.

10 “(4) The National Institute of Mental Health.

11 “(5) The Service.

12 “(6) The Office of Minority Health of the De-
13 partment of Health and Human Services.

14 “(7) The Administration for Native Americans.

15 “(8) The National Institute of Child Health
16 and Human Development (NICHD).

17 “(9) The Centers for Disease Control and Pre-
18 vention.

19 “(10) The Bureau of Indian Affairs.

20 “(11) Indian Tribes.

21 “(12) Tribal Organizations.

22 “(13) urban Indian organizations.

23 “(14) Indian fetal alcohol spectrum disorders
24 experts.

1 “(1) To develop and provide community edu-
2 cation and prevention programs related to sexual
3 abuse of Indian children or children in an Indian
4 household.

5 “(2) To identify and provide behavioral health
6 treatment to victims of sexual abuse who are Indian
7 children or children in an Indian household, and to
8 their family members who are affected by sexual
9 abuse.

10 “(3) To develop prevention and intervention
11 models which incorporate traditional health care
12 practices, cultural values, and community involve-
13 ment.

14 “(4) To develop and implement culturally sen-
15 sitive assessment and diagnostic tools for use in In-
16 dian communities and Urban Centers.

17 “(5) To identify and provide behavioral health
18 treatment to Indian perpetrators and perpetrators
19 who are members of an Indian household—

20 “(A) making efforts to begin offender and
21 behavioral health treatment while the pepe-
22 trator is incarcerated or at the earliest possible
23 date if the perpetrator is not incarcerated; and

1 “(B) providing treatment after the pepe-
2 trator is released, until it is determined that the
3 perpetrator is not a threat to children.

4 “(c) COORDINATION.—The programs established
5 under subsection (a) shall be carried out in coordination
6 with programs and services authorized under the Indian
7 Child Protection and Family Violence Prevention Act (25
8 U.S.C. 3201 et seq.).

9 **“SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION**
10 **AND TREATMENT.**

11 “(a) IN GENERAL.—The Secretary, in accordance
12 with section 701, is authorized to establish in each Service
13 Area programs involving the prevention and treatment
14 of—

15 “(1) Indian victims of domestic violence or sex-
16 ual abuse; and

17 “(2) perpetrators of domestic violence or sexual
18 abuse who are Indian or members of an Indian
19 household.

20 “(b) USE OF FUNDS.—Funds made available to carry
21 out this section shall be used—

22 “(1) to develop and implement prevention pro-
23 grams and community education programs relating
24 to domestic violence and sexual abuse;

1 “(2) to provide behavioral health services, in-
2 cluding victim support services, and medical treat-
3 ment (including examinations performed by sexual
4 assault nurse examiners) to Indian victims of domes-
5 tic violence or sexual abuse;

6 “(3) to purchase rape kits;

7 “(4) to develop prevention and intervention
8 models, which may incorporate traditional health
9 care practices; and

10 “(5) to identify and provide behavioral health
11 treatment to perpetrators who are Indian or mem-
12 bers of an Indian household.

13 “(c) TRAINING AND CERTIFICATION.—

14 “(1) IN GENERAL.—Not later than 1 year after
15 the date of enactment of the Indian Health Care Im-
16 provement Act Amendments of 2009, the Secretary
17 shall establish appropriate protocols, policies, proce-
18 dures, standards of practice, and, if not available
19 elsewhere, training curricula and training and cer-
20 tification requirements for services for victims of do-
21 mestic violence and sexual abuse.

22 “(2) REPORT.—Not later than 18 months after
23 the date of enactment of the Indian Health Care Im-
24 provement Act Amendments of 2008, the Secretary
25 shall submit to the Committee on Indian Affairs of

1 the Senate and the Committee on Natural Resources
2 of the House of Representatives a report that de-
3 scribes the means and extent to which the Secretary
4 has carried out paragraph (1).

5 “(d) COORDINATION.—

6 “(1) IN GENERAL.—The Secretary, in coordina-
7 tion with the Attorney General, Federal and tribal
8 law enforcement agencies, Indian Health Programs,
9 and domestic violence or sexual assault victim orga-
10 nizations, shall develop appropriate victim services
11 and victim advocate training programs—

12 “(A) to improve domestic violence or sex-
13 ual abuse responses;

14 “(B) to improve forensic examinations and
15 collection;

16 “(C) to identify problems or obstacles in
17 the prosecution of domestic violence or sexual
18 abuse; and

19 “(D) to meet other needs or carry out
20 other activities required to prevent, treat, and
21 improve prosecutions of domestic violence and
22 sexual abuse.

23 “(2) REPORT.—Not later than 2 years after the
24 date of enactment of the Indian Health Care Im-
25 provement Act Amendments of 2008, the Secretary

1 shall submit to the Committee on Indian Affairs of
2 the Senate and the Committee on Natural Resources
3 of the House of Representatives a report that de-
4 scribes, with respect to the matters described in
5 paragraph (1), the improvements made and needed,
6 problems or obstacles identified, and costs necessary
7 to address the problems or obstacles, and any other
8 recommendations that the Secretary determines to
9 be appropriate.

10 **“SEC. 715. BEHAVIORAL HEALTH RESEARCH.**

11 “The Secretary, in consultation with appropriate
12 Federal agencies, shall make grants to, or enter into con-
13 tracts with, Indian Tribes, Tribal Organizations, and
14 urban Indian organizations or enter into contracts with,
15 or make grants to appropriate institutions for, the conduct
16 of research on the incidence and prevalence of behavioral
17 health problems among Indians served by the Service, In-
18 dian Tribes, or Tribal Organizations and among Indians
19 in urban areas. Research priorities under this section shall
20 include—

21 “(1) the multifactorial causes of Indian youth
22 suicide, including—

23 “(A) protective and risk factors and sci-
24 entific data that identifies those factors; and

1 system involvement such as developmental delay, in-
2 tellectual deficit, or neurologic abnormalities. Behav-
3 iorally, there can be problems with irritability, and
4 failure to thrive as infants. As children become older
5 there will likely be hyperactivity, attention deficit,
6 language dysfunction, and perceptual and judgment
7 problems.

8 “(3) BEHAVIORAL HEALTH AFTERCARE.—The
9 term ‘behavioral health aftercare’ includes those ac-
10 tivities and resources used to support recovery fol-
11 lowing inpatient, residential, intensive substance
12 abuse, or mental health outpatient or outpatient
13 treatment. The purpose is to help prevent or deal
14 with relapse by ensuring that by the time a client or
15 patient is discharged from a level of care, such as
16 outpatient treatment, an aftercare plan has been de-
17 veloped with the client. An aftercare plan may use
18 such resources as a community-based therapeutic
19 group, transitional living facilities, a 12-step spon-
20 sor, a local 12-step or other related support group,
21 and other community-based providers.

22 “(4) DUAL DIAGNOSIS.—The term ‘dual diag-
23 nosis’ means coexisting substance abuse and mental
24 illness conditions or diagnosis. Such clients are

1 sometimes referred to as mentally ill chemical abusers (MICAs).
2

3 “(5) FETAL ALCOHOL SPECTRUM DIS-
4 ORDERS.—

5 “(A) IN GENERAL.—The term ‘fetal alcohol spectrum disorders’ includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.
6
7
8
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10

11 “(B) INCLUSIONS.—The term ‘fetal alcohol spectrum disorders’ may include—
12

13 “(i) fetal alcohol syndrome (FAS);

14 “(ii) fetal alcohol effect (FAE);

15 “(iii) alcohol-related birth defects; and

16 “(iv) alcohol-related
17 neurodevelopmental disorders (ARND).

18 “(6) FETAL ALCOHOL SYNDROME OR FAS.—
19 The term ‘fetal alcohol syndrome’ or ‘FAS’ means
20 any 1 of a spectrum of effects that may occur when
21 a woman drinks alcohol during pregnancy, the diagnosis of which involves the confirmed presence of the
22 following 3 criteria:
23

24 “(A) Craniofacial abnormalities.

25 “(B) Growth deficits.

1 “(C) Central nervous system abnormalities.

2 “(7) REHABILITATION.—The term ‘rehabilita-
3 tion’ means medical and health care services that—

4 “(A) are recommended by a physician or
5 licensed practitioner of the healing arts within
6 the scope of their practice under applicable law;

7 “(B) are furnished in a facility, home, or
8 other setting in accordance with applicable
9 standards; and

10 “(C) have as their purpose any of the fol-
11 lowing:

12 “(i) The maximum attainment of
13 physical, mental, and developmental func-
14 tioning.

15 “(ii) Averting deterioration in physical
16 or mental functional status.

17 “(iii) The maintenance of physical or
18 mental health functional status.

19 “(8) SUBSTANCE ABUSE.—The term ‘substance
20 abuse’ includes inhalant abuse.

21 “(9) SYSTEMS OF CARE.—The term ‘Systems of
22 Care’ means a system for delivering services to chil-
23 dren and their families that is child-centered, family-
24 focused and family-driven, community-based, and
25 culturally competent and responsive to the needs of

1 the children and families being served. The systems
2 of care approach values prevention and early identi-
3 fication, smooth transitions for children and fami-
4 lies, child and family participation and advocacy,
5 comprehensive array of services, individualized serv-
6 ice planning, services in the least restrictive environ-
7 ment, and integrated services with coordinated plan-
8 ning across the child-serving systems.

9 **“SEC. 717. AUTHORIZATION OF APPROPRIATIONS.**

10 “There is authorized to be appropriated such sums
11 as may be necessary to carry out the provisions of this
12 title.

13 **“TITLE VIII—MISCELLANEOUS**

14 **“SEC. 801. REPORTS.**

15 “For each fiscal year following the date of enactment
16 of the Indian Health Care Improvement Act Amendments
17 of 2009, the Secretary shall transmit to Congress a report
18 containing the following:

19 “(1) A report on the progress made in meeting
20 the objectives of this Act, including a review of pro-
21 grams established or assisted pursuant to this Act
22 and assessments and recommendations of additional
23 programs or additional assistance necessary to, at a
24 minimum, provide health services to Indians and en-
25 sure a health status for Indians, which are at a par-

1 ity with the health services available to and the
2 health status of the general population.

3 “(2) A report on whether, and to what extent,
4 new national health care programs, benefits, initia-
5 tives, or financing systems have had an impact on
6 the purposes of this Act and any steps that the Sec-
7 retary may have taken to consult with Indian Tribes,
8 Tribal Organizations, and urban Indian organiza-
9 tions to address such impact, including a report on
10 proposed changes in allocation of funding pursuant
11 to section 807.

12 “(3) A report on the use of health services by
13 Indians—

14 “(A) on a national and area or other rel-
15 evant geographical basis;

16 “(B) by gender and age;

17 “(C) by source of payment and type of
18 service;

19 “(D) comparing such rates of use with
20 rates of use among comparable non-Indian pop-
21 ulations; and

22 “(E) provided under contracts.

23 “(4) A report of contractors to the Secretary on
24 Health Care Educational Loan Repayments every 6
25 months required by section 110.

1 “(5) A general audit report of the Secretary on
2 the Health Care Educational Loan Repayment Pro-
3 gram as required by section 110(m).

4 “(6) A report of the findings and conclusions of
5 demonstration programs on development of edu-
6 cational curricula for substance abuse counseling as
7 required in section 125(f).

8 “(7) A separate statement which specifies the
9 amount of funds requested to carry out the provi-
10 sions of section 201.

11 “(8) A report of the evaluations of health pro-
12 motion and disease prevention as required in section
13 203(c).

14 “(9) A biennial report to Congress on infectious
15 diseases as required by section 212.

16 “(10) A report on environmental and nuclear
17 health hazards as required by section 215.

18 “(11) An annual report on the status of all
19 health care facilities needs as required by section
20 301(c)(2)(B) and 301(d).

21 “(12) Reports on safe water and sanitary waste
22 disposal facilities as required by section 302(h).

23 “(13) An annual report on the expenditure of
24 non-Service funds for renovation as required by sec-
25 tions 304(b)(2).

1 “(14) A report identifying the backlog of main-
2 tenance and repair required at Service and tribal fa-
3 cilities required by section 313(a).

4 “(15) A report providing an accounting of reim-
5 bursement funds made available to the Secretary
6 under titles XVIII, XIX, and XXI of the Social Se-
7 curity Act.

8 “(16) A report on any arrangements for the
9 sharing of medical facilities or services, as author-
10 ized by section 406.

11 “(17) A report on evaluation and renewal of
12 urban Indian programs under section 505.

13 “(18) A report on the evaluation of programs
14 as required by section 513(d).

15 “(19) A report on alcohol and substance abuse
16 as required by section 701(f).

17 “(20) A report on Indian youth mental health
18 services as required by section 707(h).

19 “(21) A report on the reallocation of base re-
20 sources if required by section 807.

21 “(22) A report on the movement of patients be-
22 tween Service Units, including—

23 “(A) a list of those Service Units that have
24 a net increase and those that have a net de-
25 crease of patients due to patients assigned to

1 one Service Unit voluntarily choosing to receive
2 service at another Service Unit;

3 “(B) an analysis of the effect of patient
4 movement on the quality of services for those
5 Service Units experiencing an increase in the
6 number of patients served; and

7 “(C) what funding changes are necessary
8 to maintain a consistent quality of service at
9 Service Units that have an increase in the num-
10 ber of patients served.

11 “(23) A report on the extent to which health
12 care facilities of the Service, Indian Tribes, Tribal
13 Organizations, and urban Indian organizations com-
14 ply with credentialing requirements of the Service or
15 licensure requirements of States.

16 **“SEC. 802. REGULATIONS.**

17 “(a) DEADLINES.—

18 “(1) PROCEDURES.—Not later than 90 days
19 after the date of enactment of the Indian Health
20 Care Improvement Act Amendments of 2009, the
21 Secretary shall initiate procedures under subchapter
22 III of chapter 5 of title 5, United States Code, to
23 negotiate and promulgate such regulations or
24 amendments thereto that are necessary to carry out
25 this Act, except sections 105, 115, 117, 202, and

1 409 through 414. The Secretary may promulgate
2 regulations to carry out such sections using the pro-
3 cedures required by chapter 5 of title 5, United
4 States Code (commonly known as the ‘Administra-
5 tive Procedure Act’).

6 “(2) PROPOSED REGULATIONS.—Proposed reg-
7 ulations to implement this Act shall be published in
8 the Federal Register by the Secretary no later than
9 2 years after the date of enactment of the Indian
10 Health Care Improvement Act Amendments of 2009
11 and shall have no less than a 120-day comment pe-
12 riod.

13 “(3) FINAL REGULATIONS.—The Secretary
14 shall publish in the Federal Register final regula-
15 tions to implement this Act by not later than 3 years
16 after the date of enactment of the Indian Health
17 Care Improvement Act Amendments of 2009.

18 “(b) COMMITTEE.—A negotiated rulemaking com-
19 mittee established pursuant to section 565 of title 5,
20 United States Code, to carry out this section shall have
21 as its members only representatives of the Federal Gov-
22 ernment and representatives of Indian Tribes, and Tribal
23 Organizations, a majority of whom shall be nominated by
24 and be representatives of Indian Tribes and Tribal Orga-
25 nizations from each Service Area.

1 “(c) ADAPTATION OF PROCEDURES.—The Secretary
2 shall adapt the negotiated rulemaking procedures to the
3 unique context of self-governance and the government-to-
4 government relationship between the United States and
5 Indian Tribes.

6 “(d) LACK OF REGULATIONS.—The lack of promul-
7 gated regulations shall not limit the effect of this Act.

8 **“SEC. 803. PLAN OF IMPLEMENTATION.**

9 “(a) IN GENERAL.—Not later than 1 year after the
10 date of enactment of the Indian Health Care Improvement
11 Act Amendments of 2009, the Secretary, in consultation
12 with Indian Tribes, Tribal Organizations, and urban In-
13 dian organizations, shall submit to Congress a plan ex-
14 plaining the manner and schedule, by title and section,
15 by which the Secretary will implement the provisions of
16 this Act. This consultation may be conducted jointly with
17 the annual budget consultation pursuant to the Indian
18 Self-Determination and Education Assistance Act (25
19 U.S.C. 450 et seq.).

20 “(b) LACK OF PLAN.—The lack of (or failure to sub-
21 mit) such a plan shall not limit the effect, or prevent the
22 implementation, of this Act.

1 **“SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED**
2 **TO INDIAN HEALTH SERVICE.**

3 “Any limitation on the use of funds contained in an
4 Act providing appropriations for the Department for a pe-
5 riod with respect to the performance of abortions shall
6 apply for that period with respect to the performance of
7 abortions using funds contained in an Act providing ap-
8 propriations for the Service.

9 **“SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.**

10 “(a) IN GENERAL.—The following California Indians
11 shall be eligible for health services provided by the Service:

12 “(1) Any member of a federally recognized In-
13 dian Tribe.

14 “(2) Any descendant of an Indian who was re-
15 siding in California on June 1, 1852, if such de-
16 scendant—

17 “(A) is a member of the Indian community
18 served by a local program of the Service; and

19 “(B) is regarded as an Indian by the com-
20 munity in which such descendant lives.

21 “(3) Any Indian who holds trust interests in
22 public domain, national forest, or reservation allot-
23 ments in California.

24 “(4) Any Indian in California who is listed on
25 the plans for distribution of the assets of rancherias
26 and reservations located within the State of Cali-

1 fornia under the Act of August 18, 1958 (72 Stat.
2 619), and any descendant of such an Indian.

3 “(b) CLARIFICATION.—Nothing in this section may
4 be construed as expanding the eligibility of California Indi-
5 ans for health services provided by the Service beyond the
6 scope of eligibility for such health services that applied on
7 May 1, 1986.

8 **“SEC. 806. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

9 “(a) CHILDREN.—Any individual who—

10 “(1) has not attained 19 years of age;

11 “(2) is the natural or adopted child, stepchild,
12 foster child, legal ward, or orphan of an eligible In-
13 dian; and

14 “(3) is not otherwise eligible for health services
15 provided by the Service,

16 shall be eligible for all health services provided by the
17 Service on the same basis and subject to the same rules
18 that apply to eligible Indians until such individual attains
19 19 years of age. The existing and potential health needs
20 of all such individuals shall be taken into consideration
21 by the Service in determining the need for, or the alloca-
22 tion of, the health resources of the Service. If such an indi-
23 vidual has been determined to be legally incompetent prior
24 to attaining 19 years of age, such individual shall remain

1 eligible for such services until 1 year after the date of a
2 determination of competency.

3 “(b) SPOUSES.—Any spouse of an eligible Indian who
4 is not an Indian, or who is of Indian descent but is not
5 otherwise eligible for the health services provided by the
6 Service, shall be eligible for such health services if all such
7 spouses or spouses who are married to members of each
8 Indian Tribe being served are made eligible, as a class,
9 by an appropriate resolution of the governing body of the
10 Indian Tribe or Tribal Organization providing such serv-
11 ices. The health needs of persons made eligible under this
12 paragraph shall not be taken into consideration by the
13 Service in determining the need for, or allocation of, its
14 health resources.

15 “(c) PROVISION OF SERVICES TO OTHER INDIVID-
16 UALS.—

17 “(1) IN GENERAL.—The Secretary is authorized
18 to provide health services under this subsection
19 through health programs operated directly by the
20 Service to individuals who reside within the Service
21 area of the Service Unit and who are not otherwise
22 eligible for such health services if—

23 “(A) the Indian Tribes served by such
24 Service Unit request such provision of health
25 services to such individuals; and

1 “(B) the Secretary and the served Indian
2 Tribes have jointly determined that—

3 “(i) the provision of such health serv-
4 ices will not result in a denial or diminu-
5 tion of health services to eligible Indians;
6 and

7 “(ii) there is no reasonable alternative
8 health facilities or services, within or with-
9 out the Service Unit, available to meet the
10 health needs of such individuals.

11 “(2) ISDEAA PROGRAMS.—In the case of
12 health programs and facilities operated under a con-
13 tract or compact entered into under the Indian Self-
14 Determination and Education Assistance Act (25
15 U.S.C. 450 et seq.), the governing body of the In-
16 dian Tribe or Tribal Organization providing health
17 services under such contract or compact is author-
18 ized to determine whether health services should be
19 provided under such contract to individuals who are
20 not eligible for such health services under any other
21 subsection of this section or under any other provi-
22 sion of law. In making such determinations, the gov-
23 erning body of the Indian Tribe or Tribal Organiza-
24 tion shall take into account the considerations de-
25 scribed in paragraph (1)(B).

1 “(3) PAYMENT FOR SERVICES.—

2 “(A) IN GENERAL.—Persons receiving
3 health services provided by the Service under
4 this subsection shall be liable for payment of
5 such health services under a schedule of charges
6 prescribed by the Secretary which, in the judg-
7 ment of the Secretary, results in reimbursement
8 in an amount not less than the actual cost of
9 providing the health services. Notwithstanding
10 section 404 of this Act or any other provision
11 of law, amounts collected under this subsection,
12 including Medicare, Medicaid, or SCHIP reim-
13 bursements under titles XVIII, XIX, and XXI
14 of the Social Security Act, shall be credited to
15 the account of the program providing the serv-
16 ice and shall be used for the purposes listed in
17 section 401(d)(2) and amounts collected under
18 this subsection shall be available for expendi-
19 ture within such program.

20 “(B) INDIGENT PEOPLE.—Health services
21 may be provided by the Secretary through the
22 Service under this subsection to an indigent in-
23 dividual who would not be otherwise eligible for
24 such health services but for the provisions of
25 paragraph (1) only if an agreement has been

1 entered into with a State or local government
2 under which the State or local government
3 agrees to reimburse the Service for the expenses
4 incurred by the Service in providing such health
5 services to such indigent individual.

6 “(4) REVOCATION OF CONSENT FOR SERV-
7 ICES.—

8 “(A) SINGLE TRIBE SERVICE AREA.—In
9 the case of a Service Area which serves only 1
10 Indian Tribe, the authority of the Secretary to
11 provide health services under paragraph (1)
12 shall terminate at the end of the fiscal year suc-
13 ceeding the fiscal year in which the governing
14 body of the Indian Tribe revokes its concur-
15 rence to the provision of such health services.

16 “(B) MULTITRIBAL SERVICE AREA.—In
17 the case of a multitribal Service Area, the au-
18 thority of the Secretary to provide health serv-
19 ices under paragraph (1) shall terminate at the
20 end of the fiscal year succeeding the fiscal year
21 in which at least 51 percent of the number of
22 Indian Tribes in the Service Area revoke their
23 concurrence to the provisions of such health
24 services.

1 “(d) OTHER SERVICES.—The Service may provide
2 health services under this subsection to individuals who
3 are not eligible for health services provided by the Service
4 under any other provision of law in order to—

5 “(1) achieve stability in a medical emergency;

6 “(2) prevent the spread of a communicable dis-
7 ease or otherwise deal with a public health hazard;

8 “(3) provide care to non-Indian women preg-
9 nant with an eligible Indian’s child for the duration
10 of the pregnancy through postpartum; or

11 “(4) provide care to immediate family members
12 of an eligible individual if such care is directly re-
13 lated to the treatment of the eligible individual.

14 “(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

15 “(1) IN GENERAL.—Hospital privileges in
16 health facilities operated and maintained by the
17 Service or operated under a contract or compact
18 pursuant to the Indian Self-Determination and Edu-
19 cation Assistance Act (25 U.S.C. 450 et seq.) may
20 be extended to non-Service health care practitioners
21 who provide services to individuals described in sub-
22 section (a), (b), (c), or (d). Such non-Service health
23 care practitioners may, as part of the privileging
24 process, be designated as employees of the Federal
25 Government for purposes of section 1346(b) and

1 chapter 171 of title 28, United States Code (relating
2 to Federal tort claims) only with respect to acts or
3 omissions which occur in the course of providing
4 services to eligible individuals as a part of the condi-
5 tions under which such hospital privileges are ex-
6 tended.

7 “(2) DEFINITION.—For purposes of this sub-
8 section, the term ‘non-Service health care practi-
9 tioner’ means a practitioner who is not—

10 “(A) an employee of the Service; or

11 “(B) an employee of an Indian tribe or
12 tribal organization operating a contract or com-
13 pact under the Indian Self-Determination and
14 Education Assistance Act or an individual who
15 provides health care services pursuant to a per-
16 sonal services contract with such Indian tribe or
17 tribal organization.

18 “(f) ELIGIBLE INDIAN.—For purposes of this sec-
19 tion, the term ‘eligible Indian’ means any Indian who is
20 eligible for health services provided by the Service without
21 regard to the provisions of this section.

22 **“SEC. 807. REALLOCATION OF BASE RESOURCES.**

23 “(a) REPORT REQUIRED.—Notwithstanding any
24 other provision of law, any allocation of Service funds for
25 a fiscal year that reduces by 5 percent or more from the

1 previous fiscal year the funding for any recurring pro-
2 gram, project, or activity of a Service Unit may be imple-
3 mented only after the Secretary has submitted to Con-
4 gress, under section 801, a report on the proposed change
5 in allocation of funding, including the reasons for the
6 change and its likely effects.

7 “(b) EXCEPTION.—Subsection (a) shall not apply if
8 the total amount appropriated to the Service for a fiscal
9 year is at least 5 percent less than the amount appro-
10 priated to the Service for the previous fiscal year.

11 **“SEC. 808. RESULTS OF DEMONSTRATION PROJECTS.**

12 “The Secretary shall provide for the dissemination to
13 Indian Tribes, Tribal Organizations, and urban Indian or-
14 ganizations of the findings and results of demonstration
15 projects conducted under this Act.

16 **“SEC. 809. PROVISION OF SERVICES IN MONTANA.**

17 “(a) CONSISTENT WITH COURT DECISION.—The
18 Secretary, acting through the Service, shall provide serv-
19 ices and benefits for Indians in Montana in a manner con-
20 sistent with the decision of the United States Court of Ap-
21 peals for the Ninth Circuit in McNabb for McNabb v.
22 Bowen, 829 F.2d 787 (9th Cir. 1987).

23 “(b) CLARIFICATION.—The provisions of subsection
24 (a) shall not be construed to be an expression of the sense
25 of Congress on the application of the decision described

1 in subsection (a) with respect to the provision of services
2 or benefits for Indians living in any State other than Mon-
3 tana.

4 **“SEC. 810. MORATORIUM.**

5 “During the period of the moratorium imposed on
6 implementation of the final rule published in the Federal
7 Register on September 16, 1987, by the Department of
8 Health and Human Services, relating to eligibility for the
9 health care services of the Indian Health Service, the In-
10 dian Health Service shall provide services pursuant to the
11 criteria for eligibility for such services that were in effect
12 on September 15, 1987, subject to the provisions of sec-
13 tions 805 and 806, until the Service has submitted to the
14 Committees on Appropriations of the Senate and the
15 House of Representatives a budget request reflecting the
16 increased costs associated with the proposed final rule,
17 and the request has been included in an appropriations
18 Act and enacted into law.

19 **“SEC. 811. SEVERABILITY PROVISIONS.**

20 “If any provision of this Act, any amendment made
21 by the Act, or the application of such provision or amend-
22 ment to any person or circumstances is held to be invalid,
23 the remainder of this Act, the remaining amendments
24 made by this Act, and the application of such provisions

1 to persons or circumstances other than those to which it
2 is held invalid, shall not be affected thereby.

3 **“SEC. 812. USE OF PATIENT SAFETY ORGANIZATIONS.**

4 “The Service, an Indian Tribe, Tribal Organization,
5 or urban Indian organization may provide for quality as-
6 surance activities through the use of a patient safety orga-
7 nization in accordance with title IX of the Public Health
8 Service Act.

9 **“SEC. 813. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-**
10 **ANCE RECORDS; QUALIFIED IMMUNITY FOR**
11 **PARTICIPANTS.**

12 “(a) CONFIDENTIALITY OF RECORDS.—Medical qual-
13 ity assurance records created by or for any Indian Health
14 Program or a health program of an Urban Indian Organi-
15 zation as part of a medical quality assurance program are
16 confidential and privileged. Such records may not be dis-
17 closed to any person or entity, except as provided in sub-
18 section (c).

19 “(b) PROHIBITION ON DISCLOSURE AND TESTI-
20 MONY.—

21 “(1) IN GENERAL.—No part of any medical
22 quality assurance record described in subsection (a)
23 may be subject to discovery or admitted into evi-
24 dence in any judicial or administrative proceeding,
25 except as provided in subsection (c).

1 “(2) TESTIMONY.—A person who reviews or
2 creates medical quality assurance records for any In-
3 dian Health Program or Urban Indian Organization
4 who participates in any proceeding that reviews or
5 creates such records may not be permitted or re-
6 quired to testify in any judicial or administrative
7 proceeding with respect to such records or with re-
8 spect to any finding, recommendation, evaluation,
9 opinion, or action taken by such person or body in
10 connection with such records except as provided in
11 this section.

12 “(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

13 “(1) IN GENERAL.—Subject to paragraph (2), a
14 medical quality assurance record described in sub-
15 section (a) may be disclosed, and a person referred
16 to in subsection (b) may give testimony in connec-
17 tion with such a record, only as follows:

18 “(A) To a Federal executive agency or pri-
19 vate organization, if such medical quality assur-
20 ance record or testimony is needed by such
21 agency or organization to perform licensing or
22 accreditation functions related to any Indian
23 Health Program or to a health program of an
24 Urban Indian Organization to perform moni-

1 toring, required by law, of such program or or-
2 ganization.

3 “(B) To an administrative or judicial pro-
4 ceeding commenced by a present or former In-
5 dian Health Program or Urban Indian Organi-
6 zation provider concerning the termination, sus-
7 pension, or limitation of clinical privileges of
8 such health care provider.

9 “(C) To a governmental board or agency
10 or to a professional health care society or orga-
11 nization, if such medical quality assurance
12 record or testimony is needed by such board,
13 agency, society, or organization to perform li-
14 censing, credentialing, or the monitoring of pro-
15 fessional standards with respect to any health
16 care provider who is or was an employee of any
17 Indian Health Program or Urban Indian Orga-
18 nization.

19 “(D) To a hospital, medical center, or
20 other institution that provides health care serv-
21 ices, if such medical quality assurance record or
22 testimony is needed by such institution to as-
23 sess the professional qualifications of any health
24 care provider who is or was an employee of any
25 Indian Health Program or Urban Indian Orga-

1 nization and who has applied for or been grant-
2 ed authority or employment to provide health
3 care services in or on behalf of such program or
4 organization.

5 “(E) To an officer, employee, or contractor
6 of the Indian Health Program or Urban Indian
7 Organization that created the records or for
8 which the records were created. If that officer,
9 employee, or contractor has a need for such
10 record or testimony to perform official duties.

11 “(F) To a criminal or civil law enforce-
12 ment agency or instrumentality charged under
13 applicable law with the protection of the public
14 health or safety, if a qualified representative of
15 such agency or instrumentality makes a written
16 request that such record or testimony be pro-
17 vided for a purpose authorized by law.

18 “(G) In an administrative or judicial pro-
19 ceeding commenced by a criminal or civil law
20 enforcement agency or instrumentality referred
21 to in subparagraph (F), but only with respect
22 to the subject of such proceeding.

23 “(2) IDENTITY OF PARTICIPANTS.—With the
24 exception of the subject of a quality assurance ac-
25 tion, the identity of any person receiving health care

1 services from any Indian Health Program or Urban
2 Indian Organization or the identity of any other per-
3 son associated with such program or organization
4 for purposes of a medical quality assurance program
5 that is disclosed in a medical quality assurance
6 record described in subsection (a) shall be deleted
7 from that record or document before any disclosure
8 of such record is made outside such program or or-
9 ganization.

10 “(d) DISCLOSURE FOR CERTAIN PURPOSES.—

11 “(1) IN GENERAL.—Nothing in this section
12 shall be construed as authorizing or requiring the
13 withholding from any person or entity aggregate sta-
14 tistical information regarding the results of any In-
15 dian Health Program or Urban Indian
16 Organizations’s medical quality assurance programs.

17 “(2) WITHHOLDING FROM CONGRESS.—Noth-
18 ing in this section shall be construed as authority to
19 withhold any medical quality assurance record from
20 a committee of either House of Congress, any joint
21 committee of Congress, or the Government Account-
22 ability Office if such record pertains to any matter
23 within their respective jurisdictions.

24 “(e) PROHIBITION ON DISCLOSURE OF RECORD OR
25 TESTIMONY.—A person or entity having possession of or

1 access to a record or testimony described by this section
2 may not disclose the contents of such record or testimony
3 in any manner or for any purpose except as provided in
4 this section.

5 “(f) EXEMPTION FROM FREEDOM OF INFORMATION
6 ACT.—Medical quality assurance records described in sub-
7 section (a) may not be made available to any person under
8 section 552 of title 5, United States Code.

9 “(g) LIMITATION ON CIVIL LIABILITY.—A person
10 who participates in or provides information to a person
11 or body that reviews or creates medical quality assurance
12 records described in subsection (a) shall not be civilly lia-
13 ble for such participation or for providing such informa-
14 tion if the participation or provision of information was
15 in good faith based on prevailing professional standards
16 at the time the medical quality assurance program activity
17 took place.

18 “(h) APPLICATION TO INFORMATION IN CERTAIN
19 OTHER RECORDS.—Nothing in this section shall be con-
20 strued as limiting access to the information in a record
21 created and maintained outside a medical quality assur-
22 ance program, including a patient’s medical records, on
23 the grounds that the information was presented during
24 meetings of a review body that are part of a medical qual-
25 ity assurance program.

1 “(i) REGULATIONS.—The Secretary, acting through
2 the Service, shall promulgate regulations pursuant to sec-
3 tion 802.

4 “(j) DEFINITIONS.—In this section:

5 “(1) The term ‘health care provider’ means any
6 health care professional, including community health
7 aides and practitioners certified under section 121,
8 who are granted clinical practice privileges or em-
9 ployed to provide health care services in an Indian
10 Health Program or health program of an Urban In-
11 dian Organization, who is licensed or certified to
12 perform health care services by a governmental
13 board or agency or professional health care society
14 or organization.

15 “(2) The term ‘medical quality assurance pro-
16 gram’ means any activity carried out before, on, or
17 after the date of enactment of this Act by or for any
18 Indian Health Program or Urban Indian Organiza-
19 tion to assess the quality of medical care, including
20 activities conducted by or on behalf of individuals,
21 Indian Health Program or Urban Indian Organiza-
22 tion medical or dental treatment review committees,
23 or other review bodies responsible for quality assur-
24 ance, credentials, infection control, patient safety,
25 patient care assessment (including treatment proce-

1 dures, blood, drugs, and therapeutics), medical
2 records, health resources management review and
3 identification and prevention of medical or dental in-
4 cidents and risks.

5 “(3) The term ‘medical quality assurance
6 record’ means the proceedings, records, minutes, and
7 reports that emanate from quality assurance pro-
8 gram activities described in paragraph (2) and are
9 produced or compiled by or for an Indian Health
10 Program or Urban Indian Organization as part of a
11 medical quality assurance program.

12 “(k) CONTINUED PROTECTION.—Disclosure under
13 subsection (c) does not permit redisclosure except to the
14 extent such further disclosure is authorized under sub-
15 section (c) or is otherwise authorized to be disclosed under
16 this section.

17 “(l) INCONSISTENCIES.—To the extent that the pro-
18 tections under the Patient Safety and Quality Improve-
19 ment Act of 2005 and this section are inconsistent, the
20 provisions of whichever is more protective shall control.

21 “(m) RELATIONSHIP TO OTHER LAW.—This section
22 shall continue in force and effect, except as otherwise spe-
23 cifically provided in any Federal law enacted after the date
24 of enactment of the Indian Health Care Improvement Act
25 Amendments of 2009.

1960

1 **“SEC. 814. CLAREMORE INDIAN HOSPITAL.**

2 “The Claremore Indian Hospital shall be deemed to
3 be a dependant Indian community for the purposes of sec-
4 tion 1151 of title 18, United States Code.

5 **“SEC. 815. SENSE OF CONGRESS REGARDING LAW EN-
6 FORCEMENT AND METHAMPHETAMINE
7 ISSUES IN INDIAN COUNTRY.**

8 “It is the sense of Congress that Congress encourages
9 State, local, and Indian tribal law enforcement agencies
10 to enter into memoranda of agreement between and
11 among those agencies for purposes of streamlining law en-
12 forcement activities and maximizing the use of limited re-
13 sources—

14 “(1) to improve law enforcement services pro-
15 vided to Indian tribal communities; and

16 “(2) to increase the effectiveness of measures to
17 address problems relating to methamphetamine use
18 in Indian country (as defined in section 1151 of title
19 18, United States Code).

20 **“SEC. 816. PERMITTING IMPLEMENTATION THROUGH CON-
21 TRACTS WITH TRIBAL HEALTH PROGRAMS.**

22 “Nothing in this Act shall be construed as preventing
23 the Secretary from—

24 “(1) carrying out any section of this Act
25 through contracts with Tribal Health Programs; and

1 “(2) carrying out sections through 214,
2 701(a)(1), 701(b)(1), 701(c), 707(g), and 712(b),
3 through contracts with urban Indian organizations.
4 The previous sentence shall not affect the authority the
5 Secretary may otherwise have to carry out other provisions
6 of this Act through such contracts.

7 **“SEC. 817. AUTHORIZATION OF APPROPRIATIONS; AVAIL-**
8 **ABILITY.**

9 “(a) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this title.

12 “(b) LIMITATION ON NEW SPENDING AUTHORITY.—
13 Any new spending authority (described in subparagraph
14 (A) or (B) of section 401(c)(2) of the Congressional Budg-
15 et Act of 1974 (Public Law 93–344; 88 Stat. 317)) which
16 is provided under this Act shall be effective for any fiscal
17 year only to such extent or in such amounts as are pro-
18 vided in appropriation Acts.

19 “(c) AVAILABILITY.—The funds appropriated pursu-
20 ant to this Act shall remain available until expended.”.

21 (b) RATE OF PAY.—

22 (1) POSITIONS AT LEVEL IV.—Section 5315 of
23 title 5, United States Code, is amended by striking
24 “Assistant Secretaries of Health and Human Serv-

1 ices (6).” and inserting “Assistant Secretaries of
2 Health and Human Services (7)”.

3 (2) POSITIONS AT LEVEL V.—Section 5316 of
4 title 5, United States Code, is amended by striking
5 “Director, Indian Health Service, Department of
6 Health and Human Services”.

7 (c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

8 (1) Section 3307(b)(1)(C) of the Children’s
9 Health Act of 2000 (25 U.S.C. 1671 note; Public
10 Law 106–310) is amended by striking “Director of
11 the Indian Health Service” and inserting “Assistant
12 Secretary for Indian Health”.

13 (2) The Indian Lands Open Dump Cleanup Act
14 of 1994 is amended—

15 (A) in section 3 (25 U.S.C. 3902)—

16 (i) by striking paragraph (2);

17 (ii) by redesignating paragraphs (1),
18 (3), (4), (5), and (6) as paragraphs (4),
19 (5), (2), (6), and (1), respectively, and
20 moving those paragraphs so as to appear
21 in numerical order; and

22 (iii) by inserting before paragraph (4)
23 (as redesignated by subclause (II)) the fol-
24 lowing:

1 “(3) ASSISTANT SECRETARY.—The term ‘As-
2 sistant Secretary’ means the Assistant Secretary for
3 Indian Health.”;

4 (B) in section 5 (25 U.S.C. 3904), by
5 striking the section designation and heading
6 and inserting the following:

7 **“SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR IN-
8 DIAN HEALTH.”;**

9 (C) in section 6(a) (25 U.S.C. 3905(a)), in
10 the subsection heading, by striking “DIREC-
11 TOR” and inserting “ASSISTANT SECRETARY”;

12 (D) in section 9(a) (25 U.S.C. 3908(a)), in
13 the subsection heading, by striking “DIREC-
14 TOR” and inserting “ASSISTANT SECRETARY”;
15 and

16 (E) by striking “Director” each place it
17 appears and inserting “Assistant Secretary”.

18 (3) Section 5504(d)(2) of the Augustus F.
19 Hawkins-Robert T. Stafford Elementary and Sec-
20 ondary School Improvement Amendments of 1988
21 (25 U.S.C. 2001 note; Public Law 100–297) is
22 amended by striking “Director of the Indian Health
23 Service” and inserting “Assistant Secretary for In-
24 dian Health”.

1 (4) Section 203(a)(1) of the Rehabilitation Act
2 of 1973 (29 U.S.C. 763(a)(1)) is amended by strik-
3 ing “Director of the Indian Health Service” and in-
4 serting “Assistant Secretary for Indian Health”.

5 (5) Subsections (b) and (e) of section 518 of
6 the Federal Water Pollution Control Act (33 U.S.C.
7 1377) are amended by striking “Director of the In-
8 dian Health Service” each place it appears and in-
9 serting “Assistant Secretary for Indian Health”.

10 (6) Section 317M(b) of the Public Health Serv-
11 ice Act (42 U.S.C. 247b–14(b)) is amended—

12 (A) by striking “Director of the Indian
13 Health Service” each place it appears and in-
14 serting “Assistant Secretary for Indian
15 Health”; and

16 (B) in paragraph (2)(A), by striking “the
17 Directors referred to in such paragraph” and
18 inserting “the Director of the Centers for Dis-
19 ease Control and Prevention and the Assistant
20 Secretary for Indian Health”.

21 (7) Section 417C(b) of the Public Health Serv-
22 ice Act (42 U.S.C. 285–9(b)) is amended by striking
23 “Director of the Indian Health Service” and insert-
24 ing “Assistant Secretary for Indian Health”.

1 (8) Section 1452(i) of the Safe Drinking Water
2 Act (42 U.S.C. 300j-12(i)) is amended by striking
3 “Director of the Indian Health Service” each place
4 it appears and inserting “Assistant Secretary for In-
5 dian Health”.

6 (9) Section 803B(d)(1) of the Native American
7 Programs Act of 1974 (42 U.S.C. 2991b-2(d)(1)) is
8 amended in the last sentence by striking “Director
9 of the Indian Health Service” and inserting “Assist-
10 ant Secretary for Indian Health”.

11 (10) Section 203(b) of the Michigan Indian
12 Land Claims Settlement Act (Public Law 105-143;
13 111 Stat. 2666) is amended by striking “Director of
14 the Indian Health Service” and inserting “Assistant
15 Secretary for Indian Health”.

16 **SEC. 3102. SOBOBA SANITATION FACILITIES.**

17 The Act of December 17, 1970 (84 Stat. 1465), is
18 amended by adding at the end the following:

19 “SEC. 9. Nothing in this Act shall preclude the
20 Soboba Band of Mission Indians and the Soboba Indian
21 Reservation from being provided with sanitation facilities
22 and services under the authority of section 7 of the Act
23 of August 5, 1954 (68 Stat. 674), as amended by the Act
24 of July 31, 1959 (73 Stat. 267).”.

1966

1 **SEC. 3103. NATIVE AMERICAN HEALTH AND WELLNESS**
2 **FOUNDATION.**

3 (a) IN GENERAL.—The Indian Self-Determination
4 and Education Assistance Act (25 U.S.C. 450 et seq.) is
5 amended by adding at the end the following:

6 **“TITLE VIII—NATIVE AMERICAN**
7 **HEALTH AND WELLNESS**
8 **FOUNDATION**

9 **“SEC. 801. DEFINITIONS.**

10 “In this title:

11 “(1) BOARD.—The term ‘Board’ means the
12 Board of Directors of the Foundation.

13 “(2) COMMITTEE.—The term ‘Committee’
14 means the Committee for the Establishment of Na-
15 tive American Health and Wellness Foundation es-
16 tablished under section 802(f).

17 “(3) FOUNDATION.—The term ‘Foundation’
18 means the Native American Health and Wellness
19 Foundation established under section 802.

20 “(4) SECRETARY.—The term ‘Secretary’ means
21 the Secretary of Health and Human Services.

22 “(5) SERVICE.—The term ‘Service’ means the
23 Indian Health Service of the Department of Health
24 and Human Services.

1967

1 **“SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS**
2 **FOUNDATION.**

3 “(a) ESTABLISHMENT.—

4 “(1) IN GENERAL.—As soon as practicable
5 after the date of enactment of this title, the Sec-
6 retary shall establish, under the laws of the District
7 of Columbia and in accordance with this title, the
8 Native American Health and Wellness Foundation.

9 “(2) FUNDING DETERMINATIONS.—No funds,
10 gift, property, or other item of value (including any
11 interest accrued on such an item) acquired by the
12 Foundation shall—

13 “(A) be taken into consideration for pur-
14 poses of determining Federal appropriations re-
15 lating to the provision of health care and serv-
16 ices to Indians; or

17 “(B) otherwise limit, diminish, or affect
18 the Federal responsibility for the provision of
19 health care and services to Indians.

20 “(b) PERPETUAL EXISTENCE.—The Foundation
21 shall have perpetual existence.

22 “(c) NATURE OF CORPORATION.—The Foundation—

23 “(1) shall be a charitable and nonprofit feder-
24 ally chartered corporation; and

25 “(2) shall not be an agency or instrumentality
26 of the United States.

1 “(d) PLACE OF INCORPORATION AND DOMICILE.—
2 The Foundation shall be incorporated and domiciled in the
3 District of Columbia.

4 “(e) DUTIES.—The Foundation shall—

5 “(1) encourage, accept, and administer private
6 gifts of real and personal property, and any income
7 from or interest in such gifts, for the benefit of, or
8 in support of, the mission of the Service;

9 “(2) undertake and conduct such other activi-
10 ties as will further the health and wellness activities
11 and opportunities of Native Americans; and

12 “(3) participate with and assist Federal, State,
13 and tribal governments, agencies, entities, and indi-
14 viduals in undertaking and conducting activities that
15 will further the health and wellness activities and op-
16 portunities of Native Americans.

17 “(f) COMMITTEE FOR THE ESTABLISHMENT OF NA-
18 TIVE AMERICAN HEALTH AND WELLNESS FOUNDA-
19 TION.—

20 “(1) IN GENERAL.—The Secretary shall estab-
21 lish the Committee for the Establishment of Native
22 American Health and Wellness Foundation to assist
23 the Secretary in establishing the Foundation.

1 “(2) DUTIES.—Not later than 180 days after
2 the date of enactment of this section, the Committee
3 shall—

4 “(A) carry out such activities as are nec-
5 essary to incorporate the Foundation under the
6 laws of the District of Columbia, including act-
7 ing as incorporators of the Foundation;

8 “(B) ensure that the Foundation qualifies
9 for and maintains the status required to carry
10 out this section, until the Board is established;

11 “(C) establish the constitution and initial
12 bylaws of the Foundation;

13 “(D) provide for the initial operation of
14 the Foundation, including providing for tem-
15 porary or interim quarters, equipment, and
16 staff; and

17 “(E) appoint the initial members of the
18 Board in accordance with the constitution and
19 initial bylaws of the Foundation.

20 “(g) BOARD OF DIRECTORS.—

21 “(1) IN GENERAL.—The Board of Directors
22 shall be the governing body of the Foundation.

23 “(2) POWERS.—The Board may exercise, or
24 provide for the exercise of, the powers of the Foun-
25 dation.

1970

1 “(3) SELECTION.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), the number of members of the
4 Board, the manner of selection of the members
5 (including the filling of vacancies), and the
6 terms of office of the members shall be as pro-
7 vided in the constitution and bylaws of the
8 Foundation.

9 “(B) REQUIREMENTS.—

10 “(i) NUMBER OF MEMBERS.—The
11 Board shall have at least 11 members, who
12 shall have staggered terms.

13 “(ii) INITIAL VOTING MEMBERS.—The
14 initial voting members of the Board—

15 “(I) shall be appointed by the
16 Committee not later than 180 days
17 after the date on which the Founda-
18 tion is established; and

19 “(II) shall have staggered terms.

20 “(iii) QUALIFICATION.—The members
21 of the Board shall be United States citi-
22 zens who are knowledgeable or experienced
23 in Native American health care and related
24 matters.

1971

1 “(C) COMPENSATION.—A member of the
2 Board shall not receive compensation for service
3 as a member, but shall be reimbursed for actual
4 and necessary travel and subsistence expenses
5 incurred in the performance of the duties of the
6 Foundation.

7 “(h) OFFICERS.—

8 “(1) IN GENERAL.—The officers of the Founda-
9 tion shall be—

10 “(A) a secretary, elected from among the
11 members of the Board; and

12 “(B) any other officers provided for in the
13 constitution and bylaws of the Foundation.

14 “(2) CHIEF OPERATING OFFICER.—The sec-
15 retary of the Foundation may serve, at the direction
16 of the Board, as the chief operating officer of the
17 Foundation, or the Board may appoint a chief oper-
18 ating officer, who shall serve at the direction of the
19 Board.

20 “(3) ELECTION.—The manner of election, term
21 of office, and duties of the officers of the Founda-
22 tion shall be as provided in the constitution and by-
23 laws of the Foundation.

24 “(i) POWERS.—The Foundation—

1 “(1) shall adopt a constitution and bylaws for
2 the management of the property of the Foundation
3 and the regulation of the affairs of the Foundation;

4 “(2) may adopt and alter a corporate seal;

5 “(3) may enter into contracts;

6 “(4) may acquire (through a gift or otherwise),
7 own, lease, encumber, and transfer real or personal
8 property as necessary or convenient to carry out the
9 purposes of the Foundation;

10 “(5) may sue and be sued; and

11 “(6) may perform any other act necessary and
12 proper to carry out the purposes of the Foundation.

13 “(j) PRINCIPAL OFFICE.—

14 “(1) IN GENERAL.—The principal office of the
15 Foundation shall be in the District of Columbia.

16 “(2) ACTIVITIES; OFFICES.—The activities of
17 the Foundation may be conducted, and offices may
18 be maintained, throughout the United States in ac-
19 cordance with the constitution and bylaws of the
20 Foundation.

21 “(k) SERVICE OF PROCESS.—The Foundation shall
22 comply with the law on service of process of each State
23 in which the Foundation is incorporated and of each State
24 in which the Foundation carries on activities.

1973

1 “(1) LIABILITY OF OFFICERS, EMPLOYEES, AND
2 AGENTS.—

3 “(1) IN GENERAL.—The Foundation shall be
4 liable for the acts of the officers, employees, and
5 agents of the Foundation acting within the scope of
6 their authority.

7 “(2) PERSONAL LIABILITY.—A member of the
8 Board shall be personally liable only for gross neg-
9 ligence in the performance of the duties of the mem-
10 ber.

11 “(m) RESTRICTIONS.—

12 “(1) LIMITATION ON SPENDING.—Beginning
13 with the fiscal year following the first full fiscal year
14 during which the Foundation is in operation, the ad-
15 ministrative costs of the Foundation shall not exceed
16 the percentage described in paragraph (2) of the
17 sum of—

18 “(A) the amounts transferred to the Foun-
19 dation under subsection (o) during the pre-
20 ceding fiscal year; and

21 “(B) donations received from private
22 sources during the preceding fiscal year.

23 “(2) PERCENTAGES.—The percentages referred
24 to in paragraph (1) are—

1974

1 “(A) for the first fiscal year described in
2 that paragraph, 20 percent;

3 “(B) for the following fiscal year, 15 per-
4 cent; and

5 “(C) for each fiscal year thereafter, 10
6 percent.

7 “(3) APPOINTMENT AND HIRING.—The ap-
8 pointment of officers and employees of the Founda-
9 tion shall be subject to the availability of funds.

10 “(4) STATUS.—A member of the Board or offi-
11 cer, employee, or agent of the Foundation shall not
12 by reason of association with the Foundation be con-
13 sidered to be an officer, employee, or agent of the
14 United States.

15 “(n) AUDITS.—The Foundation shall comply with
16 section 10101 of title 36, United States Code, as if the
17 Foundation were a corporation under part B of subtitle
18 II of that title.

19 “(o) FUNDING.—

20 “(1) AUTHORIZATION OF APPROPRIATIONS.—
21 There is authorized to be appropriated to carry out
22 subsection (e)(1) \$500,000 for each fiscal year, as
23 adjusted to reflect changes in the Consumer Price
24 Index for all-urban consumers published by the De-
25 partment of Labor.

1975

1 “(2) TRANSFER OF DONATED FUNDS.—The
2 Secretary shall transfer to the Foundation funds
3 held by the Department of Health and Human Serv-
4 ices under the Act of August 5, 1954 (42 U.S.C.
5 2001 et seq.), if the transfer or use of the funds is
6 not prohibited by any term under which the funds
7 were donated.

8 **“SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.**

9 “(a) PROVISION OF SUPPORT BY SECRETARY.—Sub-
10 ject to subsection (b), during the 5-year period beginning
11 on the date on which the Foundation is established, the
12 Secretary—

13 “(1) may provide personnel, facilities, and other
14 administrative support services to the Foundation;

15 “(2) may provide funds for initial operating
16 costs and to reimburse the travel expenses of the
17 members of the Board; and

18 “(3) shall require and accept reimbursements
19 from the Foundation for—

20 “(A) services provided under paragraph
21 (1); and

22 “(B) funds provided under paragraph (2).

23 “(b) REIMBURSEMENT.—Reimbursements accepted
24 under subsection (a)(3)—

1 “(1) shall be deposited in the Treasury of the
2 United States to the credit of the applicable appro-
3 priations account; and

4 “(2) shall be chargeable for the cost of pro-
5 viding services described in subsection (a)(1) and
6 travel expenses described in subsection (a)(2).

7 “(c) CONTINUATION OF CERTAIN SERVICES.—The
8 Secretary may continue to provide facilities and necessary
9 support services to the Foundation after the termination
10 of the 5-year period specified in subsection (a) if the facili-
11 ties and services—

12 “(1) are available; and

13 “(2) are provided on reimbursable cost basis.”.

14 (b) TECHNICAL AMENDMENTS.—The Indian Self-De-
15 termination and Education Assistance Act is amended—

16 (1) by redesignating title V (25 U.S.C. 458bbb
17 et seq.) as title VII;

18 (2) by redesignating sections 501, 502, and 503
19 (25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sec-
20 tions 701, 702, and 703, respectively; and

21 (3) in subsection (a)(2) of section 702 and
22 paragraph (2) of section 703 (as redesignated by
23 paragraph (2)), by striking “section 501” and in-
24 serting “section 701”.

1977

1 **SEC. 3104. GAO STUDY AND REPORT ON PAYMENTS FOR**
2 **CONTRACT HEALTH SERVICES.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Comptroller General of
5 the United States (in this section referred to as the
6 “Comptroller General”) shall conduct a study on the
7 utilization of health care furnished by health care
8 providers under the contract health services program
9 funded by the Indian Health Service and operated
10 by the Indian Health Service, an Indian Tribe, or a
11 Tribal Organization (as those terms are defined in
12 section 4 of the Indian Health Care Improvement
13 Act).

14 (2) ANALYSIS.—The study conducted under
15 paragraph (1) shall include an analysis of—

16 (A) the amounts reimbursed under the
17 contract health services program described in
18 paragraph (1) for health care furnished by enti-
19 ties, individual providers, and suppliers, includ-
20 ing a comparison of reimbursement for such
21 health care through other public programs and
22 in the private sector;

23 (B) barriers to accessing care under such
24 contract health services program, including, but
25 not limited to, barriers relating to travel dis-
26 tances, cultural differences, and public and pri-

1978

1 vate sector reluctance to furnish care to pa-
2 tients under such program;

3 (C) the adequacy of existing Federal fund-
4 ing for health care under such contract health
5 services program; and

6 (D) any other items determined appro-
7 priate by the Comptroller General.

8 (b) REPORT.—Not later than 18 months after the
9 date of enactment of this Act, the Comptroller General
10 shall submit to Congress a report on the study conducted
11 under subsection (a), together with recommendations re-
12 garding—

13 (1) the appropriate level of Federal funding
14 that should be established for health care under the
15 contract health services program described in sub-
16 section (a)(1); and

17 (2) how to most efficiently utilize such funding.

18 (c) CONSULTATION.—In conducting the study under
19 subsection (a) and preparing the report under subsection
20 (b), the Comptroller General shall consult with the Indian
21 Health Service, Indian Tribes, and Tribal Organizations.

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1 **TITLE II—IMPROVEMENT OF IN-**
2 **DIAN HEALTH CARE PRO-**
3 **VIDED UNDER THE SOCIAL**
4 **SECURITY ACT**

5 **SEC. 3201. EXPANSION OF PAYMENTS UNDER MEDICARE,**
6 **MEDICAID, AND SCHIP FOR ALL COVERED**
7 **SERVICES FURNISHED BY INDIAN HEALTH**
8 **PROGRAMS.**

9 (a) MEDICAID.—

10 (1) EXPANSION TO ALL COVERED SERVICES.—

11 Section 1911 of the Social Security Act (42 U.S.C.
12 1396j) is amended—

13 (A) by amending the heading to read as
14 follows:

15 **“SEC. 1911. INDIAN HEALTH PROGRAMS.”;**

16 and

17 (B) by amending subsection (a) to read as
18 follows:

19 **“(a) ELIGIBILITY FOR PAYMENT FOR MEDICAL AS-**
20 **SISTANCE.—**An Indian Health Program shall be eligible
21 for payment for medical assistance provided under a State
22 plan or under waiver authority with respect to items and
23 services furnished by the Program if the furnishing of
24 such services meets all the conditions and requirements
25 which are applicable generally to the furnishing of items

1 and services under this title and under such plan or waiver
2 authority.”.

3 (2) REPEAL OF OBSOLETE PROVISION.—Sub-
4 section (b) of such section is repealed.

5 (3) REVISION OF AUTHORITY TO ENTER INTO
6 AGREEMENTS.—Subsection (c) of such section is
7 amended to read as follows:

8 “(c) AUTHORITY TO ENTER INTO AGREEMENTS.—
9 The Secretary may enter into an agreement with a State
10 for the purpose of reimbursing the State for medical as-
11 sistance provided by the Indian Health Service, an Indian
12 Tribe, Tribal Organization, or an Urban Indian Organiza-
13 tion (as so defined), directly, through referral, or under
14 contracts or other arrangements between the Indian
15 Health Service, an Indian Tribe, Tribal Organization, or
16 an Urban Indian Organization and another health care
17 provider to Indians who are eligible for medical assistance
18 under the State plan or under waiver authority. This sub-
19 section shall not be construed to impair the entitlement
20 of a State to reimbursement for such medical assistance
21 under this title.”.

22 (4) CROSS-REFERENCES TO SPECIAL FUND FOR
23 IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING
24 OPTION; DEFINITIONS.—Such section is further

1 amended by striking subsection (d) and adding at
2 the end the following new subsections:

3 “(c) SPECIAL FUND FOR IMPROVEMENT OF IHS FA-
4 CILITIES.—For provisions relating to the authority of the
5 Secretary to place payments to which a facility of the In-
6 dian Health Service is eligible for payment under this title
7 into a special fund established under section 401(c)(1) of
8 the Indian Health Care Improvement Act, see subpara-
9 graphs (A) and (B) of section 401(c)(1) of such Act.

10 “(d) DIRECT BILLING.—For provisions relating to
11 the authority of an Tribal Health Program to elect to di-
12 rectly bill for, and receive payment for, health care items
13 and services provided by such Program for which payment
14 is made under this title, see section 401(d) of the Indian
15 Health Care Improvement Act.”.

16 (5) DEFINITIONS.—Section 1101(a) of such Act
17 (42 U.S.C. 1301(a)) is amended by adding at the
18 end the following new paragraph:

19 “(11) For purposes of this title and titles
20 XVIII, XIX, and XXI, the terms ‘Indian Health
21 Program’, ‘Indian Tribe’ (and ‘Indian tribe’), ‘Tribal
22 Health Program’, ‘Tribal Organization’ (and ‘tribal
23 organization’), and ‘urban Indian organization’ (and
24 ‘urban Indian organization’) have the meanings

1 given those terms in section 4 of the Indian Health
2 Care Improvement Act.”.

3 (b) MEDICARE.—

4 (1) EXPANSION TO ALL COVERED SERVICES.—
5 Section 1880 of such Act (42 U.S.C. 1395qq) is
6 amended—

7 (A) by amending the heading to read as
8 follows:

9 **“SEC. 1880. INDIAN HEALTH PROGRAMS.”;**

10 and

11 (B) by amending subsection (a) to read as
12 follows:

13 “(a) ELIGIBILITY FOR PAYMENTS.—Subject to sub-
14 section (e), an Indian Health Program shall be eligible for
15 payments under this title with respect to items and serv-
16 ices furnished by the Program if the furnishing of such
17 services meets all the conditions and requirements which
18 are applicable generally to the furnishing of items and
19 services under this title.”.

20 (2) REPEAL OF OBSOLETE PROVISION.—Sub-
21 section (b) of such section is repealed.

22 (3) CROSS-REFERENCES TO SPECIAL FUND FOR
23 IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING
24 OPTION; DEFINITIONS.—

1 (A) IN GENERAL.—Such section is further
2 amended by striking subsections (c) and (d)
3 and inserting the following new subsections:

4 “(b) SPECIAL FUND FOR IMPROVEMENT OF IHS FA-
5 CILITIES.—For provisions relating to the authority of the
6 Secretary to place payments to which a facility of the In-
7 dian Health Service is eligible for payment under this title
8 into a special fund established under section 401(c)(1) of
9 the Indian Health Care Improvement Act, and the require-
10 ment to use amounts paid from such fund for making im-
11 provements in accordance with subsection (b), see sub-
12 paragraphs (A) and (B) of section 401(c)(1) of such Act.

13 “(c) DIRECT BILLING.—For provisions relating to
14 the authority of a Tribal Health Program to elect to di-
15 rectly bill for, and receive payment for, health care items
16 and services provided by such Program for which payment
17 is made under this title, see section 401(d) of the Indian
18 Health Care Improvement Act.”.

19 (B) CONFORMING AMENDMENTS.—Such
20 section is further amended—

21 (i) in subsection (e)(3), by striking
22 “Subsection (c)” and inserting “Subsection
23 (b) and section 401(b)(1) of the Indian
24 Health Care Improvement Act”;

1 (ii) by redesignating subsection (e) as
2 subsection (d); and

3 (iii) by striking subsection (f).

4 (4) DEFINITIONS.—Such section is further
5 amended by amending adding at the end the fol-
6 lowing new subsection:

7 “(e) DEFINITIONS.—In this section, the terms ‘In-
8 dian Health Program’, ‘Indian Tribe’, ‘Service Unit’,
9 ‘Tribal Health Program’, ‘Tribal Organization’, and
10 ‘Urban Indian Organization’ have the meanings given
11 those terms in section 4 of the Indian Health Care Im-
12 provement Act.”.

13 (c) APPLICATION TO SCHIP.—Section 2107(e)(1) of
14 the Social Security Act (42 U.S.C. 1397gg(e)(1)) is
15 amended—

16 (1) by redesignating subparagraphs (K)
17 through (M) as subparagraphs (L) through (N), re-
18 spectively; and

19 (2) by inserting after subparagraph (J), the fol-
20 lowing new subparagraph:

21 “(K) Section 1911 (relating to Indian
22 Health Programs, other than subsection (e) of
23 such section).”.

1 **SEC. 3202. ADDITIONAL PROVISIONS TO INCREASE OUT-**
2 **REACH TO, AND ENROLLMENT OF, INDIANS**
3 **IN SCHIP AND MEDICAID.**

4 (a) ASSURANCE OF PAYMENTS TO INDIAN HEALTH
5 CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—
6 Section 2102(b)(3)(D) of the Social Security Act (42
7 U.S.C. 1397bb(b)(3)(D)) is amended by striking “(as de-
8 fined in section 4(c) of the Indian Health Care Improve-
9 ment Act, 25 U.S.C. 1603(c))” and inserting “, including
10 how the State will ensure that payments are made to In-
11 dian Health Programs and urban Indian organizations op-
12 erating in the State for the provision of such assistance”.

13 (b) INCLUSION OF OTHER INDIAN FINANCED
14 HEALTH CARE PROGRAMS IN EXEMPTION FROM PROHI-
15 BITION ON CERTAIN PAYMENTS.—Section 2105(c)(6)(B)
16 of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by
17 striking “insurance program, other than an insurance pro-
18 gram operated or financed by the Indian Health Service”
19 and inserting “program, other than a health care program
20 operated or financed by the Indian Health Service or by
21 an Indian Tribe, Tribal Organization, or urban Indian or-
22 ganization”.

23 (c) DEFINITIONS.—Section 2110(c) of such Act (42
24 U.S.C. 1397jj(c)) is amended by adding at the end the
25 following new paragraph:

1 “(9) INDIAN; INDIAN HEALTH PROGRAM; IN-
2 DIAN TRIBE; ETC.—The terms ‘Indian’, ‘Indian
3 Health Program’, ‘Indian Tribe’, ‘Tribal Organiza-
4 tion’, and ‘Urban Indian Organization’ have the
5 meanings given those terms in section 4 of the In-
6 dian Health Care Improvement Act.”.

7 **SEC. 3203. SOLICITATION OF PROPOSALS FOR SAFE HAR-**
8 **BORS UNDER THE SOCIAL SECURITY ACT**
9 **FOR FACILITIES OF INDIAN HEALTH PRO-**
10 **GRAMS AND URBAN INDIAN ORGANIZATIONS.**

11 The Secretary of Health and Human Services, acting
12 through the Office of the Inspector General of the Depart-
13 ment of Health and Human Services, shall publish a no-
14 tice, described in section 1128D(a)(1)(A) of the Social Se-
15 curity Act (42 U.S.C. 1320a-7d(a)(1)(A)), soliciting a
16 proposal, not later than July 1, 2010, on the development
17 of safe harbors described in such section relating to health
18 care items and services provided by facilities of Indian
19 Health Programs or an urban Indian organization (as
20 such terms are defined in section 4 of the Indian Health
21 Care Improvement Act). Such a safe harbor may relate
22 to areas such as transportation, housing, or cost-sharing,
23 assistance provided through such facilities or contract
24 health services for Indians.

1 **SEC. 3204. ANNUAL REPORT ON INDIANS SERVED BY SO-**
2 **CIAL SECURITY ACT HEALTH BENEFIT PRO-**
3 **GRAMS.**

4 Section 1139 of the Social Security Act (42 U.S.C.
5 1320b-9), as amended by the sections 3203 and 3204,
6 is amended by redesignating subsection (e) as subsection
7 (f), and inserting after subsection (d) the following new
8 subsection:

9 “(e) ANNUAL REPORT ON INDIANS SERVED BY
10 HEALTH BENEFIT PROGRAMS FUNDED UNDER THIS
11 ACT.—Beginning January 1, 2011, and annually there-
12 after, the Secretary, acting through the Administrator of
13 the Centers for Medicare & Medicaid Services and the Di-
14 rector of the Indian Health Service, shall submit a report
15 to Congress regarding the enrollment and health status
16 of Indians receiving items or services under health benefit
17 programs funded under this Act during the preceding
18 year. Each such report shall include the following:

19 “(1) The total number of Indians enrolled in, or
20 receiving items or services under, such programs,
21 disaggregated with respect to each such program.

22 “(2) The number of Indians described in para-
23 graph (1) that also received health benefits under
24 programs funded by the Indian Health Service.

25 “(3) General information regarding the health
26 status of the Indians described in paragraph (1),

1 disaggregated with respect to specific diseases or
2 conditions and presented in a manner that is con-
3 sistent with protections for privacy of individually
4 identifiable health information under section 264(c)
5 of the Health Insurance Portability and Account-
6 ability Act of 1996.

7 “(4) A detailed statement of the status of facili-
8 ties of the Indian Health Service or an Indian Tribe,
9 Tribal Organization, or an Urban Indian Organiza-
10 tion with respect to such facilities’ compliance with
11 the applicable conditions and requirements of titles
12 XVIII, XIX, and XXI, and, in the case of title XIX
13 or XXI, under a State plan under such title or
14 under waiver authority, and of the progress being
15 made by such facilities (under plans submitted
16 under 1911(b) or otherwise) toward the achievement
17 and maintenance of such compliance.

18 “(5) Such other information as the Secretary
19 determines is appropriate.”.

1 **SEC. 3205. DEVELOPMENT OF RECOMMENDATIONS TO IM-**
2 **PROVE INTERSTATE COORDINATION OF MED-**
3 **ICAID AND SCHIP COVERAGE OF INDIAN**
4 **CHILDREN AND OTHER CHILDREN WHO ARE**
5 **OUTSIDE OF THEIR STATE OF RESIDENCY BE-**
6 **CAUSE OF EDUCATIONAL OR OTHER NEEDS.**

7 (a) STUDY.—The Secretary shall conduct a study to
8 identify barriers to interstate coordination of enrollment
9 and coverage under the Medicaid program under title XIX
10 of the Social Security Act and the State Children’s Health
11 Insurance Program under title XXI of such Act of chil-
12 dren who are eligible for medical assistance or child health
13 assistance under such programs and who, because of edu-
14 cational needs, migration of families, emergency evacu-
15 ations, or otherwise, frequently change their State of resi-
16 dency or otherwise are temporarily present outside of the
17 State of their residency. Such study shall include an exam-
18 ination of the enrollment and coverage coordination issues
19 faced by Indian children who are eligible for medical as-
20 sistance or child health assistance under such programs
21 in their State of residence and who temporarily reside in
22 an out-of-State boarding school or peripheral dormitory
23 funded by the Bureau of Indian Affairs.

24 (b) REPORT.—Not later than 18 months after the
25 date of enactment of this Act, the Secretary, in consulta-
26 tion with directors of State Medicaid programs under title

1 XIX of the Social Security Act and directors of State Chil-
2 dren's Health Insurance Programs under title XXI of such
3 Act, shall submit a report to Congress that contains rec-
4 ommendations for such legislative and administrative ac-
5 tions as the Secretary determines appropriate to address
6 the enrollment and coverage coordination barriers identi-
7 fied through the study required under subsection (a).